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DECISION NO: **12/Den/05/04D**

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 W Hawke and Ms M Avia (Members)

Ms S D'Ath (Executive Officer)

Mrs G Rogers (Stenographer)

HEARING: Held at Auckland on 1 June 2005, and by way of telephone conference on 5 August 2005.

APPEARANCES: Ms T Baker and Mr J Tamm for the Director of Proceedings.

No appearance by or for Dr Aladdin.

Introduction

1 Doctor Aladdin is a registered dentist. He practised dentistry in Papatoetoe until being suspended in May 2005 following a competence assessment undertaken pursuant to s.39(2)(a) of the Health Practitioners Competence Assurance Act 2003 ("the Act").

2 On 14 February 2005 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 At the time he was charged Dr Aladdin was represented by senior counsel. Doctor Aladdin applied for orders suppressing publication of his name pending the Tribunal determining the charge against him. That application was declined in a decision delivered on 21 March 2005.

4 By the time the charge was heard on 1 June 2005 Dr Aladdin was no longer represented. The Tribunal received evidence of the fact the charge, and the notice advising Dr Aladdin of the place and time of hearing had been served on Dr Aladdin.

5 The Tribunal heard all of the evidence presented by the Director of Proceedings on 1 June 2005. Thereafter the Tribunal adjourned to consider its decision. Later on 1 June 2005 the Tribunal advised it had found the charge proven. The Tribunal reserved its decision on penalty because at that stage the Tribunal was informed:

5.1 The Dental Council had suspended Dr Aladdin from practice following a competence review;

5.2 The Dental Disciplinary Tribunal had found Dr Aladdin guilty of a disciplinary charge in March 2005. The circumstances of that case were similar to the facts of the present case. As at 1 June the Dentists Disciplinary Tribunal had not determined what penalty should be imposed on Dr Aladdin.

5.3 The Tribunal considered it prudent to await the outcome of the Dentists Disciplinary Tribunal decision before determining what penalty (if any) should be imposed upon Dr Aladdin in relation to this case. The decision of the Dentists Disciplinary Tribunal was delivered on 5 July 2005. The Director of Proceedings' submissions concerning penalty in this case were received by the Tribunal on 1 August and considered by the Tribunal on 5 August.

Amended Charge

6 When the Tribunal convened on 1 June 2005 it granted an application from the Director of Proceedings to amend the charge. The amendments to the charge are underlined in the following extract:

> *"1. Between 25 September 2001 and 19 March 2003 [Dr Aladdin] <u>mounted</u> a crown on tooth 21 in a manner which would <u>fail to</u> ensure retention of the crown;*
>
> *AND/OR*
>
> *2. Between 20 March 2003 and 24 March 2003 [Dr Aladdin] failed to adequately treat [his] patient's tooth 21 in that [he] fitted a post that was:*
>
> > *(a) Too short; and/or*
> >
> > *(b) Overly large in diameter; and/or*
> >
> > *(c) Off centre in the root canal; and/or*
> >
> > *(d) Fabricated with a core that was too short for effective retention of the crown;*
>
> *<u>AND/OR</u>*
>
> *3. <u>Between 25 September 2001 and 27 March 2003 [Dr Aladdin] failed to adequately document [his] care of [his] patient.</u>*

The Director of Proceedings alleged that when viewed cumulatively or separately the particulars of the charge constituted professional misconduct as defined in s.101(a)(b) of the Act.

7 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

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

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

10 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".*

11 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*

1 (1984) 4 NZAR 369
2 (1967) 1NSWLR 609
3 [1966] ALR 270
4 [1989] 1 NZLR 139 at 163
5 [1997] 1 NZLR 71
6 [1984] 4 NZAR 364, 375-376

> *charges against the appellant were grave. The elements of the charge must therefore be proved to a standard commensurate with that gravity."*

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

12.1 *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."*

12.2 *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."*

13 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.

14 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

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[7] (No 2) unreported HC Wellington, M239/87, 11 October 1990 Greig J.
[8] unreported HC Auckland, 68/95, 20 March 1996, Blanchard J
[9] CA 213/04, 4 May 2005
[10] [2005] UKPC 19

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 level of proof.

15 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 10 to 12 of this decision. The allegations against Dr Aladdin are of a serious nature and bring into question his basic levels of competence. Accordingly the Tribunal has applied a high standard of proof. The Tribunal's adverse findings have only been made where the Tribunal believes the evidence against Dr Aladdin is compelling.

Professional Misconduct

16 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*
>
> *(b) … because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the practitioner practised at the time that the conduct occurred …"*

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

18 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.

19 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

20 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:

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

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

20.3 That the plaintiff suffered compensatible damage;

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

21 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

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[11] 2nd Edition
[12] 1993 Edition

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]

22 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

23 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

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

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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
15 Supra

25 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*.

26 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:

26.1 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?

26.2 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]

Professional Misconduct under the Act

27 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:

27.1 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

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[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.

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

27.2 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.

28 The Tribunal has assessed Dr Aladdin's conduct in this case by addressing the tests noted in paragraph 27 of this decision in relation to each particularised allegation in the amended notice of charge.

Facts

29 The Director of Proceedings presented evidence from:

29.1 Mr Rennie, the complainant;

29.2 Dr T Blair, a dentist who treated Mr Rennie after the events complained of;

29.3 Dr D Purton, an expert witness;

29.4 Dr J Isdale, an expert witness;

29.5 Ms W Vonlanthen;

29.6 Ms T Bayley.

30 The last two witnesses gave affidavit evidence and produced documents made available to the Tribunal.

Mr Rennie

31 Mister Rennie informed the Tribunal that he had a crown fitted to an upper front tooth (tooth 21) in February 1992.

32 The Tribunal subsequently learnt from Dr Blair that the work on Mr Rennie's tooth 21 had been carried out by Dr Sutcliffe. Doctor Sutcliffe retired from practice in 1999. Doctor Aladdin took over part of Dr Sutcliffe's practice in November 1999.

33 Mister Rennie explained he went to see Dr Aladdin on 25 September 2001 to repair the crown on his tooth 21. The crown had broken off when Mr Rennie was eating a piece of caramel slice.

34 In his evidence Mr Rennie explained that when he was examined by Dr Aladdin on 25 September Dr Aladdin told him:

> *"… that the tooth underneath the crown had broken and that [Dr Aladdin] would have to make a post and a new crown to fit the post"*.

Mister Rennie could recall Dr Aladdin saying he would:

> *"…use a fibreglass post for this purpose"*.

35 Doctor Aladdin commenced working on Mr Rennie's tooth on 25 September. Mr Rennie could recall Dr Aladdin drilling his tooth and placing a temporary crown. Mr Rennie could also recall Dr Aladdin suggesting that part of the cost of the treatment might be covered by ACC.

36 Mister Rennie's second appointment was on 1 October 2001. At this consultation Dr Aladdin warned Mr Rennie not to continue to hold rope in his mouth when sailing (something Mr Rennie had been in the habit of doing). At the second appointment Mr Rennie recalls Dr Aladdin making moulds for a new crown.

37 The next appointment appears to have been on 10th October 2001. At that time Dr Aladdin fitted the new crown. Mr Rennie said that when fitting the crown Dr Aladdin held the crown in place with his fingers over a 20 minute period. Mr Rennie said that when the crown was in place Dr Aladdin told him to bite down on a roll of cotton-wool for another 20 minutes and warned him to only eat soft food for the rest of the day. Mr Rennie told the Tribunal that he noted:

> *"…a gap between the new crown and the teeth on either side of it and that the colour didn't seem natural. But the worst thing about the new crown was that there was a rough lump on the back surface, where the crown met the gum. The lump was very annoying as [he] could feel it with [his] tongue"*.

Mister Rennie said his:

> *"… tongue actually became quite irritated from rubbing against the lump. The lump did not go away and was there each time Dr Aladdin re-cemented the crown"*.

38 Mister Rennie returned to Dr Aladdin on 19 October because the crown had by this time come loose.

39 Mister Rennie returned to Dr Aladdin on a number of occasions to have the crown re-fitted because of it becoming loose. The records, and Mr Rennie's evidence confirm that the crown was re-fitted by Dr Aladdin on:

24 October 2001

2 November 2002

4 December 2001

40 Mister Rennie said that each time the crown was re-fitted Dr Aladdin used the same technique, namely, he would hold the crown in place for about 20 minutes and instruct Mr Rennie to bite on a cotton-wool roll for a further 20 minutes.

41 Mister Rennie recalled that on one occasion Dr Aladdin explained the crown kept working: *"…loose because it was too heavy and that he might need to send it back to the Lab to have it weighed".*

42 Mister Rennie appeared to experience no significant problems from 4 December 2001 to March 2003. On 20 March 2003 Mr Rennie went back to Dr Aladdin because the crown had again become loose. At that consultation Dr Aladdin told Mr Rennie that the post had fractured and the crown would need to be removed and a new post and core completed.

43 Mister Rennie could recall that on 20 March 2003 Dr Aladdin put a new temporary crown in place, using the same techniques that he had used on previous occasions to glue the crown in place. Mr Rennie said that the new crown worked loose in a matter of days and that he went back to Dr Aladdin on 24 March 2003. Doctor Aladdin re-cemented the crown in place by again holding the glued crown in place for about 20 minutes and telling Mr Rennie to bite on a cotton-wool roll for another 20 minutes. About an hour after that Mr Rennie found the crown had again worked loose.

44 Mister Rennie was not happy with Dr Aladdin's service. He returned to the surgery and asked to see another dentist. As a result Mr Rennie saw Dr Blair. While Dr Blair examined Mr Rennie's tooth 21 he discovered that Dr Aladdin had fitted a post that:

> *"… was too short, overly large in diameter, off centre and fabricated with a core that was too short for effective retention of the crown".*

45 Doctor Blair explained to Mr Rennie that he would need a new post and crown. Mister Rennie was very annoyed that he would have to incur $1,295 in achieving a properly fitted crown. Doctor Blair offered to fit a temporary crown, which Mr Rennie agreed to. When this was done Mr Rennie went and saw Dr Aladdin. Mister Rennie demanded a refund which Dr Aladdin refused. Apparently Dr Aladdin offered to fix the tooth again. Mister Rennie declined this offer. Mister Rennie subsequently returned to Dr Blair who fitted a new post, core and crown.

46 Doctor Blair has continued to be Mr Rennie's dentist.

<u>Dr Blair</u>

47 Doctor Blair explained that he started practising dentistry at the Papatoetoe Dental Centre in 1967. He was joined in that practice by Dr Sutcliffe in 1970. Doctor Sutcliffe left the practice in 1999. Shortly thereafter Dr Blair sold Dr Sutcliffe's interest in the practice to Dr Aladdin. Doctor Blair explained that he and Dr Aladdin ran two separate practices in association with each other. They initially shared basic expenses, such as a receptionist and dental hygienist. They also shared some equipment such as an x-ray machine and sterilising equipment. The patient records of each practice were stored in a filing cabinet. Dr Blair's patients' records were marked with a red stripe and Dr Aladdin's patients records were marked with a green stripe. In October 2001 the two practises became more separated when Dr Blair and Dr Aladdin each employed their own receptionist and dental hygienist.

48 Doctor Blair told the Tribunal that he saw Mr Rennie on 24 March and saw that the cap on tooth 21 had become loose. Before seeing Mr Rennie Dr Blair removed Mr Rennie's patient records from the filing cabinet. When Dr Blair examined Mr Rennie he noted that the crown on tooth 21:

> *"Was quite inadequate, being poorly made, with a poor colour match. Furthermore, when [he] tried to align it with the remaining tooth and core it appeared to have been a poor fit with a distinct gap between the crown and the remaining root base".*

49 Doctor Blair noted that the post system used to support the crown had fractured. On closer examination Dr Blair:

> *"Could see a short rough stump of rather jagged plastic projecting out of the root of the tooth"*.

50 Doctor Blair thought that some attempt had been made to make the crown stick to the remaining portion of the plastic stump. Doctor Blair said he was quite concerned about what he saw and decided to take a radiograph as well as some photos of the patient.

51 On examining the radiographs Dr Blair could see that the crown had been poorly fitted and the remaining tooth structure had been weakened in a number of ways, namely:

51.1 The post hole had not been centred properly and was at an angle. Doctor Blair thought the post hole very nearly perforated through the root into the surrounding periodontal ligament;

51.2 The post itself was poorly formed. It was too short and stumpy. As a consequence the surrounding tooth structure was very thin and weak. Further, because the post was so short it was likely to fail.

51.3 The crown did not appear to be supported by the tooth root. As a consequence the crown was only supported by the core. This in turn caused the core to fracture.

51.4 The crown colour did not match the colour of surrounding teeth;

51.5 There was a distinct gap between the crown and the remaining root base.

52 Doctor Blair discussed his findings with Mr Rennie and what would need to be done to restore his tooth. Doctor Blair outlined the costs involved. Doctor Blair recalled that Mr Rennie was not happy with what Dr Blair told him. Doctor Blair was led to believe that Mr Rennie did not want to have Dr Aladdin undertake any further work on his teeth.

53 In order to assist Mr Rennie, Dr Blair fitted a temporary crown. Doctor Blair subsequently prepared the root canal for a cast metal post. The cast metal post was cemented in place on 16 June 2003. The following day Dr Blair completed the replacement of the crown. Doctor Blair believed the new crown might not last long because the root of tooth 21 had become so weak. Unfortunately Dr Blair's concerns materialised in April 2004 when he found that the root of tooth 21 had split.

Dr Purton

54 Doctor Purton is a very experienced and highly regarded dentist. He is a senior lecturer in dentistry at the University of Otago and has had 14 years experience in dental practice.

55 Doctor Purton explained that when a patient presents with a tooth that has broken off at or near the gum level the remaining tooth must be root filled before a post and core is fitted. Doctor Purton explained that the root canal should be filled with gutta percha, after which about 10mm of the gutta percha is removed to make a space for the post. The post should then be cemented into the space created for the post. A core is then fabricated onto the post. The crown is then cemented over the core.

56 Doctor Purton examined Dr Aladdin's notes, and the findings and x-rays made by Dr Blair.

57 Doctor Purton was very concerned about Dr Aladdin's treatment of Mr Rennie between 25 September 2001 and 19 March 2003. Based on the radiographs taken by Dr Blair it was apparent to Dr Purton that Dr Aladdin did not fit a post. It appeared to Dr Purton that Dr Aladdin had simply used a composite substance to form a core onto which the crown was fitted. Doctor Purton told the Tribunal that it would have been impossible for Dr Aladdin to construct a satisfactory "post and core" out of composite filling material that would have had any chance of retaining a crown.

58 Doctor Purton told the Tribunal that Dr Aladdin's failure to construct a post and core following conventional principles of dentistry constituted a serious departure from accepted professional standards.

59 Doctor Purton was also very concerned about the treatment provided by Dr Aladdin during the period 20 to 24 March 2003. It was clear to Dr Purton from the radiographs taken by Dr Blair that a post was put in place on 20 March 2003. However while Dr Aladdin had fitted a post on this occasion, it was, according to Dr Purton, quite inadequate. Doctor Purton was concerned that when Dr Aladdin placed the post he misjudged the angle of the canal and drilled beyond the canal into the tissue of the tooth. Doctor Purton explained that when a dentist prepares a tooth for the placement of a post the dentist should stop frequently when drilling the canal to

ensure the post space is following the canal. If the dentist has any doubts a radiograph should be taken to ensure that the preparation is proceeding down the root canal.

60 Doctor Purton also pointed out that the post put in place on 20 March 2003 was overly large in diameter and that as a consequence the tooth structure was compromised. Doctor Purton also believed that the post was too short and would be unlikely to retain a crown.

61 Doctor Purton described Dr Aladdin's placement of the post and core on 20 March 2003 as:

> *"…a serious departure from accepted professional standards"*.

62 Doctor Purton carefully analysed Dr Aladdin's dental records and considered they also fell well below accepted professional standards. In particular Dr Purton noted:

62.1 Doctor Aladdin's notes for 25 September 2001 suggest he had fitted a post whereas the radiographic evidence and Dr Blair's observations confirm no post was fitted at this time;

62.2 Doctor Aladdin's notes of 10 October 2001 conveyed the impression that a post had been fitted when in fact this had not been done;

62.3 In his notes of 21 October 2001 Dr Aladdin wrote:

> *"Cr almost at the same strength …"*.

Doctor Purton could make no sense of this statement.

62.4 In his notes of 5 November 2001 Dr Aladdin said:

> *"Need to contact the Lab for weight of the crown"*.

Doctor Purton did not understand why the crown needed to be weighed. The weight of the crown did not cause it to constantly become loose.

62.5 In his notes of 20 March 2003 Dr Aladdin wrote:

> *"Fracture the post and core and crown attached to the glove"*.

Again, Dr Purton could not understand what Dr Aladdin meant by this comment.

63 Doctor Purton summarised his concerns about Dr Aladdin's notes by describing them as confusing and very inadequate. Doctor Purton was concerned Dr Aladdin's English appeared to be of a poor standard and that he did not use accurate dental terminology.

Dr J Isdale

64 Doctor Isdale also provided the Tribunal with expert testimony. Doctor Isdale had over 25 years experience as a practising dentist. She is a past member of the Complaints Assessment Committee of the Dental Council. Between 1992 and 1999 Dr Isdale was a dentist adviser to the Accident Compensation Corporation. Although Dr Isdale retired from dental practice in 2000, her evidence related to post and crown treatment methods which have not changed since she retired from dental practice. The Tribunal had no difficulty in accepting Dr Isdale's credentials as an expert.

65 Doctor Isdale's analysis of the evidence, and in particular Dr Aladdin's notes and the radiographs taken by Dr Aladdin and Dr Blair left Dr Isdale with a number of concerns about Dr Aladdin's treatment of Mr Rennie.

66 Doctor Isdale's principal concerns were:

66.1 It was difficult to ascertain exactly what Dr Aladdin had done between 25 September 2001 and 19 March 2003 because, although the notes referred to a post/core and crown it was clear that no post was in fact fitted.

66.2 Doctor Isdale thought it likely that Dr Aladdin had simply fashioned a composite core. She said that if a post had not been used the treatment "*would not be an accepted form of repair and would be highly likely to fail*".

66.3 The treatment provided to Mr Rennie by Dr Aladdin in 2001 was not successful. The crown did not stay in place and Mr Rennie needed to return to Dr Aladdin's surgery on at least five occasions to have the crown refitted.

66.4 The radiographs of 24 March 2003 showed that the post fitted on 20 March was too short and wide and was not created in the root canal. Doctor Isdale was concerned that because the post was too short it would not be able to withstand the functional loads to which a restored tooth would be subjected.

66.5 Doctor Aladdin's failure to ensure the "post hole" followed the root canal, and his decision to create a wide post hole meant the remaining tooth structure was weakened. Doctor Isdale said there was "*...no reason for [Dr Aladdin] to do this and the approach [he] has taken is not an acceptable standard of dentistry"*.

67 Doctor Isdale was also concerned about Dr Aladdin's clinical records. For example:

67.1 Doctor Isdale was concerned that Dr Aladdin referred to "*the post OK but crown fell down*". Doctor Isdale could not understand why Dr Aladdin would say the post was OK when it was to be replaced in a matter of days, or what he meant by "*the crown fell down"*. This note was made on 24 March 2003.

67.2 Doctor Isdale was also concerned at the suggestion in Dr Aladdin's notes of 5 November 2001 that he was going to have the weight of the crown checked. Doctor Isdale points out that the weight of the crown was not relevant.

67.3 Doctor Isdale also drew attention to a reference in Dr Aladdin's notes of 4 December 2001 which reads: *"R. L.M."* Doctor Isdale could not decipher this reference.

68 In summary, Dr Isdale thought Dr Aladdin's notes were poor. She found it difficult to understand from Dr Aladdin's notes what treatments he had provided and what materials he had used.

Tribunal's Findings in relation to each particularised allegation

Particular One: "Between 25 September 2001 and 19 March 2003 [Dr Aladdin] mounted a crown on tooth 21 in a manner which would fail to ensure retention of the crown".

69 The Tribunal is very satisfied the Director of Proceedings has proven the first particular of the charge to the requisite standard.

70 The evidence presented to the Tribunal establishes beyond any doubt Dr Aladdin failed to construct a post in Mr Rennie's tooth 21 during the period 25 September 2001 to 19 March 2003. The failure to construct a post meant the crown was not adequately supported.

71 The Tribunal is very satisfied that the failure to ensure that the crown in Mr Rennie's tooth 21 was properly supported constituted a significant failure on the part of Dr Aladdin. His actions fell well below the standards expected of a New Zealand dentist. The Tribunal is also in no doubt Dr Aladdin's errors constituted negligence within the meaning of s.100(1)(a) of the Act.

72 The Tribunal has given very careful consideration as to whether or not Dr Aladdin's mistakes when treating Mr Rennie's tooth 21 during the period 25 September 2001 to 19 March 2003 justify a disciplinary sanction. The Tribunal has concluded Dr Aladdin's conduct during this period was so serious and inexcusable that a disciplinary sanction is warranted in order to protect the public, maintain professional standards, and to punish Dr Aladdin. This conclusion is based on the Tribunal's concern that Dr Aladdin should have appreciated very early on during his treatment of Mr Rennie that the crown was not properly supported. By the time Dr Aladdin re-cemented the crown for the second time on 24 October 2001 he should have realised his treatment plan was not working. At this time Dr Aladdin should have abandoned his theory that the crown could be supported by a composite core. Instead Dr Aladdin should have provided Mr Rennie with orthodox treatment which would have included the insertion of a properly constructed post.

73 It follows from the Tribunal's conclusions in paragraphs 70 to 72 of this decision that Dr Aladdin's acts and omissions in relation to the first particular of the charge constitutes professional misconduct within the meaning of s.101(1)(a) of the Act.

Second Particular: **Between 20 March 2003 and 24 March 2003 [Dr Aladdin] failed to adequately treat [his] patient's tooth 21 in that [he] fitted a post that was:**

(a) Too short; and/or

(b) Overly large in diameter; and/or

(c) Off centre in the root canal; and/or

(d) Fabricated with a core that was too short for effective retention of the crown.

74 The Director of Proceedings has proven this particular of the charge to the requisite standard.

75 The evidence presented by Dr Blair, coupled with the radiographs taken by both Dr Blair and Dr Aladdin in March 2003 clearly established that the post inserted by Dr Aladdin in March 2003 was:

75.1 Too short; and

75.2 Too broad in diameter; and

75.3 Seriously off the centre of the root canal; and

75.4 Fabricated with a core that was too short.

76 The combined effect of these errors was that the crown could not be effectively retained. Furthermore the integrity of the remaining tooth structure was seriously compromised by Dr Aladdin's poor techniques.

77 The Tribunal agrees entirely with the concerns of both Dr Purton and Dr Isdale who expressed their misgivings about Dr Aladdin's poor clinical standards as evidenced by his treatment of Mr Rennie in March 2003. The Tribunal believes the errors made by Dr Aladdin when trying to insert a post and core in Mr Rennie's tooth in March 2003 constituted a failure to adhere to basic standards expected of a practitioner in his position. The Tribunal is in no doubt that Dr Aladdin's errors in treating Mr Rennie's tooth in March 2003 constituted negligence within the meaning of s100(1)(a) of the Act.

78 The Tribunal also believes that Dr Aladdin's failure to properly place a post in Mr Rennie's tooth 21 requires a disciplinary finding for the purposes of protecting the public, maintaining professional standards, and punishing Dr Aladdin. Doctor Aladdin's failure to correctly position the post he put in place was a failure to adhere to the most basic standards of dentistry. His errors were serious and inexcusable.

79 The Tribunal accordingly concludes Dr Aladdin's errors as established in relation to the second particular of the charge constituted professional misconduct within the meaning of s.100(1)(a) of the Act.

Third Particular: Between 25 September 2001 and 27 March 2003 [Dr Aladdin] failed to adequately document [his] care of [his] patient.

80 The Tribunal has examined Dr Aladdin's records and has concluded they are seriously deficient. Doctor Aladdin has used confusing terminology. His records are incomplete and it is not possible to adequately understand what techniques and materials Dr Aladdin has employed when treating Mr Rennie. The following illustrate the Tribunal's concerns:

80.1 Doctor Aladdin's records for 25 September and 10 October 2001 suggest he had inserted a post when in fact no post had been inserted in Mr Rennie's tooth 21 at this stage.

80.2 Doctor Aladdin's notes for 5 November 2001 suggest the crown needed to be weighed. This comment was bewildering.

80.3 Doctor Aladdin's note for 21 October that "*Cr almost at the same strength*" is incomprehensible.

80.4 Similarly, the Tribunal could make no sense of the reference *"R, L.M."* made on 4 December 2001.

81 The Tribunal stresses the importance for all dentists to maintain records that are complete and capable of being understood. Notes should be written in a way that would ensure another dentist could easily understand what treatment has been provided.

82 Doctor's Aladdin's notes fell well below the standard expected of a New Zealand dentist and as such constituted negligence within the meaning of s.100(1)(a) of the Act.

83 The Tribunal also believes Dr Aladdin's notes were so seriously deficient that a disciplinary finding is required in relation to the third particular of the charge in order to enforce professional standards. Accordingly the Tribunal finds that, in relation to the third particular of the charge Dr Aladdin's errors constituted professional misconduct within the meaning of s.100(1)(a) of the Act.

Cumulative Charge

84 The Tribunal is in no doubt that when the three particulars of the charge are viewed cumulatively, the established acts and omissions constitute serious negligence and would merit a finding of professional misconduct. However, as the Tribunal has found each particular of the charge constitutes professional misconduct it is not necessary or appropriate to make any finding in relation to the cumulative charge.

Penalty

85 In considering what penalty to impose pursuant to s.101 of the Act the Tribunal has borne in mind that the principle purpose of the Act *"…is to protect the health and safety of members of the public …"*[17].

86 The materials presented to the Tribunal in response to its request for submissions on penalty included:

86.1 A report of the Dental Council of New Zealand following its review of Dr Aladdin's competence. That report identified serious deficiencies in Dr Aladdin's practice relating to *"… cross infection control, diagnosis, treatment planning, record keeping and clinical treatment …"*.

The Council considered that Dr Aladdin's deficiencies *"…posed a risk of serious harm to the public by [him] practising below the required standard of competence"*.

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[17] Section 3(1) of the Act

The Council's concerns were such that it determined Dr Aladdin had to be suspended from practice whilst he undertook a "bridging programme" offered by the University of Otago for overseas-qualified dentists. Following completion of that programme Dr Aladdin is required to undertake and pass an assessment tailored to address his deficiencies.

86.2 A decision of the Dentists Disciplinary Tribunal delivered in two parts. The first part related to liability, and the second, dated 5 July 2005 related to penalty. In that case the Dentists Disciplinary Tribunal found 14 particulars of a charge established and that when viewed cumulatively they amounted to professional misconduct. The Dentists Disciplinary Tribunal found Dr Aladdin's treatment of his patient between 9 June 2000 and 16 November 2001 *"fell well below the accepted standard of professional competence"*. The elements of the charge which were established included:

- failing to communicate with his patient;
- failing to undertake a proper root canal filling;
- failing to keep and maintain proper records;
- failing to treat a fractured tooth in a timely manner;
- claiming payment for work not performed;
- failing to address an overhanging margin in a tooth;
- failing to take and keep proper radiographs.

In its penalty decision the Dentists Disciplinary Tribunal suspended Dr Aladdin from practising for three months with effect from 1 September 2005.

87 In her submissions the Director of Proceedings has urged Dr Aladdin's registration be cancelled. The Director of Proceedings has identified the following aggravating factors in her submissions:

87.1 Doctor Aladdin's failure to appear before the Tribunal suggests he does not understand his responsibilities and he may even have a "contemptuous attitude towards these proceedings".

87.2 At the time he commenced treating Mr Rennie Dr Aladdin was already under investigation in relation to the matter that lead to the hearing before the Dentists Disciplinary Tribunal.

87.3 Doctor Aladdin has now had two disciplinary findings against him.

88 The Director of Proceedings has suggested there are no mitigating factors in this case. Although the Tribunal has not heard from Dr Aladdin it believes there may be a mitigating factor. It appears to the Tribunal Dr Aladdin responded to his patients and has tried to do his best for them. Unfortunately, Dr Aladdin's level of competence is so low that his best efforts fell well below acceptable standards.

89 The Tribunal does not place any weight on Dr Aladdin's failure to appear before the Tribunal. There may be sound reasons why he did not appear.

90 The Tribunal has reflected very carefully over the appropriate penalty to impose. In deliberating on the question of penalty the Tribunal has kept uppermost in its mind that Dr Aladdin's level of competence in this case is so low that patients attending him for basic dental services are not likely to receive appropriate treatment.

91 The Tribunal has considered whether there is any remedial programme or course of training that may assist in rehabilitating Dr Aladdin. Unfortunately, short of studying for and passing a Bachelor of Dental Surgery there appears to be no course that can re-train Dr Aladdin in the basics of dentistry so as to ensure that patients would receive appropriate services from him.

92 Regrettably the Tribunal believes it must cancel Dr Aladdin's registration. This case, and the decision of the Dentists Disciplinary Tribunal, when read in conjunction with the Competence Assessment report leave little room for doubting Dr Aladdin does not have the most basic skills to practice dentistry in New Zealand to the standard which the community and the profession expects.

93 The Tribunal believes Dr Aladdin should not practice in New Zealand until after 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 refrain from imposing this condition on Dr Aladdin so as to provide him with a range of options to advance his rehabilitation.

94 The Tribunal orders Dr Aladdin's registration as a dentist be cancelled. This order will not take effect until 1 September 2005 so as to provide Dr Aladdin with a little time to organise his affairs. This order is made pursuant to s.101(1)(a) of the Act. The Tribunal also directs that before he applies 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 retraining should preferably be undertaken at the University of Otago. This condition is imposed pursuant to s.102(2)(a) of the Act.

95 Significant costs have been incurred by the Director of Proceedings and the Tribunal in investigating and conducting this hearing. The Director of the Proceedings costs came to $22,649.40. The Tribunal's costs were $13,586.29.

96 The Tribunal does not know what ability Dr Aladdin has to meet an award of costs. Because the Tribunal has cancelled Dr Aladdin's registration it believes it unlikely he will have employment in New Zealand so as to be able to pay any significant award of costs. Accordingly the Tribunal has 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 just $2,500 towards the costs of the Director of Proceedings and $2,500 towards the costs of the Tribunal (total $5,000).

97 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 Wellington this 10th day of August 2005.

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D B Collins QC
Chair
Health Practitioners Disciplinary Tribunal