File No CN

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
TRIBUNAL	Dr P A C Coote (Chair) Dr C Lloyd Dr W Ross Ms M Avia
LEGAL ASSESSOR	Mr G Pearson
TRIBUNALS OFFICER	Mrs S D'Ath
COUNSEL	Ms J Hughson for Director of Proceedings Mr A H Waalkens QC and Ms A L Credin for Dr Patel
DATE OF HEARING	14 February 2007
DATE OF WRITTEN DECISION	

DECISION OF THE TRIBUNAL

CHARGES

These proceedings involve three complaints against **Suresh Patel,** Dentist, of Auckland. The complaints were brought by the Complaints Assessment Committee under s54(1)(b) and (c) of the Dental Act 1988.

Dr Patel was notified of the following particulars of those complaints.

A. That when treating Stephanie Carman (your patient), which commenced on or about 23 July 1999 or thereabouts:

Failure to keep adequate dental records

1. You failed to keep and produce adequate dental records showing your patient attended your surgery, and you treated her during the years 1999 and 2000.

2. In particular your records failed to adequately record:

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

   2.2 A treatment plan for your patient;

   2.3 Treatment involving crown and bridge work undertaken for your patient;

   2.4 The fracture of tooth 23;

   2.5 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

3. To procure your patient's consent to treatment you falsely represented your qualifications, experience and ability to undertake treatment on your patient, in particular:

   3.1 You falsely represented to your patient that you had received training in Sydney, Australia, to undertake the treatment you proposed

   3.2 You falsely represented to your patient that you had lectured throughout New Zealand on treatment of the kind you proposed;

   3.3 You mislead your patient causing her to believe that you undertook specialist restoration work at a hospital, and were called in to undertake such work for accident victims.

4. Further you failed to inform your patient to obtain her consent to treatment, in that:

4.1 You 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;

4.2 You failed to inform you patient of the likely outcome of the treatment you proposed;

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

4.4 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, you misrepresented the likely cause of tooth 23 breaking. The likely cause being the faulty occlusion of tooth 23 which you had fitted, you wrongly represented it as being caused by your patient grinding her teeth.

4.5 Further in the course of surgically removing the root of tooth 23 you fractured tooth 22, and concealed that from your patient, and failed to advise her of the treatment that was required or obtain her consent for the treatment you applied (cementing post into tooth 22).

Failure to provide adequate or proper clinical care

5. You failed to provide adequate treatment for your 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).

6. In particular:

July/August 1999 treatment

6.1 You failed to perform a full evaluation of your patient's periodontal, occlusal and aesthetic condition which was required before undertaking extensive bridge work which you planned;

6.2 You failed to take satisfactory X-rays prior to treatment;

6.3 You failed to undertake root canal treatment on tooth 22 before fitting a crown;

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

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

June, July 2000 treatment

6.6 You failed to fully assess, X-ray and plan crown and bridge work following the fracture of crown 23;

6.7 You 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;

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

6.9 You 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;

6.10 You 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).

6.11 You 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;

6.12 You fitted bridge work that was unsatisfactory in fit, aesthetics and occlusion;

6.13 You failed to advise you patient of the oral hygiene requirements for the crown and bridge work;

6.14 You 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);

6.15 You failed to arrange follow-up appointments to monitor your patient.

B. That when you treated Helene Evan (your patient), which commenced on or about 7 August 2002:

Failure to provide adequate advice and obtain informed consent

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

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

8.1 You failed to advise that root canal treatment for your patient's tooth 24 would have a 60 to 70 percent chance of being successful;

Failure to provide adequate or proper clinical care

9. You failed to provide adequate treatment for your patient's abscessed tooth 24.

10. In particular:

10.1 On 12 August 2002 your 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:

10.1.1 You failed to re-dress the tooth, and failed to take steps both to control the infection associated with your 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.

10.2 The dressing on tooth 24 (which you applied on 7 August 2002) broke at some point between 12 August and 27 August, you failed to adequately monitor the dressing.

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

11. On 21 August 2002 you were required to provide an undertaking to the High Court that you would not undertake any dental work involving root canal work.

12. You were aware that the course of treatment you commenced (as previously described) on 7 August 2002 required root canal work.

13. On 21 August 2002 you were aware that you could not complete the course of treatment required by your patient.

14. At the appointment you had with your patient on 29 August 2002 you failed to notify your patient that you could not complete the treatment you had commenced, and facilitate referral to a practitioner who would complete the treatment.

C. That when treating **Jane Smith** (your patient), which commenced in or about October 1997, and continued until February 1998 or thereabouts, relating to treating her teeth 11, 21 and 25:

Failure to keep adequate dental records

15. Your clinical records failed to adequately record:

15.1 The materials used to fill teeth 11 and 21.

Failure to provide adequate or proper clinical care

16. You failed to provide adequate and competent treatment for your patient.

17. In particular:

General

17.1 You failed to assess and diagnose your patient's presenting symptoms of severe pain and discomfort;

Radiographic

17.2 You failed to obtain or interpret radiographic information to adequately assess the treatment required by your patient;

Prosthodontic Skills

17.3 You fitted crowns which were poor in shade, shape and fit.

Root Canal Treatment

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

17.5 After fitting the crowns you 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

17.6 You failed to control the pain your patient experienced in the operative and post-operative situations, between mid-October 1997 and February 1998 (or thereabouts);

17.7 You subjected your patient to undue and unnecessary pain over eight or more appointments were 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 you practice

18. On 18 August 1997 you signed an undertaking to the Dental Council, outlining restrictions and conditions under which you could practice dentistry. Your undertaking included that you would not "*practice in the areas of fixed and removable prosthodontics until such time as [you] have demonstrated that [you] have undertaken acceptable continuing education in these two areas.*"

19. The undertaking also provided that you 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.

20. The undertaking went on to say that in breaching any terms of the undertaking you would be subject to a charge of professional misconduct.

21. On 18 August 1997 you were consulted by your patient for severe toothache associated with teeth 11 and 21. At that consultation you discussed crown replacement, and sealed the margins of existing crowns.

22. You proceeded with a course of treatment involving crown replacement and by doing so you breached your undertaking.

23. Due to your inability to undertake the work competently without remedial training, the course of treatment resulted in adverse effects on your patient, in particular:

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

24. Having embarked on treatment in breach of your undertaking to the Dental Council you failed to refer your patient to appropriate practitioners instead of treating your patient yourself.

25. Both in treating your patient in breach of your undertaking to the Dental Council, and in failing to provide adequate and proper care, it was professional misconduct.

SUMMARY OF FACTS

The parties agreed on a statement of facts. The full statement of facts is attached as a schedule to this decision, and is to be read with it.

It is sufficient to note the summary of facts reflects the charges, and there is agreement the facts establish professional misconduct.

MATERIAL CONSIDERED

The Tribunal considered the following material:

- Submissions on behalf of the Complainants
- Brief of evidence for Mrs Carman
- Agreed bundles of documents for Mrs Carman, Ms Evan, and Ms Smith
- Submissions on behalf of Dr Patel
- Statement of evidence from Dr Patel
- Statement of evidence from Vilas Patel
- Reports of Dr David Crum to the Dental Council of NZ
- Correspondence between Counsel for Dr Patel and the Dental Council of New Zealand
- References from practitioners and patients

FINDINGS

In reaching its findings the Tribunal has applied the civil standard of proof on the balance of probabilities, but taking into account the seriousness of the charge and the gravity of the allegations made against Dr Patel.

Despite the admissions, the Tribunal must be satisfied that the agreed conduct amounts to professional misconduct under s 54(1)(c) of the Act.

The agreed facts together with the additional material need to be examined within the appropriate legal framework.

Legal principles

The Tribunal does not propose to canvas the relevant law in any detail. As the law is well known to both counsel and the Tribunal and as it is not disputed, a brief summary will suffice.

The primary purpose of the Tribunal's disciplinary powers is the protection of the public by the maintenance of professional standards. A further important purpose is to maintain the integrity of the profession: *Dentice v the Valuers Registration Board* [1992] 1 NZLR 720 and *B v The Medical Council* (HC, Auckland, HC 11/96, 8 July 1996, Elias J). There can also be a punitive aspect: *Taylor v General Medical Council* [1999] 2 All ER 263 and *Ziderman v General Dental Council* [1976] 2 All ER 334

The test for professional misconduct is set out in *Ongley v The Medical Practitioners Disciplinary Tribunal* [1984] 4 NZAR 369 at 374:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting medical misconduct? With proper diffidence, it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency..."*

This definition has been adopted by this Tribunal. In addition, section 54 (1)(c) makes it clear that professional misconduct includes professional negligence, that is, whether the practitioner's conduct fell below the standard of care which would reasonably be expected of a registered dentist in the circumstances of the person appearing before the Tribunal. Whether or not there has been a breach of the appropriate standards is judged against the standards of the practitioner's reasonably competent colleagues.

To determine whether a practitioner is guilty of professional misconduct requires an objective assessment. The Tribunal is not reliant on the subjective consideration of the personal circumstances or knowledge of the particular practitioner: *McKenzie v The MPDT* (HC Auckland, CIV 2002-404-153-02;12/06/03)

Comment also needs to be made on the burden of proof. New Zealand Courts have held that the burden of proof rests with the prosecution and that the appropriate burden is the civil standard of proof but with the caveat that serious allegations require a higher level of proof.

Finding of professional misconduct

In this case the parties have agreed on the facts that relate to each of the complaints. Dr Patel has admitted the charges.

The Tribunal has considered the facts before it and finds that these facts are sufficient to prove the charges and particulars before it in respect of each of the complaints.

Further, the Tribunal concludes that each of the charges and the particulars Dr Patel has admitted do in fact separately and cumulatively establish that he is guilty of professional misconduct. The Tribunal finds that Dr Patel's actions would in the eyes of any reasonably competent dental practitioner be considered professional misconduct.

PENALTY

In considering the matter of penalty, the Tribunal heard submissions on behalf of the complainants and submissions on behalf of Dr Patel. These submissions between them canvassed the purpose of disciplinary proceedings (and in particular how these purposes might translate into penalty), factors which might be described as aggravating factors, and mitigating factors.

Purpose of Disciplinary Proceedings

It has become a well established principle that the primary purpose of disciplinary proceedings is the protection of the public. Numerous decisions in a variety of settings attest to this, and a number of these decisions were drawn to the attention of the Tribunal in the submissions from the respective counsel. These have become so accepted that while bearing repetition in submissions on penalty they need not be further repeated here.

Without diminishing the protective aspect of disciplinary proceedings, there also remains a punitive aspect and also a need to maintain the integrity of the profession.

The Tribunal is well aware that the imposition of any penalty which has as its primary intent the protection of the public may also be perceived by as being punitive without there being any punitive component being specifically intended. That is to say, the Tribunal was in its deliberations on penalty, aware of this aspect and sought to reach a decision which adequately ensures the safety of the public while not adding any further unfairly burdensome penalty. This is despite the provisions of Section 55 of the Act which clearly enables the Tribunal to do so. The Tribunal was seeking to ensure the safety of the public. That this would also safeguard the public's confidence in the profession and the way it is regulated is seen as a valuable collateral

effect. That it might be regarded as being inappropriately punitive, while a matter considered by the Tribunal, is necessarily of less importance than the assurance of public safety.

Aggravating Factors

1. Breadth of charges

The charges set out above demonstrate the breadth of the offending.. In summary the admitted offending relates to the following areas:

Failure to keep adequate records (Smith and Carman charges)
Failure to provide adequate or proper clinical care (Smith, Carman and Evan)
Breach of undertaking (Smith and Evan)
Misrepresentation (Carman)
Failure to provide adequate advice and failure to obtain informed consent (Carman and Evan)

(a) Failure to keep adequate records

In the case of Mrs Smith, Dr Patel's clinical records did not describe the material used in filling tooth 22

In the case of Mrs Carman Dr Patel's clinical records make no mention of any observations which would ordinarily be expected prior to embarking on a course of advanced restorative treatment. Further, no treatment plan was recorded and there are inadequate records for a number of the treatment visits.

(b) Failure to provide adequate or proper care.

In the case of Mrs Smith Dr Patel was unable to make an appropriate diagnosis. As a result of this he fitted two new crowns to these teeth when the appropriate course of treatment would have been to root fill them prior to fitting the crowns. His subsequent management of the root treatments was inept and unsuccessful, resulting in prolonged and unnecessary pain for Mrs Smith. The crowns that he fitted were considered to be inadequate by all the dentists who subsequently saw them, but Dr Patel described them as an excellent fit. The Tribunal considers that this series of events indicates a serious lack of understanding of the practice of dentistry.

In the case of Mrs Carman, Dr Patel demonstrated a serious lack of judgment and the resulting treatment was totally unsatisfactory. The Tribunal considers that the series of events relating to Mrs Carman's treatment indicates a serious lack of understanding on the part of Dr Patel of the principles which govern the practice of dentistry .

In The case of Mrs Evan, Dr Patel failed to appropriately manage an abscess and through not continuing to treat the tooth, even when he had to opportunity to do so, he caused his patient unnecessary pain. The lack of urgent attention will have contributed to its subsequent loss. The Tribunal considers that the lack of attention to this tooth demonstrates a serious lack of judgment.

(c) Breach of undertaking

Dr Patel clearly acted in breach of his undertaking to the Dental Council in treating Mrs Smith at a time when his scope of practice was limited. In the case of Ms Evan, Dr Patel's undertaking to the High Court that he would not undertake root canal treatment was given during the course of his treatment of Ms Evan. He clearly should have referred the patient to complete the treatment.

(d) Misrepresentation.
Dr Patel made misrepresentations to Mrs Carman about his skills and experience in the area of crown and bridge work. A regrettable series of treatments and re-treatments ensued. Dr Patel admits these misrepresentations and the resultant problems with the treatment was unchallenged.

Dr Patel assured Mrs Smith that her crowns were of 'excellent fit', when clearly they were not.

(e) Failure to give adequate advice and failure to obtain informed consent.

Dr Patel's notes for Mrs Carmen make no mention of informed consent or appropriate treatment plan that would be expected for such extensive work.

2. Timing

The complaints referred to in this hearing took place over the period October 1997 to August 2002 while Dr Patel was appearing before the Tribunal on other serious matters. While those matters do not form a part of this hearing, they cannot be ignored in the considerations of penalty for the present offending. Dr Patel does not have the benefit of coming before the Tribunal with a good record. We are mindful we have proceeded on an agreed statement of facts. Accordingly, we have not regarded the fact that some (not all) aspects of the present offending were taking place while other disciplinary processes were in progress as an aggravating factor. The circumstances were not explored. However, in terms of the gravity of the offending, the totality of the offending in these charges is very serious regardless of context, and we have addressed it on that basis.

3. Record

Dr Patel's previous convictions are summarised as follows:

August 1991	Censured	Professional misconduct for failing to account for fees	Dishonesty
Nov 1991	Censured, fined $1000	'act or omission detrimental…' Failure to provide appropriate antibiotic cover	Clinical standards
Feb 1993	Censured, fined $2500	'act or omission detrimental…' Unaware of	Clinical standards

		perforating root canal	
Feb 1994	Name removed from register	False ACC claims	Dishonesty
July 2002	Name removed from register Later quashed and replaced with suspension 4 months and conditions on practise	E-W case (husband and wife)	Clinical standards
March 2003	Further conditions placed on practise	Mrs B and Mrs M cases	Clinical standards

All the provisions of Section 55 (1) have, over the years, been applied to Dr Patel. This is unique. The Tribunal concluded that the repeat offending demonstrates that these sanctions have been unsuccessful in protecting the public.

Mitigating factors.

1. Limitation of practice

Letters from practitioners to whom Dr Patel refers patients confirm that he is indeed making the appropriate referrals to be complying with these limitations to his practice. In respect of an earlier limitation on root canal therapy, it was submitted that (with the exception of Mrs Evan) all such treatments at that time were referred elsewhere for completion. To the extent that Dr Patel is not practicing in the area of crown and bridge, the public is protected.

2. Guilty plea

The Tribunal notes that Dr Patel pleaded guilty and hence avoided the need for the complainants to give evidence.

3. Refunded fees

The Agreed Bundle included copies of letters sent to Mrs Smith and Mrs Carman which make it clear that Dr Patel readily agreed to refund the fees he had been paid for the treatment these patients had received and which proved to be unsatisfactory. This also indicates a degree of awareness on the part of Dr Patel that the treatments that he had provided were unsatisfactory.

4. Letters of support

Letters of support from the following practitioners were presented to the Trubunal: Dr Gilber Watson (Prosthodontist), Dr Nina Vasan (Specialist Pediatric Dentist), Dr Aditi Patel (General Dental Practitioner), Dr Fiona Turner (Orthodontist), Dr Arita Nand (General Dental Practitioner, associate in the practice of Dr Patel). These are all practitioners to whom it is likely that Dr Patel might refer patients for various treatments. As such they are in a position to see the work that Dr Patel has performed and to hear from the patients any comments they might make about their care in the practice. All report favourably on those levels of care. Further letters from patients attest to the satisfaction they have felt in Dr Patel's care, and were written in the knowledge that Dr Patel was to appear before the Tribunal. The Tribunal acknowledges these letters and the support which they express.

5. Reports from Dr David Crum

Dr Crum is a respected member of the dental profession, who has gained a significant knowledge of Dr Patel's practice. He submitted three reports to the Dental Council during the three year period he had a supervisory role in Dr Patel's practice. The reports cover the period from April 2003 to March 2006. Dr Crum met with Dr Patel regularly during which he reviewed Dr Patel's records and treatments, and set him tasks for preparation for the following meeting. While infrequent, the reports are detailed and full. Dr Crum was impressed by the progress that Dr Patel made in the areas of record keeping, root canal treatment, continuing education, complaint management, practice organization and compliance with limitations on Dr Patel's clinical practice.

6. Continuing Education

Numerous references attest to the fact that Dr Patel has attended continuing education courses over a long period. Some of these courses have been both as a particular requirement of the Dental Council and some were voluntarily attended courses. While accepting that attendance at various courses constitutes a mitigating factor, the Tribunal also noted that their value was uncertain. The Dental Council wrote on 24 March 1998 to advise Dr Patel that having completed a prescribed course with Dr Jim Smith, Dr Patel was thenceforth permitted to practice in the area of prosthodontics.

Penalty

In consideration of the above factors the Tribunal orders as follows.

1 Dr Patel is found guilty of professional misconduct. S.54(1) (c)

2 Dr. Patel will be removed from the Dental Register, commencing 1 July 2007. S 55 (1) (a)

3 Dr Patel may apply to have his name restored to the register after a period of 2 years i.e. from 1 July 2009. S 58.

4 Dr Patel is censured. S.55(e)

6. Dr Patel is ordered to pay 20% of the costs of the hearing and prosecution. S (56).

Observation

If restoration to the register was mechanical process we would impose conditions on practice to apply on recommencement of practice. However, our decision under section 58 fixing a time when Dr Patel can apply to have his name restored does no more than allow him to apply. At that point in time the Dental Council will have to consider the application, and will evaluate it on its merits, and there may well be conditions imposed if the application is not rejected.

We are mindful competence review, retraining programmes, and supervision of practices are all undergoing development and improvement at the present time. If Dr Patel does apply for restoration, the tools available at that time for assuring professional standards will have to be considered.

We do however observe, that when exercising the power under section 58 to allow an application for restoration after two years, we do so expecting Dr Patel would not resume practice without conditions ensuring he had regular peer contact, took part in NZDA accredited courses, did not undertake crown or bridge work, or endodontics, and was subject to review by the competency adviser. Other ways of ensuring the public was protected would no doubt also be considered. These are matters for consideration later, but we emphasise them to be clear the decision we have made under section 58 is not one that leaves Dr Patel free to resume practising after two years. Such a decision would not adequately protect the public.

Philip Coote
Chairperson of the
Dentists Disciplinary Tribunal

15/3/2007