New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: **13/Den/04/02D**

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 91(1)(a) of the Act against **QUSAY ALADDIN,** Dentist, of Auckland.

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr C Lloyd, Dr H Trengrove, Dr J Edwards and Ms M Avia (Members)

Ms S D'Ath (Executive Officer)

Mrs G Rogers (Stenographer)

HEARING Held at Auckland on 20 June 2005 and by way of telephone conference on 5 August 2005.

APPEARANCES: Mr J Tamm for the Director of Proceedings.

No appearance by or for Dr Aladdin.

Introduction

1 Doctor Aladdin is a registered dentist. Until recently he practised in Auckland.

2 On 9 November 2004 the Director of Proceedings laid a disciplinary charge against Dr Aladdin with the Tribunal. The details of the charge, as amended by the Tribunal, are explained in paragraph 6 of this decision.

3 When Dr Aladdin was charged he was represented by senior counsel. Doctor Aladdin's then counsel properly raised an issue about the Tribunal's jurisdiction to hear the charge. The same issue was considered and determined by the Tribunal in Decision No.1Med/04/01D. It was decided that the present case should not be heard until the Tribunal had resolved issues relating to its jurisdiction in Decision No. 1Med/04/01D. The Tribunal's decision in that case was delivered on 15 February 2005. By that time Dr Aladdin was no longer represented by counsel, and delays were incurred in trying to set a date for this charge to be heard.

4 The Tribunal convened to hear the charge in Auckland on 20 June 2005. Doctor Aladdin did not appear. The Tribunal received from its executive officer evidence of the fact the notice of charge, and notice of the hearing date and venue were served on Dr Aladdin by way of registered post.

5 After the Tribunal received all evidence presented by the Director of Proceedings it retired to consider its decision. Later on 20 June the Tribunal advised that it was satisfied the charge had been proven. The Tribunal adjourned its decision on penalty because it was advised that:

5.1 Doctor Aladdin had been suspended from practice following a competence assessment. That suspension was ordered pursuant to s.39(2)(a) of the Health Practitioners Competence Assurance Act 2003 ("the Act"). That order was made on 23 May 2005.

5.2 The Dental Disciplinary Tribunal had heard a disciplinary charge against Dr Aladdin on 14 March 2005 and found Dr Aladdin guilty of professional misconduct under s.54(1)(c) of the Dental Act 1988 and of conduct that was detrimental to his patient under s.54(1)(b) of the same Act. The circumstances of that case were similar to the matters presented to this Tribunal. The Dentists Disciplinary Tribunal was still considering what penalty to impose on Dr Aladdin.

5.3 On 1 June 2005 this Tribunal heard a disciplinary charge brought against Dr Aladdin. The Tribunal found Dr Aladdin guilty of professional misconduct in circumstances which were also similar to the matters presented to the Tribunal on 20 June. The Tribunal which heard the case on 1 June 2005 adjourned its decision on penalty because it wanted to know what penalty was imposed on Dr Aladdin by the Dentists Disciplinary Tribunal before deciding what penalty it should impose.

5.4 The Dentists Disciplinary Tribunal's decision on penalty was delivered on 5 July 2005. The Director of Proceedings' submissions on penalty in this case were received on 1 August and considered by the Tribunal on 5 August 2005.

Amended Charge

6 When the Tribunal convened on 20 June it granted an application to amend the charge. The amended charge alleged:

> *"Between 12 February 2001 and 10 October 2002 in the course of the management of Linda Shen:*
>
> *1. [Dr Aladdin] failed to adequately perform root canal therapy in his patient's tooth 34, in that [he] did not place a root canal filling in a timely manner and/or failed to refer her to an endodontist in a timely manner in that [he] had not referred her to an endodontist by 31 March 2001;*
>
> *AND/OR*

> *2.* *[Dr Aladdin] failed to adequately perform root canal therapy in [his] patient's tooth 36 in that [he] failed to fill one mesial root canal and inadequately filled the other mesial root canal, and/or failed to refer her to an endodontist in a timely manner in that [he] had not referred her to an endodontist by 31 March 2001;*
>
> *AND/OR*
>
> *3.* *Between 2 February 2001 and 10 October 2002 [he] failed to adequately document [his] care of [his] patient."*

7 The Director of Proceedings pleaded that the conduct alleged in particulars 1 to 3 of the amended notice of charge either separately or cumulatively amounted to professional misconduct.

8 The amendments to the charge granted by the Tribunal on 20 June are underlined in paragraph 6 of this decision. The Tribunal granted the amendments sought by the Director of Proceedings pursuant to clause 15 of the First Schedule of the Act because it believed Dr Aladdin was not prejudiced by these amendments.

Legal Principles

Onus and Standard of Proof

9 The Director of Proceedings carries the burden of proving the charge.

10 The standard of proof required in professional disciplinary hearings has recently been the subject of discussion at the highest judicial levels.

11 By way of background, Jeffries J in *Ongley v Medical Council of New Zealand*[1] adopted the following passage from *Re Evitt; ex parte New South Wales Bar Association*[2]:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probability: Rejfek v McElroy*[3]*. Reference in the authorities to the clarity of proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

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1 (1984) 4 NZAR 369
2 (1967) 1NSWLR 609
3 [1966] ALR 270

12 The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[4] where it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". A similar observation was reiterated by another full bench of the High Court in *Brake v Preliminary Proceedings Committee*[5]. The Court said:

> *"The standard of proof is not the criminal standard. The Preliminary Proceedings Committee is required to prove the charge to the civil onus, that is, proof on the balance of probabilities. But the authorities have recognised that the degree of satisfaction for which the civil standard of proof calls, will vary according to the gravity of the facts to be proved: Ongley v Medical Council of New Zealand*[6]*. The charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

13 Numerous other cases have reiterated the test articulated by Jeffries J in *Ongley*. It suffices for present purposes to refer briefly to:

13.1 *M v Medical Council of New Zealand*[7]*:*

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge."*

13.2 *Cullen v Medical Council of New Zealand*[8]*:*

> *The MPDC's legal assessor, Mr Gendall, correctly described … the [standard of proof required in medical disciplinary proceedings]*
>
> > *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

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4 [1989] 1 NZLR 139 at 163
5 [1997] 1 NZLR 71
6 [1984] 4 NZAR 364, 375-376
7 (No 2) unreported HC Wellington, M239/87, 11 October 1990 Greig J.
8 unreported HC Auckland, 68/95, 20 March 1996, Blanchard J

14 In *F v MPDT*[9] William Young J suggested that in medical disciplinary proceedings the standard of proof should be proof beyond reasonable doubt. Three Judges decided that case. William Young J was the only Judge who suggested that disciplinary proceedings should be governed by the standard of proof applicable in criminal proceedings. His Honour approved a recent decision of the Privy Council in *Campbell v Hamlett*[10] in which their Lordships held that disciplinary proceedings should be decided on the basis of proof beyond reasonable doubt.

15 The Tribunal records its deep respect for William Young J. The Tribunal also observes his comments were not endorsed by the other members of the Court of Appeal. The Tribunal believes that New Zealand Courts have universally applied the standard of proof test articulated by Jeffries J in *Ongley* for the past two decades. In these circumstances the Tribunal believes that the New Zealand authorities currently require the Tribunal to assess culpability on the basis of the civil standard of proof, bearing in mind that serious allegations require a high standard of proof.

16 In this case, where the Tribunal has made findings adverse to Dr Aladdin it has done so because the evidence satisfies the test as to the standard of proof set out in paragraphs 11 to 13 of this decision. The allegations against Dr Aladdin are of a serious nature and bring into question his basic level of competence when undertaking root canal therapy. Accordingly the Tribunal has applied a high level of proof. The Tribunal's adverse findings have only been made where the Tribunal believes the evidence against Dr Aladdin is compelling.

Professional Misconduct

17 Professional misconduct is defined in sections 100(1)(a) and (b) of the Act. The Act refers to a practitioner being guilty of professional misconduct in two circumstances, namely:

> *"(a) … because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or*
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> *(b) … because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to*

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9 CA 213/04, 4 May 2005
10 [2005] UKPC 19

> *the profession that the practitioner practised at the time that the conduct occurred …"*

18 The definition of professional misconduct in the Act is modelled on the definition of professional misconduct found in the Nurses Act 1977.

19 Those who drafted s100(1)(a) of the Act intended to draw a distinction between malpractice and negligence. Whilst there are differences between malpractice and negligence, it is quite conceivable for acts and omissions to constitute both malpractice and negligence.

20 Malpractice is defined in the Collins English dictionary[11] as meaning:

> *"The immoral, illegal or unethical conduct or neglect of professional duty. Any incidence of improper professional conduct"*

The same term is defined in the New Shorter Oxford English Dictionary[12] as meaning:

> *"Improper treatment or culpable negligence of a patient by a physician or of a client by a lawyer …a criminal or illegal action: wrong doing, misconduct"*.

Negligence

21 The term negligence has a specific meaning in law. Before a plaintiff could successfully sue a health practitioner for negligence they would need to prove four matters, namely:

21.1 That the practitioner owed the plaintiff a duty of care;

21.2 That the practitioner breached the duty of care they owed the plaintiff;

21.3 That the plaintiff suffered compensatible damage;

21.4 That the damage suffered by the plaintiff was caused by the practitioner's breach of the duty of care they owed the plaintiff.

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[11] 2nd Edition
[12] 1993 Edition

22 It is highly unlikely the drafters of s100(1)(a) of the Act envisaged those prosecuting health practitioners would need to prove all the criteria required by the common law to establish negligence on the part of a health practitioner. In the Tribunal's view, the term "negligence", as used in s100(1)(a) of the Act focuses on a practitioner's breach of their duty in a professional setting. The test as to what constitutes negligence in s100(1)(a) of the Act requires, as a first step in the analysis, a determination of whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal. Whether or not there has been a breach of the appropriate standards is measured against the standards of a responsible body of the practitioner's peers.[13]

23 The approach set out in paragraph 22 of this decision avoids the need for prosecuting authorities to prove damage. Thus for example, a practitioner who fails to make appropriate notes of a consultation may not cause damage to their patient, but may nevertheless be guilty of negligence within the meaning of s100(1)(a) HPCA Act.

Discredit to the Profession

24 The term to "bring discredit to the profession" was considered by Gendall J in *Collie v Nursing Council of New Zealand*[14] when considering an appeal brought under the Nurses Act 1977. His Honour noted:

> *"To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the nursing profession was lowered by the behaviour of the nurse concerned."*

Background Jurisprudence

25 In New Zealand, most discussions about the meaning of professional misconduct in a medical setting commence with a reference to the judgment of Jeffries J in *Ongley v*

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[13] See for example, *Maynard v West Midlands Regional Health Authority* [1985] 1 All ER 635 (HL).
[14] HC Wellington, AP 300/99, 5 September 2000

Medical Council of New Zealand[15]. In that case His Honour formulated the test as to what constituted professional misconduct as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional bretheren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

26 Legislative changes to the composition and structure of medical disciplinary bodies in 1995 caused the analysis as to what constituted professional misconduct to evolve from the seminal test articulated by Jeffries J in *Ongley*.

27 Under the Dental Act 1988, the test as to what constituted professional misconduct became distilled to two questions. Those two questions were very similar to the tests applied in medical disciplinary proceedings namely:

27.1 The first portion of the test involved an objective evaluation of the evidence and answer to the following question:

> Had the practitioner so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the practitioner's colleagues and representatives of the community as constituting professional misconduct?

27.2 Secondly, if the established conduct fell below the standards expected of a practitioner was the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the practitioner?[16]

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[15] Supra

[16] Refer *G v Dental Council of New Zealand*, (unreported, HC Auckland, CP 58/95, 4 March 1996, Morris J): *A v Dentists Disciplinary Tribunal*, (unreported, HC Wellington, AP 12/95, 11 February 1997, Neazor J.

Professional Misconduct under the Act

28 The Tribunal is of the view that much of the jurisprudence concerning the meaning of professional misconduct under earlier legislative regimes continues to be relevant under the Act. In particular, the Tribunal believes that the test as to what constitutes professional misconduct continues to involve a two step process:

28.1 The first step involves an objective analysis of whether or not the health practitioner's acts or omissions in relation to their practice can be reasonably regarded by the Tribunal a constituting:

malpractice; or

negligence; or

otherwise meets the standard of having brought, or was likely to bring discredit to the practitioner's profession.

28.2 The second step of the process requires the Tribunal to be satisfied that the health practitioner's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards and/or punishing the health practitioner.

29 The Tribunal has assessed Dr Aladdin's conduct in this case by addressing the tests noted in paragraph 28 of this decision in relation to each particularised allegation in the amended notice of charge.

Facts

30 The Director of Proceedings adduced evidence from:

30.1 Mrs Linda Shen, the complainant;

30.2 Dr David Parkins, an endodontist who took over the care of Mrs Shen in December 2001;

30.3 Dr David Purton who was called as an expert witness.

30.4 Ms Wendy Vonlanthen

30.5 Ms Jean Bayley

30.6 Mr Trevor Morley

The last three witnesses gave evidence about attempts to contact Dr Aladdin, the sending of relevant documents to Dr Aladdin, and the process by which dental records were obtained.

31 Mrs Shen told the Tribunal that between August 2000 and February 2001 she attended an unregistered dentist, a Dr Zhaeng. Dr Zhaeng treated a number of Mrs Shen's teeth. Mrs Shen suffered considerable pain and discomfort when being treated by Dr Zhaeng. Mrs Shen decided to consult Dr Aladdin at Papatoetoe whose rooms were only a ten minute walk from her home.

32 Mrs Shen first went to Dr Aladdin on 12 February 2001. Doctor Aladdin's records state that Mrs Shen needed root canal treatment in relation to teeth 36, 35 and 34. Root canal treatment was commenced on tooth 36 on 12 February 2001.

33 Mrs Shen next visited Dr Aladdin on 16 February 2001. At that time Dr Aladdin commenced root canal treatment on tooth 35. Mrs Shen returned to Dr Aladdin on 19 February 2001 when Dr Aladdin carried out further work on tooth 35.

34 On 22 February 2001 Mrs Shen returned to Dr Aladdin. On this occasion Dr Aladdin recorded carrying out further work on tooth 36.

35 The notes made by Dr Aladdin record that he next saw Mrs Shen on 26 February 2001 at which time he had noted that the mesial root of tooth 36 was "obstructed". Doctor Aladdin resolved to keep tooth 36 under observation.

36 Mrs Shen next saw Dr Aladdin on 1 March 2001 when Dr Aladdin undertook work on tooth 34. Doctor Aladdin recorded that tooth 34 was "obturated" (obdurated) and he advised Mrs Shen that he would use a solvent to attempt to unblock the canal. Doctor Aladdin's notes for this day recorded:

> *"RCT … for 34 it obtrated and material put in for dissolving then I will re-open again" (sic)*

37 On 8 March 2001 Mrs Shen returned to Dr Aladdin. He has recorded that he applied more solvent to tooth 34 and that he would see his patient again in three weeks time.

38 Mrs Shen saw Dr Aladdin on 29 March 2001. Mrs Shen told the Tribunal that Dr Aladdin advised her that the canal was blocked because of the work that had been

done by Dr Zhaeng. Doctor Aladdin proposed keeping teeth 34 and 36 under observation. Doctor Aladdin's notes record that he applied a temporary filling to tooth 34 with the intention of seeing Mrs Shen in two months time.

39 When Mrs Shen returned to Dr Aladdin on 6 June 2001 a discussion took place about applying a permanent filling to tooth 34. Doctor Aladdin's notes record that:

> "*Patient request to put the permanent filling on the tooth. See her in July"*.

Mrs Shen told the Tribunal that it was Dr Aladdin who raised the issue of a permanent filling because there was nothing else he could do for her.

40 Mrs Shen saw Dr Aladdin on 8 August 2001. She returned for a further examination on 14 November 2001 at which time Dr Aladdin recorded Mrs Shen was concerned about the sensitivity of her teeth in her upper left jaw. Arrangements were made for Mrs Shen to return in another six months.

41 On 6 March 2002 Mrs Shen went back to Dr Aladdin. She was suffering pain in her lower left back teeth and was in considerable discomfort. Doctor Aladdin took a radiograph from which he identified a radiolucency in the mesial root of tooth 36. Doctor Aladdin prescribed an antibiotic and recorded that he would "… keep watching the tooth". Mrs Shen told the Tribunal that Dr Aladdin explained that she was experiencing gum problems and that a "dentist can't fix a gum problem".

42 Towards the end of 2002 Mrs Shen had a filling in tooth 46. This also proved to be very painful. Mrs Shen's experiences in relation to tooth 46 were the "final straw". She decided to see another dentist, Dr Al-Zibari, on 7 November 2002.

43 Doctor Al-Zibari referred Mrs Shen to a specialist endodontist, Dr David Parkins on 9 November 2002. Mrs Shen wanted to ensure that Dr Parkins had all relevant information. Mrs Shen returned to Dr Aladdin and asked to be referred to an endodontist. Doctor Aladdin provided Mrs Shen with a written referral to Dr Jardine, also an endodontist. Mrs Shen sent Dr Aladdin's letter of referral to Dr Parkins whom she first saw on 17 December 2002.

44 Dr Parkins commenced treating Mrs Shen's tooth 36 on 17 December. Doctor Parkins cut through the existing restoration which consisted of a composite resin material. Doctor Parkins found an untreated mesiolingual canal, gutta percha root filling

material in the distal canal and a cement material in the mesiobuccal canal. Doctor Parkins prepared the canals to the stage where they were ready to obturate (fill).

45 Doctor Parkins continued his restorative work on tooth 36 on 31 January 2003. The tooth was root filled. Mrs Shen's level of discomfort had already resolved because of the treatment provided by Dr Parkins on 17 December. Mrs Shen returned to Dr Parkins on 3 February to fix a small fracture in tooth 36.

46 Doctor Parkins started treating teeth 34 and 35 on 24 February 2003.

47 Doctor Parkins found that in relation to tooth 34, an access cavity had been made, but no work had been done on the canal. The canal appeared not to have been located. Doctor Parkins located the canal and undertook restorative work to the canal of tooth 34. On the same day Dr Parkins cleaned gutta percha out of the root canal of tooth 35 and prepared that tooth for conventional root canal filling.

48 On 10 March Dr Parkins substantially completed the root canal treatment of teeth 34 and 35. Both teeth were filled, stainless steel posts were inserted and the teeth restored with composite fillings. Follow up treatment was completed on 13 March 2003.

49 A review by Dr Parkins on 8 September 2003 showed that teeth 34, 35 and 36 had healed and by this stage Mrs Shen had a normal bone pattern around all three teeth.

Expert Evidence

50 Doctor Purton provided the Tribunal with his expert analysis of the facts. Doctor Purton is a senior lecturer in dentistry. He has taught at the University of Otago for 14 years where he teaches both graduate and undergraduate students. Doctor Purton has also had 14 years dental practice in addition to his academic experience.

51 Doctor Purton explained to the Tribunal that root canal therapy is a "fundamental form of treatment" which a fourth year dental student should be able to undertake.

52 The basic steps to be followed when undertaking root canal therapy are:

52.1 The removal of any pulp tissue in the canal;

52.2 The application of disinfectant and occasionally antibiotics to treat any infection;

52.3 Ensuring the canal is completely clean from the base of the crown to the end of the canal. In order to achieve this a dentist uses an endodontic file of a measured length from which the "working length" can be determined. Radiographs should be taken with the file in place to ensure the end of the canal has been reached;

52.4 Once the canal has been cleaned, each canal is shaped for root filling material. The common filling material is gutta percha, which is compressed and cemented into the canal in order to prevent any micro-leakage of bacteria.

52.5 It is essential that the filling material creates a complete seal otherwise there is a risk of infection, pain and the loss of the tooth.

Tooth 34

53 Doctor Purton was very critical of Dr Aladdin's attempts at treating Mrs Shen's tooth 34. Doctor Purton was of the view that Dr Aladdin did not provide any root canal therapy and that he should have referred his patient to an endodontist no later than 31 March 2001.

54 Doctor Purton told the Tribunal Dr Aladdin "most likely" commenced treating tooth 34 on 1 March 2001. Doctor Aladdin's notes recorded tooth 34 was obturated. Doctor Purton believes this was a misuse of terminology. The word obturated is used by dentists to describe a filled canal. Doctor Aladdin appears to have used the term obdurated when referring to an obstructed canal.

55 Doctor Purton was very concerned that Dr Aladdin appears to have tried to unblock the canal of tooth 34 by placing some sort of solvent in it. This was a technique that Dr Purton had not heard of in relation to the treatment which should have been carried out on tooth 34.

56 Of equal concern was the fact that it would appear Dr Aladdin did not in fact locate the canal of tooth 34. When Dr Parkins examined tooth 34 he found that the canal was not in fact blocked, and that Dr Aladdin was operating on the wrong part of the tooth to find the canal.

57 Doctor Purton was also concerned Dr Aladdin's notes did not record what substance was being used to try and unblock the canal, as Dr Aladdin perceived it. Doctor Purton told the Tribunal that Dr Aladdin's "operating in the wrong location and his

failure to record the substance used inside the tooth [was] evidence of the generally poor standard of care provided by Dr Aladdin to Mrs Shen".

58 Doctor Purton noted Dr Aladdin continued to treat tooth 34 on 8 March 2001. This was a source of concern for Dr Purton because Dr Aladdin was still operating on the wrong part of the tooth to locate the canal. Doctor Aladdin appears to have simply applied more solvent.

59 Doctor Aladdin saw Mrs Shen again on 29 March in relation to tooth 34. Again Dr Aladdin persisted with the treatment he had initiated earlier that month. Doctor Aladdin simply continued with his "wait and see" approach. Doctor Purton was adamant that by this stage Dr Aladdin should have discontinued his treatment and referred Mrs Shen to an endodontist. Doctor Purton said that Dr Aladdin's decision on 29 March to simply defer treatment amounted to a serious departure from accepted professional standards.

Tooth 36

60 Doctor Purton advised the Tribunal that from his reading of Dr Aladdin's notes, Dr Aladdin began treating tooth 36 on 12 February 2001 when he cleaned the canal, applied Ledermix and placed a temporary filling.

61 On 22 February 2001 Dr Aladdin recorded a canal length and diameter in relation to tooth 36.

62 Doctor Aladdin's notes suggest he resumed treating tooth 36 on 26 February 2001 when his notes record a blockage in a canal in the mesial root. Doctor Aladdin decided to keep the tooth under observation. Doctor Purton was critical of this course of management. Doctor Purton said:

> *"As with tooth 34 there was nothing to be gained by taking a 'wait and see' approach. At this point he should have referred the patient to an endodontist for treatment …".*

63 The next entry in the notes for tooth 36 is on 6 March 2002. On that day Dr Aladdin noted Mrs Shen was in pain and that a radiograph showed radiolucency adjacent to the mesial root of tooth 36. Doctor Purton told the Tribunal that:

> *"… radiolucency is indicative of bone loss due to the presence of infection."*

Dr Purton was in *"… no doubt that the infection [was] in large part due to Dr Aladdin's inaction"*.

64 Doctor Purton observed that there appeared to be no further treatment or management of tooth 36 until 6 March 2002 when Dr Aladdin again recorded radiolucency in the mesial root of tooth 36. He prescribed an antibiotic and noted his intention to "*keep watching the tooth"*.

65 Doctor Purton was very critical of Dr Aladdin's failure to take steps to actively treat tooth 36 and/or refer Mrs Shen to an endodontist. He said:

> *"In my opinion Dr Aladdin's failings in this respect amount to an extremely serious departure from acceptable professional standards. Given the time involved, the pain, and the diagnosis of infection, it was inexcusable for a registered dentist to have acted in this way"*.

Records

66 Doctor Purton was also critical of Dr Aladdin's records. Doctor Purton's concerns included:

66.1 The records for 12 February 2001 indicated root canal treatment had been performed on teeth 34 and 35 but the treatment provided (if any) was not explained.

66.2 The records for 22 February refer to a working length measurement for only one canal of tooth 36. Typically tooth 36 has three or four canals, each of different lengths and diameters.

66.3 The records for 1 March suggest teeth 34 and 36 were "obturated" when Dr Aladdin probably meant "obstructed".

66.4 The records for 1 March do not explain what solvent was used on teeth 34 and 36.

66.5 The notes for 8 March 2001 were very sparse and do not adequately explain what was done.

66.6 There were no working length radiographs or records of the working length achieved in relation to tooth 34 on 8 March 2001.

66.7 The records of 29 March do not explain what treatment was carried out on tooth 34.

66.8 There is no record of what, if any, treatment was provided on 6 June 2001.

66.9 Doctor Aladdin's records of 20 March 2003 incorrectly refer to Dr David Parkins as Diavd Parkinson.

67 Doctor Purton summarised his concerns about Dr Aladdin's notes by telling the Tribunal:

> *"Doctor Aladdin's dental records fall well below the accepted professional standards. He uses confusing and inaccurate dental terminology, writes poor English, and doesn't describe the materials or techniques he used in sufficient detail. The effect is that any dentist reading his records has difficulty gaining accurate information about what was done for the patient".*

Tribunal's Findings in Relation to Each Particularised Allegation

Particular 1: [Dr Aladdin] failed to adequately perform root canal therapy in [his] patient's tooth 34 in that [he] did not place a root canal filling in a timely manner and/or failed to refer her to an endodontist in a timely manner in that [he] had not referred her to an endodontist by 31 March 2001.

68 The Tribunal is in no doubt the Director of Proceedings has proven the first particular of the charge to the requisite standard.

69 The evidence establishes beyond any doubt Dr Aladdin did not undertake root canal therapy on Mrs Shen's tooth 34. By the time Dr Parkins commenced treating Mrs Shen's teeth 34 and 35 on 24 February 2003 it was very clear that Dr Aladdin had not even located the root canal of tooth 34, let alone carried out any of the basic steps normally associated with root canal therapy.

70 The Tribunal agrees entirely with Dr Purton's assessment that Dr Aladdin's failure to carry out orthodox root canal therapy on tooth 34 was a failure to adhere to the standards normally expected of a dentist in Dr Aladdin's position. Doctor Aladdin's

failure to provide routine root canal therapy amounted to negligence within his scope of practice (s100(1)(a) of the Act).

71 The Tribunal is also of the view that Dr Aladdin needed to refer Mrs Shen to an endodontist by the end of March 2001. Having recorded on 12 February 2001 that tooth 34 required root canal therapy (and having charged Mrs Shen $500 for the planned treatment) it was incumbent on Dr Aladdin to attend to this treatment in a prompt manner. Doctor Aladdin saw Mrs Shen on 7 occasions by the time she visited him on 29 March. By that stage Dr Aladdin should have realised his treatment plan was not achieving anything. His "wait and see" approach was totally unacceptable. Doctor Aladdin should have referred Mrs Shen to an endodontist so that she could receive proper care. Doctor Aladdin's failure to refer Mrs Shen to an endodontist constituted negligence within the meaning of s.100(1)(a) of the Act.

72 Doctor Aladdin's errors were serious. The Tribunal would not expect any registered dentist in New Zealand to commit the mistakes made by Dr Aladdin in relation to Mrs Shen's tooth 34.

73 The Tribunal is convinced that a disciplinary sanction is justified in relation to the first particular of the charge. A disciplinary finding is warranted in order to protect the public, maintain professional standards and punish Dr Aladdin. The Tribunal accordingly finds Dr Aladdin guilty of professional misconduct in relation to the first particular of the charge.

Particular 2: **[Dr Aladdin] failed to adequately perform root canal therapy in [his] patient's tooth 36 in that [he] failed to fill one mesial root canal and inadequately filled the other mesial root canal, and/or failed to refer her to an endodontist in a timely manner in that [he] had not referred her to an endodontist by 31 March 2001.**

74 The Tribunal is completely satisfied Dr Aladdin did not carry out adequate root canal therapy on Mrs Shen's tooth 36. The evidence of Dr Parkins clearly establishes that when he commenced treating Mrs Shen's tooth 36 on 17 December 2002 the mesiolingual canal in tooth 36 had not been treated. Two other canals had been inadequately filled with gutta percha and another unknown substance.

75 Doctor Aladdin's notes record that he recognised the need for root canal therapy on tooth 36 when he saw Mrs Shen on 12 February 2001. When Dr Aladdin saw Mrs Shen on 26 February 2001 he identified a blockage in a canal and recorded that he would "keep watching this tooth".

76 As with tooth 34, Dr Aladdin's "wait and see approach" was not appropriate. Doctor Aladdin did nothing more in relation to tooth 36 until 6 March 2002 when he noted his patient was in pain and that a radiograph showed radiolucency adjacent to the mesial root of tooth 36.

77 Doctor Aladdin's failure to carry out standard root canal therapy on tooth 36 constituted a serious departure from professional standards. Furthermore, it should have been apparent to Dr Aladdin by the time he saw Mrs Shen on 29 March 2001 that he had not carried out orthodox root canal therapy on tooth 36. It was incumbent upon him to refer Mrs Shen to an endodontist at this stage because Dr Aladdin must have appreciated that tooth 36 would simply continue to deteriorate unless proper root canal therapy was undertaken.

78 Doctor Aladdin's errors in mis-managing tooth 36 were very serious and constituted a significant departure from the standards normally expected of a New Zealand registered dentist. Doctor Aladdin's mistakes in relation to tooth 36 constituted negligence within the meaning of s.100(1)(a) of the Act.

79 The Tribunal is satisfied that a disciplinary finding is warranted in relation to the second particular of the charge. This finding is required in order to protect the public, maintain professional standards and to punish Dr Aladdin. Accordingly the Tribunal finds Dr Aladdin guilty of professional misconduct in relation to the second particular of the charge.

Particular 3: Between 2 February 2001 and 10 October 2002 [Dr Aladdin] failed to adequately document [his] care of [his] patients.

80 The Tribunal agrees with Dr Purton's assessment that Dr Aladdin's notes were inadequate. Doctor Aladdin used confusing and inappropriate terminology and failed to fully and adequately explain the procedures and materials he used when treating Mrs Shen. Of particular concern was Dr Aladdin's decision to use a solvent to clear the canal of tooth 34. A New Zealand dentist, reading Dr Aladdin's notes, would be very bewildered by that comment and is unlikely to be able to understand what treatment Dr Aladdin had actually provided.

81 Whilst the Tribunal is satisfied Dr Aladdin's notes fall well below the standard expected of a dentist in New Zealand, the Tribunal does not believe that a disciplinary sanction is required in relation to this particular charge. The Tribunal believes that the public's interest, and the interests of the profession will be adequately addressed by the Tribunal's findings in relation to the first two particulars of the charge, and its cumulative findings.

Cumulative Finding

82 The Tribunal finds that when viewed cumulatively, the adverse findings made against Dr Aladdin in relation to all three particulars of the charge constitute professional misconduct. When viewed cumulatively, Dr Aladdin's failures to:

82.1 Properly treat teeth 34 and 36; and

82.2 Refer Mrs Shen to an endodontist by the end of March 2001; and

82.3 Maintain proper records

constitutes negligence within the meaning of s.100(1)(a) of the Act. The established particulars of the charge, when viewed cumulatively justify a finding of professional misconduct in order to protect the public and maintain professional standards.

However, in order to avoid any suggestions of "double punishment" the Tribunal will not impose any penalty in relation to its findings in relation to the cumulative charge.

Penalty

83 The Tribunal considered what penalty to impose on Dr Aladdin after first determining its penalty in 12/Den/05/4D. As with its decision in 12/Den/05/4D the Tribunal has borne in mind that the principal purpose of the Act *"…is to protect the health and safety of members of the public …"*[17].

84 In its decision in 12/Den/05/4D the Tribunal cancelled Dr Aladdin's registration as a dentist. It did so because:

84.1 A report of the Dental Council of New Zealand following a review of Dr Aladdin's competence in May 2005 raised very serious concerns about Dr Aladdin's competence in relation to a wide range of matters, namely, *"… cross infection control, diagnosis, treatment planning, record keeping and clinical treatment"*.

The Dental Council of New Zealand suspended Dr Aladdin from practising until he undertook remedial training and was re-assessed.

84.2 On 5 July 2005 the Dentists Disciplinary Tribunal suspended Dr Aladdin from practising for three months with effect from 1 September 2005. In that case the Dentists Disciplinary Tribunal found Dr Aladdin's standards *"fell well below the accepted standards of professional competence"*. The Dentists Disciplinary Tribunal made adverse findings against Dr Aladdin in relation to:

- his standard of communication with his patients;
- his failure to carry out a proper root canal filling;
- his failure to keep and maintain proper records;
- his failure to keep and maintain proper records;
- his failure to treat a fractured tooth in a timely manner;

[17] Section 3(1) of the Act

- his claiming payment for work not performed;
- his failure to address an overhanging margin in a tooth;
- his failure to keep proper radiographs.

84.3 In 12/Den/05/4D the Tribunal found Dr Aladdin:

- failed to properly mount a crown in his patient's tooth;
- failed to properly fit a post into his patient's tooth;
- failed to keep proper records.

84.4 The combined effect of these findings left the Tribunal with no doubt that Dr Aladdin did not have the basic skills required to practice dentistry in New Zealand.

85 In this case the Director of Proceedings has again urged Dr Aladdin's registration be cancelled, and has advanced reasons in support of that submission which are essentially the same as those which were put to the Tribunal in 12/Den/05/4D.

86 The Tribunal has again carefully reflected on the appropriate penalty in this case. As with 12/Den054D, the Tribunal believes it has no option other than to cancel Dr Aladdin's registration. The combined effect of:

86.1 The Competence Assessment into Dr Aladdin conducted in May 2005; and

86.2 The decision of the Dentists Disciplinary Tribunal suspending Dr Aladdin; and

86.3 The decision of this Tribunal in 12/Den/05/4D; and

86.4 The Tribunal's findings in this case

establish beyond doubt Dr Aladdin does not have the basic skills required to practise dentistry in New Zealand.

87 As with its decision in 12/Den/05/4D the Tribunal has considered whether or not a remedial course of training may be available to salvage Dr Aladdin's career in this country. Regrettably, Dr Aladdin's short comings are so profound and cover so many aspects of dentistry the Tribunal believes he must be re-trained as a dentist before he practises in New Zealand again.

88 As in 12/Den/05/4D the Tribunal believes Dr Aladdin should not practise in New Zealand until he has re-trained in a University acceptable to the Dental Council of New Zealand. Ideally Dr Aladdin should re-train at Otago University, however the Tribunal will not impose this condition on Dr Aladdin so as to provide him with a range of options to achieve rehabilitation.

89 The Tribunal orders Dr Aladdin's registration as a dentist be cancelled with effect from 1 September 2005. This order is made pursuant to s.101(1)(a) of the Act. The Tribunal also directs that before he reapplies for registration Dr Aladdin must satisfy the Dental Council of New Zealand that he has been appropriately re-trained as a dentist to a level of competency acceptable to the Dental Council of New Zealand. Dr Aladdin's retaining should preferably be undertaken at the University of Otago. This condition is imposed pursuant to s.102(2)(a) of the Act.

90 In this case the costs incurred by the Director of Proceedings in investigating and prosecuting the charge came to $19,507.84. The costs of the Tribunal were $11,967.28. Because the Tribunal has cancelled Dr Aladdin's registration, and because the Tribunal does not know what resources Dr Aladdin has, it has assumed that Dr Aladdin is unlikely to be able to pay any significant award of costs. Accordingly the Tribunal has again decided to impose a nominal order for costs against Dr Aladdin pursuant to s.101(f) of the Act. Doctor Aladdin will be required to pay $2,500 towards the costs of the Director of Proceedings and $2,500 towards the costs of the Tribunal (total $5,000).

91 The Executive Officer is directed to publish a summary of the Tribunal's findings in the Dental Council Newsletter and the Manukau Courier. This order is made pursuant to s.157(2) of the Act.

DATED at this 10th day of August 2005

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Dr D B Collins QC
Chair
Health Practitioners Disciplinary Tribunal