IN THE DENTISTS DISCIPLINARY TRIBUNAL

IN THE MATTER of the Dental Act 1988

AND

IN THE MATTER of complaints by Mrs S Carman, Ms H Evan, and Ms J Smith against **Suresh Kanji Patel** of Auckland, Dentist

AGREED SUMMARY OF FACTS

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AGREED SUMMARY OF FACTS

Background

1. Dr Suresh Kanji Patel ("Dr Patel") is a registered dentist who lives in Auckland.

2. Dr Patel is self-employed and practises from the Point Chevalier Dental Centre in Auckland. Previously he practised in Whangarei at the Kowhai Court Dental Centre. The matters the subject of the charges against Dr Patel in respect of Mrs Stephenie Carman ("the Carman charge") and Mrs Jane Smith ("the Smith charge") relate to events at Kowhai Court Dental Centre in Whangarei. The matters the subject of the charge against Dr Patel in respect of Ms Helene Evan ("the Evan charge") relate to events at the Point Chevalier Dental Centre in Auckland.

Smith Charge

3. The events the subject of the charge in respect of Dr Patel's patient, Mrs Jane Smith of Dunedin (formerly of Whangarei) relate to the period October 1997 through to February 1998 and relate to Dr Patel's treatment of teeth 11 and 21.

4. On 18 August 1997 Mrs Smith had the first of fifteen appointments she would have with Dr Patel between then and 18 February 1998. Prior to the appointment it had become obvious to Mrs Smith that the crowns of her two top front teeth (tooth 11 and tooth 21) would need to be replaced. She had severe sensitivity (hot and cold sensation). Mrs Smith presented at the appointment with Dr Patel on 18 August 1997 with symptoms of severe pain and discomfort. Dr Patel failed to assess and diagnose those presenting

symptoms. At the appointment with Dr Patel discussed crown replacement with Mrs Smith. Dr Patel sealed the margins of the crowns. An x-ray was taken by Dr Patel [AB; Vol 2; 23].

5. By the time Dr Patel came to fit new crowns pre-existing conditions in Mrs Smith coupled with treatment by Dr Patel had resulted in irreversible pulpitis. On 6 October 1997 Dr Patel inserted temporary crowns on teeth 11 and 21 and on 10 October 1997 he fitted new crowns to teeth 11 and 21. Dr Patel fitted the new crowns without having first undertaken the necessary root canal treatment.

6. Dr Patel did not adequately record the material he used to fill teeth 11 and 21 in his records.

7. The crowns which Dr Patel fitted were poor in shade, shape and fit. In his records for 10 October 1997, Dr Patel noted that the crowns were an "excellent fit".

8. Post-operatively, between mid October 1997 and February 1998 Mrs Smith continued to experience severe pain in her teeth. Dr Patel failed to control that pain. In the eight or more appointments Mrs Smith had with Dr Patel subsequently (in the period from 11 November 1997 to 13 February 1998) Dr Patel subjected Mrs Smith to pain which he now accepts was undue and unnecessary and during that period failed to adequately control infection in Mrs Smith's teeth. That necessitated Mrs Smith seeking emergency antibiotic and anti-inflammatory treatment as described below.

9. On 11 November 1997 Dr Patel diagnosed irreversible pulpitis of teeth 11 and 21 and he removed the necrotic pulp of those teeth. Dr Patel redressed tooth 11 with Ledermix, calcium hydroxide and Cresopoane (see notes). On 25 November 1997 Dr Patel completed root canal treatment by filling teeth

11 and 21 [AB; Vol 2; 12]. Before doing that he did not first redress tooth 11 with the use of a calcium hydroxide or similar product. Dr Patel redressed tooth 11 because of pain on 28 November 1997 and again on 12 December 1997. Dr Patel treated the infection in tooth 11 by using Ledermix.

10. Dr Patel did not refer Mrs Smith for specialist care at this time even though Mrs Smith had not responded to post-operative root canal dressing at the appointments on 28 November 1997 and 12 December 1997.

11. On 28 November 1997 Dr Patel stopped charging Mrs Smith for root canal treatment, after the root canal treatment appointments on 11 November and 25 November 1997 respectively, were not providing pain relief for her. Dr Patel did not charge Mrs Smith for the further five appointments she had with him, the last of which was on 13 February 1998.

12. On 29 December 1997 Mrs Smith had an emergency telephone consultation with Dr Cohen at Kowhai Court Dental Centre because she was still experiencing pain. A prescription for antibiotic and inflammatory medication was faxed to Maunu Pharmacy in Whangarei.

13. On 31 December 1997, because of continuous pain in tooth 11, Mrs Smith sought an emergency appointment with Dr Beverely van Melsem at Maunu Dental Centre. Dr van Melsem told Mrs Smith that she did not like what she saw and that she was not happy about the margins of the new crowns. She treated the tooth by redressing it and asked Mrs Smith to return and see Dr Stallworthy.

14. On 6 January 1998 Mrs Smith saw Dr Patel again. Dr Patel considered that Mrs Smith may need to be referred to an endodontist, Dr David Parkins [AB; Vol 2; 13]. That course of action was declined at that time. Dr Patel

recorded in Mrs Smith's records that he called Dr Parkins and Dr Stallworthy (his Dental Council mentor) on that day.

15. Dr Patel continued root canal therapy to tooth 11 on 31 January, 2 February and 13 February 1998.

16. On 8 April 1998 Dr Stallworthy performed an apicectomy under general anaesthetic on tooth 11. Dr Stallworthy reported to Dr Patel that the margins of the crowns were very poor and that the crowns should be redone [AB; Vol 2; 24].

17. On 15 May 1998 Dr Patel saw Mrs Smith for a routine examination and he smoothed a broken cusp.

18. On 18 February 1999 Mrs Smith saw Dr Patel and complained of on-going symptoms of tooth 11. She described an "odd twinking sensation".

19. On 9 March 1999, 16 months after he had first commenced root canal treatment on Mrs Smith's teeth, Dr Patel wrote to Dr David Parkins, Endodontist of Auckland and requested him to examine Mrs Smith's x-rays and advise what the next step should be for a solution to Mrs Smith's ongoing dental problems [AB; Vol 2; 33]. Dr Parkins reported back to Dr Patel that treatment in respect of tooth 11 would involve retreating "via the crown, redebride and redress". Dr Parkins advised Dr Patel not to replace the crown until all symptoms had resolved [AB; Vol 2; 36]

20. On 9 April 1999 Mrs Smith sought a second opinion from Dr Grant Croft of Whangarei. Dr Croft advised Mrs Smith to see Dr Parkins and to have the tooth 11 and tooth 21 root canal treatments re-done. He also advised Mrs Smith to get new crowns on teeth 11, 12 and 22, six to twelve months after she had had the root canal treatments re-done [AB; Vol 2; 30]. In addition,

Dr Croft advised Mrs Smith that she should seek a refund of the fees she had paid Dr Patel for root canal therapy.

21. On 22 April 1999 Mrs Smith wrote a letter of complaint to Dr Patel and requested that he refund $1730 for the root canal treatment. Dr Patel refunded this amount to Mrs Smith on 29 April 1999 [AB; Vol 2; 10-11].

22. Mrs Smith saw Dr Parkins for root canal treatment on tooth 11. Dr Parkins completed the root canal filling on 10 June 1999. Dr Parkins wrote to Dr Patel on 6 July 1999 and reported his findings [AB; Vol 2; 36].

23. On 30 July 1999 Mrs Smith consulted Dr Dennis Shepherd, Whangarei and in nine further appointments until 22 September 2000 he replaced the root canal filling on tooth 21 and replaced the crowns on teeth 11 and 21 [AB; Vol 2; 45].

24. Mrs Smith currently sees Dr Roger Smith, Dental Surgeon of Dunedin, for dental care.

25. In respect of his treatment of Mrs Smith which commenced in or about October 1997 and continued until February 1998 or thereabouts, relating to treating her teeth 11, 21, and 25 Dr Patel admits as follows:

Failure to keep adequate dental records

26. That his clinical records failed to adequately record the materials used to fill teeth 11 and 21.

Failure to provide adequate or proper clinical care

27. That he failed to provide adequate and competent treatment for his patient.

28. In particular, he:

General

i. failed to assess and diagnose his patient's presenting symptoms of severe pain and discomfort;

Radiographic

ii. failed to interpret radiographic information to adequately assess the treatment required by his patient;

Prosthodontic Skills

iii. Fitted crowns which were poor in shade, shape and fit.

Root Canal Treatment

iv. On or about 10 October 1997, fitted crowns to teeth 11 and 21, when he had failed to undertake necessary root canal treatment prior to crown placement;

v. After fitting the crowns he continued to fail to control infection associated with those teeth, and masked the situation in respect of tooth 11 by the inappropriate use of Ledermix;

Pain Control

vi. Failed to control the pain his patient experienced in the operative and post-operative situations, between mid-October 1997 and February 1998 (or thereabouts);

vii. Subjected his patient to undue and unnecessary pain over eight or more appointments where treatment was undertaken between 11 November 1997 and 13 February 1998 (or thereabouts); and during that period failed to control infection necessitating emergency anti-biotic and anti-inflammatory treatment;

Breach of undertaking and failure to refer patient for care outside the limits of his practice

29. On 30 June 1997 Dr Patel signed an Undertaking to the Dental Council, outlining restrictions and conditions under which he could practice dentistry. His Undertaking included that he would not "practice in the areas of fixed and removable prosthodontics until such time as [he] ha[d] demonstrated that [he] ha[d] undertaken acceptable continuing education in these two areas." (Clause 1)

30. The Undertaking also provided that Dr Patel would accept a senior practitioner, appointed by the Council as a mentor, who would report to the Chairperson of the Council on practice management and personal issues. Dr David Stallworthy of Whangarei was appointed as Dr Patel's mentor.

31. The Undertaking went on to provide (Clause 7) that in breaching any terms of the undertaking Dr Patel would be subject to a charge of professional misconduct.

32. Six and a half weeks after he signed his Undertaking to the Dental Council, on 18 August 1997 Dr Patel was consulted by his patient, Mrs Smith for severe toothache associated with teeth 11 and 21. As stated, at that consultation Dr Patel discussed crown replacement, and he sealed the margins of existing crowns.

33. Dr Patel admits that he proceeded with a course of treatment on Mrs Smith involving crown replacement and that by doing so he breached his Undertaking to the Dental Council.

34. In his January 1998 mentoring report to the Dental Council, Dr Stallworthy "expressed concerns that Dr Patel appeared to be ignoring his undertaking by practising prosthodontics". On 30 January 1998 the Registrar of the Dental Council wrote to Dr Patel reminding him of Clause 1 of his Undertaking. It was further pointed out that any further practice in this area, before he had satisfactorily completed further training, would be viewed as a breach of his Undertaking [AB; Vol 2; 66].

35. As stated, on 31 January, 2 February and 13 February 1998 Dr Patel continued root canal therapy on Mrs Smith's tooth 11.

36. The Dental Council duly considered the matter of Dr Patel's breach of undertaking at it meeting in February 1998 [AB; Vol 2; 71-73]. No disciplinary action was initiated. On 28 March 1998 Dr Patel was advised by the Dental Council that he was permitted to practise in all areas of dentistry, the Council being satisfied that he had satisfactorily completed an assignment and modelling work related to prosthodontics.

37. In addition, Dr Patel admits that due to his inability to undertake the work competently without remedial training, the course of treatment resulted in adverse effects on his patient, Mrs Smith, in particular:

- Pre-existing conditions, or inept treatment had resulted in irreversible pulpitis by the time Dr Patel fitted crowns (temporary on or about 6 October 1997 and final on or about 10 October 1997).

38. Dr Patel further admits that having embarked on treatment in breach of his Undertaking to the Dental Council he failed to refer his patient to appropriate practitioners instead of treating his patient himself.

39. Dr Patel admits that both treating his patient in breach of his Undertaking to the Dental Council, and in failing to provide adequate and proper care was professional misconduct.

Carman Charge

40. The events the subject of the charge in respect of Dr Patel's patient, Mrs Stephenie Carman of Napier (formerly of Whangarei) relate to the period July 1999 through to July 2000 and relate to Dr Patel's treatment of teeth 22-24.

41. In July 1999 Mrs Carman was living in Whangarei. She had attended the Kowhai Court Dental Centre and seen Dr Isobel Greensmith since November 1993 for various treatments. On 21 July 1999 Mrs Carman rang Kowhai Court to make an appointment to see Dr Greensmith about a chipped front tooth (tooth 22). The tooth had chipped when Mrs Carman was sucking a lollipop. Mrs Carman was informed that Dr Greensmith had moved on and that Dr Patel had bought the practice. She was asked if she wanted to see Dr Patel. She said she would and an appointment was made for later that day.

42. At that time Dr Patel had recently resumed practice after a period of practising under restriction (not practising crown and bridge work), retraining and supervision following a three year deregistration from the Dental Register.

43. Mrs Carman attended her first appointment with Dr Patel on 21 July 1999 [AB; Vol 1; 10]. At that appointment Dr Patel took an x-ray and advised Mrs Carman that her tooth (tooth 22) would need to be root-filled. Dr Patel did not advise Mrs Carman of the state of her dentition and made no mention of any other treatment options available (filling or extraction) and the risks and benefits that were foreseeable for the other forms of treatment. Dr Patel did not inform Mrs Carman of the likely outcome of the treatment suggested.

44. Dr Patel's clinical records do not adequately record this appointment for the treatment of tooth 22, its restoration and root canal dressing.

45. During the root filling procedure that day, the possibility of crown and bridge work for Mrs Carman's top teeth (she had a top plate and a bottom plate but only the top plate was discussed) was discussed. Dr Patel showed Mrs Carman an album of 'before and after' photographs of crown and bridge work he had done in the past. Mrs Carman will say that Dr Patel made several representations to her about his qualifications, training and experience which led her to give her informed consent to the crown and bridge work Dr Patel proposed. Dr Patel denies that he made any such representations.

46. There was no discussion about the likely outcome of the crown and bridge work Dr Patel proposed. Mrs Carman was not told of any likely or possible complications or anything about her general dental health which might have precluded or had some effect on treatment.

47. After discussing matters with her husband that evening, Mrs Carman met with Dr Patel again a couple of days later (23 July 1999) [AB; Vol 1; 10].

At that second appointment Dr Patel took impressions of Mrs Carman's top and bottom teeth.

48. Subsequent appointments in July and August 1999 involved Dr Patel providing treatment for tooth 22 and fitting crowns for teeth 21, 22 and 23 and bridges in respect of teeth 11,12,13, 15, 16 and 17 to replace the existing plate for three top teeth (which Dr Patel did not specify in his dental records). The crowns and bridges were obtained from Western Crown and Bridge Laboratory, Auckland [AB; Vol 1; 14-15].

49. Dr Patel's records do not adequately record a treatment plan for Mrs Carman and the treatment involving crown and bridgework he went on to undertake for her. Before undertaking the extensive bridge work which he planned on Mrs Carman Dr Patel did not perform a full evaluation of Mrs Carman's periodontal, occlusal and aesthetic condition. Nor did he take satisfactory x-rays prior to treating Mrs Carman. In addition before fitting a crown on tooth 22 Dr Patel failed to undertake the necessary root canal treatment.

50. In the course of fitting crowns for teeth 21,22, 23 and bridges for teeth 11-13 and 15-17, Dr Patel represented to Mrs Carman that the crowns fitted adequately, when they did not. The crowns and bridges were unsatisfactory in fit, aesthetics and occlusion, with midline off centre and no contact between back teeth. The unsatisfactory fit of the crowns and bridges was such that it caused Mrs Carman long-term pain and affected her speech to such an extent that she developed a lisp.

51. Mrs Carman required treatment from Dr Patel in June and July 2000. That treatment was required because the new crown on tooth 23 which Dr Patel had fitted in 1999 had snapped off. The appointments in June and July 2000

involved the surgical removal of tooth 23 and the fitting of new (replacement) crowns and bridges for teeth 22-24 [AB; Vol 1; 9-10].

52. Mrs Carman saw Dr Patel on 10 July 2000 following the fracture of tooth 23. Dr Patel advised Mrs Carman that he recommended the extraction of the root of tooth 23 and to bridge the new gap between teeth 22-24. No other treatment options were mentioned.

53. Dr Patel did not assess, x-ray and plan the crown and bridge work he proposed.

54. At the appointment on 10 July 2000, in the course of surgically removing the root of tooth 23, Dr Patel fractured tooth 22. Dr Patel did not advise his patient, Mrs Carman that he had broken tooth 22. He did mention to Mr Carman, who was present at the consultation, that he had broken a tooth, and was told by him not to advise Mrs Carman of this. Further, Dr Patel did not advise Mrs Carman of the treatment that was required or obtain her consent for the treatment he went on to apply to that tooth. In that regard Dr Patel cemented a post into tooth 22 leaving a high risk of apical infection, and for the second time, he crowned tooth 22 without taking an x-ray and identifying apical pathology which indicated that root canal treatment was required.

55. In the course of surgically removing the root of tooth 23 and fitting new crowns and bridges for teeth 22-24 Dr Patel misrepresented to Mrs Carman the likely cause of tooth 23 breaking. Dr Patel told Mrs Carman he believed the fracture was caused by her grinding her teeth. He accepts the likely cause was the faulty occlusion of tooth 23 which he had fitted.

56. Dr Patel fitted glass ionomer cement against exposed bone in the socket of tooth 23. That course of action precluded healing and contributed to sepsis

developing in that area, and consequent pain and discomfort for Mrs Carman. In addition Dr Patel did not allow sufficient time for the socket of tooth 23 to heal before he undertook further treatment in that area (two months or more being required before a bridge could be appropriately fitted in that area). Dr Patel placed bridge sealant in a "wet field" thereby limiting the longevity of the sealant and creating a risk of decay and sensitivity from poorly sealed margins.

57. Dr Patel did not advise Mrs Carman of the oral hygiene requirements for the new crown and bridge work.

58. Dr Patel's records do not adequately record the fracture of tooth 23 nor the abutment preparation of the crown on tooth 24 and impressions for the work he had planned.

59. The bridge work fitted by Dr Patel in June/July 2000 was unsatisfactory in fit, aesthetics and occlusion.

60. Mrs Carman was still experiencing pain and discomfort a few days after the treatment she had received (on 10 July 2000). She and her husband returned to Dr Patel and complained about having a sore jaw, that her teeth clicked together and that she was unable to bite or eat anything firm. Dr Patel told Mr and Mrs Carman that the crowns needed some final adjusting to fix the bite. Dr Patel then attempted to restore the occlusion by grinding down Mrs Carman's lower opposing anterior teeth. He did so with inadequate consideration for the long-term effects of that (including ongoing pain and the need for restoration work in the future).

61. Dr Patel made no arrangements for follow-up appointments with Mrs Carman to enable him to monitor her.

62. Mrs Carman continued to experience pain and discomfort, including sore, swollen and bleeding gums. She sought a second opinion from Dr Gilbert Stehbens of Auckland on 2 September 2000 [AB; Vol 1; 22]. Dr Douglas Waters, Periodontist also attended at the consultation Mrs Carman had with Dr Stehbens. Dr Stehbens examined Mrs Carman's teeth and advised her that the treatment she had received from Dr Patel was "third world dentistry" [AB; Vol 1; 23]. Dr Waters advised Mrs Carman that she would need extensive periodontal and restorative work.

63. On 3 September 2000 Mr Carman and Dr Patel agreed that he would reimburse the fees to Mr and Mrs Carman and as such the sum of $8000 was paid to Mr and Mrs Carman [AB; Vol 1; 12-13].

64. Subsequent to her treatment by Dr Patel, Mrs Carman required replacement of all of Dr Patel's crown and bridge work. In addition correction of severe periodontal defect involving extensive surgery in the region of tooth 23 was required (carried out by Dr Waters; AB; Vol 1; 30,37 and 39-49), along with continual maintenance by a dental hygienist.

65. In respect of his treatment of Mrs Carman, Dr Patel admits as follows:

Failure to keep adequate dental records

66. He failed to keep and produce adequate dental records showing his patient attended his surgery, and he treated her during the years 1999 and 2000.

67. In particular his records failed to adequately record:

i. The initial appointment for treatment of tooth 22, its restoration and root canal dressing;

ii. A treatment plan for his patient;

iii. Treatment involving crown and bridge work undertaken for his patient;

iv. The fracture of tooth 23;

v. Abutment preparation of the crown on tooth 24, and impressions for work planned in June 2000 (or thereabouts).

Misrepresentation, Failure to provide adequate advice and Failure to obtain informed consent

68. He failed to inform his patient to obtain her consent to treatment, in that:

i. He failed to inform your patient of the state of her dentition, the treatment options available, and the risks and benefits that were foreseeable for the alternative courses of treatment;

ii. He failed to inform his patient of the likely outcome of the treatment he proposed;

iii. Further, in the course of fitting crowns for teeth 21, 22 and 23, and bridges for teeth 11 – 13, and 15 – 17 he wrongly represented that the crowns fitted adequately;

iv. Further, in the course of (in June, July 2000 or thereabouts) when surgically removing the root of tooth 23, and fitting new crowns and bridge for teeth 22 – 24, he misrepresented the likely cause of tooth 23 breaking. The likely cause being the faulty occlusion of tooth 23 which he had fitted, he wrongly represented it as being caused by his patient grinding her teeth.

v. Further in the course of surgically removing the root of tooth 23 he fractured tooth 22, and concealed that from his patient,

and failed to advise her of the treatment that was required or obtain her consent for the treatment he applied (cementing post into tooth 22).

Failure to provide adequate or proper clinical care

69. He failed to provide adequate treatment for his patient in the course of fitting crowns for teeth 21, 22 and 23, and bridges for teeth 11 – 13, and 15 – 17 (about July or August 1999); and further when surgically removing the root of tooth 23, and fitting new crowns and bridge for teeth 22 – 24 (in June, July 2000 or thereabouts).

70. In particular:

July/August 1999 treatment

i. He failed to perform a full evaluation of his patient's periodontal, occlusal and aesthetic condition which was required before undertaking extensive bridge work which he planned;

ii. He failed to take satisfactory X-rays prior to treatment;

iii. He failed to undertake root canal treatment on tooth 22 before fitting a crown;

iv. He fitted crowns and bridges which were unsatisfactory in fit, aesthetics and occlusion, with midline off centre and no contact between back teeth;

v. The unsatisfactory fit of the crowns and bridges was such that it caused his patient long-term pain, and affected her speech so that she developed a lisp;

June, July 2000 treatment

vi. He failed to fully assess, X-ray and plan crown and bridge work following the fracture of crown 23;

vii. He cemented a post into fractured tooth 22, leaving a high risk of apical infection, and for the second time crowned tooth 22 without taking an X-ray and identifying the apical pathology which indicated that root canal treatment was required;

viii. Given the apical pathology affecting tooth 22 he inappropriately fitted a crown, and fitted an immediate bridge for teeth 22 – 24;

ix. He placed glass ionomer cement against exposed bone in the socket of tooth 23, which precluded healing and contributed to sepsis developing in that area, and consequent pain and discomfort;

x. He failed to allow sufficient time for the socket of tooth 23 to heal before undertaking further treatment in that area (two months or more being required before a bridge could be appropriately fitted in that area).

xi. He placed bridge sealant in a "wet field" thereby limiting the longevity of the sealant and creating a risk of decay and sensitivity from poorly sealed margins;

xii. He fitted bridge work that was unsatisfactory in fit, aesthetics and occlusion;

xiii. He failed to advise his patient of the oral hygiene requirements for the crown and bridge work;

xiv. He attempted to restore occlusion by excessive grinding down of lower opposing anterior teeth, with no consideration for the long-term effects (including ongoing pain and the need for restorative work);

xv. He failed to arrange follow-up appointments to monitor his patient.

Evan Charge

71. The events the subject of the charge in respect of Dr Patel's patient, Mrs Helene Evan of Waimauku, Auckland relate to the period 7 August 2002 through to 29 August 2002 and relate to Dr Patel's treatment of tooth 24.

72. Ms Helene Cecile Evan is a social worker employed by Waitemata Health Board. She holds a Diploma of Social Work and a Bachelor of Social Work Practice (Counselling). At the time of the events in question Ms Evan was working as a prison counsellor. She is a diabetic [AB; Vol 3; 5]

73. Ms Evan first went to see Dr Patel on 7 August 2002 because of pain and swelling in her front tooth, tooth 24. In his dental records Dr Patel noted Ms Evan had "severe toothache, continuous ache 24 carious pulp exposure...".[AB; Vol 3; 6-7]

74. Dr Patel x-rayed tooth 24 [AB; Vol 3; 7- 8]. Dr Patel informed Ms Evan that her tooth was abscessed and that it would need a dressing and root canal filling at a cost of $600.00. In his records he recorded "...2 canals, ledermix, composite restoration...". Dr Patel did not advise Ms Evan that root canal treatment for tooth 24 would have a 60 to 70 percent chance of being successful.

75. Ms Evan returned to Dr Patel on 12 August 2002 and reported pain associated with tooth 24 and symptoms of local and systemic infection likely to be associated with that tooth. At that appointment Dr Patel carried out cosmetic work (fixed front fillings) on four of Ms Evan's anterior top teeth (teeth 12, 11, 21 and 23) [AB; Vol 3; 6-7]. Dr Patel did not re-dress tooth 24 and he took no steps to control the infection associated with Ms Evan's front tooth (having regard to the fact that Ms Evan was a diabetic and the associated increased risk of infection). Further, Dr Patel did not provide appropriate analgesic treatment.

76. At some point between 12 August 2002 and 27 August 2002 the temporary filling on tooth 24 broke. Ms Evan phoned Dr Patel's dental surgery for a further appointment and was told that Dr Patel was away. An appointment was made for her to see Dr Patel on 27 August 2002. On 27 August 2002 Ms Evan phoned Dr Patel's surgery and advised that she would be late for her scheduled appointment because of an emergency which had arisen at her work.

77. At the time Ms Evan first consulted Dr Patel, he was awaiting the decision of the Dentists Disciplinary Tribunal on charges it had heard against him relating to other patients. That decision was issued on 19 August 2002. The Tribunal found Dr Patel guilty of six charges of professional misconduct and ordered that his name be removed from the Dental Register. Dr Patel immediately filed an appeal and an application for stay (pending appeal), the latter which was heard in the High Court at Auckland on 21 August 2002.

78. By oral decision on 21 August 2002, Priestley J ordered Dr Patel to provide a written Undertaking to the High Court that he would not undertake any dental work involving root canal work (and crown and bridge work) before 1 November 2002. The effect of the Undertaking which Dr Patel provided

to the High Court was that he could not complete the course of treatment required by Ms Evan. Dr Patel admits that on 21 August 2002 he was aware that he could not complete that course of treatment on Ms Evan.

79. Dr Patel next saw Ms Evan on 29 August 2002. By that time Ms Evan was still in pain. She had consulted her general practitioner about this and was told it was neuralgic pain and to "step up the Nurofen".

80. On 29 August 2002 Dr Patel patched the broken temporary filling on tooth 24. He also carried out a large filling on tooth 36. In addition he arranged for Ms Evan to see a hygienist on 5 September 2002 and he advised her that tooth 24 required further work as it only had a temporary filling in it. A further appointment for 6 September 2002 had been pre-arranged so as to continue with the proposed treatment as root canal treatment was carried out over 2 – 3 appointments. Dr Patel admits that when he saw Ms Evan on 29 August 2002 he failed to notify Ms Evan that he could not complete the treatment he had commenced and he admits that he did not facilitate a referral to another practitioner who could complete the treatment.

81. On 1 September 2002 Ms Evan watched the "20/20" Programme and learnt that Dr Patel was not currently permitted to be undertaking root canal treatment because of the undertaking he had provided.

82. On 3 September 2002 Ms Evan consulted Dr Alma Trupenic for a second opinion. Dr Trupenic pan x-rayed Ms Evan's mouth and this along with her clinical findings of tooth 24 being very tender to percussion and the buccal sulcus painful on pressure with some swelling, confirmed an abscess on tooth 24. Dr Trupenic prescribed oral antibiotics and three days later (6 September 2002) commenced root canal treatment. Dr Trupenic reported to the Complaints Assessment Committee in 2003 that Ms Evan had no facial swelling and no significant limited opening of the mouth. Ms Evan later

consulted a naturopath and elected to have the tooth removed because the pain had not settled.

83. On 4 September 2002 Ms Evan wrote her letter of complaint to the Dental Council.

84. In respect of the course of treatment of his patient, Ms Evan, which commenced on or about 7 August 2002, Dr Patel admits as follows:

Failure to provide adequate advice and obtain informed consent

85. On 7 August 2002, his patient presented with an abscessed front tooth 24.

86. He failed to obtain informed consent before embarking on a course of treatment involving dressing and root canal treatment for tooth 24. In particular:

i. He failed to advise that root canal treatment for his patient's tooth 24 would have a 60 to 70 percent chance of being successful.

Failure to provide adequate or proper clinical care

87. He failed to provide adequate treatment for his patient's abscessed tooth 24.

88. In particular:

i. On 12 August 2002 his patient presented and reported pain associated with tooth 24, and reported symptoms of local and systemic infection likely to be associated with tooth 24, at that consultation:

ii. He failed to re-dress the tooth, and failed to take steps both to control the infection associated with his patient's tooth 24 (having regard to her diabetic condition and the associated increased risk from infection), and further failed to provide appropriate analgesic treatment.

89. The temporary filling on tooth 24 (which he had applied on 7 August 2002) broke at some point between 12 August and 27 August 2000. Dr Patel admits he failed to adequately monitor that dressing.

Failure to refer patient for care outside those limits of his practice

90. On 21 August 2002 Dr Patel was required to provide an Undertaking to the High Court that he would not undertake any dental work involving root canal work.

91. Dr Patel was aware that the course of treatment he had commenced on Ms Evan (as previously described) on 7 August 2002 required root canal work.

92. On 21 August 2002 Dr Patel was aware that he could not complete the course of treatment required by his patient.

93. Dr Patel admits that at the appointment he had with his patient on 29 August 2002 he failed to notify his patient that he could not complete the treatment he had commenced, and that he failed to facilitate referral to a practitioner who would complete the treatment.

Other Relevant Matters

Summary of Previous Disciplinary History

94. Dr Patel was first registered as a dentist in 1989. Subsequently he was disciplined by this Tribunal on three matters, two of which related to the quality of his clinical care. In 1994 Dr Patel's name was removed from the Register on terms that he not apply for restoration for three years. That was following his conviction in the District Court on 34 charges of ACC fraud. Dr Patel undertook further training during his striking off period and was re-registered in July 1997.

95. When Dr Patel resumed practice the Dental Council required two Undertakings of him. The first Undertaking, dated 14 April 1997 included a skills assessment, a commitment to limiting himself to a "fully supervised practice", and periodic reports from the supervisor. This was to continue until the Dental Council released Dr Patel in writing. The second Undertaking (the Undertaking dated 30 June 1997 referred to above in the context of the Smith charge) involved a commitment not to practise in the area of fixed and removable prosthodontics (bridge and crown work) until he had demonstrated that he undertaken acceptable continuing education. He would limit himself to a practice that was approved by the Dental Council and offered general oversight of his clinical practice and practice management; if he operated a sole practice, he would employ a practice manager. Both Undertakings recorded that any breach of them would result in charges of professional misconduct.

96. Dr Patel practised alone in Whangarei at the Kowhai Court Dental Centre. Dr David Stallworthy was appointed as his mentor and he reported periodically to the Dental Council. On 17 January 1998 Dr Stallworthy reported that Dr Patel had been practising in prosthodontics contrary to the

undertaking (for example, fitting Mrs Smith's teeth with crowns), and that he had not taken up the offer of a short course in Dunedin to allow him to meet the requirements of the undertaking. Dr Patel did subsequently undergo further training and having considered the matter at it meeting in February 1998, by letter dated 24 March 1998 the Dental Council authorised Dr Patel to practise in all areas of dentistry, including prosthodontics.

97. Following receipt of further mentoring reports from Dr Stallworthy, in July 1998 the Dental Council required Dr Patel to undertake further training. It continued to monitor his ongoing training until around the end of 1999.

98. In July 2002 the Dentists Disciplinary Tribunal heard charges against Dr Patel relating to his treatment of Mr and Mrs Elson-White who were the subject of the "20/20" Programme referred to above. The treatment the subject of the charges was provided by Dr Patel in 1998 and 1999. The Tribunal found Dr Patel guilty of the charges and ordered that his name be removed from the Register. Dr Patel appealed to the High Court and made an application for stay of the order that his name be removed from the Register. The decision of Priestley J dated 21 August 2002 reinstated Dr Patel on terms including the provision of the written Undertaking to the High Court referred to above; pending determination of his appeal. Dr Patel undertook not to carry out any dental work involving bridgework, crown work or root canal work.

99. The "20/20" Programme screened on or around 1 September 2002. The three complaints the subject of the charges before this Tribunal, were made as a consequence of and following the broadcast of that programme in September 2002.

100. On 8 October 2002 Randerson J in the High Court at Auckland quashed the Tribunal's order that Dr Patel be struck off the Register for his mistreatment of Mr and Mrs Elson-White. Dr Patel was instead censured, suspended for four months from 1 December 2002, and restricted from performing any crown and bridge work for three years. He was ordered not to recommence such work or engage in sole practice without the permission of the Dental Council.

101. On 25 March 2003 the Dentists Disciplinary Tribunal issued its decision on two other charges it had recently heard against Dr Patel relating to his treatment of Ms Bird and Ms Munt respectively. The Tribunal found that Dr Patel made clinical errors when treating Ms Munt between August and November 1999 and when treating Ms Bird between August 2000 and early 2001. The errors involved root canal work, failures of diagnosis and failure to give appropriate advice. Dr Patel was fined and prohibited from undertaking root canal treatment for a period of at least 12 months with leave to recommence root canal work only with the approval of the Dental Council. Dr Patel was also to practise under supervision for three years from the date of the decision.

102. Dr Patel practised under supervision from Dr David Crum from 25 March 2003 until March 2006.

I, **SURESH KANJI PATEL**, admit all of the facts in the Agreed Summary of Facts and that the admitted conduct as set out in paragraphs 25-39 (Smith Charge) cumulatively amounts to professional misconduct; the conduct admitted as set out in paragraphs 65-70 (Carman Charge) cumulatively amounts to professional misconduct; and the conduct admitted as set out in paragraphs 80 and 84-92 (Evan Charge) cumulatively amounts to professional misconduct.

Dated this day of February 2007

Suresh Kanji Patel