Dental Professionals Hearings Service

PUBLIC DETERMINATION

PUBLIC HEARING

Professional Conduct Committee
Initial Hearing

**3 – 6 April 2023; 19 – 23 June 2023; 3 – 21 July 2023;
6 – 8 September 2023; 9 – 13 October 2023; 13 – 17 November 2023;
7 – 9 February 2024; 15 and 17 – 19 April 2024; and 4 - 6 November 2024**

Name:	MEW, Michael
Registration number:	69138
Case number:	CAS-192947

General Dental Council:	Miss Lydia Barnfather, Counsel Instructed by Natalie Ayling, Capsticks Solicitors
Registrant:	Present Represented by Mr Stephen Vullo, KC Instructed by Lucinda Hawthorn, Twelve Tabulae Solicitors

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Fitness to practise:	Impaired by reason of misconduct
Outcome:	Erased
Immediate order:	Immediate suspension order

Committee Members:	Andy Skelton	(Lay)
	Carson Black	(Dentist)
	Louise Fletcher	(Dental Care Professional)
Legal Adviser:	Paul Kilcoyne	
Committee Secretary:	Andrew Keeling	

CHARGE

MEW, Michael Gordon, a dentist, BDS Lond 1993, is summoned to appear before the Professional Conduct Committee for an inquiry into the following charge:

"That, being a registered dentist:

1. *Between September 2013 and May 2019, you provided advice and treatment to:*

   (a) *Patient A, identified in Schedule A[1]; and*
   (b) *Patient B, identified in Schedule A.*

Patient A

2. *In September 2016, when Patient A was 6 years old, you recommended she underwent treatment you referred to as 'Orthotropic' treatment involving:*

   (a) *upper and lower arch expansion appliances;*
   (b) *the wearing of neck gear.*

3. *You informed Patient A's parents that the principal aims of the treatment you proposed were:*

   (a) *to expand Patient A's upper and lower arches and thereby "make way for the tongue, far more than would be required for the teeth";*
   (b) *to "gain a substantial increase in nasal capacity";*
   (c) *to "improve the midface (the area under the eyes and either side of the nose)";*
   (d) *to "change the swallowing pattern";*
   (e) *to "correct the cause of the problem and guide facial growth and development through gaining structural changes of facial and dental form" and through "correcting the oral environment in this way, more space for the teeth and tongue is created, so that all the 32 teeth (including the wisdom teeth) align naturally without the need for fixed braces";*
   (f) *based on, "the Tropic Premise which states that anyone who exhibits a number of features will have permanently well aligned teeth and good facial form", the features to be exhibited including standing up straight, establishing a lip seal with nasal breathing, maintaining a "Butterfly bite", resting with the tongue on the roof of the mouth and swallowing with the tongue on the roof of the mouth.*

[1] Schedule A is a private document which cannot be disclosed.

4. *Patient A had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development.*

5. *Your recommendations for treatment and comments as set out at paragraph 2 and/or 3 were inappropriate and/or misleading in that:*

   (a) *treatment was not clinically indicated for Patient A;*
   (b) *you had no adequate objective evidence to suggest the treatment proposed for Patient A would achieve the aims stated.*

6. *You inappropriately informed Patient A's parents:*
7.

   (a) *"Most orthodontists have been told that we are not evidence based and are "bad" but few really have any idea of what we do";*
   (b) *"for younger children it is also important to push many orthodontists into giving their opinion as to what may happen in the future, as it is too easy to sit on the fence and placate parents for years until it is too late to avoid extractions or surgery."*

8. *On 20 September 2016 Patient A was fitted with upper and lower expansion appliances.*

9. *On 6 October 2016 Patient A was fitted with neck gear.*

10. *On or about 2 November 2016 you recommended Patient A underwent a lingual tongue-tie release for a tongue tie which you stated:*

    (a) *was restricting her ability to rest with her tongue on the roof of her mouth comfortably at rest;*
    (b) *was creating an imbalance in the strength of her jaw and tongue muscles;*
    (c) *was responsible for night-time teeth grinding and clicking;*
    (d) *was negatively affecting her oral posture and which, if left untreated, would negatively impact her facial growth and dental malocclusion;*
    (e) *if treated, would complement her 'Orthotropic' therapy with the result that she would not need orthodontic or other intervention at some point in the future.*

11. *Your recommendation that Patient A underwent a lingual tongue-tie release and your comments as set out at paragraph 9 were inappropriate and/or misleading in that:*

    (a) *a lingual tongue-tie release was not clinically indicated for Patient A;*
    (b) *you had no adequate objective evidence to suggest a lingual tongue-tie was causing the issues stated or potential issues;*

(c) *you had no adequate objective evidence that a lingual tongue-tie release would achieve the outcomes indicated or implied.*

12. *On 8 May 2017 Patient A was seen by a Consultant Oral and Maxillofacial Consultant and found:*

    (a) *not to require a lingual tongue tie-release;*
    (b) *to have developed a large anterior open bite;*
    (c) *to have a traumatic ulcer on the lingual frenum.*

13. *A photograph taken in September 2017 shows Patient A had recession of the labial gingiva of the permanent lower incisors.*

14. *A photograph taken in April 2019 shows Patient A had:*

    (a) *recession of the labial gingiva of the permanent lower incisors;*
    (b) *an unresolved anterior open bite;*
    (c) *an unaligned UL2.*

15. *In respect of Patient A:*

    (a) *you failed to carry out appropriate and/or adequate monitoring of her treatment;*
    (b) *you failed to carry out any cephalometric analysis or similar.*

16. *You ought to have known that that the treatment provided to Patient A as set out at paragraph 7 and/or 8:*

17.
    (a) *was not clinically indicated for Patient A;*
    (b) *was not in Patient A's best interests;*
    (c) *was liable to cause harm.*

Patient B

18. *In November 2013, when Patient B was 2 years old:*

    (a) *you took an upper impression with the intention of providing an expansion appliance;*
    (b) *you informed Patient B's parents that the aim of the proposed expansion appliance would be to improve tongue space and upper nasal airway.*

19. *The treatment proposed and comments as set out at paragraph 16 were inappropriate and/or misleading in that:*

(a) treatment was not clinically indicated for Patient B;
(b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.

20. In February 2018, when Patient B was 6 years, you reviewed him and informed Patient B's parents:

(a) that, "both upper and lower jaws have dropped down as is consistent with the concept of Craniofacial Dystrophy";
(b) the aim of treatment you proposed for Patient B would be, "to improve the craniofacial development so that he no longer had any sleep issues and create an environment in which the teeth align themselves";
(c) "As the upper and lower jaws have dropped down and back, the face has lengthened affecting the airway leading to a forward head posture and a modified resting tongue position. The latter dictating a pattern of malocclusion that we see";
(d) the aim of treatment you proposed for Patient B would be, "not to align teeth but create an environment in which teeth will align themselves as they do in 5,400 species of mammals and our ancestors since the dawn of time."

21. You recommended Patient B underwent treatment you referred to as 'Orthotropic' treatment involving:

(a) the widening of both arches, with greater widening of the maxilla;
(b) the wearing of head gear at night;
(c) the potential provision of a 'Myobrace' or 'training appliance'.

22. Patient B had a Class 1 occlusion on a Class 1 skeletal base and normal craniofacial development.

23. Your recommendations for treatment and comments as set out at paragraph 18 and/or 19 were inappropriate and/or misleading in that:

(a) treatment was not clinically indicated for Patient B;
(b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.

24. On 16 August 2018 Patient B was fitted with upper and lower arch expansion appliances.

25. On 23 August 2018, following questions and concerns raised by Patient B's parents, you informed them:

(a) *that the treatment you proposed "was designed to create more space for the tongue and then train an individual to change. In this way, it becomes easier for patients to correct themselves. Malocclusions improve and there is a positive impact on the airway with improved sleep, fewer nasal obstructions and better oral posture";*
(b) *"the changes they achieve are stable and as long as patients continue to be aware of their oral posture, these changes are permanent";*
(c) *that in Patient B's case, "there is a lack of space for his tongue and this is the reason his facial form has down swung";*
(d) *"It is necessary in his case to gain this additional space by widening his arches as well as lengthening".*

26. *Your recommendations for treatment and comments as set out at paragraph 23 were inappropriate and/or misleading in that:*

(a) *treatment was not clinically indicated for Patient B;*
(b) *you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated.*

27. *On 30 August 2018 Patient B was provided with head gear.*

28. *In respect of Patient B, you failed:*

(a) *to carry out any cephalometric analysis or similar;*
(b) *to treat or ensure decay was treated at ULD, ULE, LLD, URE, LRE and/or LRD prior to commencing treatment;*
(c) *to obtain study models;*
(d) *to communicate with Patient B's paediatrician;*
(e) *to carry out appropriate and/or adequate monitoring.*

29. *On 10 December 2018 Patient B was seen by another practitioner and found to have recession of the labial gingiva of a permanent lower incisor.*

30. *You ought to have known that the treatment provided to Patient B as set out at paragraph 22 and/or 25:*

(a) *was not clinically indicated;*
(b) *was not in Patient A's best interests;*
(c) *was liable to cause harm.*

"YouTube"

31. *In a video posted on YouTube in about September 2017 titled "Orthodontics*

Beyond Teeth" you stated:

(a) words to the effect, that if you create enough tongue space, and children use that tongue space, that can influence facial growth and the craniofacial structure and, "expansion of the brain, expansion of the dental arches as well";

(b) that, "…if a patient walks into my office over the age of 8, they're into the area where it's going to be compromise, it depends how hard they work. If someone comes in at the age of 5, 6 I can almost get a complete correction. If someone comes in younger I can give them advice on how they can correct themselves".

32. Your claims as set out above at paragraph 29 were inappropriate and/or misleading in that they were made without adequate objective evidence.

And that, by reason of the facts alleged, your fitness to practice is impaired by reason of your misconduct."

Mr Mew,

1. This is a Professional Conduct Committee inquiry into the facts which form the basis of the allegation against you that your fitness to practise is impaired by reason of misconduct. Stage 1 of the hearing (the factual enquiry) took place over a period of 44 days on the following dates:

    - 3 – 6 April 2023;
    - 19 – 23 June 2023;
    - 3 – 21 July 2023;
    - 6 – 8 September 2023;
    - 9 – 13 October 2023;
    - 13 – 17 November 2023;
    - 7 – 9 February 2024;
    - 15 and 17 – 19 April 2024.

2. On 19 April 2024, the Committee adjourned the hearing to deliberate in private on its findings of fact.

3. You attended the hearing and you were represented by Mr Stephen Vullo KC. Miss Lydia Barnfather, Counsel, presented the General Dental Council's (GDC) case. The hearing took place in person at the hearing suite of the Dental Professionals Hearing Service in Wimpole Street, London, apart from the dates in April 2024, when the hearing took place remotely on Microsoft Teams.

Admissions

4. As part of the documents for this hearing, the Committee was provided with a document which set out your admissions and denials to the heads of charge. You admitted to the following heads of charge: 1(a), 1(b), 2(a), 2(b), 7, 8, 22 and 25.

5. Mr Vullo, on your behalf, informed the Committee that you also admitted to the following heads of charge: 3(a) to 3(f), 4, 11(a) to 11(c), 12, 13(a) to 13(c), 16(b), 18(a) to 18(d),19(a) to 19(c), 20, 23(a) to 23(d), 27, 29(a) and 29(b). However, he stated that these admissions were contextual.

Decision on Admissions (3 April 2023)

6. The Committee noted your admissions and announced all the admitted factual allegations, which were heads of charge 1(a), 1(b), 2(a), 2(b), 7, 8, 22 and 25, as found proved.

7. In respect of the contextual admissions, the Committee decided to defer making a finding on these until all the evidence had been adduced.

Background

8. You are registered with the GDC as a Specialist Orthodontist. You are also the owner and principal of a clinic which provides 'Orthotropic Treatment' exclusively under private contract. Orthotropic Treatment is not recognised or available within the NHS nor recognised as a speciality by the GDC.

9. Orthotropics was originated largely by your father, Mr John Mew, and you have continued its practice from your clinic. You have also been involved in training and lecturing on the practice of Orthotropics. In very brief summary, Orthotropic practice maintains that the cause of malocclusion is largely, if not entirely, environmental, and that effecting environmental change early in development can avoid malocclusion. This environmental intervention includes increasing the space in the maxilla and mandible, and attempting to influence tongue positioning, and head and neck posture. It is also stated in correspondence that other benefits of the orthotropic approach may include improvements in sleep and airway problems.

10. Orthotropics is now practised in a number of countries, although it remains a non-mainstream approach in the UK. You are the only Orthotropic practitioner within the UK. As an extensive trainer and well-known proponent of Orthotropics, many Orthotropic practitioners appear to have had some professional contact with you. You accept that it is outside the mainstream, and that it remains a controversial approach.

11. Related to the hypothesis of Orthotropics is the concept of cranio-facial dystrophy (an environmentally driven lengthening of the face).

12. Orthotropics is defined on your Clinic website as, *"…a branch of dentistry that specialises in treating malocclusion by guiding growth of the facial bones and correcting the oral environment. This treatment creates more space for the teeth and tongue. The main focus of this treatment is to correct patients oral and head posture"*.

The Allegations

13. The allegations against you relate to the provision of Orthotropic Treatment to two young patients (Patient A and Patient B) and the promotion of your treatment philosophy by way of inappropriate and misleading claims. It is alleged the misleading claims were made to the patients' parents in correspondence as well as to the public via a YouTube video titled, '*Orthodontics Beyond the Teeth…*'.

The allegations centre on claims made concerning the need for treatment, your diagnoses, and the assertions you made about the benefits and outcomes of Orthotropic Treatment, specifically for Patients A and B.

14. The children's parents were allegedly told by you that your treatment would remedy purported defects in facial form and growth, alleviate breathing and sleeping disorders, and cause the teeth to naturally align. The GDC allege that there was no clinical indication for the treatment proposed and that the claims made in respect of the aims and outcomes of Orthotropic Treatment to the parents, as well as the claims made on YouTube, were inappropriate and misleading given the absence of a proper evidential basis in support of them. The GDC further allege that you went so far as suggesting in your YouTube video that Orthotropic Treatment could expand the brain.

15. The GDC allege that Patients A and B both underwent treatment with you from the age of six years, commencing in 2016 and 2018, respectively. It is alleged that an earlier failed attempt to initiate treatment for Patient B occurred when he was only two years old. It is alleged that the Orthotropic Treatment provided was demanding of the patients and involved the provision of both upper and lower removable 'arch expansion' appliances, as well as head and neck gear together with exercises. Patient A, whose mother remains a supporter of your treatment, still continues to undergo treatment with you. Patient B's treatment with you ceased within four months, after his parents were concerned about the alleged harm being caused to Patient B.

16. It is alleged that Patient A was seen by a Consultant Oral and Maxillofacial Surgeon (Witness 1) on 8 May 2017 after you had recommended that she underwent a lingual tongue-tie release. Witness 1 has stated that he became concerned that the Orthotropic Treatment Patient A was undergoing was causing her harm. As a result, Witness 1 was so concerned about Patient A he reported the matter to the GDC on 12 May 2017.

17. The GDC's allegations have been presented to the Committee in the following three areas:

    - Charges 2 – 15: The treatment provided to Patient A between 2016 and 2019, which included upper and lower expansion appliances and head and neck gear, together with the claims made about her treatment;

    - Charges 16 – 28: The virtually identical treatment provided to Patient B including in 2013 but more particularly in 2018, together with the claims made about his treatment; and

- Charges 29 and 30: Inappropriate and misleading claims made by you in a video posted on your YouTube channel in September 2017.

Application under Rule 57 to adduce evidence (20 June 2023)

18. Mr Vullo, on your behalf, made an application under Rule 57 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") for Dr Simon Wong's addendum witness statement, dated 7 June 2023, and Ms Lucinda Hawthorn's witness statement, dated 12 June 2023, to be admitted as evidence.

19. The Committee first heard submissions from Miss Barnfather on her reasons for opposing the application.

GDC's Submissions

20. Miss Barnfather took the Committee through the background to the case with reference to her written objections. She informed the Committee that shortly before the hearing commenced in April 2023, the GDC expert witnesses were made aware of a thesis titled '*Skeletal and Dental Changes from the Compliance-based Orthotropic Treatment Approach with Exercises to Improve Orofacial Posture'* carried out by Dr Faraz Tavoossi ("the Tavoossi thesis"). Miss Barnfather stated that the study and thesis was carried out in partial fulfilment of the requirements for the Master of Science (MSc) in Orthodontics at the University of Alberta, Canada.

21. She informed the Committee that the thesis is available online and is the only study, of which the GDC experts are aware, that is directly concerned with the provision of Orthotropics. The aim of the study was "*to investigate the skeletal and dental changes that occur using compliance-based orthotropic treatment approach with orofacial posture exercises aimed at controlling vertical facial skeletal growth in the mixed dentition*". She stated that Dr Wong had provided case studies for the thesis of 102 of his patients who he had treated using your Orthotropic Biobloc technique with orofacial exercises. She stated that the study found that there was insufficient evidence to conclude that the Orthotropic treatment had a meaningful effect on skeletal and dental changes.

22. Miss Barnfather submitted that Dr Wong was a private general dental practitioner practising in Australia. Miss Barnfather submitted that Dr Wong has no further specialist training or qualifications in dentistry or orthodontics, but was trained in Orthotropics by you and is a very firm advocate for Orthotropics. She submitted that it has been agreed by parties that Dr Wong's evidence is not to be treated as expert evidence. However, she submitted that in his addendum statement Dr Wong purports to give expert evidence on the Tavoossi thesis by suggesting that it contains significant flaws.

23. Miss Barnfather submitted that the GDC objects to the admission of Dr Wong's further statement as it amounts to inadmissible expert opinion evidence. She submitted that Dr Wong does not have sufficient expertise to comment as an expert on the thesis, and that his evidence is far from being impartial or reliable. She submitted that his evidence is not relevant to the issues in the case and distracts the Committee from its business. Furthermore, she submitted that the witness statement contains inadmissible hearsay evidence of the purported comments and opinion of other individuals. She also submitted that both the GDC and defence experts have seen and commented on the Tavoossi thesis, and that any necessary exploration of this research could be achieved through cross-examination of the experts.

24. In respect of Ms Hawthorn's statement, Miss Barnfather submitted that Ms Hawthorn is a solicitor at the firm you have instructed in this case. Miss Barnfather informed the Committee that Ms Hawthorn conducted an online search using a number of search terms including 'Myofunctional therapy'. Within her statement she produces some of the results of that search and extracts from the websites of the British Orthodontic Society, the 'British Society of Myofunctional Therapy', multiple pages from Colgate's website, pages from a website called 'Myofunctional Therapy UK' and further pages from a website called 'Smile Direct Club'.

25. Miss Barnfather submitted that the GDC objects to the admission of this material as it has been served late and, more importantly it is inadmissible and irrelevant to the Committee's task. She submitted that the Committee has the factual and expert evidence to consider, and should not rely upon someone's Google search as to whether there is adequate and objective scientific evidence to support your claims for Orthotropics. In conclusion, she submitted that Ms Hawthorn's evidence is neither helpful nor in the interests of justice, and should not be admitted.

Your Submissions

26. Mr Vullo, on your behalf, submitted that this is a different case than usual for the Committee to consider as it will have to determine whether Orthotropics is a valid treatment. Therefore, he submitted that it requires the Committee to look at different types of evidence. In respect of Ms Hawthorn's witness statement, he submitted that it rebuts the suggestion by the GDC that Orthotropics has no traction in the mainstream. He submitted that he instructed Ms Hawthorne to undertake the Google search and he was surprised by the number of results that appeared. He submitted that the information clearly has relevance and is admissible. He also submitted that the material can be used when the GDC expert is being cross-examined.

27. In respect of Dr Wong's witness statement, he submitted that this should be admitted to show that Orthotropic treatment works and has validity. He accepts that Dr Wong is not providing expert evidence, however, he submitted that Dr Wong can give evidence about the treatment of his own patients. Therefore, he submitted that his evidence would benefit the Committee in deciding on whether there is a beneficial effect to Orthotropic treatment. He submitted that the GDC could also challenge the evidence and cross-examine Dr Wong on the efficacy of his Orthotropic treatment.

28. In conclusion, Mr Vullo submitted that both Ms Hawthorne's and Dr Wong's additional evidence go directly to the question of whether there is a reasonable body of opinion that Orthotropics is a legitimate treatment. He invited the Committee to accept the evidence, on the grounds of relevance and fairness.

The Committee's Decision

29. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with your interests.

30. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

    (1) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.

    (2) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.

31. The Committee first considered Dr Wong's witness statement. It noted that it is accepted by both parties that Dr Wong is not giving expert evidence. However, the Committee considered that his witness statement contained opinion evidence. The Committee further noted that Dr Wong has no specialist qualifications, and although he gives evidence about the treatment of his own patients, this would not be relevant or helpful for the Committee when making its determination regarding the patients in this case. The Committee was also satisfied that both the GDC experts and your experts would be able to be cross-examined regarding the merits or otherwise of the Tavoossi thesis.

32. The Committee next considered Ms Hawthorne's witness statement. The Committee determined that the results of a Google search undertaken by a solicitor of the firm that you have instructed would not be evidence that could be satisfactorily relied upon. Furthermore, the Committee was satisfied that the evidence would not be helpful as the efficacy of Orthotropic treatment could be more properly explored by cross-examination of the expert witnesses in this case.

33. Accordingly, the Committee determined that neither Dr Wong's addendum statement nor Ms Hawthorne's statement would be relevant or helpful to its deliberations in this case and should not be admitted into evidence.

Application for No Case to Answer under Rule 19(3) – 19 July 2023

34. At the conclusion of the GDC's case, Mr Vullo made a submission, on your behalf, that pursuant to Rule 19(3) of the Rules, there was no case for you to answer in respect of heads of charge 5(a), 5(b), 14(a), 14(b), 15(a), 15(b), 17(a), 17(b), 21(a), 21(b), 24(a), 24(b), 26(a), 26(b), 26(c), 26(e), 28(a), 28(b) and 30. He also submitted that he would be making a discrete submission in respect of head of charge 26(d).

35. Mr Vullo submitted that in deciding on the application, the Committee must pose and answer the following questions:

    1. *Are we satisfied that the expert evidence we have heard has been given impartially and in accordance with the legal duties imposed on all experts?*

    2. *Are we satisfied that Orthotropics is not a legitimate practice per se?*

    3. *Having answered the questions above, are the Panel satisfied that there is sufficient evidence at this stage to raise a case to answer when applying the test as expressed in Galbraith?*

36. In respect of question 1, Mr Vullo submitted that in their oral evidence, both GDC experts, Mr Stephen Powell, an Orthodontist, and Mr Keith Smith, an Oral and Maxillofacial Surgeon, had failed to uphold their duties as experts. He referred the Committee to Part 35 of the Civil Procedure Rules 1998, where the duties of an expert witness in regulatory proceedings are prescribed. He submitted that their oral evidence was biased, partisan and advocated the GDC's case. For example, he submitted that Mr Smith's assertion that you were one of the anonymous reviewers of the Kahn reference was made without any evidential basis. The Kahn reference is central to your case and he submitted that both Mr

Smith and Mr Powell made a united effort to undermine the legitimacy of this reference by implying a behind-the-scenes conspiracy and false or over inflated attribution of the authors.

37. In respect of question 2, Mr Vullo submitted that there was a '*fundamental flaw'* in the GDC's case, in that the expert evidence it was relying on was challenging the legitimacy of the practice of Orthotropics rather than simply the manner in which you had practised it. However, the heads of charge have been pleaded as though the case fell into the latter category. He submitted that the Committee cannot properly proceed to consider the facts and the expert evidence called without having answered question 2. If the Committee's answer to this question is 'yes', he submitted that there would be certain ramifications that flow from this. Firstly, the only expert evidence the Committee has heard has been from experts in fields other than Orthotropics whose opinions were underpinned by the view that Orthotropics has no legitimacy whatsoever. Secondly, this expert opinion was not judging you by the standards of the skill/art you were practising at the time as applied in the cases of *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582 and *Bolitho v. City and Hackney Health Authority* [1998] AC 232. Thirdly, the Committee has not heard any opinion evidence from an independent Orthotropic practitioner, by which it could judge whether or not there was adequate objective evidence to support the treatment provided. Mr Vullo submitted that the GDC has not provided sufficient evidence to show that the practice of Orthotropics is not legitimate. Your position is that Orthotropics is legitimately practised throughout the world and that you have the right to be judged by the standards of an Orthotropist.

38. In respect of question 3, Mr Vullo referred the Committee to the case of *R V Galbraith (1981) 1 WLR 1039*. He submitted that if the Committee determine that the GDC's experts have provided impartial evidence then their evidence can be given little or no weight. If the Committee answer ''no' to question 2, then the expert evidence would be tenuous in nature and insufficient as it has been given by an expert in the incorrect field.

39. In respect of head of charge 26(d), Mr Vullo submitted that the Committee has not heard sufficient evidence that Patient B was under the care of a paediatrician specifically for the purposes of his sleep apnoea. He submitted that although there is evidence that points to Patient B being under the care of a paediatrician at some point in time, it is insufficient to conclude that this was the case in 2018, which the head of charge alleges.

40. Miss Barnfather, on behalf of the GDC, firstly addressed the Committee with regard to the legal principles relating to this application as outlined in the cases of *Galbraith* and *Razak v GMC [2004] EWHC 205 (Admin).* She submitted that there was no provision for the Committee to remove a head of charge under what has

been termed by Mr Vullo as 'judicial discretion'. She submitted that the Committee is confined to making decisions on the charges before it, and is not required to make a determination on 'the legitimacy of Orthotropics per se'. She submitted that the three questions posed by Mr Vullo were not correct in either law or logic.

41. In respect of the purported lack of impartiality of the GDC experts, Miss Barnfather submitted that there is no proper basis upon which it can be said that the experts arrived at opinions or assessments on a desire to 'bolster the GDC case' as opposed to their expertise. She submitted that the allegation that both GDC experts had united to undermine the legitimacy of the Kahn reference was entirely without basis. She submitted that both GDC experts were appropriately qualified and experienced experts, who both gave evidence independent of each other.

42. With regard to the question as to whether Orthotropics is a legitimate practice, Miss Barnfather submitted that Mr Vullo had confused the principles in the *Bolam* and *Bolitho* cases with the evidence that the GDC has to adduce in order to establish a prima facie case. She submitted that there is no separately recognised qualification of Orthotropist and no specialist list or speciality as recognised by the NHS, GDC or the British Orthodontic Society (BOS). Furthermore, she submitted that it is open to you to adduce evidence by calling evidence from Orthotropic experts to opine on your conduct.

43. Lastly, with regard to the discrete matter of head of charge 26(d), Miss Barnfather submitted that Mr Vullo's submission was predicated on the assumption that Patient B remained under the care of a paediatrician. However, this is not what is written in the charge. She submitted that there is clear and strong evidence, including expert evidence, that you had an obligation to communicate with Patient B's paediatrician. Therefore, the head of charge should proceed.

Committee's Decision

44. The Committee accepted the advice of the Legal Adviser and it applied the direction and test set out in the case of *R V Galbraith (1981) 1 WLR 1039*. The Committee had regard to all the evidence thus far adduced. It took account of the submissions made by Mr Vullo, on your behalf, and those made by Miss Barnfather on behalf of the GDC.

45. The Committee first considered the question posed by Mr Vullo as to whether the GDC experts' evidence had been given impartially. The Committee considered that there were some unfortunate comments made by the experts during their evidence. For example, the suggestion by Mr Smith that you might be one of the

two anonymous reviewers of the Kahn reference, a suggestion for which Mr Smith apologised and later withdrew. However, the Committee was of the view that overall, both Mr Powell and Mr Smith gave fair and impartial evidence based on their experience and expertise as an Orthodontist and Oral and Maxillofacial Surgeon respectively. The Committee noted that although both experts stated that there was no evidence to support the premise of Orthotropics, they made comments that could be considered fair-minded to you and your case. For example, both experts stated that they would support Orthotropic treatment if they could see evidence that it worked, and Mr Powell made positive comments about elements of Simon Wong's practice, including his use of cephalometrics. The Committee also noted that both experts did not always agree with each other, which was shown when Mr Smith acknowledged that he did not agree with Mr Powell about the need for randomised control trials to show the efficacy of Orthotropics. In conclusion, the Committee determined that there was insufficient evidence to show that either expert was biased when giving their oral evidence. Furthermore, the Committee did not consider either expert's evidence to be so unsatisfactory that it could not be relied upon to determine whether the heads of charge could be capable of being proved to the required standard.

46. The Committee next considered the appropriateness of the GDC experts' professional qualifications when giving their opinion on Orthotropics, and whether they were entitled to opine on your conduct. The Committee noted that Mr Powell was an Orthodontist with many years' experience, including involvement in the treatment of sleep apnoea, and that as an Oral and Maxillofacial Surgeon, Mr Smith would have appropriate experience in dealing with the issues in this case, including working closely with Consultants in Orthodontics and Paediatric Dentistry. The Committee also noted that Orthotropics was not a recognised specialty by the NHS, GDC or the BOS, and you are registered with the GDC as a Dental Surgeon and are included in the Orthodontic specialist list. The Committee was satisfied therefore that it was appropriate for both Mr Powell and Mr Smith to provide expert evidence in this case.

47. The Committee then considered each head of charge applicable to this application, bearing in mind the principles in the case of *Galbraith* and taking into consideration the evidence from Mr Powell and Mr Smith. It determined that there was sufficient evidence that these heads of charge could be capable of being proved to the required standard.

48. Lastly, the Committee considered head of charge 26(d). The Committee was of the view that it had heard sufficient evidence from both experts upon which it could conclude that the charge was well founded. The Committee also noted that its decision on whether it would be found proved would depend on the way it interprets the wording of the charge. The Committee was satisfied therefore for this head of charge to proceed.

49. The Committee, therefore, did not accede to the No Case to Answer application.

Request for Clarification on Committee's Rule 57 decision (11 October 2023)

50. Mr Vullo, on your behalf, requested the Committee to clarify its previous decision made on 20 June 2023 not to admit Dr Simon Wong's addendum witness statement into evidence. He submitted that although the Committee decided that Dr Wong's evidence about the treatment of his own patients would not be relevant or helpful, he did not take that to mean that Dr Wong's evidence should be excluded in its entirety. He submitted that if that was the Committee's intention, then he would not be able to call Dr Wong as a witness as Dr Wong could only give evidence about his own patients. Furthermore, if that was the Committee's intention then he would ask the Committee to reconsider its decision.

51. Mr Vullo referred the Committee to the Tavoossi thesis, to which Dr Wong provided 102 case studies of his patients. He submitted that 33 per cent of Dr Wong's patients used in the study were classed as hyper-divergent. However, it has been accepted by the GDC's expert, Dr Powell, that only three to four percent of the general population are hyper-divergent. He submitted that it was important to note this in respect of the findings in the Tavoossi thesis.

52. Mr Vullo, therefore, requested that the Committee clarifies whether it intended to exclude all of Dr Wong's evidence in his addendum witness statement and whether Dr Wong would be able to give evidence in respect of his own patients. He submitted that he has randomly selected six of those patients from the study and would like to ask Dr Wong about the treatment he offered them and the results of that treatment.

53. Miss Barnfather, on behalf of the GDC, referred the Committee to her submissions in respect of your previous application for Dr Wong's addendum statement to be admitted into evidence. She submitted that the Committee had previously determined that Dr Wong's addendum witness statement would not be relevant or helpful to the Committee in its decision about your treatment of the patients in this case. She submitted that you are now seeking to adduce part of Dr Wong's addendum witness statement into evidence by a different route, and, in effect asking the Committee to revisit its previous decision. She submitted that Dr Wong is a dentist with no specialist qualifications and does not hold the status of an expert. However, you are seeking to adduce '*quasi-expert*' evidence without the witness having to abide by the requirements of expert witnesses.

54. Miss Barnfather submitted that you state that the issue now is one of hyper divergence. However, she submitted that the definition of hyper-divergence can vary. If the Committee does allow you to question Dr Wong about these six patients, she submitted that this may derail the proceedings as she may have to recall the GDC experts to give evidence. She submitted that the Committee has clearly ruled on this previously and it would be quite inappropriate for the Committee to make a further decision. She submitted that she objected to this evidence as it is not relevant or admissible, and invited the Committee to look at its original ruling.

The Committee's Decision

55. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with your interests.

56. The Committee firstly sought to clarify its previous decision made on 20 June 2023 in respect of the admissibility of Dr Wong's addendum witness statement. The Committee confirmed that its previous decision applied solely to Dr Wong's addendum witness statement, dated 7 June 2023, in relation to opinion evidence. This addendum statement provided opinion evidence and concluded with an expert declaration by Dr Wong. There is no dispute between the parties that Dr Wong is not an expert for the purposes of this case. The Committee re-iterated its previous decision that Dr Wong was not an expert and therefore could not give expert evidence about the treatment of his own patients as this would neither be relevant nor helpful to the Committee in its considerations in this case.

57. The Committee, however, is of the view that Dr Wong can provide relevant factual evidence in relation to the background of his patients, who are the subject matter of the Tavoossi thesis. The Committee is mindful that it needs to confidently assess how much weight it should give to the Tavoossi thesis. It noted that the experts in this case were aware of the issues in respect of the Tavoossi thesis in relation to group reliability, namely the definition of hyper-divergence and the percentage of hyper-divergent patients in the treatment cohort. The Committee was of the view, therefore, that it would be relevant and helpful to hear factual evidence from Dr Wong on this discrete issue. Experts on either side can opine on this as appropriate.

58. For the avoidance of doubt, the Committee noted its earlier decision of 20 June 2023, in which it stated that, "*evidence about the treatment of his own patients…would not be relevant or helpful to the Committee when making its determination on the patients in this case*". Therefore, Mr Wong is not to be questioned on the six randomly selected patients.

59. The Committee directs that Dr Wong provides a further factual statement detailing the following:

    - The definition of hyper-divergence used by Dr Wong;
    - The incidence of hyper-divergence (expressed as a percentage) in his patient group (the 152 patients) based on this definition.

Application under Rule 57 to adduce evidence (13 October 2023)

60. Mr Vullo, on your behalf, made an application under Rule 57 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") for the following to be admitted as evidence:

    - Witness statement from Dr Brian Hockel, dated 29 September 2023;
    - Witness statement from Dr Helen Jones, dated 29 September 2023;
    - Witness statement from Dr Sandra Kahn, dated 2 October 2023; and
    - Periodontist report on Patient A, dated 17 April 2023.

61. In addition, Miss Barnfather, on behalf of the GDC, made an application to admit Patient B's mother's complaint to the GDC, dated 30 March 2019, as evidence. Mr Vullo indicated to the Committee that he did not oppose this application.

Your Submissions

62. In respect of his application, Mr Vullo submitted that an important issue for the Committee to consider is whether there is a reasonable body of practitioners that practise orthotropics. He submitted that the Committee has heard evidence that orthotropics is practised all over the world, particularly in the United States and Australia. In addition, he submitted that the Committee has heard oral evidence from Professor Stephen Sheldon that he regularly refers his patients for assessment for orthotropic treatment. He submitted that the GDC is asserting that you are a 'maverick' and lone practitioner of orthotropics as it is practised differently worldwide. Therefore, the evidence he wishes to adduce is relevant as he is seeking to challenge this assertion.

63. Mr Vullo submitted that each of the witnesses have practised orthotropics for a number of years, and although some of their treatment may differ from yours, it can all be grouped under the umbrella term of orthotropics. He submitted that the evidence from these witnesses will allow the Committee to make a balanced decision as to whether there is a reasonable body of practitioners that practise orthotropics.

64. In addition, Mr Vullo addressed the Committee on a discrete matter contained within Dr Kahn's statement in respect of the academic paper she had published entitled, '*The Jaw Epidemic: Recognition, Origins, Cures and Prevention*'. He submitted that this was included in Dr Kahn's witness statement to show how the paper came into being in response to the criticisms made of it by the GDC's expert, Mr Keith Smith, during his oral evidence.

65. With regard to the timing of his application, Mr Vullo submitted that the issue of whether there is a reasonable body of practitioners practising orthotropics has been there from the beginning of this hearing. However, it only became relevant after the oral evidence of the GDC experts, Mr Powell and Mr Smith. A bundle was subsequently prepared over the summer and served on the GDC. Mr Vullo submitted that the GDC made certain criticisms of the bundle, which he accepted, and this led to a revision of the bundle. Therefore, this application is being made now.

66. In respect of the periodontist report on Patient A, Mr Vullo submitted that this forms part of Patient A's medical records. He submitted that whether there was harm caused to Patient A is an important issue in this case. He also submitted that Patient A's mother read the report out during her oral evidence, and it will therefore assist the Committee to have a copy of it.

GDC Submissions

67. Miss Barnfather, on behalf of the GDC, submitted that Mr Vullo has been persistent and consistent in his attempts to adduce evidence in respect of whether there is a reasonable body of practitioners that practise orthotropics. However, she submitted that this is irrelevant as the only matters the Committee needs to decide on is your specific treatment of Patients A and B. She submitted that the Committee will be assisted in this by the qualified professional opinion of the experts.

68. Miss Barnfather took the Committee through the chronology of the case and informed it that the GDC had been provided with these witness statements last week. She submitted that if these witness statements are accepted by the Committee then she would have to cross-examine each of the witnesses and this will delay the progress of the hearing.

69. Miss Barnfather took the Committee through each witness statement. She submitted that each of the statements were set up in the style of an expert

report, for example in the way that it details the author's background and professional credentials. She further submitted that the statements contained opinion evidence, which was not admissible, and none of the witnesses were independent.

70. In respect of Dr Kahn's academic paper, she submitted that this has been included in order to rebut any allegations made by Dr Smith about Dr Kahn's integrity. She submitted that Dr Smith raised concerns about the quality of the science and the inappropriate extrapolation of data. However, the witness statement does not assist the Committee in deciding on the scientific merit of the paper.

71. In conclusion, Miss Barnfather submitted that the witness statements were neither admissible nor helpful to the Committee. She submitted that they make a mockery of the whole process of expert opinion evidence, and she strongly urged the Committee to reject the application.

72. In respect of the periodontist report on Patient A, Miss Barnfather submitted that the document is not admissible as it does not form part of your medical records regarding your care and treatment of Patient A. Therefore, she submitted that it is a hearsay document and should have been accompanied by a witness statement from the periodontist. She submitted that it is ultimately a matter for the Committee as to whether it is helpful, and whether it is fair and in the interests of justice for it to be admitted.

The Committee's Decision

73. The Committee took into account the submissions made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with your interests.

74. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

> *(3) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.*
>
> *(4) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.*

75. The Committee first considered each of the witness statements in turn with regard to the issue of whether they would assist the Committee in its deliberations. In respect of these witness statements, it noted that they are not being called as expert witnesses. However, their statements contained opinion evidence, which would not be admissible. The Committee also noted Mr Vullo's submissions that the intention for adducing this evidence was to show that there was a reasonable body of practitioners that practised orthotropics. However, the Committee noted that it had already heard evidence from your expert Professor Sheldon on this topic, it has had sight of academic papers regarding the practise of orthotropics and similar therapies, and is aware of these being practised on a global basis. Furthermore, the Committee noted that it is due to hear evidence from your other expert, Professor Daniele Garcovich, who can also opine on this issue as appropriate.

76. The Committee also bore in mind the effect that this might have on the progress of the hearing. It noted that if it allowed the evidence to be admitted, this may have an adverse effect on the hearing proceeding expeditiously. The Committee noted that this hearing was originally listed in November 2021, then November 2022, and that some allegations date back to September 2016 (seven years ago).

77. The Committee next considered Dr Kahn's witness statement, with particular reference to her academic paper. The Committee noted that this was an important issue for you, particularly in light of the criticism made by Mr Smith of the paper during his oral evidence. However, as stated above, the Committee was mindful of the impact this may have on the timely progress of the hearing if the statement were to be admitted. The Committee was satisfied that it will be in a position to consider the academic paper. It noted that it had already heard from Professor Sheldon in this regard, and is yet to hear from Professor Garcovich. It further noted that Mr Smith had withdrawn, and apologised for, his earlier criticisms he made regarding the impartiality of the paper. The Committee concluded, therefore, that the potential delay to the hearing would outweigh any benefit it would receive from admitting this evidence.

78. Accordingly, the Committee determined that the witness statements from Dr Hockel, Dr Jones and Dr Kahn should not be admitted into evidence.

79. The Committee then considered the periodontist report on Patient A. The Committee was already aware of the contents of this report as it had already been read out in full by Patient A's mother during her oral evidence without challenge from either party. The Committee acknowledged that the document was hearsay evidence, but considered that it would be fair to you to admit it into

evidence. The Committee would then consider the weight it should attach to it when making its decision at the fact-finding stage.

80. Accordingly, the Committee determined that the periodontist report on Patient A should be admitted into evidence.

81. In respect of Patient B's mother's patient complaint to the GDC, dated 30 March 2019, the Committee noted that you did not oppose the GDC's application. Accordingly, the Committee determined that this document should also be admitted into evidence.

Application under Rule 57 to adduce evidence (13 November 2023)

82. Mr Vullo, on your behalf, made an application under Rule 57 of the General Dental Council (Fitness to Practise) Rules 2006 ('the Rules") for the following documents to be admitted as evidence:

    - An abstract of an MSc thesis from Texas A&M University (the Texas Abstract);
    - An addendum report considering the Texas Abstract, dated 10 November 2023, from Professor Daniele Garcovich.

83. Both Mr Vullo and Miss Barnfather provided the Committee with written submissions and gave oral submissions in respect of this application.

Your Submissions

84. Mr Vullo informed the Committee that the MSc thesis from Texas A&M University is the second study of the patients treated by Dr Simon Wong, following the study conducted at the University of Alberta in the form of the Tavoosi thesis. He submitted that following the existence of the Texas Abstract coming to light this was immediately served on the GDC on the morning of 13 October 2023, which was the last day of the previous sitting of this hearing. The Texas Abstract was posted on Texas A&M University's website. He submitted that his team has contacted the University to obtain the full thesis. However, they have not received any response and the author of the thesis has placed the work under an embargo. He informed the Committee that the reasons for the embargo are not known, and therefore no adverse inference should be drawn from this. He submitted that his team would continue to make enquiries with the University in order to obtain disclosure of the thesis.

85. Mr Vullo submitted that he seeks to rely on the Texas Abstract and the addendum report on the abstract by Professor Garcovich. He submitted that the results of the study, as contained in the Texas Abstract, are significant and

positive from the perspective of Orthotropics. He submitted that although there are limitations with the Texas Abstract, this does not make it inadmissible. If it is admitted into evidence, the Committee would be able to judge the weight to give it. He submitted that it provides balance to what has been said about the Tavoosi thesis and should be admitted as a matter of fairness. He further submitted that the Texas Abstract is highly relevant to these proceedings as it is, along with the Tavoosi thesis, part of the best evidence regarding the practice of Orthotropics that exists at this time. Therefore, he invited the Committee to admit both the Texas Abstract and Professor Garcovich's addendum report into evidence.

GDC Submissions

86. Miss Barnfather, on behalf of the GDC, opposed the application. She informed the Committee that the Texas Abstract is dated 1 May 2023, but was not provided to the GDC until 13 October 2023. She referred the Committee to day 16 of the hearing on 11 July 2023 when Mr Vullo cross-examined Dr Powell about the ongoing Texas study. However, she submitted that the Committee has no evidence in respect of this study other than by way of reference to the Texas Abstract and Professor Garcovich's comment. She submitted that the GDC has been seeking information from your representatives about the study since July 2023 and understood that issues had arisen in respect of it and that it required further work prior to completion and publication. She queried whether that was the reason the thesis had been embargoed by the author.

87. Miss Barnfather submitted that the Texas Abstract is of low quality and does not set out a clear outline of the study objectives, a clear outline of the methodology, the results and discussion, or a conclusion. She submitted that it is striking that Mr Vullo has submitted that weight should be given to this embargoed thesis following his previous position that no weight should have been given to the Tavoosi thesis. She submitted that the difference between both the studies is that the experts can comment on the strengths and weaknesses of the Tavoosi Thesis, but they are unable to do this with the isolated Texas Abstract. She submitted that the Texas Abstract provides no information about the selection criteria for the 46 patients selected or about the control group, and the methodology is unclear and questionable. Furthermore, she submitted that the abstract is inadequate to provide any relevant and meaningful evidence to assist the Committee in reaching its findings with regard to the claims made, and treatment provided, to Patients A and B.

88. In respect of Professor Garcovich's report, Miss Barnfather submitted that he has sought to rely on the Texas Abstract to support his opinion in favour of your case and Orthotropics. She submitted that his report does not address the limitations and weaknesses of the Texas Abstract, but references the university's status to lend support to the abstract's purported conclusions. She submitted that this

raises questions about his impartiality as an expert, and that there is insufficient information in the Texas Abstract for him to make the comments and opinions in his addendum report.

89. In conclusion, Miss Barnfather referred the Committee to its powers to admit evidence under Rule 57(1) of the Rules and submitted that neither the Texas Abstract nor Professor Garcovich's addendum report would be admissible in civil proceedings. She referred to Rule 57(2), which allows the Committee to admit other evidence that it considers would be of assistance and in the interests of justice to admit it. However, she submitted that the evidence would neither be helpful to the Committee nor would it be in the interests of justice to admit it, but it unnecessarily further protracts the proceedings and diverts from the issues and other evidence properly available from both sides.

The Committee's Decision

90. The Committee took into account the submissions, written and oral, made by both parties and accepted the advice of the Legal Adviser. The Committee had regard to the interests of justice and remained mindful of the principle of fairness. It balanced the interests of the GDC with your interests.

91. The Committee noted its powers under Rules 57(1) and 57(2), which are as follows:

> *(5) A Practice Committee may in the course of the proceedings receive oral, documentary or other evidence that is admissible in civil proceedings in the appropriate court in that part of the United Kingdom in which the hearing takes place.*
>
> *(6) A Practice Committee may also, at their discretion, treat other evidence as admissible if, after consultation with the legal adviser, they consider that it would be helpful to the Practice Committee, and in the interests of justice, for that evidence to be heard.*

92. The Committee firstly acknowledged that the full thesis has been embargoed and there is no current information about when or if this will be lifted. The Committee was also mindful of the limitations of the Texas Abstract, as mentioned in Professor Garcovich's report. For example, the abstract has not been peer reviewed and there was no information regarding the methodology used. However, notwithstanding these limitations, the Committee considered that the Texas Abstract does appear to be relevant to the issues in this case, in that it relates to the efficacy of Orthotropics, by re-analysing material similar to that dealt with in the Tavoosi Thesis. It noted Professor Garcovich's report which

states that the abstract is supportive of the practice of Orthotropics. The Committee also bore in mind that the Tavoosi thesis has already been admitted into evidence.

93. The Committee also considered any potential delay to proceedings that admitting this evidence may cause. It noted the GDC submissions that their experts would need to consider the Texas Abstract and a joint expert report would need to be produced. However, the Committee noted that any potential delay was mitigated by the fact that this was a discrete issue in respect of a short abstract document which could be dealt with expeditiously.

94. The Committee considered, therefore, it would be fair to you and in in the interests of justice to admit both the Texas Abstract and Professor Garcovich's addendum report into evidence. The Committee considered that the Texas Abstract, along with the Tavoosi thesis, represents the available current evidence regarding the efficacy of Orthotropics. The Committee therefore believes that it merits further exploration by the experts in this case. The Committee would then consider the weight it should attach to it when making its decision at the fact-finding stage.

95. Accordingly, the Committee determined that the Texas Abstract and Professor Garcovich's addendum report should be admitted into evidence.

Evidence Received

96. The factual evidence from the GDC included signed witness statements from Witness 1 (dated 24 September 2020 and 19 March 2021) and Witness 2 (dated 7 July 2022), a general dentist who was employed at your clinic from 2017 until 2020. In addition, the Committee heard oral evidence from Witness 1 and Witness 2.

97. Furthermore, the Committee received a signed statement from Witness 3, a member of the British Orthodontic Society (BOS) who raised concerns with the GDC on 25 September 2017 about the alleged claims you made in your YouTube video. Witness 3's statement was received into evidence by agreement without the need for the witness to attend the hearing. The Committee was also provided with the footage and transcript for two YouTube videos, one entitled *'Orthodontics Beyond the Teeth'* and the second entitled, *'A response to Mike Wertheimer'*.

98. The Committee was provided with dental and hospital records for Patient A and Patient B.

99. The GDC's expert evidence comprised expert reports from Mr Stephen Powell, a specialist in Orthodontics, dated 18 October 2022, and from Mr Keith Smith, a specialist in Oral and Maxillofacial Surgery, dated 21 April 2021. Mr Powell and Mr Smith also gave oral evidence at this hearing. Further addendum reports, dated 1 February 2024 and 2 February 2024, were received from Mr Smith and Mr Powell respectively.

100. The Committee was also provided with a thesis titled '*Skeletal and Dental Changes from the Compliance-based Orthotropic Treatment Approach with Exercises to Improve Orofacial Posture'* carried out by Dr Faraz Tavoossi (*'the Tavoossi Thesis')*. Expert reports, both dated 4 April 2023, were also provided in respect of this thesis from Mr Powell and Mr Smith. Further, the Committee were later provided with an abstract of an unpublished thesis titled *'The Effects of Early Biobloc Treatment on Hyper Divergent children' ('The Harvey Abstract')*. This was followed by addendum statements by Mr Smith and Mr Powell, dated 1 and 2 February 2024 respectively.

101. The evidence the Committee received from you included your witness statements, dated 27 October 2022, 20 March 2023 and 22 March 2023, and a further undated statement. In addition, it heard oral evidence from you.

102. The Committee also received the following signed witness statements:

- Two statements from Dr Simon Wong, a general dental practitioner in Australia, dated 26 October 2022 and 22 February 2024;
- Witness 4 (Patient A's mother); dated 25 October 2022 and 22 February 2024;
- Ms Lucinda Hawthorn, solicitor, dated 17 November 2023, 1 December 2023 and 19 January 2024;

103. Your expert evidence consisted of reports from Professor Daniele Garcovich, an Associate Professor in Paediatric Dentistry and Professor in the Master of Advanced Orthodontics in Spain, dated 26 October 2022 and 3 May 2023, and from Professor Stephen Sheldon, a Professor of Paediatrics and Neurology in the USA, dated 26 October 2022. Professor Garcovich also provided addendum reports, dated 30 May 2023 and 10 November 2023, in respect of the Tavoossi Thesis and Harvey Abstract respectively. Professor Garcovich and Professor Sheldon gave oral evidence at this hearing.

104. Joint expert reports by Mr Powell, Mr Smith and Professor Sheldon, and by Mr Powell, Mr Smith and Professor Garcovich, were also made available to the Committee.

105. The Committee was also provided with historical character references provided in support of your case from Professor Sheldon, dated 4 September 2019, and from Professor Garcovich, which was undated. These character references were prepared prior to their engagement as experts in this case.

The Committee's Approach

106. The Committee considered all the documentary evidence presented to it, which included those listed above. It took account of the submissions made by Miss Barnfather, on behalf of the GDC, and Mr Vullo's submissions on your behalf. The Committee heard and accepted the advice of the Legal Adviser. In accordance with that advice, it has 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 matters are found proved on the balance of probabilities.

107. Before making its decision on the facts, the Committee considered that it would be appropriate, in the particular circumstances of this case, to set out its views on the following matters:

- Orthotropics;
- Expert Evidence;
- The Tavoossi Thesis;
- The Harvey Abstract;
- The Jaw Epidemic;
- Clinical Indication;
- Adequate Objective Evidence;
- Application of The Bolam/Bolitho Test.

Orthotropics

108. The Committee noted from Mr Vullo's written closing submissions that, *'Orthotropics combines bimaxillary expansion, functional devices based on basic principles of physics, human behaviour and myofunctional therapy. All of these treatment modalities are widely practised and well supported in the scientific literature.'* The Committee further noted from Mr Vullo's submissions that, '*the efficacy of the treatments provided under orthotropics (expansion/functional devices/myofunctional therapy) are well evidenced in the scientific literature…*'.

109. The Committee noted that functional devices of different types had been used for many years in mainstream Orthodontics, and therefore some of the treatment modalities were similar to the ones used in Orthotropics. For example, the use of

neckgear in Orthotropics was not unique in itself, but similar in concept to the headgear used in mainstream Orthodontics.

110. However, the Committee did consider that the core belief which underpins Orthotropics was unique in that its premise is that environmental factors are the major cause of malocclusion, as opposed to the mainstream Orthodontic view that, while there may be environmental factors at play, genetics is the primary cause. Furthermore, Orthotropics is unique in claiming that it can purportedly prevent other health issues developing relating to breathing, swallowing and sleep apnoea.

111. After taking account of all the evidence in this case, the Committee did not consider that environmental factors are the primary cause of malocclusion. The Committee noted that there was no adequate objective evidence to support this view and the emerging view within the profession, and re-iterated at times by experts in this case, was that the cause of malocclusion was multi-factorial. As to whether Orthotropics could cure disorders such as sleep apnoea, the Committee noted the views of Professor Sheldon and Professor Garcovich, who both stated that such treatment would require a multi-disciplinary approach.

Expert Evidence

112. Turning to the question of expert evidence generally, the Committee reminded itself of the guidance provided by the Legal Adviser. Given the volume of information and evidence in this case, the Committee found it beneficial to outline its thinking on the expert opinion, both generally and individually. There are four experts in this case: Mr Powell and Mr Smith, instructed by the GDC, and Professor Garcovich and Professor Sheldon, instructed by you. No expert has been called by you who purports to be a specialist or practises in Orthotropics, although the Committee has of course heard from you on this issue.

113. The Committee has carefully weighed and considered the expert evidence before it. It had some criticisms of both Mr Powell and Mr Smith in the way that they presented their evidence. However, it felt that this was outweighed by their skill, experience and expertise as detailed below.

114. In relation to Professor Garcovich and Professor Sheldon, the Committee also had concerns about their evidence. Professor Garcovich is a friend of yours and prepared a character reference for you in these proceedings prior to being instructed as your expert. It had similar concerns about Professor Sheldon. He too acted as a character referee for you in these proceedings before being instructed as your expert.

115. Further, neither Professor Garcovich nor Professor Sheldon seemed to be familiar with the formal requirements of acting as an expert in proceedings of this nature or the obligations of experts as set out in the legal advice given to the Committee and highlighted in the case of *'The Ikarian Reefer'* as recently applied and discussed by Mr Justice Cotter in the case of *Brian Muyepa v MOD (2022) EWHC 2648.* This may very well be because of their lack of familiarity with the responsibilities of being an expert in disciplinary proceedings in the UK or general regulatory inexperience.

116. On balance, the Committee found Mr Powell and Mr Smith to be the more persuasive experts. That is not to say that it did not accept in part, and in relation to some of the issues in the case, the evidence of Professors Garcovich and Sheldon.

Mr Stephen Powell

117. The Committee had regard to Mr Powell's full CV. It considered that he is an Orthodontist with many years' experience and he is well-qualified to provide expert evidence in this case. The Committee did note, however, that he was firm in his view that genetic factors are the main cause of malocclusion, and he appeared unwilling to consider alternative views. Mr Powell was very clear about the hierarchy of evidence and the required standards of objective evidence, consistently stating the primacy of the randomised control trial. However, Mr Powell also showed even-handedness by taking the Committee to the Proffit textbook on a number of occasions (*'Contemporary Orthodontics'*, 2018). Proffit's book is one of the most well-respected texts within Orthodontics, together with Graber's textbook (*'Orthodontics: Current Principles and Techniques'*, 2023). Proffit is clear on the need for evidence but also the acceptability of using clinical assessment where the evidence is lacking.

Mr Keith Smith

118. The Committee noted that Mr Smith's CV and experience in Maxillofacial surgery qualified him to opine on facial structures and maxillofacial matters. They considered him less well qualified to opine on orthodontics. The Committee also found at times, as noted in its *'No Case To Answer'* determination, dated 19 July 2023, that Mr Smith made some unfortunate comments during his oral evidence, relating to assertions of your involvement with the Kahn paper (*'The Jaw Epidemic'*). These assertions, for which he apologised, were later withdrawn. Nonetheless, it noted that he was willing to disagree with Mr Powell on some issues, for example he did not agree with Mr Powell about the need for randomised control trials to show the efficacy of Orthotropics. Mr Smith has also agreed with your experts on some issues.

Professor Daniele Garcovich

119. The Committee noted from Professor Garcovich's CV that he was qualified as an Orthodontist to provide expert evidence in this case. The Committee noted his view that there were shared aspects in the practice of both Orthotropics and Orthodontics. The Committee also considered that he attempted to be fair and balanced.

120. The Committee noted that he had provided a character reference for an earlier listing of this hearing, and that he had been a friend of yours. The Committee considered whether this undermined his evidence as an independent expert witness. However, the opinions in his character reference were balanced and consistent with his opinions in his expert report. For example, the Committee noted the following from his character reference, '*A literature review at this stage suggests a lack of evidence to prove that early treatment carries additional benefit over an* [sic] *above that achieved with treatment commencing later; however, this does not necessarily imply that early treatment is ineffective'.* The Committee noted that he re-iterated this view in his expert report.

121. The Committee did consider that it was highly unusual for an expert to act on behalf of a Registrant in professional disciplinary proceedings, having also provided a character reference in support of the same Registrant. It was also noted that this was not disclosed in his expert report. Furthermore, the Committee noted that his expert report did not include the standard expert declaration contained in such reports. The Committee bore these matters in mind when considering his evidence in determining the charges in this case.

122. The Committee also noted that he acknowledged that the evidence in support of Orthotropics was controversial. Furthermore, although he was appearing as your expert witness, the Committee noted that he was not afraid to criticise you during his evidence, for example when he suggested that you made too many "*sharp comments*" at times and were prone to exaggeration. Overall, the Committee was satisfied that he tried his best to assist it by giving a balanced and unbiased opinion on Orthotropics.

Professor Stephen Sheldon

123. The Committee noted that Professor Sheldon had also provided an earlier positive character reference for you. The Committee noted that as a specialist in Sleep Medicine, he had limited knowledge of the practice of Orthotropics. The Committee noted that he referred patients, potentially for Orthotropics, but did not see the results of those treatments.

124. The Committee noted that when giving oral evidence, Professor Sheldon appeared not to understand the duties of an expert witness within a UK regulatory system. Furthermore, the Committee noted that he was not present at the hearing to hear the GDC experts' evidence. The Committee concluded that Professor Sheldon was very well-qualified to opine on sleep apnoea as an expert. However, whilst his suitability to opine on Orthotropics was limited, the Committee found his evidence helpful regarding the multi-disciplinary approach required in the treatment of patients, and the circumstances in which he would refer patients on for the consideration of Orthotropic treatment.

The Committee's View on the Expert Opinion

125. The Committee was taken to a large amount of academic review, discussion, and research papers. Tab 10A, titled '*Index for exhibits to defence witness statements*', contained 15 articles; Tab 10B, *'Index to reference materials used by defence experts*', contained 86 papers; and Tab 14, *'Additional research articles*', contained a further 19 articles. You were taken and cross examined on these articles and papers.

126. The Committee was aware throughout that no Orthotropic practitioner has been called as an expert in this case. In making its way through the volume of academic papers put before it, the Committee has had regard to the experts' guidance and opinions. Ultimately this Committee has to accept or reject the opinions of the experts in this case, based upon its own weighing of their evidence. The Committee noted that these research papers do relate to distinct elements of the Orthotropic premise. For example, they examine the issue of environmental effects on growing patterns, or historically analyse changes in skull dimensions. The Committee was of the view that these papers, while having varying degrees of significance, do not address the issue of whether Orthotropics, as practised by you, achieves the specific and wider results described.

127. The Committee preferred the expert advice of Mr Powell and Mr Smith. It found that Mr Powell and Mr Smith were more appropriately placed to independently comment because of their professional qualifications and experience, as shown in their CVs, and because their backgrounds were more relevant to the wider issues in this case, including orthodontics and maxillofacial growth. They were able to comment on the standards expected of dental/orthodontic treatment within the United Kingdom. Also, they were able to articulate the need for an evidence base for the outcome of Orthotropics in a persuasive manner.

The Tavoossi Thesis

128. The Tavoossi thesis, which analyses material provided by Dr Wong, was admitted into evidence during the hearing. It appears that you were aware of this thesis but did not bring it to the attention of the GDC. The objective of the research is to investigate the skeletal and dental changes that occur using an orthotropic treatment approach. The thesis reports that there is insufficient evidence to conclude that the treatment protocol has a meaningful effect on skeletal and dental changes.

129. The Committee noted that the Tavoossi Thesis was the only comprehensive evidence available to the Committee relating to Orthotropics, as accepted in evidence by yourself. The Committee was mindful of the experts' evidence on the thesis and the criticisms made by Mr Vullo, on your behalf. This paper and its findings are consistent with the opinions given by Mr Powell and Mr Smith.

The Harvey Abstract

130. During the hearing, the Harvey abstract, which also analyses material provided by Dr Wong, was admitted into evidence. The full thesis has not yet been published, as it is subject to an embargo. However, it was thought to be fair to admit the abstract, as this was the second independent piece of research conducted into orthotropic related interventions. The thesis attempts to evaluate the skeletal and dental changes produced when treating hyperdivergent children with biobloc appliances. This preliminary study showed that biobloc therapy produces significant improvements within skeletal and dental relationships.

131. The Committee was mindful that it was accepted by all parties that this was an abstract and it was, therefore, cautious when considering the abstract's conclusion that biobloc therapy produced significant improvements in outcomes.

The Jaw Epidemic

132. *'The Jaw Epidemic'* is an article much relied on by you. This paper was put before the Committee in the original bundle of papers and supplementary material. There was extensive cross examination of the GDC experts on this paper (Mr Powell on 3 July 2023, Mr Smith on 14 July 2023), and it is cited by Mr Vullo in his closing remarks, stating that this paper is *'of crucial importance'* and provides *'high level scientific support'*. The Committee agrees with the GDC expert opinion that this is an overview paper, and so by definition does not provide any new research-based evidence.

Clinical Indication

133. The Committee considered the nature of clinically indicated treatment, particularly with regard to this case. Professor Garcovich highlighted the importance of the patient's wishes within Orthodontics and the Committee accepts that this is one of a number of factors that has to be taken into consideration. It also balanced this approach with the views of the GDC experts that neither Patient A nor B had any obvious need for treatment at the time. Ultimately the Committee preferred the view that the provision of any treatment, especially when the stated outcomes are wider than the purely aesthetic, has to be considered alongside a number of other factors, including patient/parental wishes, risk, medical history, the evidence base, and the possibility of any issues resolving through normal growth patterns.

Adequate Objective Evidence

134. The Committee also had to consider the nature of adequate objective evidence. It noted your reliance on a number of academic papers which deal with the foundational thinking behind the Orthotropic hypothesis. The Committee balanced this with the acceptance that there is extremely limited objective research (namely one published thesis and an abstract) into the outcomes of orthotropic based interventions, and that this evidence was not available at the time of the matters that are the subject of this hearing. The Committee also reminded itself of the frequent occasions during examination and cross examination when you accepted that the evidence was lacking, and that Orthotropics remains hypothetical. Based on this, the Committee concluded that there was a lack of adequate objective evidence to support the claims and efficacy of Orthotropics.

135. The Committee accepted the expert opinion of Mr Powell and Mr Smith on this issue and has also accepted the frank admissions made by you concerning the lack of objective evidence regarding Orthotropics. Although it has taken into account and considered the numerous research papers in this case, which have been carefully considered by the experts, it reminded itself that its task was to accept or reject the expert opinion that is currently before it from the four experts involved in this case. The relevance of many of these papers cannot be fully understood without expert guidance and opinion.

136. It is important to note that when considering whether there is objective evidence to support the claims/efficacy of Orthotropic treatment, the Committee has considered very carefully your views on the issue. In particular, it noted your observations in oral evidence when cross-examined on this question of objective evidence:

"Q. If you put your father to one side, this as a factual statement is true, is it not, apart from the Tavoossi thesis, there is no research into the Mew Orthotropics?
A. If I put aside all the papers that my father was involved in, including other people, then, yes, that is true."

"Q. The answer to the question is this an unproven hypothesis is yes, is it not?
A. In relative terms, yes, it must be, more so than more conventional orthodontists."

"Q. Do you accept this – and I think we are agreed on this – you did not have adequate objective evidence – objective meaning not your own – objective evidence to suggest the treatment proposed would achieve the aims that you claimed?
A. The objective evidence of…
Q. As opposed to your own.
A. Out of our own evidence and our own research and own what we're doing, probably not."

"Q Mr Mew, is the short answer to the question that you don't have evidence?
A For elements of it clearly I don't have evidence."

137. Further, the Committee noted that on a number of occasions during your oral evidence, you have requested that there is research done in relation to obtaining objective evidence to support Orthotropics:

"I have written to all the dental schools. I have tried to engage with Guy's, Thomas's and King's. The professor they have they train 25 per cent of the dentists in the country. I am saying to him, "Look, you know, this is different. I would love to have a chat with you. I would love to start some research".

"You know, I've been trying so hard and my father before me. We just want engagement. We want some level of scientific engagement so that I can answer these questions…. I just want to do the most basic research. I'm in your catchment area. Please can I – help me run a cohort, run some comparisons. Help me get the information so that when I turn up in court like this and Ms Barnfather says to me, 'You haven't got this objective evidence' I can say, 'Ah yes, here it is'".

138. Further, during the *Wertheimer Response* YouTube video, you confirmed that Orthotropics required a huge amount of research and said, *"…don't ask me to defend or to prove Orthotropics"*.

139. The Committee would like to add that you clearly want your ideas to be researched further so that they can be supported by objective evidence, but at this present time, the Committee accepts the views expressed by Mr Powell and Mr Smith and your observations when cross-examined that such objective evidence is currently not available.

Application of The Bolam/Bolitho Test

140. The Committee was addressed by both parties on the case of *Bolam v Friern Hospital Management Committee [1957] WLR 582* as modified by *Bolitho v City & Hackney Health Authority [1998] AC 232.* The Bolitho test, the Committee is informed, is applied in civil courts in clinical negligence cases and is used to establish if a clinician has acted in breach of duty by judging his act or omission by the standards of a responsible body of medical opinion. The Bolam test itself does not form part of the charges that are before the Committee. Whether treatment would be supported by a responsible body of dental opinion is a matter that has been considered by the Committee, having addressed the expert evidence before it and its relevance in relation to specific charges. The Committee has considered whether a responsible body of practitioners would have carried out similar treatments in relation to Patients A and B. The relevance of the Bolam test in this case is whether the treatment offered and claims made by you would be supported by a responsible body of dental/orthodontic opinion. On this issue, the Committee has been guided by and preferred the evidence of Mr Powell and Mr Smith.

The Committee's Findings of Fact

141. The Committee's findings in relation to each head of charge are as follows:

1.	Between September 2013 and May 2019, you provided advice and treatment to:
1(a)	Patient A; and **Admitted and Found Proved** The Committee accepted your admission to this head of charge.
1(b)	Patient B. **Admitted and Found Proved** The Committee accepted your admission to this head of charge.

Patient A	
2.	In September 2016, when Patient A was 6 years old, you recommended she underwent treatment you referred to as '*Orthotropic'* treatment involving:
2 (a)	upper and lower arch expansion appliances; **Admitted and Found Proved** The Committee accepted your admission to this head of charge.
2 (b)	the wearing of neck gear. **Admitted and Found Proved** The Committee accepted your admission to this head of charge.
3.	You informed Patient A's parents that the principal aims of the treatment you proposed were: (a) to expand Patient A's upper and lower arches and thereby "*make way for the tongue, far more than would be required for the teeth*"; (b) to "*gain a substantial increase in nasal capacity*"; (c) to "*improve the midface (the area under the eyes and either side of the nose)*"; (d) to "*change the swallowing pattern*"; (e) to "*correct the cause of the problem and guide facial growth and development through gaining structural changes of facial and dental form" and through "correcting the oral environment in this way, more space for the teeth and tongue is created, so that all the 32 teeth (including the wisdom teeth) align naturally without the need for fixed braces*"; (f) based on, "*the Tropic Premise which states that anyone who exhibits a number of features will have permanently well aligned teeth and good facial form*", the features to be exhibited including standing up straight, establishing a lip seal with nasal breathing, maintaining a "*Butterfly bite*", resting with the tongue on the roof

	of the mouth and swallowing with the tongue on the roof of the mouth. **All Admitted (in context)** **Found proved in its entirety** You admitted to head of charge 3 in its entirety. However, you stated that the information you provided to Patient A's parents must be seen in the context of all the information and advice you provided to them. The Committee had sight of the document titled, '*Classic Orthotropic Therapy*' which was included with your letter to Patient A's parents, dated 21 September 2016. The Committee was satisfied that all of the quotations contained in heads of charge 3(a) to 3(f) were contained within this document. Accordingly, the Committee found head of charge 3 proved in its entirety.
4.	Patient A had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development. **Admitted (in context)** **Found Proved** The Committee noted your admission to this head of charge in that you agreed that Patient A having a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development would have been the mainstream orthodontic diagnosis. The Committee had sight of Patient A's records, including the photographs of Patient A. The Committee noted that both the GDC experts, Mr Powell and Mr Smith, agreed with this diagnosis. It is stated within the joint expert report that they both, '*agree the photos and records show a normal skeletal pattern, within the normal range of a growing child*'. The Committee noted that Professor Garcovich largely agreed with the GDC experts' view in the joint expert report. He stated within the joint expert report that, '*…the photos and records show the craniofacial form and occlusion are around the norm…*'.

	The Committee accepted the evidence of the GDC's experts in this regard and noted that you acknowledged that this would have been the mainstream Orthodontic diagnosis. Furthermore, the Committee noted that Professor Garcovich on balance agreed with this diagnosis. Accordingly, the Committee found this head of charge proved.
5.	Your recommendations for treatment and comments as set out at paragraph 2 and/or 3 were inappropriate and/or misleading in that:
5(a)	treatment was not clinically indicated for Patient A; **Not Admitted** **Found Proved (Head of Charge 2 – inappropriate only)** **Found Not Proved (Head of Charge 2 – misleading)** **Found Proved (Head of Charge 3 – inappropriate and misleading)** You denied this head of charge. You stated in your oral evidence that you had decided that treatment was clinically indicated after analysing the photographs of Patient A, which showed that her face had lengthened and there was crowding of her lower front teeth. The Committee noted that both the GDC experts agreed that the photographs of Patient A showed that she did not have downswing of her facial form and had a normal and balanced face. They concluded, therefore, that there was no clinical indication for treatment. Furthermore, Mr Powell stated that if Patient A's parents were concerned then the patient could have been seen again in 18 months and there was no need to take immediate action. Professor Garcovich stated in the joint expert report that the records provided were insufficient to determine whether treatment was clinically indicated for Patient A and that it would be down to the wishes of the parents. The Committee further noted Mr Vullo's closing submissions, in which he stated that '*clinically indicated*' is not the same as clinically necessary as the vast majority of mainstream orthodontics are done for aesthetic reasons. In this case, he submitted that Patient A's mother sought treatment as she was concerned about mild crowding, wanted to avoid extractions and wanted Patient A to have the benefit of being a nose breather. Mr Powell and Mr Smith were consistent in their opinions that the photographs of Patient A did not show a clinical need for treatment.

	Professor Garcovich was open-minded both about the need for treatment, and the form any such treatment might take. The Committee accepted the GDC experts' opinion that in the absence of cephalometric analysis the measurement of the soft tissues was not a reliable indicator of any abnormalities and also accepted their opinion that growth patterns may change naturally. It therefore accepted the logic of the GDC experts' opinion to wait a further 18 months before re-visiting any clinical indication for treatment. It noted that there was mild overcrowding but this was not significant enough to justify urgent clinical intervention. The Committee further noted that the Orthotropic treatment, was invasive and required in your own words, *'tough love'*. The Committee determined that this would be disproportionate in the context of Patient A's case of mild overcrowding. The Committee noted that it has previously determined that Patient A had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development. It considered that it would have been more appropriate to see the patient again in 18 months, as suggested by Mr Powell, which would have negated the need for urgent treatment with its attendant risks. The Committee determined that your recommendations for treatment for Patient A and comments, as set out at heads of charge 2 and 3, were not clinically indicated and were therefore inappropriate. In respect of misleading, the Committee concluded that there was nothing in the wording of head of charge 2 that could be constituted as misleading as you were recommending treatment that was subsequently carried out. Accordingly, the Committee determined that your recommendations for treatment were not misleading and found this not proved. The Committee next went on to consider head of charge 3. It bore in mind that it has found proved that your treatment for Patient A was not clinically indicated. It therefore concluded that the representations you made regarding that treatment and its aims were inappropriate. In respect of misleading, the Committee first went on to determine head of charge 5(b) before considering this head of charge. It determined in 5(b) that there was no adequate objective evidence to suggest the treatment proposed for Patient A would achieve the aims stated. In light of its conclusion, the Committee determined that your actions were also

	misleading, in that they described unevidenced outcomes, as well as inappropriate.
5(b)	you had no adequate objective evidence to suggest the treatment proposed for Patient A would achieve the aims stated. **Not Admitted** **Found Proved (inappropriate and misleading)** When considering this head of charge, the Committee considered heads of charge 2 and 3 together. The Committee noted from the Joint Expert report, that both Mr Smith and Mr Powell were clear in their opinion that there was no objective evidence to support the Orthotropic treatment you were recommending or the aims of the treatment. The Committee also noted that you had conceded that there was no objective evidence to support Orthotropic treatment. The Committee acknowledged that there is emerging evidence on the efficacy of Orthotropics. However, it considered that taken as a whole treatment pathway from initial diagnosis to completion, there is currently insufficient objective evidence to support it. The Committee reminded itself that the only entire piece of independent research before it (the Tavoossi Thesis) reported that there was insufficient evidence to conclude that Orthotropics has a meaningful effect on skeletal and dental changes. Accordingly, the Committee found proved that your actions at heads of charge 2 and 3 were inappropriate and misleading in that you had no adequate objective evidence to suggest the treatment proposed for Patient A would achieve the aims stated.
6.	You inappropriately informed Patient A's parents:
	(a) "*Most orthodontists have been told that we are not evidence based and are "bad" but few really have any idea of what we do*"; (b) "*for younger children it is also important to push many orthodontists into giving their opinion as to what may happen in*

the future, as it is too easy to sit on the fence and placate parents for years until it is too late to avoid extractions or surgery."

Not Admitted
Found Proved in its entirety

The Committee had sight of and noted that these quotations were taken from page 3 of the Orthotropic Clinical Information Sheet, which was sent to Patient A's mother along with the consultation letter dated 17 October 2014.

You denied this head of charge. You stated that the above quotations had to be read in their proper context as they were excerpts from a wider section which was titled, '*choice*'.

In your witness statement, you stated that:

'*As will be apparent from the full quotation, the overall purpose of this section was to advise patients to obtain a second opinion from a conventional Orthodontist before deciding to proceed with Orthotropic therapy. This was to ensure that parents were able to make a properly informed choice before deciding to commence Orthotropic therapy. I believe this is appropriate advice to give to patients.*'

Both Mr Powell and Mr Smith stated that these comments were unprofessional, and Professor Garcovich called these "*sharp*" comments.

The Committee acknowledged that these comments were part of your overall advice to patients before they commenced Orthotropic treatment. The Committee further noted that your stated motive in providing this advice to patients was so that they could make a properly informed choice.

However, the Committee also noted that by stating that "*most orthodontists have been told that we are not evidence based...*" would lead most patients to infer that Orthotropics was in fact evidence based. Furthermore, the Committee noted that the advice you provided was in the context of a patient seeking a second opinion. The Committee determined that, based on your advice, patients would have pre-determined thoughts about the reliability of any advice they would

	receive from Orthodontists, and this would impact on their treatment choices. In conclusion, the Committee acknowledged that the stated purpose of your advice was to support a patient in obtaining a second opinion from a mainstream Orthodontist. However, in the Committee's view your actions would have the effect of influencing choice as you were predicting how a mainstream Orthodontist would react and, therefore, how the patient should view and manage that second opinion. Accordingly, the Committee found heads of charge 6(a) and (b) proved.
7.	On 20 September 2016 Patient A was fitted with upper and lower expansion appliances. **Admitted and Found Proved** The Committee accepted your admission to this head of charge and found it proved.
8.	On 6 October 2016 Patient A was fitted with neck gear. **Admitted and Found Proved** The Committee accepted your admission to this head of charge and found it proved.
9.	On or about 2 November 2016 you recommended Patient A underwent a lingual tongue-tie release for a tongue tie which you stated: (a) was restricting her ability to rest with her tongue on the roof of her mouth comfortably at rest; (b) was creating an imbalance in the strength of her jaw and tongue muscles; (c) was responsible for night-time teeth grinding and clicking; (d) was negatively affecting her oral posture and which, if left untreated, would negatively impact her facial growth and dental malocclusion; (e) if treated, would complement her 'Orthotropic' therapy with the result that she would not need orthodontic or other intervention at some point in the future.

	Admitted and Found Proved The Committee noted that you admitted to these allegations in their entirety during your oral evidence at this hearing on 7 September 2023. Accordingly, the Committee found these heads of charge proved.
10.	Your recommendation that Patient A underwent a lingual tongue-tie release and your comments as set out at paragraph 9 were inappropriate and/or misleading in that:
	(a) a lingual tongue-tie release was not clinically indicated for Patient A; (b) you had no adequate objective evidence to suggest a lingual tongue-tie was causing the issues stated or potential issues; (c) you had no adequate objective evidence that a lingual tongue-tie release would achieve the outcomes indicated or implied. **Not Admitted** **Found Proved** The Committee had sight of and noted that all of the statements in head of charge 9 were taken from one paragraph in your referral letter dated 2 November 2016. You denied this head of charge. You stated in your witness statement that, "*The issue of whether a tongue tie release surgery was clinically indicated was clearly something which required a doctor's opinion, and I advised Patient A's mother of this*". The Committee reminded itself of the background to this tongue-tie referral, in that Patient A's mother had been unhappy with the initial referral and had emailed you with further comments regarding her views on the outcomes of a tongue-tie release, comments which ultimately found their way into your correspondence. Furthermore, in oral evidence you stated that this was a *"grey area"*, and you perhaps incorporated some of Patient A's mother's comments about the tongue-tie release in your letter and you recognised now that you should have been more assertive with her. The Committee noted from the joint expert report that both GDC experts stated that a tongue-tie release for Patient A was not clinically indicated. Professor Garcovich stated that this was outside his field of expertise.

	The Committee noted that there was no evidence to show that a lingual tongue tie was causing any issues for Patient A and the subsequent examination by Witness 1 confirmed that there was no functional problem. The Committee noted from Witness 1's statement that they advised Patient A's mother, "*…that there did not seem to be a clear rationale for the tongue tie release…*". Furthermore, the Committee noted from the records that your father, another Orthotropic practitioner, did not diagnose Patient A as suffering from a tongue tie when he saw her in October 2014. The Committee concluded therefore that a lingual tongue-tie release was not clinically indicated for Patient A, and that there was no adequate objective evidence to suggest either a lingual tongue-tie was causing or likely to cause any current or future issues, or that a lingual tongue-tie release would achieve the outcomes indicated or implied. Accordingly, the Committee found this head of charge proved in that it was inappropriate and misleading.
11.	On 8 May 2017 Patient A was seen by a Consultant Oral and Maxillofacial Consultant and found: (a) not to require a lingual tongue tie-release; (b) to have developed a large anterior open bite; (c) to have a traumatic ulcer on the lingual frenum. **All Admitted** **Found Proved** The Committee accepted your admissions to these heads of charge and found them proved.
12.	A photograph taken in September 2017 shows Patient A had recession of the labial gingiva of the permanent lower incisors. **Admitted (in context)** **Found Proved** You admitted to this head of charge, but queried whether the recession was pathological or not. The Committee had sight of the photo of Patient A. The Committee considered the expert view of Professor Garcovich relating to the

	difficulties in diagnosing from photographic evidence. The Committee also noted that in his expert report, Mr Powell stated that, "*…Patient A was seen to have recession of the labial gingivae of a permanent lower incisor*". The Committee considered these opposing views together with your contextual admission, and the wording of the charge. The Committee's findings on this charge were related to Patient A's presentation at the time of the photograph and the Committee's findings with regard to the significance of any recession is addressed later at head of charge 15(c). Accordingly, the Committee found this head of charge proved.
13.	A photograph taken in April 2019 shows Patient A had: (a) recession of the labial gingiva of the permanent lower incisors; (b) an unresolved anterior open bite; (c) an unaligned UL2. **Admitted ((a) and (b) in context; (c) outright)** **Found Proved in its entirety** In respect of head of charge 13(a), you admitted that there was some recession visible at the time the photograph was taken. However, you did not accept that the recession represented permanent damage to Patient A. In respect of head of charge 13(b), you admitted that it was *'unresolved'* at the time the photograph was taken as treatment was ongoing. In respect of head of charge 13(c), you admitted to this outright. The Committee had sight of the photograph of Patient A. It also noted and accepted your admissions. The Committee's findings on this charge were related to Patient A's presentation at the time of the photograph and the Committee's findings with regard to the permanence of any harm is addressed later at head of charge 15(c). Accordingly, it found this head of charge proved in its entirety.
14.	In respect of Patient A:

14 (a)	you failed to carry out appropriate and/or adequate monitoring of her treatment; **Not Admitted** **Found Proved** You denied this head of charge. You stated that the measurements and records kept were appropriate and adequate monitoring for the treatment of Patient A. The Committee noted Mr Powell's expert report in which he stated that: *"In October 2017 Patient A was seen to have recession of the labial gingivae of a permanent lower incisor* *…* *Careful monitoring of the treatment should have noted this early on in 2016 when trauma was occurring from the labial bar of the lower expansion appliance. This should have been adjusted away from the gingival margins of the lower incisors…."* The Committee noted that Mr Smith agreed with this opinion. Professor Garcovich, however, disagreed and stated that he did not categorise this as harm but as something that would have resolved itself. The Committee recognised that there had been a period of time in which there had been physical changes at the gingival margin which had not been recorded or referred to in the records. Regardless of cause or the potential of any long-term effects, given that gingival recession is a well-known risk of the treatment, the Committee was of the view that this should have been monitored. The Committee accepted Mr Powell's evidence and noted from Patient A's records that there was no evidence that you carried out appropriate and/or adequate monitoring of her treatment. Accordingly, the Committee found this head of charge proved.
14 (b)	you failed to carry out any cephalometric analysis or similar. **Not Admitted** **Found Proved**

	You denied this head of charge. You stated that you did not require cephalometric analysis to deliver the intended treatment to Patient A, particularly when balancing the use of cephalometrics against the risk of radiation. You stated that you relied on photographic overlays and described how you drew vertical lines on the photographs and compared these to earlier ones as these "*just knock cephs out of the water*". You further stated that the lines and photographs provide soft tissue reference points you can identify and that are just as "*…fixed as any other point in the head*". However, you did acknowledge during your oral evidence that the use of photographic overlays is not a recognised alternative to cephalometrics. The Committee considered Mr Powell's expert report in respect of the use of photographs. It noted his conclusions in his expert report that: '*To verify claims of therapeutically induced spatial change of the facial skeleton, radiographs using standard magnification such as cephalometric lateral skull views are essential to monitor the progress of these aims. Fiducial points on each radiograph are aligned to show the evolution of the bony growth and measure this.'* and '*Facial photographs although important in assessing an overall facial appearance therefore cannot be used to develop metrics in the elucidation of craniofacial growth.'* The Committee further noted Mr Powell's opinion in his report in respect of the use of the indicator line to determine the direction of maxillary growth, as used in Orthotropics. The Committee noted from the report that the 'Indicator Line' in Orthotropics is defined as the distance from the tip of the nose to the incisal edge of the lowest central incisor. However, the Committee noted Mr Powell's opinion that, *"the nose as a reference point, is not an accurate measure of maxillary bone growth"*. Mr Powell went on to state that: *"The use of the indicator line to determine the direction of maxillary growth, as employed by Orthotropics, is therefore not a valid concept. The nasal tip grows independently from the basal maxilla and the tip of the upper incisor is also subject to change in position, as the maxillary alveolar bone remodels with growth*

	or orthodontic treatment. It is valueless as an indicator of the direction and distance of maxillary basal bone growth as used in Orthotropics." The Committee noted and accepted Mr Powell's evidence that measurements of maxillary growth would be compromised by using soft tissue points that may grow independently to the underlying facial structure. The Committee further noted that all experts were in agreement that the use of photographic overlay would not give the precise data compared to cephalometrics. Professor Garcovich in his oral evidence stated that *"you need to take cephs…cephs are or should be part of the orthodontic armamentarium"*. The Committee considered that you had provided insufficient scientific evidence to show that your use of photographic overlay would produce similarly accurate measurements as achieved by using cephalometrics. Accordingly, the Committee found this head of charge proved.
15.	You ought to have known that that the treatment provided to Patient A as set out at paragraph 7 and/or 8:
	(a) was not clinically indicated for Patient A; (b) was not in Patient A's best interests; **Not Admitted** **Found Proved** The Committee considered heads of charge 15(a) and 15(b) together as it deemed it appropriate given the wording of the charge. You denied these heads of charge. The Committee noted that both GDC experts stated that given the presentation of Patient A, there was no need for clinical treatment. The Committee also noted that it has found proved all the heads of charge in respect of your treatment of Patient A. In particular, it has determined in head of charge 5(a) that treatment was not clinically indicated for Patient A in respect of your recommendations for treatment

	and that the more appropriate course was to see the patient again in 18 months. It noted the following from its previous decision in 5(a): *The Committee accepted the GDC experts' evidence in this case. It noted that there was mild overcrowding but this was not significant enough to justify urgent clinical intervention. The Committee further noted that the Orthotropic treatment, was invasive and required in your own words, 'tough love'. The Committee determined that this would be disproportionate in the context of Patient A's case of mild overcrowding. The Committee noted that it has previously determined that Patient A had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development. It considered that it would have been more appropriate to see the patient again in 18 months, as suggested by Mr Powell, which would have negated the need for urgent treatment with its attendant risks.* Accordingly, the Committee found these heads of charge proved.
15 (c)	was liable to cause harm. **Not Admitted** **Found Proved** You denied this head of charge. You stated that there were risks associated with Orthotropic treatment and that Patient A's mother was aware of these risks. When considering this head of charge, the Committee interpreted the wording as meaning that your treatment of Patient A had the potential to cause actual harm and considered that harm in this circumstance was something that had an adverse effect on the patient. The Committee took into consideration your admissions that there is a risk of harm in Orthotropic treatment, which included a large anterior open bite and gingival recession, as well as the likelihood of discomfort necessitating '*tough love*'. The Committee noted that you outlined the risks of Orthotropic treatment on the consent form, which was signed by Patient A's mother on 20 September 2016. The Committee also noted the opinion of Witness 1 and his observation that Patient A was suffering from a large traumatic ulcer on the lingual frenum.

	The Committee also however heard evidence from Patient A's mother, who was not concerned about any longstanding harm and had been provided with a periodontist report, dated 17 April 2023, which stated that *'there is no evidence of any gingival recession affecting any of [Patient A's] teeth at this stage'*. The Committee recognised the shortcomings of the periodontist report as it amounted to hearsay evidence, but noted that it was still a professional opinion from a specialist periodontist. Furthermore, it recognised that although Patient A's mother was supportive, she was providing personal testimony and not expert evidence. The Committee also acknowledged that placing any appliance in a patient's mouth could be harmful, but considered that Orthotropics was no different to mainstream Orthodontics in this regard. Therefore, the Committee concluded that, based on Witness 1's evidence, the traumatic ulcer suffered by Patient A did amount to harm. However, the Committee acknowledged that this liability to cause harm arose from the recognised risks from both Orthotropic and Orthodontic interventions. Accordingly, the Committee found this head of charge proved.
Patient B	
16.	In November 2013, when Patient B was 2 years old:
16 (a)	you took an upper impression with the intention of providing an expansion appliance; **Not Admitted** **Found Proved** You denied this head of charge. You stated that you had no settled intention of providing an expansion appliance. You stated that you took an upper impression in order to assess if anything could be done. The Committee had sight of Patient B's dental records, which included your letter, dated 2 October 2013, to Patient B's parents. The Committee noted within that letter you suggested that Patient B should

	return for another appointment with you to allow you to take an impression in order to *'attempt some upper expansion'*. The Committee had sight of a further letter, dated 12 February 2018, which you sent to Patient B's parents. The Committee noted that it stated that you saw Patient B in November 2013 and, '*at the time we had taken an upper impression with the hope that we could make a simple expansion appliance*'. The letter went on to state that it was not possible to make the expansion appliance at the time owing to a lack of any undercut. The Committee concluded that there was no doubt that you had taken an upper impression of Patient B. The Committee then went on to consider whether it was your intention to provide an expansion appliance. The Committee noted from your letter, dated 2 October 2013, that in respect of treatment you stated, '*I would recommend that we attempt this…*'. Furthermore, your letter also mentioned the cost of the appointment and for any appliances constructed. The Committee noted your denial of this head of charge as you stated it was never your settled intention to provide an expansion appliance. However, the Committee gave more weight to the contemporaneous documents. The Committee considered that the wording of both of the letters to Patient B's parents demonstrated that it was your intention to provide an expansion appliance to Patient B. Accordingly, the Committee found this head of charge proved.
16 (b)	you informed Patient B's parents that the aim of the proposed expansion appliance would be to improve tongue space and upper nasal airway. **Admitted and Found Proved** The Committee accepted your admission and found this head of charge proved. However, it did note that you had informed Patient B's parents in a letter dated in October 2013 rather than November 2013 as written in the charge.

17.	The treatment proposed and comments as set out at paragraph 16 were inappropriate and/or misleading in that:
17 (a)	treatment was not clinically indicated for Patient B; **Not Admitted** **Found Proved** You denied this head of charge on the basis that there was no proposed treatment. You also stated that your comments were not inappropriate/misleading and there was no intention to mislead. The Committee noted the opinion of the experts. Mr Powell opined that your first job should have been to find out the cause and ask advice concerning the clinical details from the Consultant Paediatrician dealing with Patient B's sleep apnoea. Mr Smith agreed that it was not appropriate for Patient B to undergo treatment at this age. Professor Garcovich stated that he did not usually treat patients at two years old as it was difficult to fit an appliance and gain compliance at that age. However, he further stated that treatment could be considered if the patient's parents wanted treatment. The Committee further noted that Professor Sheldon stated during oral evidence, upon reviewing Patient B's records, that he did not see the need for clinical treatment. In light of this expert evidence, therefore, the Committee concluded that treatment was not clinically indicated for Patient B. The Committee also took account of its previous decision for head of charge 16(a) where it found that you had an intention to provide treatment. Accordingly, it found this head of charge proved in that it was both inappropriate and misleading.
17 (b)	you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated. **Not Admitted** **Found Proved** You denied this head of charge on the basis that you did not propose any treatment for Patient B.

	The Committee noted the opinions of the experts in the joint expert report who were in agreement that, as stated by Professor Sheldon, *'improved tongue space doesn't affect sleep apnoea'*. Furthermore, Professor Sheldon stated that he would refer the patient to appropriately trained professionals for evaluation and diagnosis. In light of the view of the experts, the Committee determined that you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated and that this was inappropriate. Accordingly, it found this head of charge proved in that it was both inappropriate and misleading.
18.	In February 2018, when Patient B was 6 years, you reviewed him and informed Patient B's parents: (a) that, "*both upper and lower jaws have dropped down as is consistent with the concept of Craniofacial Dystrophy*"; (b) the aim of treatment you proposed for Patient B would be, "*to improve the craniofacial development so that he no longer had any sleep issues and create an environment in which the teeth align themselves*"; (c) "*As the upper and lower jaws have dropped down and back, the face has lengthened affecting the airway leading to a forward head posture and a modified resting tongue position. The latter dictating a pattern of malocclusion that we see*"; (d) the aim of treatment you proposed for Patient B would be, "*not to align teeth but create an environment in which teeth will align themselves as they do in 5,400 species of mammals and our ancestors since the dawn of time.*" **Admitted (in context)** **Found Proved** You admitted to these heads of charge. However, you stated that the advice given must be seen within the context of all the information and other advice given. The Committee noted your admissions. It also had sight of your letter, dated 12 February 2018, to Patient B's parents in which the above quotations can be found.

	Accordingly, it found these heads of charge proved in their entirety.
19.	You recommended Patient B underwent treatment you referred to as 'Orthotropic' treatment involving: (a) the widening of both arches, with greater widening of the maxilla; (b) the wearing of head gear at night; (c) the potential provision of a 'Myobrace' or 'training appliance'. **Admitted (in context)** **Found Proved** You admitted to these heads of charge. However, you stated that the advice given must be seen within the context of all the information and other advice given. The Committee noted your admissions. It also had sight of your letter, dated 12 February 2018, to Patient B's parents in which the above treatment as detailed in 19(a), (b) and (c) is described under the heading, '*Treatment Plan – What to do now*'. Accordingly, it found these heads of charge proved in their entirety.
20.	Patient B had a Class 1 occlusion on a Class 1 skeletal base and normal craniofacial development. **Admitted and Found Proved.** The Committee accepted your admission to this head of charge and found it proved.
21.	Your recommendations for treatment and comments as set out at paragraph 18 and/or 19 were inappropriate and/or misleading in that:
	(a) treatment was not clinically indicated for Patient B; (b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated. **Not Admitted** **Found Proved (Head of Charge 18 – inappropriate and misleading)** **Found Proved (Head of Charge 19 – inappropriate only)** **Found Not Proved (Head of Charge 19 – misleading)**

	The Committee considered heads of charge 21(a) and (b) together. You denied that your recommendations for treatment or comments were inappropriate and stated that you had no intention to mislead. The Committee noted from the joint expert report that all the experts agreed that the records do not indicate a need for treatment and that there was no objective evidence to support the treatment. Furthermore, they agreed that if you had concerns about the patient experiencing sleep problems, a referral should have been made to investigate this. In light of the experts' agreement on this head of charge, the Committee found heads of charge 21(a) and (b) proved in that your actions were inappropriate and misleading in regard to head of charge 18, and inappropriate, but not misleading, in relation to head of charge 19. The Committee appreciate your views that you had no deliberate intention to mislead, but found that recommending treatment without adequate objective evidence is likely to mislead patients.
22.	On 16 August 2018 Patient B was fitted with upper and lower arch expansion appliances. **Admitted and Found Proved** The Committee accepted your admission to this head of charge and found it proved.
23.	On 23 August 2018, following questions and concerns raised by Patient B's parents, you informed them: (a) that the treatment you proposed "was designed to create more space for the tongue and then train an individual to change. In this way, it becomes easier for patients to correct themselves. Malocclusions improve and there is a positive impact on the airway with improved sleep, fewer nasal obstructions and better oral posture"; (b) "the changes they achieve are stable and as long as patients continue to be aware of their oral posture, these changes are permanent";

	(c) that in Patient B's case, "there is a lack of space for his tongue and this is the reason his facial form has down swung"; (d) "It is necessary in his case to gain this additional space by widening his arches as well as lengthening". **All Admitted (in context)** **Found Proved** You admitted to these heads of charge but stated that the advice must be seen within the context of all the information and other advice given. The Committee noted your admissions. It also had sight of your letter, dated 23 August 2018, to Patient B's parents and noted that all the quotations in this head of charge could be found in the letter. Accordingly, the Committee found these heads of charge 23(a) to (d) proved.
24.	Your recommendations for treatment and comments as set out at paragraph 23 were inappropriate and/or misleading in that: (a) treatment was not clinically indicated for Patient B; (b) you had no adequate objective evidence to suggest the treatment proposed for Patient B would achieve the aims stated. **Not Admitted** **Found Proved in its Entirety** The Committee considered heads of charge 24(a) and (b) together. You initially denied these heads of charge. However, the Committee noted during your oral evidence that you conceded you did not have a *'proper basis to say that treatment was necessary'*. The Committee had sight of the clinical records. It noted that the records did not make clear the nature of the sleep issues that Patient B was suffering from at the time. The Committee noted that on the Medical History form, dated 8 February 2018 and which was completed by Patient B's parents, it stated that Patient B's sleep had improved. Furthermore, the Committee noted the email, dated 3 August 2018, from Patient B's parents to you, which stated that, 'we *have finally managed to get him into a good sleeping routine…*'.

	The Committee noted the joint view of the experts that, *'there is not a reasonable body of evidence based literature that any expansion could lead to improved tongue space or upper nasal airway…'*. The Committee also noted the view of all the experts that no obvious treatment was needed, although a referral onwards may have been indicated. Taking all this into consideration, the Committee determined that heads of charge 24 (a) and (b) were proved in that your recommendations for treatment and comments as set out at head of charge 23 were inappropriate and misleading.
25.	On 30 August 2018 Patient B was provided with head gear. **Admitted and Found Proved** The Committee accepted your admission to this head of charge and found it proved.
26.	In respect of Patient B, you failed:
26 (a)	to carry out any cephalometric analysis or similar; **Not Admitted** **Found Proved** You denied this head of charge on the grounds that you did not require cephalometric analysis to deliver the intended treatment for Patient B. The Committee had sight of Patient B's records and could see no evidence that you carried out any cephalometric analysis. The Committee reminded itself of its decision regarding Patient A and the lack of cephalometric analysis. Within this consideration, the Committee noted Mr Powell's expert report that *'cephalometric lateral skull views are essential to monitor the progress…'*. The Committee accepted the views of the GDC's experts that measurements of maxillary growth would be compromised by using soft tissue points that may grow independently from the underlying facial structure. The Committee noted that all experts were in agreement that use of photographic overlay would not give precise data.

	Accordingly, the Committee found this head of charge proved.
26 (b)	to treat or ensure decay was treated at ULD, ULE, LLD, URE, LRE and/or LRD prior to commencing treatment; **Not Admitted** **Found Proved** You denied this head of charge as you were not Patient B's treating dentist. The Committee also heard oral evidence from Witness 2 that Patient B's general dental practitioner should have been treating the decay. The Committee noted Mr Vullo's closing submissions in respect of this head of charge. He submitted that Witness 2 would have confirmed with Patient B's parents that Patient B's dental needs were being cared for by a dentist. He submitted that either Patient B's dentist missed the caries or Patient B's mother was aware of the caries but did not inform either yourself or Witness 2. He submitted that either way, it was neither your fault nor Witness 2's fault. The Committee had sight of Mr Powell's expert report. He stated that: *'As at 17.10.2018 there was uncontrolled dental caries in the deciduous dentition not diagnosed at outset by the Registrant. All primary dental disease should be determined if present and eliminated before the outset of orthodontic/orthotropic intervention.'* The Committee accepted Mr Powell's evidence that any caries should have been treated before any orthodontic/orthotropic treatment commenced, especially in the light of your oral evidence that it would be *"highly beneficial"* to have caries effectively treated before treatment commences. Accordingly, the Committee found this head of charge proved.
26 (c)	to obtain study models; **Not Admitted** **Found Proved**

	You denied this head of charge stating that study models were not necessary in respect of the intended treatment. The Committee noted from the joint expert report that all the experts agreed that study models were necessary. The Committee had sight of the records and could see no evidence of study models being taken. Accordingly, the Committee found this head of charge proved.
26 (d)	to communicate with Patient B's paediatrician; **Not Admitted** **Found Proved** You denied this head of charge as you stated you were told by Patient B's parents that Patient B was no longer under the care of a paediatrician as the sleep apnoea had been resolved. The Committee noted from the joint expert report that all the experts agreed that there was a requirement for you to make a referral to a paediatrician to establish a diagnosis before commencing treatment. The Committee noted from Patient B's medical records that he had a complex medical history. The Committee noted that Patient B had had cardiac treatment in June 2018, and that in October 2018, Patient B's father had stated that Patient B was having seizure-like episodes. Patient B was still under the care of a cardiologist in December 2018. Furthermore, the Committee noted the following from Mr Powell's expert report: '*The Consultant Physician/Paediatrician in charge of this case should have been contacted for advice regarding all the medical matters including the records and investigations obtained regarding the sleep apnoea and it severity, along with the other medical conditions with which Patient B presented.*' In light of Patient B's complex medical history and the opinion of the experts, the Committee determined that you should have communicated with Patient B's paediatrician.

	Accordingly, it found this head of charge proved.
26 (e)	to carry out appropriate and/or adequate monitoring. **Not Admitted** **Found Proved** The Committee took into account its previous findings for this head of charge, in that you failed to carry out any cephalometric analysis, to ensure that any decay had been treated prior to commencing treatment, to obtain study models and to communicate with Patient B's paediatrician. The Committee determined that these failures amounted to a failure to carry out appropriate and/or adequate monitoring of Patient B. Accordingly, the Committee found this head of charge proved.
27.	On 10 December 2018 Patient B was seen by another practitioner and found to have recession of the labial gingiva of a permanent lower incisor. **Admitted and Found Proved** The Committee accepted your admission and found this head of charge proved.
28.	You ought to have known that the treatment provided to Patient B as set out at paragraph 22 and/or 25: a) was not clinically indicated; b) was not in Patient B's best interests; c) was liable to cause harm. **Not Admitted** **Found Proved in its entirety** The Committee noted that there was no evidence to show that the treatment provided to Patient B was clinically indicated. The Committee also noted your oral evidence under cross-examination. It was put to you in respect of Patient B's treatment that, *"Do you accept that you didn't have a proper basis to tell the parents that this treatment was necessary?"*. In response you stated, *"I'll concede that"*.

	The Committee further noted that you accepted that Patient B had a Class 1 occlusion on a Class 1 skeletal base and normal craniofacial development. You had commenced treatment on Patient B primarily to deal with Patient B's purported sleep apnoea. However, the Committee has determined that there was insufficient evidence to show that your proposed treatment would resolve this. The Committee determined, therefore, that the treatment provided to Patient B as set out at heads of charge 22 and 25 was not clinically indicated. The Committee also determined that as treatment was not clinically indicated, and carried known risks, it was not in Patient B's best interests. This was particularly in the light of Patient B's complex medical history. The Committee considered that any risks may have been exacerbated by Patient B's mother's non-compliance with the treatment protocol, but ultimately concluded that these risks would not have arisen if treatment, which was not clinically indicated, had not been prescribed. (The Committee noted that head of charge 28(b) refers erroneously to Patient A rather than Patient B and the Committee amended this subject to further representations from parties). Furthermore, the Committee determined that the provision of intra-oral appliances in circumstances where treatment was not clinically indicated or in Patient B's best interests was liable to cause Patient B harm. Accordingly, the Committee found heads of charge 28 (a), (b) and (c) proved.
"YouTube"	
29.	In a video posted on YouTube in about September 2017 titled "*Orthodontics Beyond Teeth*" you stated: 1. words to the effect, that if you create enough tongue space, and children use that tongue space, that can influence facial growth and the craniofacial structure and,

	"expansion of the brain, expansion of the dental arches as well"; 2. that, *"…if a patient walks into my office over the age of 8, they're into the area where it's going to be compromise, it depends how hard they work. If someone comes in at the age of 5, 6 I can almost get a complete correction. If someone comes in younger I can give them advice on how they can correct themselves"*. **All Admitted (in context)** **Found Proved** You admitted these heads of charge, but stated that your words must be read in context of the conversation as a whole and the situation in which the words were spoken. The Committee reviewed this video and the transcript, and noted that you stated the words as set out in these heads of charge. Accordingly, it found this head of charge proved.
30.	Your claims as set out above at paragraph 29 were inappropriate and/or misleading in that they were made without adequate objective evidence. **Not Admitted** **Found Proved** You denied that your comments were either inappropriate or misleading. You stated that you were entitled to freedom of speech and to express your professional opinion within the context of social media debate. You denied that you were making any serious suggestion that Orthotropic treatment could expand the brain and improve intelligence, but that the remarks were made in the context that people should expand how they are thinking. The Committee determined that your references to expanding the brain did imply that you could increase the intelligence of a child and this was inappropriate and misleading as there was no objective evidence to support this view. The Committee noted that elsewhere in the video, in discussion, you relate improvements in breathing to *"…the intelligence of your child, for the rest of their life"*. The Committee observed that the video was made in a professional setting, including your wearing of

	clinical scrubs. The Committee further noted that in your oral evidence you referred to further comments you made on YouTube regarding an improvement to facial form reducing sleep apnoea, and leading to a resulting increase in IQ. Furthermore, the Committee noted from the joint expert report that all the experts agreed that there was no evidence to support your claim that, *‘if treatment is commenced at 5 or 6 years he will achieve an almost complete correction’* of craniofacial structure and occlusion with teeth aligning themselves naturally. The Committee, therefore, found that your claims in head of charge 29 were inappropriate and misleading. Accordingly, the Committee found this head of charge proved.

142. The Committee resumed consideration of your case between 4 November 2024 and 6 November 2024.

Amendment of Charge (4 November 2024)

143. Before formally announcing its findings of fact, the Committee put on record that, as outlined in its findings of fact, it had amended head of charge 28(b) so that it correctly referenced Patient B rather than Patient A. Neither party made any representations on this matter.

Summary of the Committee’s Findings

144. The Committee has found proved that the Orthotropic Treatment you provided to Patient A and Patient B, when they were children, was not clinically indicated, not in their best interests and was liable to cause them harm. It also found proved that the misleading claims you made to the patients’ parents in correspondence concerning the need for treatment, your diagnoses, and the assertions you made about the benefits and outcomes of Orthotropic Treatment were inappropriate and on occasion misleading.

145. In respect of Patient A, you recommended in September 2016, when she was six years old, that she underwent Orthotropic treatment. This was despite the fact that she had a Class 1 occlusion on a Class 1 skeletal base with normal craniofacial development. The Committee determined that there was no clinical indication for treatment and that it would have been more appropriate to wait 18 months before reviewing whether any clinical treatment was required. Furthermore, the Committee found proved that there was no objective evidence

to support the Orthotropic treatment you were recommending or the aims of the treatment. The Committee considered that, *"…taken as a whole treatment pathway from initial diagnosis to completion, there is currently insufficient objective evidence to support it"*.

146. In November 2016, you recommended that Patient A underwent a lingual tongue tie release in order to, amongst other things, complement her Orthotropic therapy. The Committee determined that there was no evidence to show that a lingual tongue tie was causing any issues for Patient A and, therefore, concluded that a lingual tongue tie release was not clinically indicated for Patient A. It was also found proved that you failed to carry out appropriate or adequate monitoring of Patient A's treatment by not undertaking any cephalometric analysis. Instead, you relied on photographic overlays. However, the Committee determined that you had provided insufficient scientific evidence to show that your use of photographic overlays would produce similarly accurate measurements as achieved by using cephalometrics.

147. The Committee found proved that the treatment you provided to Patient A (the fitting of upper and lower expansion appliances) had caused her harm as it resulted in a traumatic ulcer. However, the Committee acknowledged that this liability to cause harm arose from the recognised risks from both Orthotropic and Orthodontic interventions.

148. In respect of Patient B, in November 2013 when he was two years old, you took an upper impression with the intention of providing an expansion appliance in order to improve tongue space and upper nasal airway. The Committee determined that this treatment was not clinically indicated. Furthermore, the Committee determined that there was no objective evidence to suggest the treatment you had proposed would achieve the aims stated and that this was inappropriate.

149. In February 2018, when Patient B was six years old, you recommended that he underwent Orthotropic treatment, despite the fact that he had a Class 1 occlusion on a Class 1 skeletal base and normal craniofacial development. The Committee determined that treatment was not clinically indicated for Patient B or in his best interests as there was no objective evidence to support treatment.

150. In August 2018, you fitted Patient B with upper and lower arch expansion appliances. The Committee determined that this treatment was not clinically indicated. Furthermore, you failed to ensure that decay was treated prior to commencing treatment, to carry out any cephalometric analysis, to obtain study models, to communicate with Patient B's paediatrician (in the light of Patient B's complex medical history) or to carry out appropriate/adequate monitoring.

151. Furthermore, the Committee found proved that the claims, you made in a video posted on YouTube in or about September 2017 titled "*Orthodontics Beyond Teeth*", which included implying that you could increase the intelligence of a child, were inappropriate and misleading as they were made without adequate objective evidence.

Submissions

152. In accordance with Rule 20 of the General Dental Council (Fitness to Practise) Rules 2006 (the Rules), the Committee then heard submissions from Miss Barnfather, on behalf of the GDC, and submissions from Mr Vullo, on your behalf, in relation to the matters of misconduct, impairment and sanction.

153. Miss Barnfather provided written submissions to the Committee and supplemented these with her oral submissions as outlined below.

154. In accordance with Rule 20(1)(a), Miss Barnfather first informed the Committee that you have no previous fitness to practise history with the GDC.

155. Miss Barnfather referred the Committee to the concerns raised by the British Orthodontic Society (BOS), which reflect some of the social media issues in this case. These concerns led to a referral to the GDC by the BOS in September 2018.

156. With regard to misconduct, Miss Barnfather submitted that, owing to the seriousness of the facts admitted and found proved, the Committee should have no hesitation in finding that they amount to misconduct. She submitted that they go to the heart of the profession and involve misleading the public and patients about treatment which was not only not indicated but liable to cause harm. She submitted that you have exploited the trust that patients and members of the public place in registrants and brought the profession into disrepute. She also referred the Committee to the GDC's *'Standards for the Dental Team'* (the GDC Standards) and Guidance on Advertising and outlined those standards and guidance which she submitted were of particular relevance for this case.

157. Miss Barnfather then moved on to the issue of current impairment. She referred the Committee to Dame Janet Smith's 5th Shipman report and the cases of *Cheatle v GMC 2009 EWHC 645 (Admin)* and *CHRE v Grant 2011 EWHC 927 (Admin)*. She submitted that the failings in the circumstances of this case could not be considered remediable, and that the PCC cannot exclude an underlying personality or attitudinal trait and will not have been reassured by your ongoing commitment to the Orthotropic credo. She submitted that there has been an absence of insight during the course of your evidence at this hearing and an absence of any attempts at remediation. Therefore, she submitted that the PCC

will be unable to conclude that there will be no risk of repetition. In conclusion, she submitted that you posed an ongoing risk to patients and the public, and that confidence in the profession would be undermined if a finding of impairment of fitness to practice was not made.

158. Miss Barnfather next addressed the Committee on the matter of sanction. She submitted that the appropriate and proportionate sanction would be one of erasure. She submitted that you are fundamentally unsuitable for continued membership of the profession, and that the public would not be protected, public confidence in the profession would not be maintained nor would professional standards be upheld if you were to remain on the register.

159. You provided a letter reflecting on the Committee's decision. Mr Vullo, on your behalf, read out your letter to the Committee, dated 4 November 2024. In that letter, you outlined your views as to "*…whether a disciplinary hearing was the correct or even appropriate forum for the weighing of complex scientific evidence as to the aetiology of malocclusion…*". You state that, in the light of the Committee's findings, you would not be able to *"…continue clinical practice with integrity. That is because to do so would be to break with all that I believe and know"*. You go on to address the Committee in that letter and state, *"…I hope to be able to practice again but accept that under the current regime and in light of your decision I will not be able to do so at present"*.

160. Mr Vullo submitted that given your stance and the Committee findings, it was clear that misconduct and impairment would be found. Mr Vullo stated that he had no instructions to challenge the issue of misconduct. In respect of your suggested lack of insight, Mr Vullo submitted that this was evidence of the strength of your belief in Orthotropics. With regard to sanction, Mr Vulllo submitted that owing to your commitment to the Orthotropic premise you accept that you cannot treat patients without stating your views on the aetiology and treatment of malocclusion. Mr Vullo submitted that a sanction of suspension would not change your views regarding Orthotropics and you would return to Orthotropic practice after a period of suspension. You did not put forward any submissions regarding mitigation or remediation, and you acknowledge that erasure can be the only outcome.

Committee's Decision

161. The Committee has borne in mind that its decisions on misconduct, impairment and sanction are matters for its own independent judgment. There is no burden or standard of proof at this stage of the proceedings. The Committee had regard to the GDC's Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020) (the

GDC's Guidance). The Committee also received advice from the Legal Adviser which it accepted.

Misconduct

162. The Committee first considered whether the facts found proved against you amounted to misconduct. In doing so it had regard to the GDC Standards. It determined that your actions were in breach of the following:

- *1.3.2: You must make sure you do not bring the profession into disrepute.*

- *1.3.3: You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading and complies with the GDC's guidance on ethical advertising.*

- *1.4.2: You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes.*

  If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision.

- *7.1: Provide good quality care based on current evidence and authoritative guidance.*

- *7.1.2: If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.*

- *9.1: You must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public's trust in the dental profession.*

- *9.1.3 You should not publish anything that could affect patients' and the public's confidence in you, or in the dental profession, in any public media, unless this is done as part of raising a concern.*

163. The Committee also had regard to the GDC's *'Guidance on Advertising'* and noted the following in particular:

  - *vi) 'avoid claims intended or likely to create an unjustified expectation about the results you can achieve'.*

164. The GDC had further regard to paragraph 48 of the GDC's Guidance on the use of 'Social Media and the internet' which stated:

> *"48. When considering cases relating to the use of social media, the PCC may wish to take into account some or all of the following:*
>
> - *whether any statements provided by the Registrant in respect of their social media use raise questions about the Registrant's judgment or sense of professional responsibility, for example expressing a view that social media content can be 'private', or that personal social media does not impact on professional standing;*
> - *whether the dental professional has shown insight into the potential impact of their behaviour;*
> - *whether the Registrant's social media use would be likely to undermine public confidence in the profession."*

165. In considering all its findings of fact, the Committee determined that providing invasive treatments to young children, with all the attendant risks of harm and in the absence of any clinical indication, and making unjustified claims on social media, falls far short of the standards expected of dental professionals and would be viewed as serious by fellow dental professionals.

166. In conclusion, therefore, the Committee determined that your conduct was serious and amounts to misconduct.

Impairment

167. The Committee then considered whether your fitness to practise is currently impaired by reason of your misconduct.

168. In reaching its decision on impairment, the Committee had regard to the GDC Guidance section on impairment and the relevant case law, including the cases of *Cheatle v GMC 2009 EWHC 645 (Admin)* and *CHRE v Grant 2011 EWHC 927 (Admin).* In addition, it reviewed the Fifth Shipman report by Dame Janet Smith which set out the following four potential grounds to consider when determining current impairment:

> 1. *He/she has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*

2. *He/she has in the past brought and/or is liable in the future to bring the medical profession into disrepute;*
3. *He/she has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*
4. *He/she has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

169. The Committee considered that the first three grounds were engaged in this case.

170. The Committee noted that the clinical failings in this case, in respect of Patients A and B, may be capable of being remedied. However, the Committee noted that there was no evidence that they had been remedied. The Committee noted that throughout these proceedings you still firmly believed that Orthotropic treatment, as opposed to mainstream Orthodontic treatment, would provide the best outcomes for patients and that you could not practise in any other way as "*…to do so would be to break with all that I believe and know*". In light of this, the Committee determined that you possessed minimal insight into your misconduct and that there was a high risk that you would continue to treat patients without adequate objective evidence. Furthermore, the Committee noted that owing to your beliefs, you acknowledged that a finding of current impairment would be made.

171. Accordingly, the Committee determined that your fitness to practice is currently impaired on the ground of public protection.

172. The Committee also determined that a finding of impairment for your misconduct was necessary in the wider public interest to maintain public confidence in the profession and the regulator and to uphold proper standards of conduct. The Committee has concluded that a reasonable and informed member of the public, who was aware that you had provided invasive treatment to two young children without clinical indication and objective evidence to support the treatment and had shown no insight or evidence of remediation, would have their confidence in the profession severely undermined if a finding of impairment were not made in the circumstances of this case.

Sanction

173. The Committee next considered what sanction, if any, to impose on your registration. It recognised that the purpose of a sanction is not to punish you but to protect patients and the wider public from the risk of harm. The Committee applied the principle of proportionality balancing your interest with the public interest. It also took into account the *GDC's Guidance*.

174. The Committee considered the mitigating and aggravating factors in this case as outlined in the GDC's guidance at paragraphs 5.17 and 5.18.

175. The Committee considered that the only mitigating factor in this case was that you had no previous fitness to practice history.

176. The aggravating factors in this case include:

- actual harm or risk of harm to a patient or another;
- Premeditated misconduct;
- Breach of trust;
- The involvement of vulnerable patients;
- Misconduct sustained and repeated over a period of time;
- Blatant and wilful disregard of the role of the GDC and the systems regulating the profession;
- Lack of insight regarding misconduct.

177. The Committee decided that it would be inappropriate to conclude this case with no further action. It would neither protect the public nor satisfy the public interest given the serious nature of your misconduct and the finding made of current impairment owing to your lack of insight and remediation.

178. The Committee then considered the available sanctions in ascending order starting with the least serious.

179. The Committee concluded that misconduct of this nature could not be adequately addressed by way of a reprimand. It cannot be said to be at the lower end of the spectrum. Neither the public interest nor the public would be sufficiently protected by the imposition of such a sanction owing to the high likelihood of repetition of your misconduct. The Committee therefore determined that a reprimand would be inappropriate and inadequate.

180. The Committee then gave careful consideration as to whether a conditions of practice order would be appropriate. It noted that there were aspects of your misconduct that could be satisfactorily addressed by the imposition of conditions on your registration, which would protect the public and uphold public confidence in the profession. However, the Committee noted that you have clearly stated that you were unable and unwilling to abide by any conditions. In your letter of 4 November 2024, you stated, *"Given your finding on this issue I cannot in good faith suggest any conditions that could allow me to continue clinical practice with integrity"*.

181. In these circumstances, the Committee therefore determined that a conditions of practice order would be unworkable and inappropriate.

182. The Committee next considered whether to suspend your registration for a specified period. It questioned whether a suspension would be sufficient in all the circumstances to address the misconduct that it had found. In reaching its decision, the Committee had regard to the factors listed under paragraph 6.28 of the Guidance, which dealt with the sanction of suspension. The Committee noted that the majority of these factors were present in your case. The Committee also noted that the maximum period of suspension that could be imposed was for 12 months.

183. However, having regard to all the circumstances in your case, the Committee concluded that suspension would serve no useful purpose. The Committee noted that your firm, unwavering and longstanding belief in Orthotropics meant that it was unlikely that there would be any change in the circumstances of your case in 12 months' time.

184. In considering whether the sanction of erasure was proportionate and appropriate, the Committee had regard to paragraph 6.34 of the Guidance, which states:

> *"Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion."*

185. The Committee considered the following factors applied in this case:

- *"serious departure(s) from the relevant professional standards;*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

186. The Committee noted that you have shown minimal insight and no evidence of remediation of your misconduct that amounted to a serious departure from the standards expected of dental professionals. No mitigation has been advanced on your behalf. The Committee therefore concluded that your behaviour was fundamentally incompatible with being a dental professional.

187. In all the circumstances, the Committee has determined to erase your name from the Dentists' Register. It recognises that this may have an impact on you, but considers that this is far outweighed by the need to protect patients and the public interest in this case.

188. The Committee will now consider whether an immediate order should be imposed on your registration, pending the taking effect of its determination for erasure.

Decision on Immediate Order – 6 November 2024

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

190. Miss Barnfather, on behalf of the GDC, submitted that such an order is necessary for the protection of the public and is otherwise in the public interest. She submitted that an immediate order would be entirely consistent with the Committee's findings in respect of impairment and sanction. She referred the Committee to the relevant section on immediate orders in the GDC's Guidance for The Practice Committees including Indicative Sanctions Guidance (October 2016, revised December 2020) (the GDC's Guidance). She submitted that an immediate order is appropriate for the reasons as outlined at paragraph 6.38 of the GDC's Guidance, namely that your behaviour is considered to pose a risk, you have placed patients at risk through poor clinical care and immediate action is required to protect public confidence in the profession.

191. Miss Barnfather further submitted that, in response to your anticipated submissions that you may not have had time to make plans for the patients you are already treating, although this was regrettable, it did not diminish the necessity for an immediate order.

192. Mr Vullo, on your behalf, invited the Committee to make no immediate order in this case. He submitted that it was unfair to state that you had not prepared for the outcome of this case. He informed the Committee that you have not taken on any new patients since these proceedings have begun. Furthermore, the terms of your current insurance do not allow you to take on any new patients. He submitted, therefore, that the imposition of an immediate order is not necessary to protect the public.

193. Mr Vullo submitted that in respect of the 105 patients that you are currently treating, you need to arrange for one-to-one meetings with each of these patients to either establish how to complete their treatment or to refer to another practitioner. He submitted that an informed member of the public would expect

that you should be allowed for these preparations to take place. He submitted, therefore, that it would be unfair and unwarranted for an immediate order to be imposed.

194. The Committee has considered the submissions made. It has accepted the advice of the Legal Adviser.

195. The Committee is satisfied that an immediate order of suspension is necessary for the protection of the public and is otherwise in the public interest. The Committee concluded that given the nature of its findings and its reasons for the substantive order of erasure in your case, it is necessary to direct that an immediate order of suspension be imposed on both of these grounds. The Committee considered that not to impose an immediate order would be inconsistent and undermine its findings which found that you were a risk to public safety as you were undertaking treatments with no objective evidence base. Furthermore, given its findings, it determined that public confidence in the profession would be undermined if no immediate order were imposed and you were allowed to practise unrestricted until the substantive order takes effect

196. The effect of this direction is that your registration will be suspended immediately. Unless you exercise your right of appeal, the substantive order of erasure will come into effect 28 days from the date on which notice of this decision is deemed to have been served on you. Should you exercise your right of appeal, this immediate order for suspension will remain in place until the resolution of any appeal.

197. That concludes this hearing.