General
Dental
Council

HEARING HEARD IN PUBLIC

DOCA, Sorin-Cristian

Registration No: 246852

PROFESSIONAL CONDUCT COMMITTEE

JUNE - SEPTEMBER 2020

Outcome: Erased with immediate suspension

DOCA, Sorin-Cristian, a dentist, DMD Timisoara 2005, was summoned to appear before the Professional Conduct Committee on 29 June 2020 for an inquiry into the following charge:

Charge (as amended on 29 June 2020)

"That being registered as a dentist Sorin-Cristian Doca's fitness to practise is impaired by reason of misconduct in that:

1. Between 20 August 2015 and 25 August 2015, you failed to provide an adequate standard of care to Patient A, in that you:
   a) did not take an updated medical history;
   b) provided a poor standard of root canal treatment at the UR6 in that you:-
      i. did not diagnose the presence of a perforation of the distal root at the UR6;
      ii. did not communicate the inadequacy of the root filling at the UR6 and its poor prognosis;
      iii. did not take any, or any adequate, preoperative and/or postoperative radiographs of the UR6.
   c) did not discuss the full risks and benefits of the proposed treatment in relation to the UR6;
   d) did not provide the patient with all treatment options for the proposed treatment in relation to the UR6;
2. Between 20 August 2015 to 25 August 2015, you failed to obtain informed consent for the treatment provided to Patient A, in relation to the UR6.
3. Between 20 August 2015 to 25 August 2015, you failed to maintain an adequate standard of record keeping in respect of Patient A, in that you did not record:
   a) an updated medical history;
   b) the full risks and benefits of the proposed treatment in relation to the UR6;
   c) all treatment options for the proposed treatment in relation to the UR6;
   d) adequate details of the clinical procedures and assessments carried out during the root filling of UR6;
   e) the presence of a perforation of the distal root at the UR6;
   f) the inadequacy of the root filling at the UR6 and its poor prognosis;

g) the clinical evaluation and/or grade of each radiograph taken.

h) The dose of local anaesthetic administered.

4. From 25 May 2018 to 3 December 2018, you failed to cooperate with an investigation conducted by the GDC, in respect to Patient A, in that you did not provide the GDC with any evidence of your indemnity arrangements.

5. Between 26 February 2016 and 4 May 2018, you failed to provide an adequate standard of care to Patient B, in that you:

a) did not take an updated medical history between 17 March 2017 and 4 May 2018.

b) did not carry out any, or any sufficient, intraoral and extraoral examinations on or around;

i. 11 August 2017;

ii. 07 November 2017;

iii. 12 January 2018.

c) did not carry out any, or any sufficient, Basic Periodontal Examinations ('BPE') between 26 February 2016 and 1 June 2018;

d) Withdrawn

e) took periapical radiographs of insufficient diagnostic quality on: -

i. 08 September 2017;

ii. 15 September 2017;

iii. 13 October 2017;

iv. 08 December 2017;

v. 05 January 2018.

f) did not take any, or any sufficient, periapical radiographs of the lower teeth and bitewing radiographs on or around 26 February 2016 and 01 March 2017.

g) did not adequately assess and/or treat periodontal disease at any or all of the UR8, UR7, UR6, UR5, UR1, UL1, UL3 and UL7;

h) did not discuss the full risks and benefits of the proposed implant treatment between 17 March 2017 and 01 June 2018;

i) did not discuss all treatment options for the proposed implant treatment between 17 March 2017 and 1 June 2018;

j) provided implant treatment, to any or all of the UR1, UL2, UL4, and UL1, which was not clinically indicated, in view of the presence of untreated periodontal disease;

k) did not arrange adequate aftercare, by leaving the patient without continuity of care for their implant treatment, following the appointment on 1 June 2018.

6. Between 26 February 2016 and 1 June 2018, you failed to obtain informed consent for the implant treatment provided to Patient B, in relation to the any or all of the UR1, UL2, UL4, and UL1.

7. Between 26 February 2016 and 4 May 2018, you failed to maintain an adequate standard of record keeping in respect of Patient B's appointments, in that you did not record:

   a) an updated medical history between 17 March 2017 and 4 May 2018;

   b) any, or any adequate, details of intraoral and extraoral examinations undertaken on or around:

      i. 11 August 2017;

      ii. 07 November 2017;

      iii. 12 January 2018.

   c) any, or any adequate, details of pre-treatment investigations in relation to the proposed implant treatment between 1 March 2017 and 1 June 2018;

   d) any, or any adequate, details of BPE assessments between 26 February 2016 and 1 June 2018;

   e) Withdrawn

   f) a clinical evaluation of the periapical radiographs taken between 8 September 2017 and 5 January 2018;

   g) a clinical evaluation of a CBCT scan, and/or obtain a report, on or around 31 March 2017;

   h) the full risks and benefits of the proposed implant treatment between 17 March 2017 and 1 June 2018;

   i) all treatment options for the proposed implant treatment between 17 March 2017 and 1 June 2018;

   j) any, or any adequate, details of the clinical procedures carried out in relation to the placement and restoration of implants between 8 September 2017 and 20 April 2018;

   k) Withdrawn

   l) the dosage of local anaesthetic administered on any or all of 8 September 2017, 24 November 2017, 9 February 2018 and 22 March 2018;

   m) any, or any adequate, details for the long-term maintenance and after care of the implants post 1 June 2018;

   n) any, or any adequate, details in the clinical notes for the appointments on any or all of 28 April 2017, 5 February 2018, 4 May 2018, 18 May 2018 and 24 May 2018;

   o) any, or any adequate, details of the presenting symptoms and/or the clinical reason for prescribing antibiotics on 28 November 2017.

8. Between 5 January 2018 and 16 February 2018, whilst not being registered on the General Dental Council ('GDC') register, you provided dental services to:

a) One or more patients;

b) Patient B, on:

i. 5 January 2018

ii. 12 January 2018;

iii. 5 February 2018;

iv. 9 February 2018;

v. 16 February 2018.

9. From 30 August 2018 to 31 July 2019, you failed to cooperate with an investigation conducted by the GDC, in respect to Patient B, into your fitness to practice, in that you did not provide the GDC with:

a) Details of your employment;

b) Proof of your indemnity arrangements."

Mr Doca was not present and was not represented. On 3 July 2020 the Chairman announced the findings of fact to the Counsel for the GDC:

"This is a Professional Conduct Committee hearing. The members of the Committee, as well as the Legal Adviser and the Committee Secretary, conducted the hearing remotely via Skype in line with Her Majesty's Government's current advice concerning COVID-19. Mr Doca was neither present nor represented in this hearing. Mr Ahmed, Case Presenter for the General Dental Council (GDC) attended via Skype.

Decision on service of notification of hearing

Mr Doca was neither present nor represented in this hearing. Mr Ahmed made an application under Rule 54 of the General Dental Council (Fitness to Practise) Rules 2006 ("the Rules") that the hearing should proceed in Mr Doca's absence. He submitted that the notification of hearing had been served on Mr Doca in accordance with Rules 13 and 65 and that the committee could exercise its discretion to proceed with the hearing.

The Committee had before it a copy of the notification of hearing letter dated 27 May 2020 which was sent by first class post and special delivery to Mr Doca's registered address as it appears in the Dentists Register. It was satisfied that the letter contained all the components necessary such as the date, time and venue (via Skype) in accordance with Rule 13. The Committee noted the Royal Mail track and trace report which showed that the letter was delivered on 3 June 2020, however, the notice was returned to sender as Mr Doca was no longer at that address. The notice of hearing was also sent on 27 May 2020 to Mr Doca via email to an email address which Mr Doca had used previously to corresponded with the GDC in relation to the investigation of the matters now before the Committee. The email enclosed a copy of the notice letter. The Committee also had sight of a GDC record which indicated that the email had not been downloaded.

Having accepted the advice of the Legal Adviser, the Committee was satisfied that the notification of hearing had been served in accordance with Rules 13 and 65.

Decision on proceeding in Mr Doca's absence

Mr Ahmed then made an application under Rule 54 that the hearing should proceed in Mr Doca's absence. The Committee bore in mind that its discretion to proceed with a hearing in these circumstances should be exercised with the utmost care and caution. It took account of Mr Ahmed's submissions and it accepted the advice of the Legal Adviser.

The Committee noted that there was no information from Mr Doca before it in relation to this hearing. Mr Ahmed submitted that several attempts have been made by the GDC to contact Mr Doca via post, email and telephone. Furthermore, Mr Ahmed provided the Committee with a screenshot of a Swiss clinic containing Mr Doca's profile. On 17 June 2020 the GDC emailed the clinic requesting confirmation whether Mr Doca worked at the clinic. No response was received. The Committee found all reasonable efforts had been made to send notification of the hearing to Mr Doca. There was no request from Mr Doca for an adjournment of the hearing. In considering the exercise of its discretion to proceed in his absence the Committee had regard, amongst other things, to the public interest in the expeditious disposal of this case, the potential inconvenience to the witnesses called to attend this hearing and fairness to Mr Doca. The Committee was of the view that adjournment was unlikely to secure Mr Doca's attendance at a future hearing given that he has not engaged with these proceedings at all and was satisfied there was no good reason to inconvenience witnesses. For all these reasons the Committee determined to proceed with the hearing in Mr Doca's absence. In reaching this decision the Committee had full regard to all the principles set out in the case of GMC v Adeogba [2016] EWHC Civ 162 relevant to the exercise of its discretion under Rule 54.

Amendment to the Charge

Mr Ahmed made an application to amend the charge under Rule 18 of the Rules. He applied to amend the wording as follows: Charge 5(a) replace *'1 June'* to *'4 May'* and Charge 7(a) to replace *'1 June'* to *'4 May'*. Mr Ahmed further applied to withdraw Charge 5(d), Charge 7(e) and Charge 7(k).

The Committee accepted the advice of the Legal Adviser. It notes that two of the amendments would have the effect of reducing the period of the relevant allegations and withdrawing of two particulars. In relation to charge 7(k) the Committee waited to hear from the expert before withdrawing this Charge. The Committee was satisfied, having regard to the merits of the case and the fairness of the proceedings, that the proposed amendments can be made without injustice. Therefore, the Committee acceded to Mr Ahmed's application.

The Charge

The allegations relate to three main areas. Firstly, clinical concerns in respect of two patients. Secondly, a failure by Mr Doca to cooperate with two GDC investigations by not providing employment details and proof of indemnity when requested to do so. Thirdly, whilst Mr Doca was unregistered on the GDC Register due to non-payment of his annual retention fee, he provided dental services to patients.

Evidence

The Committee received a witness statement dated 10 April 2019 from Patient A. The Committee found Patient A to be a credible witness and accepted her evidence. It considered that Patient A was honest and that her oral evidence was consistent with her statement.

The Committee received a witness statement dated 08 December 2019 from Patient B. The Committee found that whilst his recall memories had faded over the passage of time it did not undermine the credibility or reliability of his evidence.

The Committee received a witness statement dated from Witness C, an administration assistant at the Practice, dated 16 December 2019. The Committee noted that she provided records from the practice but had not met Mr Doca. However, it considered her oral evidence was of limited additional value to the documents that she had produced.

In considering the allegations against Mr Doca the Committee also relied on statements from three witnesses at the GDC. Witness D and Witness F, case workers at the GDC and Witness E, GDC Registration Manager. The Committee did not hear oral evidence from the witnesses. It adopted their statements and exhibits and accepted that their statements were constructive in reference to records that are kept at the GDC.

The Committee received reports dated 16 April 2019 and 6 January 2020 from Mr Canty, expert witness for the GDC. His written reports and oral evidence were clear. The Committee accepted his evidence and considered that he provided a careful and thorough analysis of the available evidence and presented fair and balanced opinions.

The Committee took account of all the oral and documentary evidence presented in this hearing. It considered the submissions made by Mr Ahmed. The Committee drew no adverse inferences from Mr Doca's absence.

The Committee accepted the advice of the Legal Adviser. In accordance with that advice it considered each head and sub-head of charge separately.

The burden of proving the facts alleged is on the GDC and the standard of proof is the civil standard which is on the balance of probabilities. Mr Doca is not required to prove anything.

I will now announce the Committee's findings in relation to each head of charge:

	PATIENT A
1.(a)	Between 20 August 2015 and 25 August 2015, you failed to provide an adequate standard of care to Patient A, in that you: e) did not take an updated medical history; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1.1 which states: *"You must make and keep complete and accurate patient records, including an up-to-date medical history, each time that you treat patients."* The Committee was satisfied there is a clear duty for Mr Doca to provide an adequate standard of care in taking an updated medical history. The Committee had regard to Patient A's evidence in which she states she does not recall Mr Doca completing a medical history. The Committee also had sight of Patient A's records and noted that there was no evidence of any record of a medical history between the relevant dates. The Committee had regard to Mr Canty's evidence. He was of the view that a medical history ought to have been taken by Mr Doca and confirmed that

	there was nothing to be located within the patient notes. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
1.(b)	Provided a poor standard of root canal treatment at the UR6 in that you:- iv. did not diagnose the presence of a perforation of the distal root at the UR6; **Found Not Proved** The Committee gave the word 'diagnose' its ordinary English meaning. The Committee had regard to Patient A's evidence in which she states that she was not informed of the perforation. The Committee also had sight of Patient A's records and noted that there was no evidence of any diagnosis in the records. However, the Committee had regard to Mr Canty's evidence that the presence of the perforation would have been apparent from the post-operative radiograph that was taken by Mr Doca. Mr Canty also stated that it is possible Mr Doca may have noticed the perforation from having a feel as to how the procedure was going and he mentioned the feel of instrumentation in terms of the measurements, feel of the drill potentially going off course and bleeding. The Committee accepted Mr Canty's evidence and finds that on a balance of probabilities Mr Doca diagnosed the perforation as it was apparent on the radiograph. Accordingly, this charge is found not proved.
1.(b)	ii. did not communicate the inadequacy of the root filling at the UR6 and its poor prognosis; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 3.1.3 which states: *"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."*

	The Committee was satisfied there is a clear duty for Mr Doca to communicate the inadequacy of the root filling at the UR6 and its poor prognosis. The Committee had regard to Patient A's evidence in which she states she does not recall being told of the problem. The Committee also had sight of Patient A's clinical records and noted that there was no evidence of any record to show this was communicated to Patient A. The Committee had regard to Mr Canty's evidence. Mr Canty was not critical of the root canal treatment carried out by Mr Doca. Furthermore, Mr Canty was critical that Mr Doca did not communicate the poor prognosis and the inadequacy of the root filling to the Patient A when he had a duty to do so. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
1.(b)	iii. did not take any, or any adequate, preoperative and/or postoperative radiographs of the UR6. **Found Proved** The Committee had regard to the Ionising Radiation Regulations 1999 & Ionising Radiation (Medical Exposure) Regulations IRMER (2000). The Committee was satisfied there is a clear statutory duty for Mr Doca to carry out appropriate radiographic assessments. <u>Preoperative radiograph(s)</u> The Committee had sight of a preoperative radiograph which had been taken by a previous treating dentist prior to Patient A seeing Mr Doca. It found no evidence of a preoperative radiograph taken by Mr Doca within the patient notes. The Committee had regard to Mr Canty's evidence that he would not be critical of Mr Doca for not taking a preoperative radiograph if he had sight of the radiograph that was taken by the previous treating dentist. However, the previous dentist had taken the radiograph several days prior to Patient A seeing Mr Doca, it was taken in a separate practice and that there in nothing within the radiographs to show that this radiograph had been requested or considered by Mr Doca. The Committee finds that Mr Doca did not take a preoperative radiograph as required. <u>Postoperative radiograph(s)</u> The Committee had sight of a postoperative radiograph that was taken by Mr Doca. However, the Committee had regard to Mr Canty's evidence that this postoperative radiograph was of poor quality, lacked sufficient detail and should have been retaken by Mr Doca. He further stated that the radiograph did not show the full roots of the UR6 together with the completed root filling and that it was of little clinical value except in showing the distal root perforation. The Committee finds that the postoperative

	radiograph is inadequate contrary to the IRMER regulations. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
1.(c) – (d)	(c) Did not discuss the full risks and benefits of the proposed treatment in relation to the UR6; (d) Did not provide the patient with all treatment options for the proposed treatment in relation to the UR6; **Found Proved** The Committee considered charges 1(c) and (d) together. The Committee had regard to the Standards for Dental Professionals, Standard 3.1.3 which is detailed in charge 1(b)(ii) above. The Committee was satisfied there is a clear duty for Mr Doca to discuss the risks and benefits of the proposed treatment and to provide Patient A with all the treatment options. The Committee had regard to Patient A's evidence that Mr Doca did not discuss the full risks and benefits and treatment options in relation to the UR6. It also had regard to the Patient notes and noted there was a complete absence in the records that Mr Doca did this either on the 20 August 2015 when he first saw Patient A or on the 24 August 2015 when he carried out the root canal treatment. The Committee notes the entry of the previous treating dentist that the risks and benefits and options were discussed with the patient A at a separate date. However, Mr Canty confirmed that notwithstanding that this had already been discussed before by the previous dentist, it was Mr Doca's duty to ensure that Patient A was fully informed before progressing with the treatment. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
2.	Between 20 August 2015 to 25 August 2015, you failed to obtain informed consent for the treatment provided to Patient A, in relation to the UR6. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 3.1 which states: *"You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs.* The Committee was satisfied there is a clear duty for Mr Doca to obtain valid consent prior to any treatment. The Committee found in charges 1(c) and (d) above that Mr Doca did not discuss the risks benefits and treatment options. Therefore, Patient A would not have been in a position to give informed consent and Mr Doca failed to obtain informed consent.

	The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
3.	Between 20 August 2015 to 25 August 2015, you failed to maintain an adequate standard of record keeping in respect of Patient A, in that you did not record: i) an updated medical history; The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which states: *"You must make and keep contemporaneous, complete and accurate patient records."* The Committee was satisfied there is a clear duty for Mr Doca to maintain an adequate standard of record keeping. The Committee found in charge 1(a) above that there was no evidence of a medical history contained within Patient A's records. Based on this finding the Committee finds this charge is found proved.
3.(b)-(c)	(b) The full risks and benefits of the proposed treatment in relation to the UR6 (c) All treatment options for the proposed treatment in relation to the UR6; **Found Proved** The Committee considered charges 3(b) and (c) together. The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 1(c) and (d) above that there was no evidence that Mr Doca discussed the full risks and benefits and the treatment options of the proposed treatment. Based on this finding the Committee finds this charge is found proved.
3.(d)	Adequate details of the clinical procedures and assessments carried out during the root filling of UR6; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had regard to Mr Canty's evidence who stated that Mr Doca failed to record adequate details of the clinical procedures and assessments carried out during the root filling of UR6. He stated that he would have expected Mr Doca to have recorded details about whether he attempted to find and navigate the distal buccal root including how this was carried out and any problems which may have arisen in locating or instrumentation of the canals. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.

3.(e)	The presence of a perforation of the distal root at the UR6; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 1(b)(i) above that there was no evidence that Mr Doca recorded his diagnosis of the perforation of the distal root at the UR6. Based on this finding the Committee finds this charge is found proved.
3.(f)	The inadequacy of the root filling at the UR6 and its poor prognosis; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 1(b)(ii) above that there was no evidence that Mr Doca recorded the inadequacy of the root filling at the UR6 and its poor prognosis. Based on this finding the Committee finds this charge is found proved.
3.(g)	The clinical evaluation and/or grade of each radiograph taken. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 1(b)(iii) above that Mr Doca had taken a postoperative radiograph. Mr Canty in his evidence stated that in accordance with IRMER Regulations and the Faculty of General Dental Practitioners (UK) (2009) (FGDP Guidelines) there is a statutory duty on registrants to review and record radiographs. He confirmed that there is no evidence Mr Doca recorded a clinical evaluation or graded the postoperative radiograph. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
3.(h)	The dose of local anaesthetic administered. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had sight of Patient A's records and noted that Mr Doca had recorded which local anaesthetic was given to Patient A but there was no record of the dosage administered. Mr Canty confirmed this in his evidence.

	The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
4.	From 25 May 2018 to 3 December 2018, you failed to cooperate with an investigation conducted by the GDC, in respect to Patient A, in that you did not provide the GDC with any evidence of your indemnity arrangements. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 9.4 which states: *"You must co-operate with any relevant formal or informal inquiry and give full and truthful* information and Standard 9.4.1 which states: *"If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association."* The Committee was satisfied there is a clear duty for Mr Doca to cooperate the GDC investigation. The Committee had regard to the evidence from Witness D, a caseworker at the GDC. Witness D's statement exhibits correspondence between the GDC and Mr Doca during this investigation in regard to Patient A. The GDC sent emails and letters to Mr Doca including the initial notification letter requesting proof of indemnity on 25 May 2018. Further correspondence was sent 22 June 2018, 28 June 2018 and 18 July 2018 all chasing Mr Doca's proof of indemnity arrangements. On 16 November 2018 the GDC informed Mr Doca via letter that the matter was being transferred to the Case Examiner and the GDC received a download receipt for this letter. The Committee noted that Mr Doca did respond via email on 25 May 2018 indicating that he would provide the information requested by the GDC and again on the 28 June 2018 stating that he had moved abroad and that it will take some time for him to respond. Subsequent to these responses there has been no further communication from Mr Doca. The Committee also noted that the initial letters sent by the GDC provided a deadline for the provision of Mr Doca's indemnity arrangements and reminded him of his duty to cooperate with the GDC. It advised Mr Doca that an allegation could be raised that his fitness to practise may be impaired. Accordingly, the Committee finds Mr Doca failed to cooperate with the GDC investigation up until 16 November 2018 during the dates specified by not providing the GDC with evidence of his indemnity arrangements.
	Patient B
5.(a)	Between 26 February 2016 and 4 May 2018, you failed to provide an adequate standard of care to Patient B, in that you: l) did not take an updated medical history between 17 March 2017 and 4 May 2018. **Found Proved**

	The Committee had regard to the Standards for Dental Professionals, Standard 4.1.1 which is detailed in charge 1(a) above. The Committee was satisfied there is a clear duty for Mr Doca to provide an adequate standard of care in taking an updated medical history. The Committee had regard to Patient B's evidence that he was unsure whether a medical history was updated. The Committee also had sight of Patient B's records and noted that an initial medical history was taken by Mr Doca at the appointment on 26 February 2016 and on the 4 May 2018. However, the records show an absence of any medical history taken in between those dates. The Committee had regard to Mr Canty's evidence. He was of the view that a medical history ought to have been updated by Mr Doca during that intervening period and particularly at the outset of courses of treatment. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(b)	Did not carry out any, or any sufficient, intraoral and extraoral examinations on or around; iv. 11 August 2017; v. 07 November 2017; vi. 12 January 2018. **Found Proved in its entirety** The Committee had regard to Patient B's evidence in which he states that he remembers having a routine examination at the start and was unable to recall anymore. The Committee had regard to Mr Canty's evidence that a full examination was carried out by Mr Doca at the initial appointment on 26 February 2016. He referred to this as an example of what should take place and what should be recorded in accordance with FGDP (UK) Guidance 2016. Mr Canty confirmed that apart from the initial appointment he was unable to find any record that a full intra oral and extra oral examination of the soft and hard tissues was carried out and particularly on 11 August 2017, 07 November 2017 and 12 January 2018 when it appeared to him that courses of treatment commenced. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(c)	Did not carry out any, or any sufficient, Basic Periodontal Examinations ('BPE') between 26 February 2016 and 1 June 2018; **Found Proved** The Committee had regard to Mr Canty's evidence that there is no record Mr Doca carried out a BPE of any type during the period under review. He further stated that within the records the previous treating dentist had recorded a scoring mainly twos and threes. Mr Canty stated that BPEs

	should be recorded at every routine examination. Therefore, given the previous scoring and that this was a two year period, it would have been expected for Mr Doca to carry out a BPE. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(d)	***Withdrawn***
5.(e)	Took periapical radiographs of insufficient diagnostic quality on: - vi. 08 September 2017; vii. 15 September 2017; viii. 13 October 2017; ix. 08 December 2017; x. 05 January 2018. **Found Proved** The Committee had regard to the IRMER. (2000). Ionising Radiation Regulations 1999 & Ionising Radiation (Medical Exposure) Regulations. The Committee was satisfied there is a clear duty for Mr Doca to carry out appropriate radiographic assessments. The Committee had regard to Mr Canty's evidence. He was able to locate six periapical radiographs that were taken by Mr Doca. However, Mr Canty was of the view that these were of poor quality. During his oral evidence Mr Canty referred the Committee to the radiographs and it demonstrated that two radiographs were coned off with incomplete images of the target area and 4 radiographs were significantly distorted and elongated. Mr Canty stated that the radiographs did not show a complete view of the teeth, the roots, the implants and surrounding bone area. He stated that the radiographs were of little clinical use and should have been retaken. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(f)	Did not take any, or any sufficient, periapical radiographs of the lower teeth and bitewing radiographs on or around 26 February 2016 and 01 March 2017. **Found Proved** The Committee had regard to the IRMER. (2000). Ionising Radiation Regulations 1999 & Ionising Radiation (Medical Exposure) Regulations. The Committee was satisfied there is a clear duty for Mr Doca to carry out appropriate radiographic assessments. The Committee had regard to Mr Canty's evidence. He reviewed Patient B's records and was of the view that there were no bitewing radiographs taken nor periapical radiographs of the lower teeth. Mr Canty indicated that in view of the implant treatment proposed, a radiograph of the lower teeth

	should have been taken prior to any treatment in order to carry out a proper assessment of the oral health condition of the teeth and jaws. Mr Canty stated that Patient B presented as a medium caries risk and was of the view that bitewing radiographs should have been taken at the very least at 12 month intervals notwithstanding prior to any implant treatment. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(g)	Did not adequately assess and/or treat periodontal disease at any or all of the UR8, UR7, UR6, UR5, UR1, UL1, UL3 and UL7; **Found Proved** The Committee had regard to Mr Canty's evidence. He reviewed Patient B's records and noted from the subsequent treating dentist notes on 29 June 2018 that Patient B had chronic periodontitis for some time with heavy calculus present also. Mr Canty stated that this would have been evident nine months earlier when Mr Doca began the placement of the implants in September 2017. Mr Canty further stated that in terms of assessment and treatment, Patient B's clinical records show that Mr Doca carried out a full examination of the soft and hard tissues of the initial appointment on 26 February 2016 and recorded Patient B's hygiene as good and periodontal risk was low. It was recorded that on 1 March 2016 a scaling and polishing was carried out which indicated the presence of calculus. However, Mr Canty informed the Committee that this was not adequate to treat the periodontal disease. There is no record of any BPEs or a more detailed periodontal assessment carried out, further scaling and polishing appointments recorded, or any advice given on oral hygiene to Patient B. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(h)-(i)	(h) Did not discuss the full risks and benefits of the proposed implant treatment between 17 March 2017 and 01 June 2018 (i) Did not discuss all treatment options for the proposed implant treatment between 17 March 2017 and 1 June 2018; **Found Proved** The Committee considered charges 5(h) and (i) together. The Committee had regard to the Standards for Dental Professionals, Standard 3.1.3 which is detailed in charge 1(b)(ii) above. The Committee was satisfied there is a clear duty for Mr Doca to discuss the risks and benefits of the proposed treatment and to provide Patient B with all the treatment options. The Committee had regard to Patient B's evidence that apart from Mr Doca indicating to him that he was suitable for implant treatment, there was no discussion about risk and benefits or treatment options. The Committee also had regard to Patient B's records and noted there was

	a complete absence in the records that Mr Doca did this. This was confirmed by Mr Canty who stated that in view of the complicated nature of the treatment which included implants, these are details that should have been discussed with Patient B. Mr Canty did identify that two treatment plans had been provided by Mr Doca to Patient B but they only contained the basic details of the proposed treatment and the costs associated. Mr Canty stated that these were not sufficient to provide Patient B with the information required. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(j)	Provided implant treatment, to any or all of the UR1, UL2, UL4, and UL1, which was not clinically indicated, in view of the presence of untreated periodontal disease; **Found Proved** The Committee found in charge 5.(g) above that Mr Doca did not adequately assess or treat patient B's periodontal disease. It noted from Patient B's records that Mr Doca provided implant treatment to at least UR1, UL2 and UL4 according to the manufacturers labels. The Committee had regard to Mr Canty's evidence who stated that the presence of periodontal disease would have been apparent to Mr Doca prior to the implant treatment being started and that the treatment should not have started until the periodontal disease has been treated successfully reviewed and maintained. Mr Canty stated that due to this it was not clinically indicated to commence implant treatment as there was an increase in the failure rate of the implants. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
5.(k)	Did not arrange adequate aftercare, by leaving the patient without continuity of care for their implant treatment, following the appointment on 1 June 2018. **Found Proved** The Committee had regard to Patient B's evidence who stated that he was informed by Mr Doca in March 2018 that he was due to leave the practice in May 2018. He further stated that Mr Doca told him that his treatment should be completed prior to his resignation taking effect or make arrangement from him to be referred to see another dentist. The Committee had sight of Mr Doca's resignation letter which indicates that he left on 1 June 2018 to take up a job opportunity abroad. The Committee had regard to Mr Canty's evidence that it is Mr Doca's responsibility to ensure the continuity of after care. Subsequent to Mr Doca's departure from the practice the Committee could see no evidence that Mr Doca left any correspondence demonstrating that care should be provided by a specific dentist or practice. Furthermore, there was no evidence within Patient B's records indicating what treatment had

	commenced, what treatment was outstanding and what treatment was required. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
6.	Between 26 February 2016 and 1 June 2018, you failed to obtain informed consent for the implant treatment provided to Patient B, in relation to the any or all of the UR1, UL2, UL4, and UL1. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 3.1 which is detailed in charge 2 above. The Committee was satisfied there is a clear duty for Mr Doca to obtain valid consent prior to any treatment. The Committee found in charges 5(h) and (i) above that Mr Doca did not discuss the risks benefits and treatment options. Therefore, Patient B would not have been in a position to give informed consent and therefore Mr Doca failed to obtain informed consent. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
7.(a)	Between 26 February 2016 and 4 May 2018, you failed to maintain an adequate standard of record keeping in respect of Patient B's appointments, in that you did not record: a) an updated medical history between 17 March 2017 and 4 May 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. The Committee was satisfied there is a clear duty for Mr Doca to maintain an adequate standard of record keeping. The Committee found in charge 5(a) above that there was no evidence of a medical history within Patient A's records between these dates. Based on this finding the Committee finds this charge is found proved.
7.(b)	Any, or any adequate, details of intraoral and extraoral examinations undertaken on or around: iv. 11 August 2017; v. 07 November 2017; vi. 12 January 2018. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. The Committee was satisfied there is a clear duty for Mr Doca to maintain an adequate

	standard of record keeping. The Committee found in charge 5(b) above that there was no evidence within the patient records of any details of intraoral and extraoral examinations undertaken on the dates specified in the charge. Based on this finding the Committee finds this charge is found proved.
7.(c)	Any, or any adequate, details of pre-treatment investigations in relation to the proposed implant treatment between 1 March 2017 and 1 June 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. The Committee was satisfied there is a clear duty for Mr Doca to maintain an adequate standard of record keeping. The Committee had sight of Patient B's records and noted that there was no evidence of any writing up of radiographs, no records of BPEs, no study models and no records of any pre-treatment investigations during that period. This was confirmed by Mr Canty's evidence who stated that Mr Doca failed to record full assessments as part of planning and carrying out implant treatment. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
7.(d)	Any, or any adequate, details of BPE assessments between 26 February 2016 and 1 June 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. The Committee was satisfied there is a clear duty for Mr Doca to maintain an adequate standard of record keeping. The Committee found in charge 5(c) above that there was no evidence within the patient records of any BPE assessments undertaken between the dates specified in the charge. Based on this finding the Committee finds this charge is found proved.
7.(e)	***Withdrawn***
7.(f)	A clinical evaluation of the periapical radiographs taken between 8 September 2017 and 5 January 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 5(e) above that Mr Doca had taken six periapical radiographs. Mr Canty in his evidence stated that in accordance with IRMER Regulations there is a statutory duty on registrants to review and report radiographs. He confirmed that there is no evidence Mr Doca

	recorded a clinical evaluation. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
7.(g)	A clinical evaluation of a CBCT scan, and/or obtain a report, on or around 31 March 2017; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had regard to Mr Canty's evidence that sometimes the scan service will provide a report for a fee but there is no record of a report by the service or Mr Doca within Patient B's notes in accordance with IRMER Regulations. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
7.(h)-(i)	(h) The full risks and benefits of the proposed implant treatment between 17 March 2017 and 1 June 2018; (i) All treatment options for the proposed implant treatment between 17 March 2017 and 1 June 2018; **Found Proved** The Committee considered charges 7(h) and (i) together. The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charges 5(h) and (i) above that there was no evidence recorded in the patient notes that Mr Doca discussed the full risks and benefits and the treatment options of the proposed treatment. Based on this finding the Committee finds this charge is found proved.
7.(j)	Any, or any adequate, details of the clinical procedures carried out in relation to the placement and restoration of implants between 8 September 2017 and 20 April 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had regard to Patient B's records and noted that there were some details in the clinical notes. It also had regard to Mr Canty's evidence who stated that the records were inadequate and lacked basic details regarding the surgical procedure. The Committee accepted the evidence before it. Accordingly, on a balance

	of probabilities, it finds this charge is found proved.
7.(k)	***Withdrawn***
7.(l)	The dosage of local anaesthetic administered on any or all of 8 September 2017, 24 November 2017, 9 February 2018 and 22 March 2018 **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had sight of Patient B's records and noted there is no records of the dosage administered. It also had regard to Mr Canty's evidence that on 8 September 2017, 24 November 2017, 09 February 2018 and 22 March 2018 Mr Doca recorded the basic information expected has been adequately recorded with the exception of the dosage of the local anaesthetic that was administered. The Committee accepted the evidence before it. Accordingly, on a balance of probabilities, it finds this charge is found proved.
7.(m)	Any, or any adequate, details for the long-term maintenance and after care of the implants post 1 June 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee found in charge 5.(k) above that Mr Doca had recorded that Patient B was to be referred to another practice. However, when Mr Doca left the practice, the Committee could see no evidence that he had created a referral letter or recorded what treatment had commenced, what treatment was outstanding and what treatment was required. The Committee accepted the evidence before it and finds on a balance of probabilities that Mr Doca had failed to record any adequate details for the long-term maintenance and after care of the implants.
7.(n)	Any, or any adequate, details in the clinical notes for the appointments on any or all of 28 April 2017, 5 February 2018, 4 May 2018, 18 May 2018 and 24 May 2018; **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had regard to the Patient B's records and noted that on the appointment of 4 May 2018 there is a reference to medical history updated but no other information was recorded by Mr Doca. For all the other appointments there are no clinical notes recorded in Patient B's records. The Committee was also provided with an appointment history from

	Witness C which confirms that all the specified dates in the charge were attended. The Committee accepted the evidence before it and finds on a balance of probabilities that Mr Doca had failed to adequately record details in the clinical notes specified.
7.(o)	Any, or any adequate, details of the presenting symptoms and/or the clinical reason for prescribing antibiotics on 28 November 2017. **Found Proved** The Committee had regard to the Standards for Dental Professionals, Standard 4.1 which is detailed in charge 3(a) above. It is satisfied there is a clear duty for Mr Doca to maintain adequate record keeping. The Committee had sight of Patient B's records and noted Mr Doca had made an entry that Patient B had attended for a review and swelling was identified in his mouth. A prescription was given for Metronidazole 500mg x 21 tablets. The Committee also had regard to Mr Canty's evidence that Mr Doca had failed to record adequate details of Patient B's presenting symptoms and justification for prescribing Metronidazole 500mg. The Committee accepted the evidence before it and finds on a balance of probabilities that Mr Doca had failed to adequately record details of the presenting symptoms and the clinical reason for prescribing the Metronidazole.
8.(a)	Between 5 January 2018 and 16 February 2018, whilst not being registered on the General Dental Council ('GDC') register, you provided dental services to: c) One or more patients; d) Patient B, on: vi. 5 January 2018 vii. 12 January 2018; viii. 5 February 2018; ix. 9 February 2018; x. 16 February 2018. **Found Proved in its entirety** The Committee had regard to Witness E, GDC Registrations Manager. Witness E's statement indicates that Mr Doca was removed from the GDC Register for non-payment of his annual retention fee on 5 January 2018. A letter was sent by the GDC to Mr Doca confirming this. Mr Doca did contact the GDC on 2 January 2018 and was advised that because he had missed the deadline he would need to make an application for restoration. Mr Doca subsequently made an application but was refused by the GDC as it did not contain all relevant information. Eventually, Mr Doca submitted his

	application, payment was received, and he was restored to the GDC register on 15 March 2018. a) One or more patients; The Committee had regard to Witness C's statement who confirmed that Mr Doca had been employed as a self-employed associate dentist full time working 40 hours a week. In particular Witness C confirmed that between 4 January 2018 and 16 February 2018, Mr Doca was employed by the practice and was treating patients. In support of this Witness C provided a work diary which showed Mr Doca was treating patients between those dates. b) Patient B, on: i. 5 January 2018 ii. 12 January 2018; iii. 5 February 2018; iv. 9 February 2018; v. 16 February 2018. Witness C also confirmed that Patient B was treated by Mr Doca on 5 January 2018, 12 January 2018, 9 February 2018 and 16 February 2018. The Committee also had regard to the working day lists and the patient notes to corroborate this evidence. The Committee accepted the evidence before it and finds on a balance of probabilities that Mr Doca provided dental services whilst not being registered on the GDC register.
9.(a)	From 30 August 2018 to 31 July 2019, you failed to cooperate with an investigation conducted by the GDC, in respect to Patient B, into your fitness to practice, in that you did not provide the GDC with: c) Details of your employment; d) Proof of your indemnity arrangements." **Found Proved in its entirety** The Committee had regard to the Standards for Dental Professionals, Standard 9.4 and 9.4.1 which is detailed above in charge 4. The Committee was satisfied there is a clear duty for Mr Doca to cooperate the GDC investigation. The Committee had regard to the evidence from Witness F, a caseworker at the GDC. Witness F's statement exhibits correspondence between the GDC and Mr Doca during the relevant dates. The GDC sent the first initial notification on 30 August 2018 requesting proof of employment and indemnity. The Committee noted that the initial letter sent by the GDC provided a deadline for the provision of the details requested and reminded him of his duty to cooperate with the GDC. It advised Mr Doca that an allegation could be raised that his fitness to practise may be impaired. A

	further chaser letter was sent via email on 2 November 2018 reminding Mr Doca of his duty to cooperate. No response was received from Mr Doca. Further correspondence was sent by the GDC to Mr Doca on 21 March 2019, 14 May 2019, 24 May 2019 and 10 June 2019, 9 July 2019 and 31 July 2019. Witness F's statement confirmed that Mr Doca did not make any contact with the GDC during that period albeit there was a download receipt which indicated that some of the correspondence had been downloaded in Switzerland. The Committee accepted the evidence before it and finds on a balance of probabilities that Mr Doca failed to cooperate with the GDC investigation during the dates specified by not providing the GDC with evidence of his employment details and indemnity arrangements.

We move to Stage Two."

On 3 July 2020 the hearing adjourned part heard and resumed on 1 September 2020.

On 2 September 2020 the Chairman announced the determination as follows:

"The hearing adjourned part-heard on 3 July 2020 upon the announcement of the findings of fact. The Committee resumed today at Stage two of the hearing with a time estimate of two days (1-2 September 2020).

Mr Ahmed appeared for the General Dental Council (GDC) prior to the hearing adjourning in July 2020. Ms Headley now appears for the GDC at the resumption of the hearing. Mr Doca remains neither present nor represented at the hearing.

Service and absence

Ms Headley submitted that notification of the resumption of this hearing had been served on Mr Doca and that the hearing should continue to proceed in his absence.

The Committee accepted the advice of the Legal Adviser.

The Committee was satisfied that the notification of the hearing dated 17 August 2020 contained the information particularised under Rule 13 of the General Dental Council (Fitness to Practise) Rules 2006 (the "Rules"), including the time, date and (remote) venue of this hearing. This is a continuation of the initial hearing which adjourned part-heard on 3 July 2020 and not a resumed hearing for the purposes of the Rules (and so Rule 28 is not engaged).

The notification advised Mr Doca of the Committee's power to proceed in his absence and warned him that: "*If you do not attend the hearing this is likely to be severely prejudicial to your case and may lead to a more severe sanction being imposed by the Committee*". The notification also urged Mr Doca to seek independent legal advice and provided Mr Doca with the contact details for LawWorks and also the Bar Council, in terms of seeking pro bono representation.

The notification was sent to Mr Doca by email only on 17 August 2020. On 25 August 2020 Mr Evans, one of the lawyers at the GDC, emailed Mr Doca to follow up the notification of hearing and to ask Mr Doca to confirm whether he would be attending the hearing. Mr Doca

replied the same day with a holding response. At 9:41 on 26 August 2020 Mr Doca emailed Mr Evans to state: "*I would like to confirm that I will not be attending the hearing on the 7th of September, nor will I have legal representation or demand postponing. I also don't have any documents to submit, as I do not have any of my previous files.*" Both the notification of hearing and the email from Mr Evans very clearly stated that the hearing was listed for 1-2 September 2020. The Committee was therefore satisfied that reference to "*7th September*" in Mr Doca's reply was a typographical error, rather than there being any actual confusion over the date of the hearing.

Mr Evans replied at 10:07 on 26 August 2020 to clarify with Mr Doca whether he needed to be forwarded any copies of documents sent to him previously. Mr Evans also quoted guidance for Mr Doca on Mr Doca's ability to give evidence under oath to the Committee and/or to make submissions on the questions of impairment and sanction. Mr Doca replied at 11:15 to state: "*Thank you for this, but I really don't think any of it would make a difference. As you mentioned that you had inside information from my previous employers, I'm sure they were happy to put everything on me. But, unfortunately, I don't have any documents to submit.*"

No further communication from Mr Doca is before the Committee.

The Committee was satisfied that Mr Doca was aware of the resumption of the hearing today. The Committee's findings of fact determination had been served on him. He has been given sufficient notice to provide any documentary evidence or written submissions on which he wants to rely at Stage two. He has been given sufficient notice to attend this hearing by video link. There is no application from him for a postponement. There is nothing before the Committee to suggest that an adjournment would make his attendance any more likely in the future. He has not attended the hearing so far. There has been only limited engagement from him by email in respect of these proceedings. His most recent emails on 26 August 2020 made clear that he does not intend to attend the hearing now at Stage two. The Committee was therefore satisfied that Mr Doca had voluntarily absented himself and that it would be fair and in the public interest to proceed with the hearing, notwithstanding his absence.

Stage two

Ms Headley submitted that the facts found proved amount to misconduct, addressing the Committee in terms of three aspects of misconduct: the clinical failings; the period of unregistered practice; and non-cooperation with the GDC investigations. Ms Headley submitted that Mr Doca's fitness to practise is currently impaired by reason of his misconduct and, although it is not a submission which the GDC makes lightly, erasure is the only appropriate outcome in this case.

The Committee accepted the advice of the Legal Adviser.

The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016, last revised May 2019) (the "ISG").

Stage two of these proceedings carries no burden standard of proof: the questions of misconduct, impairment and sanction are matters entirely for the professional judgement of the committee.

Misconduct

Misconduct is a serious departure from the standards reasonably expected of a dental professional. It can be characterised as negligence or incompetence to a high degree, or conduct which fellow members of the profession would regard as deplorable.

In assessing whether the facts found proved amount to misconduct, the Committee had regard to the following principles from *Standards for the Dental Team* (September 2013):

> 1.4 You must take a holistic and preventative approach to patient care which is appropriate to the individual patient
>
> 2.3 You must give patients the information they need, in a way they can understand, so that they can make informed decisions
>
> 3.1 You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs
>
> 3.3 You must make sure that the patient's consent remains valid at each stage of investigation or treatment
>
> 4.1 You must make and keep contemporaneous, complete and accurate patient records
>
> 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.
>
> 4.1.2 You should record as much detail as possible about the discussions you have with your patients, including evidence that valid consent has been obtained. You should also include details of any particular patient's treatment needs where appropriate.
>
> 4.1.6 If you refer a patient to another dental professional or other health professional, you must make an accurate record of this referral in the patient's notes and include a written prescription when necessary.
>
> 6.3.5 If you need to refer a patient to someone else for treatment, you must explain the referral process to the patient and make sure that it is recorded in their notes.
>
> 7.1 You must provide good quality care based on current evidence and authoritative guidance
>
> 7.2 You must work within your knowledge, skills, professional competence and abilities
>
> 9.4 You must co-operate with any relevant formal or informal inquiry and give full and truthful information
>
> 9.4.1 If you receive a letter from the GDC in connection with concerns about your fitness to practise, you must respond fully within the time specified in the letter. You should also seek advice from your indemnity provider or professional association

The Committee also had regard to the British Society of Periodontology Guidelines and to the Faculty of General Dental Practitioners Good Practice Guidelines on Clinical Examination and Record-Keeping.

The Committee's findings of fact fall into three categories: (i) Mr Doca's clinical care and treatment of Patients A and B; (ii) his continuing to treat patients (including Patient B) for a period of approximately 2 months without GDC registration; and (iii) his non-cooperation with two GDC investigations. The Committee considered the question of misconduct in respect of each of these areas.

Clinical care and treatment: The relevant period of treatment was five days for Patient A and over two years for Patient B. There were similar failings in the care and treatment for both patients, including failure to obtain the informed consent of each patient for the treatment provided (by failing to discuss the risks, benefits and treatment options), failures in record keeping, failures in radiography and failures to take an updated medical history. The Committee accepted the opinion of Mr Canty, the GDC instructed expert witness, that Mr Doca's failings fell far below the standards reasonably expected of him and that those failings exposed each patient to an unwarranted risk of harm. These were failings in basic and elementary aspects of dental practice.

In respect of Mr Doca's radiography failings, these were also in breach of statutory requirements under the Ionising Radiation Regulations 1999 & Ionising Radiation (Medical Exposure) Regulations IRMER (2000).

In respect of Patient A, the Committee found a poor standard of root canal treatment.

In respect of Patient B, the Committee viewed as particularly serious Mr Doca's fundamental failure to assess and treat the patient's extensive periodontal disease before placing implants.

The Committee was satisfied that Mr Doca's clinical failings amount to misconduct.

Unregistered practice: Mr Doca was removed from the GDC Register on 5 January 2018, as he had failed to pay his annual retention fee (ARF) to renew his registration for 2018. He contacted the GDC on 2 January 2018 about his registration and was advised that because he had missed the deadline of 31 December 2017 and he would need to make an application for restoration. Mr Doca subsequently made an application and was ultimately restored to the Register on 15 March 2018. The removal of his name from the Register for non-payment of the ARF was purely administrative. The issue before the Committee was that Mr Doca continued to treat patients whilst unregistered. He treated Patient B on five occasions between 5 January 2018 and 16 February 2018 and also treated other patients during that period of approximately 2 months. This was a most serious breach of GDC standards. It undermined the role of the GDC and its scheme of professional registration. It was also unlawful to practise dentistry without GDC registration as highlighted in the Removal Notice sent to Mr Doca dated 12 January 2018 and in the Return of Application letter dated 26 January 2018. Further, Mr Doca's indemnity arrangements were likely to be invalid during the period he was practising without GDC registration, including his treatment of Patient B during the period.

The Committee was satisfied that Mr Doca's conduct in continuing to treat patients after his registration had lapsed was serious and that it amounts to misconduct.

Non-cooperation with the GDC investigations: Mr Doca failed to cooperate with the GDC's two ensuing investigations into his fitness to practise in respect of his care and treatment of Patients A and B respectively. Despite numerous formal requests from the GDC, Mr Doca failed to provide the GDC with details of his indemnity arrangements in relation to Patient A and details of his employment details and indemnity arrangements in relation to Patient B. As with his period of practising without GDC registration, such conduct undermines the important regulatory role of the GDC in being able to adequately investigate fitness to practise concerns. The Committee was satisfied that Mr Doca's failures to cooperate with the two GDC investigations were particularly serious and amount to misconduct.

Accordingly, there have been significant breaches of the above quoted standards and the Committee determined that the facts found proved amount to misconduct in respect of each of the three categories.

Impairment

The Committee considered whether Mr Doca's misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public interest, which includes the need to uphold and declare appropriate standards of conduct and behaviour, so as to maintain public confidence in the profession and this regulatory process. The Committee had regard to the overarching principles summarised at paragraph 5.11 of the ISG:

> The PCC exists to protect the public interest, which includes:
>
> - protecting patients, colleagues and the wider public from the risk of harm;
> - maintaining public confidence in the dental profession;
> - upholding the reputation of the dental professions; and
> - declaring and upholding appropriate standards of conduct and competence among dental professionals.

In the Committee's judgment, some of Mr Doca's clinical failings were basic and elemental. They were departures from basic standards which even a newly qualified dentist would be able to demonstrate. All of the clinical failings identified in this case are remediable through reflection, learning and embedded improvement in practice. However, Mr Doca demonstrates no remediation whatsoever. He provides no evidence to suggest that he has taken any steps to acknowledge and address his failings. These were not isolated failings but were repeated. In the case of Patient B, the failings continued for over 2 years. Mr Doca's care and treatment of Patient A only extended over 5 days, but there were in some respects thematically similar failings over that short period to those demonstrated over a longer period in respect of Patient B. The failings put both patients at unwarranted risk of harm. In respect of Patient B in particular, Mr Doca's placing of implants without first assessing and treating the corresponding periodontal disease was an extremely serious failing which exposed the patient to a significant risk of harm in respect of the implant treatment, which was a complex and invasive surgical procedure that was not clinically indicated.

Mr Doca's period of unregistered practice was also particularly serious in the Committee's judgment. Any patient would be alarmed and deeply concerned to learn that the dentist treating them was not registered with the GDC. Mr Doca's conduct demonstrated a blatant disregard for the regulatory role of the GDC and the importance of GDC registration. He has demonstrated conduct which is likely to seriously undermine public confidence in the profession and in the GDC as the regulator, aggravated by the fact that he had also previously practised without GDC registration. His treating patients whilst unregistered was also in breach of the law and likely meant that any indemnity arrangements he had would not have been valid during the period of his unregistered practice.

Mr Doca's failure to cooperate with two ensuing GDC investigations also demonstrated a blatant disregard for the role of the GDC and was conduct which is likely to undermine public confidence in the profession and in the GDC as regulator.

The Committee has not received any evidence that Mr Doca has taken any remediable steps to address any aspect of his misconduct, nor has it seen any evidence of insight into his misconduct. The only engagement from Mr Doca are intermittent emails and in the latest email he appears to attempt to deflect blame to his previous employer. There remains a real risk of repetition should he be allowed to practise without restriction, and, consequently, a risk of harm to the public. In the absence of any evidence of insight or reflection, a finding of impairment is also necessary to maintain public confidence in the profession and this regulatory process. There have been breaches of fundamental standards. There is a clear need in the circumstances of this case to declare and uphold proper standards.

The Committee therefore determined that Mr Doca's fitness to practise as a dentist is currently impaired on both public protection and wider public interest grounds.

Sanction

The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public interest, as described in paragraph 5.11 of the ISG, as set out above. In reaching its decision, the Committee applied the principle of proportionality, balancing the public interest with Mr Doca's interests.

The Committee balanced the aggravating and mitigating factors in this case.

In mitigation, the Committee accepted that Mr Doca is of previous good character. The Committee also noted the passage of time which has elapsed since the incidents.

The aggravating features in this case are as follows:

a. There was a risk of harm to both patients.

b. Misconduct sustained or repeated over a period of time. The failures in respect of Patient B occurred over a two year period. Some of the failings in respect of Patient A were thematically similar to those involving Patient B. The non-cooperation with the GDC occurred over a sustained period.

c. Blatant or wilful disregard of the role of the GDC and the systems regulating the profession. This was particularly apparent to the Committee through Mr Doca's treating patients whilst not registered and his failures to cooperate with the GDC investigations.

d. Lack of insight.

As to insight, the Committee reminded itself of the importance of insight in these regulatory proceedings, as discussed at paragraph 5.22 of the ISG:

> In the context of a hearing, insight on the part of the dental professional is an important factor. Insight might be defined as an expectation that they will be able to:
>
> - review their own performance or conduct;
> - recognise that they should have behaved differently in the circumstances being considered; and
> - identify and put in place measures that will prevent a recurrence of such circumstances.

The Committee considered each sanction in ascending order of severity.

First, to conclude this case with no further action or a reprimand would be wholly inappropriate. The Committee had regard to the factors which might make a reprimand the appropriate sanction and determined that a reprimand would not be sufficient to mark the

seriousness of the misconduct in this case. The Committee accepted Ms Headley's submission that a reprimand would be unduly lenient and offers no protection to the public.

The Committee next considered conditions of practice. The Committee could not be satisfied that Mr Doca would comply with any conditions on his registration, owing to his lack of engagement and the fact that two areas of his misconduct relate to treating patients without GDC registration and non-cooperation with the GDC investigations. He has demonstrated a total disregard for the GDC as a regulator. Further, the Committee does not know Mr Doca's current address and whether he is practising in the United Kingdom. The evidence before the Committee indicates that Mr Doca is now practising in another country. For these reasons, the Committee concluded that conditions of practice would not be workable. In any event, conditions of practice would not be sufficient to mark the seriousness of Mr Doca's misconduct, nor would they adequately protect the public.

The Committee next considered whether to direct that Mr Doca's registration be suspended for a period of up to 12 months with a review. A number of the factors indicated in the ISG for suspension are present in this case, except for the final bullet point: "there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)".

The Committee also had regard to the following factors indicated in support of erasure:

serious departure(s) from the relevant professional standards;

where a continuing risk of serious harm to patients or other persons is identified;

a persistent lack of insight into the seriousness of actions or their consequences.

The Committee was satisfied that each of these factors was present to a substantial degree. The Committee was also satisfied that there is evidence of professional attitudinal problems. Mr Doca continued to treat patients without GDC registration and then failed to cooperate with two GDC investigations over a substantial period of time. He shows no evidence of insight and reflection. There is no evidence before the Committee to suggest that he would demonstrate any insight and reflection following a period of suspension in order to remediate such failings. Having regard to all the circumstances, the Committee was satisfied that he has demonstrated a pattern of behaviour which is fundamentally incompatible with his remaining on the Register. No lesser sanction than erasure would meet the statutory purpose of both declaring and upholding appropriate standards of conduct among dental professionals, and maintaining public confidence in the dental profession.

Accordingly, the Committee directs that the name of Sorin-Cristian Doca be erased from the Register.

The Committee now invites submissions on the question of an immediate order.

The interim order on Mr Doca's registration is hereby revoked.

Ms Headley applied for an immediate order of suspension under section 30(1) of the Dentists Act 1984 on the basis that such an order is necessary for the protection of the public and is otherwise in the public interest.

The Committee accepted the advice of the Legal Adviser.

The Committee was satisfied that it is necessary for the protection of the public and is otherwise in the public interest to make an immediate order of suspension. The Committee has determined that Mr Doca demonstrates no insight or remediation into his serious failings. There is therefore a real risk of repetition which puts patients at risk of harm. Further, he has demonstrated a blatant disregard for the role of the GDC and the systems regulating the profession. It would be inconsistent with the Committee's determination on erasure not to make an immediate order.

The effect of this order is that Mr Doca's registration is immediately suspended from when notification of this order is served on him. Unless he exercises his right of appeal, his name will be erased from the Register on the expiry of his 28 day appeal period. Should he exercise his right of appeal, this immediate order will remain in force pending the disposal of the appeal.

That concludes the hearing."