Dental Professionals Hearings Service

PUBLIC DETERMINATION

Professional Conduct Committee
Initial Hearing

27 – 29 January 2025

Name:	**BIGU, Ildiko**	
Registration number:	281487	
Case number:	CAS-205996-Q3B4W6	
General Dental Council:	Reka Hollos, Counsel Instructed by IHLPS	
Registrant:	Present Represented by Scott Ivill, Counsel Instructed by MDDUS	
Fitness to practise:	Misconduct found, not currently impaired	
Committee members:	Marnie Hayward Stephanie Yarwood James Hurden	(Chair, Dental Care Professional member) (Dentist member) (Lay member)
Legal adviser:	Melissa Coutino	
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 hybrid hearing at the General Dental Council's (GDC) London offices located at 37 Wimpole Street, London for Monday 27 January 2025. The remainder of the hearing was conducted remotely via Microsoft Teams.

2. You were present at the hearing and represented by Mr Scott Ivill, Counsel, instructed by the MDDUS.

3. Ms Reka Hollos, Counsel, appeared as Case Presenter on behalf of the GDC.

<u>Charges</u>

4. The charges being considered by the Committee, as detailed in the Notice of Hearing, dated 28 November 2024, are as follows:

   'That being registered as a dentist Ildiko Bigu's (281487) fitness to practise is impaired by reason of misconduct. In that:

   1. You failed to provide an adequate standard of care to Patient A from 10 March 2021 to 8 November 2021 in that you:

      (a) did not accurately diagnose Patient A's level of dental disease and/or restorative needs;
      (b) did not take bitewing radiographs with the frequency required in light of Patient A's risk of caries;
      (c) did not offer Patient A the crown treatment for UR5 as part of an NHS course of treatment.

   2. Your conduct in relation to 1(c) lacked integrity.

   3. You failed to obtain informed consent from Patient A in relation to the treatment of:

      (a) his UR5; and/or
      (b) his UL6 and UR4.'

5. At the outset of the hearing, Mr Ivill, on your behalf, informed the Committee that you made admissions for the following charges:

   Charges1(a) – 1(c); and
   Charges 3(a) and (b).

6. Mr Ivill confirmed that you deny Charge 2.

7. Having carefully considered each of the admissions detailed by Mr Ivill on your behalf, the Committee was unable to identify any discrepancies that would require further exploration of the

admitted allegations and acknowledged supporting evidence for each of the admitted allegations. The Committee could not identify any good reason to go behind your admissions.

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

Finding of facts

9. In its consideration of the remaining disputed allegation (Charge 2), the Committee had regard to the background of this case and the evidence adduced.

Background

10. Patient A was a patient at the Practice for approximately three years and saw two other dentists, along with you, whilst a patient at the Practice. Patient A was seen by another dentist at the Practice in January 2021 and received treatment for a crown and four fillings.

11. On 10 March 2021, Patient A attended a recall examination and was seen by you at the Practice. His presenting complaint was in relation to a problem with his UR5 and having lost a filling in that tooth. Patient A's medical records show that the following treatment options were discussed: do nothing, fit a denture on the NHS, or fit a crown privately for UR5.

12. Patient A said that he wished to undergo crown restoration, and it is the GDC's case that you told Patient A that this could only be done privately, and you did not give any reasons why it could only be done privately.

13. Subsequently, Patient A stated that, having been told that the Practice no longer undertook NHS treatment and was only able to offer private treatment, he sought dental treatment from a nearby dental practice, Practice 2, in January 2022.

14. Patient A sent a letter of complaint to the Practice, dated 20 January 2022, regarding the treatment you had completed on UR5. Patient A received written responses from you, dated 7 February 2022, and from the Practice Manager at the Practice, dated 8 February 2022. Patient A accepted the offer of compensation offered by the Practice, which he stated paid for subsequent treatment undertaken at Practice 2.

15. In or around May 2022, whilst receiving treatment at Practice 2 for fillings, Patient A stated that the crown at UR5 failed. As a result, a further letter of complaint was sent, dated 18 May 2022.

16. The GDC received a webform complaint from Patient A regarding the treatment you had completed for him, dated 30 June 2022.

Evidence

17. The Committee had regard to a number of documents included within the GDC hearing bundle, referred to as Exhibit 1. This bundle included, but was not limited to, the following documents:

- Written statements and supporting documents of the following witnesses:
  - Patient A

- Caroline Bell (W1) (Subsequent treating dentist at Practice 2);

- Signed Expert Report of Dr Simon Quelch, dated 28 May 2024;
- Clinical records from the Practice;
- Clinical records from subsequent dental practice, Practice 2; and
- Your signed witness statement, dated 10 October 2024.

18. The Committee also heard oral evidence from Patient A and from you.

Submissions

19. Ms Hollos, on behalf of the GDC, invited the Committee to find Charge 2 proved and referred the Committee to relevant case law in support of the GDC's case. She submitted that integrity is broader than honesty. She stated that integrity denotes an adherence to ethical standards and does not require professionals to be paragons of virtue, but the professional's integrity is linked to the manner in which that profession serves the public. In this regard, she referred the Committee to Standard 1.3 of the GDC's document, *'Standards for the Dental Team (2014)'.*

20. Ms Hollos stated that you have accepted that you did not offer the crown treatment on the NHS to Patient A and he was left with the misleading impression that it was only available privately. However, she referred the Committee to the expert evidence of Dr Quelch, who detailed that the treatment was available to Patient A in his particular circumstances. Ms Hollos submitted that the importance of the failure to offer the crown on the NHS is that the choice as the treatment option was taken away from Patient A. She accepted that you stated there was no bad intention and that you genuinely believed in offering the crown privately was acting in Patient A's best interests as it would fit better if done privately. The GDC's case is however well-intentioned that choice was not yours to make and your role as the treating dentist was to provide Patient A with all the information available to make his own choice.

21. Ms Hollos submitted that it was for you to advise Patient A why you believed the private treatment option had a better chance of success but that, armed with all the information, the choice was Patient A's to make. In making the decision for Patient A, Ms Hollos submitted that you prioritised your professional expertise over Patient A's right to choose. The GDC submitted this is a falling short of the ethical standards expected of a registered professional and Ms Hollos therefore invited the Committee to find Charge 2 proven.

22. Mr Ivill, on your behalf, submitted that the burden of proof remains on the GDC, and it is not for you to prove that an alleged event did or did not happen in terms of the applicable standard of proof. He invited the Committee to make its assessment taking into account the inherent probability, or improbability, of whether it occurred and referred the Committee to the relevant case law.

23. In this case, Mr Ivill submitted that the starting point is that you are a dentist of good character, with no fitness to practise history and the testimonial evidence provided speaks extremely highly of you. Against that background, Mr Ivill submitted that the GDC case against you nonetheless alleges that you acted without integrity and would jeopardise your professional standard by behaving in a way which you have neither acted before or since. He therefore submitted that such a scenario falls into the category of improbable.

24. Mr Ivill invited the Committee to consider the testimonials provided and submitted that the descriptions do not accord with someone who acts with a lack of integrity. He submitted that the positive comments support your good character, good standards, and good reputation. He stated that your good character supports your credibility and is something to be taken into account by the Committee when considering whether you are to be believed, and that as someone of good character, you may be less likely to have behaved in the way alleged. Mr Ivill stated that there is a degree of dispute in what you suggest was discussed during the consultation and the Committee should take this into account when considering the possibility that an honest witness nonetheless may be mistaken, believing their account to be correct, or that there was a misunderstanding.

25. In its consideration of the sole remaining disputed allegation, Mr Ivill invited the Committee to take into account your credibility generally and reminded the Committee that the allegation detailed in Charge 2 was previously being advanced on a different basis, it having been previously suggested that you were dishonest and/or lacked integrity. The allegation that you were dishonest is plainly no longer being made. He reminded the Committee that it was not alleged that your motivation was financial or personal gain, and the absence of such features are important when making an assessment when considering whether or not there was a lack of integrity.

26. In addition to your written evidence, Mr Ivill stated that the Committee has had the benefit of hearing from you, and this will assist it in assessing whether you struck the Committee as a person lacking in integrity, or whether you gave your evidence in a completely transparent and honest way. He stated that you have explained that the motive for offering a private crown was solely because you genuinely believed it was the best option for the tooth and in Patient A's best interests as the tooth was in such a poor state and he submitted that your genuine belief and motivation is the lens through which integrity should be viewed.

27. Mr Ivill invited the Committee to consider whether your conduct could be viewed as a lack of integrity if you genuinely believe you had acted in your patient's best interests and would result in the best outcome. He submitted that such an approach may be classified as misguided or an error in judgement, but not a lack of integrity. Mr Ivill submitted there seems to be somewhat of a potential paradox here in that if, for example, a practitioner deliberately acts in a manner that they felt was contrary to a person interests, that would plainly be a lack of integrity; but here, the GDC's case is that, even if you act in a sincere and well-intentioned way, only motivated by genuine belief you were acting in a patient's best interests, that is also acting without integrity.

28. In this regard, Mr Ivill submitted that when viewing the evidence as a whole in the proper context, you have not acted with a lack of integrity, and that the evidence in relation to Charge 2 is insufficiently compelling to meet the required evidential threshold of proof. Therefore, Mr Ivill invited the Committee to find Charge 2 not proved.

Committee's findings

29. The Committee considered all the evidence presented to it and took account of the closing submissions made by Ms Hollos, on behalf of the GDC, and by Mr Ivill, on your behalf. The Committee accepted the advice of the Legal Adviser. It 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 2

2. *'Your conduct in relation to 1(c) lacked integrity.'*

30. The Committee noted that at Charge 1(c), you did not offer Patient A the treatment for a crown on the NHS and there was a duty for you to offer that. You accepted in cross-examination that you knew what the standards were, and that a crown was available on the NHS to Patient A in his particular circumstances. You detailed in Patient A's clinical records what Patient A's options were, as follows:

'do nothing/ denture (nhs)/ post&core + crown (private) for UR5'.

31. The Committee was satisfied that, from your own notes of the appointment, you did not offer NHS crown treatment as one of the options available to Patient A and, having accepted the evidence of Dr Quelch, this was an option available to him. The Committee also bore in mind that Patient A had recently had an NHS crown and was NHS patient, so it was likely that NHS treatment would have been discussed during the appointment, particularly as you noted that you discussed an NHS denture.

32. The Committee noted that it was accepted by you in your oral evidence, and it was clear from your factual admissions that you knew NHS treatment was available to Patient A. The Committee noted Ms Hollos' submissions that as Patient A's treating clinician, it was your responsibility to offer ALL options to Patient A and to use your expertise to guide Patient A in his choice.

33. It was clear from the evidence before the Committee that this was an obligation you were aware of and whilst you should have provided Patient A with sufficient information relating to NHS crown treatment, including the pros and cons and prognosis of the treatment, you chose not to.

34. The Committee took into account your evidence that you held a well-meaning and genuine belief that the NHS crown would have had a poor prognosis and that it was your personal and professional opinion that a private crown would have a better outcome for Patient A. However, regardless of your well-meaning intentions, the Committee was satisfied that it is the responsibility of dental professionals to provide a patient with all available options to allow them to make an informed choice and that providing a patient with the benefit of your professional experience, they are able to make their own decision about their treatment. It also noted it is the responsibility of dental professionals to respect that a patient may make a decision about their care that is not in keeping with the best outcome and that this is the basis of patient-centred decision-making.

35. By not providing Patient A with all available options, you removed Patient A's ability to make a choice based on all the information provided and allowing him to make informed consent.

36. The Committee noted that you did not provide an explanation for why you did not explain to Patient A that the NHS crown was an inferior option to the private crown and that, whilst it accepted that your explanation that you genuinely believed you were acting in Patient A's best interests, omitting the option of the NHS crown did not accord with the Standard 1.3 and this lacked integrity.

37. Therefore, the Committee found that by not offering Patient A the treatment for a crown on the NHS, your conduct lacked integrity.

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

Decision on impairment and sanction

39. Having announced its decision on the facts, the Committee then moved on to consider whether the facts admitted and found proved amount to misconduct and, if so, whether your practice is currently impaired. In accordance with Rule 20 of the Fitness to Practise Rules 2006, the Committee heard submissions from Ms Hollos, on behalf of the GDC and Mr Ivill's submissions, on your behalf, in relation to the matters of misconduct, impairment and sanction. The Committee accepted the advice of the Legal Adviser who made reference to any relevant case law.

Evidence

40. The Committee also had regard to a bundle of remediation documents, provided on your behalf, referred to as Exhibit 2. This bundle consisted of the following documents:

- A reflective statement, dated 28 January 2025;
- Certification for Continual Professional Development (CPD) courses;
- Audits logs for record keeping and radiography, dated between 21 June – 9 September 2024.

Submissions

41. Ms Hollos submitted that the facts in this case amounted to a serious falling short of the standards expected and outlined a number of the GDC's Standards that the GDC considered you have breached and that these amounted to a finding of misconduct.

42. In respect of impairment, Ms Hollos reminded the Committee that this is a forward-looking exercise, and it is for the Committee to consider whether your fitness to practise is impaired as of today and not in the past. She referred the Committee to the evidence of remediation provided today and stated that the GDC recognises the volume of CPD and the manner in which it has been targeted towards the clinical failures in this case. Ms Hollos stated that although you did not accept at the outset of these proceedings that you demonstrated a lack of integrity by not offering Patient A crown treatment on the NHS, the Committee can consider your insight in that regard in your reflective statement.

43. Ms Hollos submitted that if the Committee did not find current impairment on the personal component, it can find it on the public component, as there is a need to uphold professional standards and maintain public confidence in the profession in a case where the PCC has found a lack of integrity by a dental professional.

44. In relation to sanction, Ms Hollos referred the Committee to the GDC document*, 'Guidance for the Practice Committees including Indicative Sanctions Guidance'*, referred to hereafter as the ISG, and submitted that the least severe sanction that deals with the issues in this case whilst protecting the public interest would be that of a short suspension of two to three months and referred the Committee to paragraph 6.28 of the ISG.

45. Mr Ivill submitted the conduct in this case is plainly remediable and you have provided evidence of targeted, focused remediation in Exhibit 2 with a view to addressing the concerns in this case. He submitted that you have treated the complaints seriously and have worked hard on embedding your remediation. Mr Ivill confirmed that you have no previous fitness to practise history and there has been a period of more than three years without further concern since the material time. He submitted that the episode can properly be described as isolated and has not been repeated either before or since. Mr Ivill submitted that this is relevant to insight and to whether the conduct is remediable and is likely to be repeated. He referred the Committee to the case of *Cohen v General Medical Council* [2008] EWHC 851, and the finding that an act of misconduct that was an isolated error on the part of the practitioner and with the chance of repetition being so remote, a registrant's fitness to practise may not be impaired. Mr Ivill submitted that this is the situation in this case. He submitted that you have demonstrated insight in your reflective statement, have accepted the seriousness of the findings and the potential impact on patients, colleagues, and the wider public interest. He also submitted that you have demonstrated regret and apologised for your conduct and confirmed a number of changes in practice to safeguard against repetition. Mr Ivill therefore submitted that the risk of repetition is low.

46. Mr Ivill also submitted that it would not be justified to find current impairment as you have shown full insight, reflected and remediated your previous conduct, expressed genuine regret and made a full apology. He reminded the Committee that the failures in this case related to the treatment of one patient in 2021, and that such conduct has not been repeated. Therefore, he submitted that there is no current risk to patient safety and the public would be reassured that you have apologised and demonstrated genuine regret, shown insight, and remediated and therefore public interest would not be undermined if a finding of current impairment were not made.

47. However, should the Committee find impairment, Mr Ivill stated that, at the time of the events, you were an inexperienced practitioner having only started your first paid role as a dentist in summer 2019. He referred the Committee to paragraph 6.9 of the ISG and outlined the factors that demonstrated that a reprimand is the most appropriate outcome in this case.

48. If the Committee was minded to impose a more restrictive sanction, Mr Ivill addressed both conditions of practice and a suspension. He submitted that the shortcomings in this case have already been fully remediated and there is no need for further rehabilitative steps. Consequently, he submitted that a conditions of practice order is not necessary.

49. Mr Ivill referred to Ms Hollos' submission that a short suspension may be appropriate but he submitted the factors outlined in paragraph 6.28 of the ISG did not support the imposition of a suspension in this case. He accepted that a finding of a lack of integrity is serious but submitted

that, on a spectrum of seriousness, the facts of this case are at the lower end of the spectrum. He also outlined your personal circumstances and any financial implications resulting from a period of suspension submitted that a suspension would be disproportionate in the particular circumstances of this case.

Committee's decision and reasons on misconduct

50. The Committee bore in mind that misconduct can be described as *'a serious falling short of the standards reasonably expected of a dental professional'*. In considering whether the facts both admitted and found proved amount to misconduct, the Committee had regard to the following principles from the Standards:

> *1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions;*
>
> *1.3 Be honest and act with integrity;*
>
> *1.7.2. If you work in a practice that provides both NHS (or equivalent health service) and private treatment (a mixed practice), you must make clear to your patients which treatments can be provided under the NHS (or equivalent health service) and which can only be provided on a private basis;*
>
> *1.7.3 You must not mislead patients into believing that treatments which are available on the NHS (or equivalent health service) can only be provided privately. If you work in a purely private practice, you should make sure that patients know this before they attend for treatment;*
>
> *3.1 Obtain valid consent before starting treatment, explaining all the relevant options and the possible costs; and*
>
> *7.1 Provide good quality care based on current evidence and authoritative guidance.*

51. The Committee carefully considered the expert report of Dr Quelch and its own findings in relation to Stage 1. It concluded that a qualified dentist ought to be able to diagnose dental disease, to take radiographs, and to determine what restorative work was required but that in relation to Patient A, you did not do so. The Committee also took into account that Patient A would have been interested in undertaking NHS treatment for the crown at UR5 but that you did not offer this to him, despite conceding in your oral evidence it was an option available to him. The Committee noted that Standard 1.3 requires all dental professionals to act with integrity and that you were found to have not done so. Further, you did not obtain informed consent from Patient A regarding his treatment as you were obligated to do as a dental professional.

52. The Committee was satisfied that by failing in these areas, your conduct fell far below the standards expected of a dentist and amounted to misconduct.

Committee's decision and reasons on impairment

53. The Committee considered whether your 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 proper standards of conduct and behaviour to maintain public confidence in the profession and this regulatory process. The Committee took into account your defence bundle and oral evidence, paying particular attention to any demonstration of insight, remediation, remorse, and evidence of mitigation of future risk.

54. The Committee first considered the personal component and took into account the bundle you have provided today and your oral evidence. It was reassured by the numerous certificates of targeted CPD you provided, and took account of the variation of courses, variation of providers, and the mixture of online and attended courses. The Committee considered the coverage of your CPD to be extensive and in-depth and could not see a clinical concern that has failed to be addressed by your targeted remediation.

55. The Committee found your reflective statement to be genuine and heartfelt and noted the steps you have taken to remediate your conduct and minimise the risk of repetition. It considered your reflection to be articulate, well-constructed and squarely focused on the impact your conduct had on the public, your patient, and your clinical practice. You clearly detailed where you considered yourself to have failed in your clinical practice and outlined what you had done to correct those failures, noting the importance of honesty and integrity in clinical practice. The Committee noted that you have reflected on the findings of the Committee in relation to Charge 2, having sat through cross-examination and answered every question put to you and answering very succinctly and directly, with no attempt to obfuscate or diminish your responsibility. You fully accepted the questions put to you as well as your own culpability

56. The Committee considered this to be a marker of someone who does display integrity and, whilst your conduct in March 2021 lacked integrity in one single appointment by failing to offer Patient A NHS treatment for his crown, you are not a practitioner who lacks integrity today. The Committee was therefore satisfied that you have demonstrated embedded remediation, thereby minimising the risk of repetition, and shown the Committee genuine remorse and considerable insight into your previous failings.

57. In light of these findings, the Committee did not consider that you fitness to practise is currently impaired on the ground of public protection.

58. In relation to public interest, the Committee was satisfied that in light of its findings regarding public protection, an informed member of the public would not be appalled if your previous conduct was not marked with a finding of current impairment in the particular circumstances of this case. It bore in mind that this case involves a single patient on one occasion some three years ago where you made a poor choice and have since demonstrated that you have learned from. In these circumstances, the Committee did not consider that public would expect your conduct to be marked as so deplorable that a finding of current impairment is required.

59. The Committee determined that a regulator that acknowledges that practitioners can make mistakes, learn from them, and return to safe practice, is a regulator able to build confidence in the public that it is a fair and proportionate organisation that does not unduly punish people. By not finding current impairment, the Committee was satisfied that it would maintain public confidence in the profession and the GDC as its regulator.

60. In addition, the Committee took into account that this case has been heard in public session and that the determination, including the Committee's decision and reasons, will be made available to the public. For all these reasons, the Committee concluded that a finding of current impairment is not required on the ground of public interest.

61. Accordingly, the Committee determined that your fitness to practise is not currently impaired.

62. This will be confirmed to you in writing.

63. That concludes this determination.