New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO 714/Den15/309D

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of a Charge laid by the Director of Proceedings designated under the Health and Disability Commissioner Act 1994 pursuant to Section 91(1)(a) of the Health Practitioners Competence Assurance Act 2003 against **GAURAV LAKRA**, of Taumaranui, Dentist

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

HEARING held in Auckland on 12 June 2015

TRIBUNAL: Mr Kenneth Johnston (Chair), Dr Robert East, Dr Paopio Luteru, Dr Hugh Trengrove and Mr Tony Young (Members)

IN ATTENDANCE: Miss Debra Gainey (Executive Officer)
Ms Helen Hoffman (Stenographer)

APPEARANCES: Ms Helena Cooke and Ms Nicola Wills for Director of Proceedings
Mr Harry Waalkens QC and Ms Hannah Stuart for Practitioner

Introduction

1. The Director of Proceedings designated under s15 of the Health and Disability Commissioner Act 1994 commences this proceeding against the Practitioner by Notice of Charge dated 4 March 2015, alleging professional misconduct in these terms:

> ***"TAKE NOTICE** that pursuant to sections 91 and 100(1)(a) and 100(1)(b) of the Health Practitioners Competence Assurance Act 2003 ("the Act"), the Director of Proceedings has reason to believe that a ground exists entitling the Tribunal to exercise its powers against you and charges that between 3 July 2008 and 13 December 2010, whilst caring for your patient [Mr Y]you, being a registered dentist, acted in such a way that amounted to professional misconduct."*

2. The Notice of Charge goes on to particularise the grounds for those allegations as follows:

> ***"IN PARTICULAR***
>
> *1. During and/or after the performance of a root canal commenced on 3 July 2008 and completed on 14 July 2008, you failed to:*
>
> *(a) inform your patient that an instrument had separated and remained in your patient's root canal;*
>
> ***and/or***
>
> *(b) inform your patient of the treatment options following the instrument separation, including any necessary re-treatment, and the risks, side effects, benefits, and costs of those options;*
>
> ***and/or***
>
> *(c) document full details of the procedure carried out on your patient, including the occurrence of the separated instrument.*
>
> ***AND/OR***
>
> *2. On or about 2 August 2010 when you undertook re-treatment of your patient's root canal, you failed to:*
>
> *(a) disclose to your patient the reasons for re-treatment;*
>
> *(b) inform your patient fully of all the treatment options available, the risks, side effects, benefits, and costs of those options, and also your skills and experience in performing each option;*

(c) inform your patient fully of the proposed re-treatment procedure, specifically of your intention to attempt to remove the instrument and re-do the root canal.

AND/OR

3. On each occasion your patient visited subsequently on 16 August 2010, 15 September 2010, and 13 December 2010 for re-treatment, you continued to fail to disclose the full reasons for re-treatment, including the separated instrument retained in your patient's root, and to fully inform your patient of the options available.

AND/OR

4. You failed to adequately document the fact of the separated and retained instrument, and/or the reasons for, and/or nature of the re-treatment carried out on your patient, and the information, if any, you provided to your patient in relation to the re-treatment of tooth 46 at each subsequent consultation on:

(i) 2 August 2010

(ii) 16 August 2010

(iii) 15 September 2010

(iv) 13 December 2010.

The conduct alleged in the above four particulars separately and/or cumulatively amounts to professional misconduct. Specifically, the conduct is alleged to amount to malpractice and/or negligence and/or is conduct that brought or was likely to bring discredit to the dental profession under s100(a) and (b) of the Act."

3. The evidence before the Tribunal consisted of:

3.1 An Agreed Statement of Facts dated 30 April 2015 signed by both the Director and the Practitioner;

3.2 An Agreed Bundle of Documents in evidence by consent which, aside from the Notice of Charge, included the Practitioner's clinical records relating to the patient, the patient's letter of complaint dated 18 September 2011 (signed by the patient and his parents), the Practitioner's reply to that letter dated 10 October 2011, the records of two dental specialists who treated the patient, the

New Zealand Dental Association's 2005 Code of Ethics, the Association's 2005 Code of Practice concerning informed consent and the Association's 2006 Code of Practise concerning record keeping;

3.3 A proof of evidence from Mary Towers who gave expert evidence. Ms Towers was not called to give evidence. Her proof of evidence was before us by consent, and was unchallenged;

3.4 A small bundle of documents put in by the Practitioner by consent which consisted of the New Zealand Dental Association's summary of continuing professional development undertaken by the Practitioner between 2005 and 2015, a Certificate evidencing the Practitioner's successful completion of a course specifically directed at communication by dentists with their patients and references provided by three of the Practitioner's professional colleagues (including his wife with whom he practises);

3.5 A Dental Council of New Zealand document dated April 2014 evidencing the fact that the Practitioner is participating in a recertification programme which the Tribunal was told he is close to completing.

4. The Tribunal sets out the Agreed Summary of Facts (redacted as necessary) below:

*"**Parties***

1. The consumer, [Mr Y] was 15 – 17 years old at the time of the events outlined in the charge. On 22 December 2006 [Mr Y] was enrolled with Ruapehu Dental Excellence Centre ("Ruapehu Dental") under the Dental Benefits Scheme.[1]

2. Dr Gaurav Lakra ("Dr Lakra") is a registered dental practitioner. He has practised for 10 years in New Zealand, and a further 4 years in Hisar, India.

3. At the relevant time, Dr Lakra was a dentist at Ruapehu Dental with [a] *general scope of practice.*

Background to treatment

4. On 21 February 2007 [Mr Y], aged 13 years was seen by an associate dentist of Ruapehu Dental for an annual check-up. The associate dentist carried out a full examination and took posterior bite wing X-rays and an X-ray of tooth

[1] A government funded scheme providing free dental care for adolescents.

23. The associate dentist noted that tooth 23 was erupting, and tooth 36 and 46 had decay, with the latter requiring a filling.

5. On 1 August 2007, then aged 14 years, [Mr Y] returned to Ruapehu Dental complaining of toothache in tooth 46 (the lower first molar). He thought a filling had fallen out. The X-rays showed evidence of a large, deep amalgam restoration. He was assessed by the associate dentist as having a fracture to the filling in tooth 46, which was repaired with a composite restoration.

Root canal treatment & separated instrument

6. On 3 July [Mr Y], then aged 15, presented to Ruapehu Dental and was seen by Dr Gaurav Lakra. [Mr Y] complained of a dull, constant ache from tooth 46, however this was not recorded in the clinical notes.

7. Dr Lakra took posterior bite wing X-rays and diagnosed [Mr Y] as having chronic irreversible pulpitis in tooth 46. Dr Lakra informed [Mr Y] that he required a root canal, which he commenced by opening up the tooth, removing the inflamed nerve, and dressing the tooth in preparation for completing the root canal at a subsequent visit.

8. There is no criticism of Dr Lakra in this regard. The root canal was indicated and was an appropriate treatment for chronic irreversible pulpitis.

9. [Mr Y] accepts that Dr Lakra told him he needed a root canal and that he agreed to the treatment.

10. On 14 July 2008 Dr Lakra completed the root canal, which involved the tooth being cleaned and the roots sealed with rubber based material and cement. However during the treatment on 14 July 2008, one of the fine instruments used for the root canal separated or broke off, and was left in one of the three roots of [Mr Y's] root canal.

11. Dr Lakra was aware that the instrument had separated during the root canal. Dr Lakra says he considered that it and the other two roots had been adequately cleaned so as not to cause any later issues for [Mr Y]. He did not document the separated instrument in the clinical records.

12. Dr Lakra did not tell [Mr Y] about the separated and retained instrument on 14 July 2008. Dr Lakra says he believed that there would be no issues arising from it and he did not wish to cause unnecessary concern to [Mr Y] or his family.

13. Dr Lakra accepts that his failure to inform [Mr Y] of the separated instrument was not consistent with ethical standards.

Retreatment of tooth 46

14. Two years later, on 27 July 2010 [Mr Y], then aged 17 years, attended Ruapehu Dental for an annual check-up. He was seen by Dr Lakra, who carried out an examination and took X-rays. He also scaled and polished all of [Mr Y's] teeth. No issues were identified during this visit.

15. However on 2 August 2010, [Mr Y] again presented to Ruapehu Dental, complaining of a dull toothache. He was seen by Dr Lakra, who identified signs of recurrent infection.

16. Dr Lakra sought to retreat the tooth by removing/bypassing the separated instrument and cleaning the canals.

17. Following this treatment, Dr Lakra recorded in the clinical notes that he had applied "emergency dressings" to tooth 46 and that, on examination, the pulp chamber was large, and that the roots were cleaned and the tooth dressed. The notes record that verbal postoperative instructions were given to [Mr Y], but the details of these were not documented.

18. Dr Lakra did not fully document the fact of the separated instrument, the procedure he carried out, or the information he provided to [Mr Y] in relation to the retreatment. He did not disclose to [Mr Y] the full reasons for retreatment or inform [Mr Y] fully of the proposed retreatment procedure, specifically his intention to attempt to remove/bypass the instrument and re-do the root canal. He simply advised [Mr Y] of the need to retreat the tooth to relieve his ongoing toothache.

19. Dr Lakra did not inform [Mr Y] fully of all the treatment options available, the risks, side effects, benefits, and costs, of those options. He also did not inform [Mr Y] of his skills and experience in performing the proposed retreatment, or discuss the possibility of referral to a specialist endodontist.

20. Accordingly, Dr Lakra accepts that he did not obtain [Mr Y's] informed consent for the retreatment.

Further retreatment

21. On 16 August 2010 [Mr Y] returned for further "emergency dressings" to be applied to tooth 46 as a follow-up to complete treatment. The clinical notes do not record the separated instrument or what advice [Mr Y] was given.

22. When [Mr Y] asked Dr Lakra about the reason for his ongoing pain, Dr Lakra told him that there was nothing wrong, but that he was just trying to clear out some infection.

23. [Mr Y's] parents became concerned about their son's extensive dental treatment. Dr Lakra sought to explain the treatment simply and in laymen's terms to [Mr Y's] parents by saying that he was trying to clear infection from the tooth. Dr Lakra did not tell them about the separated instrument.

24. On 15 September 2010 Dr Lakra completed retreatment of tooth 46. In attempting to retreat the tooth, he had removed some sound hard tooth tissue and also perforated the root. The separated instrument was not removed.

25. Dr Lakra recorded that a perforation had occurred, and repaired this with the correct material (MTA) however it resulted in discolouration of the tooth and a weakened structure. In addition, the final full cover sealed restoration of the tooth crown was not done.

26. A temporary filling was put in place with a plan to review the filling in three months' time for a permanent restoration. Dr Lakra advised [Mr Y] at this time that an extraction was likely in the event of any further problems.

27. On 13 December 2010, Dr Lakra reviewed the retreatment of the root canal and placed a restoration on the front half of the tooth. A partial restoration is sometimes done as a temporary cover but there is always a risk of the tooth fracturing mechanically and compromising the seal of the root canal restoration. For [Mr Y], this subsequently led to breakage of the already weakened tooth.

28. At both of the 15 September 2010 and 13 December 2010 appointments, Dr Lakra did not document the fact of the separated instrument or the reason for the required retreatment. Dr Lakra did not disclose to [Mr Y] the true reason for re-treatment (the separated instrument) and did not obtain [Mr Y's] informed consent to the on-going re-treatment.

Outcomes of retreatment

29. In May 2011 part of [Mr Y's] tooth 46 broke away. [Mr Y] sought a second opinion from another dentist in Hamilton, Dr Ron Ritchie. Following his assessment, Dr Ritchie advised [Mr Y] that an instrument had previously broken off in the root canal and remained there, and that the root had been widened and damaged. It was not until this assessment that [Mr Y] learned of the separated instrument. Dr Ritchie then referred [Mr Y] to an endodontist, Dr Mike Gordon.

30. Dr Gordon saw [Mr Y] on 30 May 2011 and confirmed Dr Ritchie's assessment. He observed:

"There is a fractured instrument in the mesial root which the dentist has attempted to remove and has resulted in the loss of a great deal of the tooth structure and possibly also leading to a strip perforation. The restoration is fractured and the tooth is blue most likely from an inter-appointment dressing of ledermix paste."[2]

31. Dr Gordon discussed treatment options with [Mr Y] and his father, recommending that the tooth be removed and an implant retained crown be placed. Dr Gordon then referred [Mr Y] to a prosthodontist, Dr Andrew Mackie, for an implant consultation.

Complaint

32. On 18 September 2011 [Mr Y] and his parents wrote to Ruapehu Dental with concerns about Dr Lakra's treatment of [Mr Y] in 2010, and advised that the tooth would cost $6,500 to fix.

33. [Mr Y] and his parents were upset that Dr Lakra had not advised them of the separated instrument at the time, that he had misinformed them throughout [Mr Y's] retreatment in 2010, and that Dr Lakra had not obtained informed consent for the retreatment of the problem.

34. Dr Lakra responded to this complaint, explaining that he had thought that a solution could be reached by observing the healing, completing the further treatment and clearing the infection that had developed. He explained that informing [Mr Y] and his parents of the underlying reason for the required

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[2] Ledermix paste is a steroid and antibiotic used for the treatment of pain associated with inflammation of the tooth.

treatment would cause them unnecessary upset. However he has accepted that he ought to have told [Mr Y], and he accepts responsibility for the same. He has apologised unreservedly to [Mr Y] and his family.

35. *In a subsequent letter to [Mr Y] and his parents, Dr Lakra told [them] that this appointment consisted of further cleaning of the roots and attempted removal/bypassing of a separated instrument. He advised that the tooth was redressed for an infection to be cleared. Dr Lakra did explain that because the roots were narrow, the root was perforated during this process, and that this was managed with a cement sealer in accordance with recommended guidelines.*

36. *In this letter, Dr Lakra also told [Mr Y and his parents] that he accepted that he failed to advise them of the real circumstances of the treatment (the instrument separation), and that he should have been more open about the ongoing treatment.*

Relevant standards

37. *The New Zealand Dental Association ("NZDA") and the Dental Council of New Zealand ("DCNZ") Code of Practice: Patient information and records (2006) states:*

> *"2.6 The patient's treatment record **must** contain a record of any and all treatment or service provided within a dental practice …*
>
> *2.7 This record **must** include:*
>
> *…*
>
> *(e) Reason for the attendance;*
> *(f) Detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon;*
> *(g) A concise description of any and all treatment or services provided;*
> *…*
>
> *2.8 The record **should**, in the interests of best practice, also include:*
> *(i) A description of any procedure, including any material used, variation from any standard or usual technique, and any general comments on the procedure undertaken. The detail of the*

description should reflect the complexity of the treatment or the seriousness of the potential outcomes;

…

(k) Consents obtained for treatment;

(l) Advice given to the patient on any pre- and postoperative instructions and any likely treatment outcomes and/or complications; … [emphasis in original].”

38. *The NZDA and the DCNZ Code of practice: Informed Consent (2005) sets out the criteria for the informed consent process. It notes that consumers are entitled to “honest and accurate answers to questions about services, and the identity and qualifications of the provider.”*

39. *Specialist referral: where treatment is of a complex nature and outside the practitioner’s training qualifications and experience, the dentist is required to fully and frankly inform a patient of the significance that specialist training and experience may have for the patient’s treatment, along with the availability of such services.”*

40. *The Code of Practice notes the importance for dentists to keep accurate and contemporaneous written records of the discussion that has taken place prior to the provision of treatment.*

41. *In particular, it requires that a dentist ensure a consumer understands the costs (fees) involved prior to providing treatment. It states it is unwise for a dentist to prejudge a patient’s ability to afford a particular treatment and the value a patient puts on the treatment.*

42. *The Code of Practice also sets out the “Information to be given”, including:*

- *an explanation of the patient’s condition;*
- *the nature, status (whether orthodox or developmental) and purpose of the treatment or procedure, including its expected benefits;*
- *the likelihood of achieving that purpose: the prognosis;*
- *all significant known risks, the degree of that risk and the probability of its occurrence;*
- *possible complications or side effects of treatment;*
- *possible consequences of not receiving the treatment;*

- *all relevant management options/alternatives with their probable effects and outcomes;*
- *the name and status of the person who will carry out the procedure.*

43. *Some examples of areas which need special care in communication include endodontics, including the options available, success rates, compromise versus definitive procedures, and separated instruments as a risk during treatment.*

Steps taken since complaint

44. *Since receiving this complaint, Dr Lakra has made various changes to his practice. One such change is the introduction of an informative leaflet to be provided to patients requiring root canals, namely: "Informed Consent for Root Canal Treatment." This provides information to the patient on associated risks of root canals and on the option of choosing a specialist treatment provider from the outset.*

45. *An "AAE Endodontics Case Difficulty Assessment Form" has also been introduced as a result of this incident. This provides a checklist for quality control, and provides more information about the case difficulty and the level of expertise required in each case.*

46. *In addition, Dr Lakra has attended a two day patient communication course. He has also participated in and followed the Dental Council guidelines towards management of endodontic treatment cases.*

47. *Further, two new policies have been introduced:*

    a. *Patients requiring root canals are shown photographs and x-rays and these are explained to the patient both before and after treatment.*

    b. *All patients under the age of 18 are required to have a guardian or parent* [present] *when they schedule for any treatment so the parents are well informed.*

Professional misconduct

48. *Dr Lakra accepts the facts as detailed above are an accurate account of what occurred. Furthermore Dr Lakra accepts the expert advice in its entirety and accepts that the advice and the relevant standards stated in paragraphs 36 – 43 of the Agreed Statement of Facts accord with his understanding of the standards of the profession.*

49. Dr Lakra accepts that his actions as particularised in the charge amount to professional misconduct.

50. For the removal of doubt, Dr Lakra accepts that on the basis of the above facts the charge warrants a disciplinary finding against him."

5. The factual background to this proceeding, and the basis for the agreement between the parties that the Director is able to make out the allegation of professional misconduct against the Practitioner, are supported by the additional evidence contained in the agreed bundle of documents to which we have already made reference. No useful purpose would be served by referring to this evidence in any more detail at this stage.

6. It will be apparent from the terms of the Notice of Charge and the Agreed Statement of Facts that the essential allegations made by the Director – and admitted by the Practitioner – are that in the course of his treatment of the patient between July 2008 and December 2010 the Practitioner:

6.1 Failed adequately to inform the patient throughout the relevant period;

6.2 Failed adequately to advise the patient as to treatment options and obtain his informed consent to the treatment which did take place; and

6.3 Failed to maintain proper clinical records.

7. An important point which in the Tribunal's view should not be overlooked in this case is that the Director does not allege, and nor is there any evidence which would suggest, that the Practitioner's clinical treatment of the patient, in and of itself, was inappropriate. His diagnosis of the patient's condition and the procedures which were carried out are not criticised.

8. At the conclusion of the hearing the Tribunal retired to consider the evidence before it and submissions made on behalf of both parties, and, in due course, returned to convey its decision to the parties:

8.1 With respect to liability, that the allegation of professional misconduct made by the Director against the Practitioner was established;

8.2 As to penalty, that the Tribunal had determined to:

8.2.1 Censure the Practitioner for his professional misconduct;

8.2.2 Fine the Practitioner $3,000; and

8.2.3 Order that the Practitioner pay 30% of the costs in connection with the proceeding.

8.3 That the Tribunal intended to direct the Executive Director to refer a copy of this decision to the New Zealand Dental Council, so that that body could give what consideration it regarded as appropriate to the Tribunal's conclusions in the context of the current recertification programme; and

8.4 That final orders would be made suppressing the name of the patient and his family.

9. The Tribunal now records its reasons for those conclusions.

Liability

10. Although the allegation of professional misconduct made by the Director against the Practitioner is admitted, the Tribunal is obliged to reach its own conclusion as to liability.

11. In the Tribunal's judgment the evidence establishes, to the necessary standard, that the Practitioner failed to discharge his professional obligations to his patient by failing adequately to inform him, failing to advise him as to treatment options and get informed consent to treatment, and failing to keep adequate clinical records.

12. On its face, this evidence establishes that in all three of these respects the Practitioner failed to comply with the relevant components of the Code of Ethics and relevant Codes of Practice promulgated by the Dental Council of New Zealand and the New Zealand Dental Association.

13. Although not definitive, professional organisations' statements of minimum standards are strong evidence of the standards which the public is entitled to expect of health professionals. In this case, the Tribunal would have been inclined to agree with the position taken by both parties that a failure to comply with the Code of Ethics and relevant Codes of Practice constituted professional misconduct.

14. In any event, the Tribunal also has the unchallenged evidence of Ms Towers. She is an experienced practitioner, well qualified to express opinions as to minimum professional standards. Having reviewed the available background material, Ms Towers expressed very clear views, which the Tribunal accepts, that the Practitioner's failure to inform the patient, failure to advise the patient as to treatment options and

obtain informed consent to treatment, and failure to keep adequate clinical records fell below minimum acceptable standards, and constituted professional misconduct.

15. The Tribunal reiterates that the Director's allegation of professional misconduct in those three senses is not challenged by the Practitioner.

16. Accordingly, the Tribunal has had little hesitation in concluding that the Director has made out her allegation of professional misconduct.

Penalty

17. The principles applicable to the determination of what, if any, penalty should be imposed in professional disciplinary proceedings are now well settled:

    17.1 The primary purposes of professional disciplinary proceedings are the protection of the public and the maintenance of professional standards;[3]

    17.2 Depending on the circumstances of the case, other purposes which may be relevant include such things as the prospects of the Practitioner's rehabilitation;[4]

    17.3 Although punishment may be the inevitable outcome of the imposition of any form of penalty, it is not, itself, an objective;[5]

    17.4 The Tribunal is obliged to consider the full range of penalties available in any given case;[6]

    17.5 The objective is to identify the least punitive outcome which will enable the Tribunal to meet both the seriousness of the case and to discharge its obligations in relation to the protection of the public and the maintenance of professional standards;[7]

    17.6 Regard must be had to the importance of consistency in the imposition of penalties – like cases should generally attract like outcomes;[8]

    17.7 In the end, the search is for a fair, reasonable and proportionate penalty.[9]

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3 *Roberts v PCC* [2012] NZHC 3354 and *Katamat v PCC* [2012] NZHC 1633
4 Roberts (supra)
5 *Z v CAC* [2009] 1 NZLR 1 (SC) and *Singh v Director of Proceedings* [2014] NZHC 2848
6 *Patel v Dentists Disciplinary Tribunal* (unreported), High Court, Auckland, Randerson J, 8 October 2002
7 Patel (supra)
8 Roberts (supra)
9 Roberts (supra)

18. This is a serious case. The Practitioner has admitted fundamental failings to comply with minimum professional standards requiring him to deal frankly with patients, provide patients with advice as to treatment options so as to enable them to make informed decisions and to keep proper clinical records. These obligations exist for the protection of the public. As submitted on the Director's behalf by Ms Cooke, the Practitioner's *"…conduct is aggravated by its deliberateness, the multiple opportunities for disclosure, and the vulnerability [of the patient] by virtue of his age."*

19. As against that, as Mr Waalkens' submits on the Practitioner's behalf, there are also mitigating considerations:

- The Practitioner's hitherto unblemished record;
- The Practitioner's cooperation in the context of these professional disciplinary proceedings;
- The steps which the Practitioner has taken since these events effectively to re-educate himself in relation to the relevant professional obligations;
- The support which the Practitioner has received from professional colleagues, including professional colleagues involved in the treatment of this patient;
- The point that the Tribunal made earlier concerning the scope of the allegation made by the Director in this case as to causation.

20. Even with the assistance of the careful and responsible submissions made by both Ms Cooke and Mr Waalkens, and the guidance to be derived from the authorities referred to, the Tribunal observes that this is by no means an easy case in which to determine the appropriate outcome.

21. The serious nature of the Practitioner's professional misconduct, and the way that it engages the issues of the protection of the public and the maintenance of professional standards, demands, in the Tribunal's view, the imposition of a penalty.

22. That said, the Tribunal is persuaded, having had the benefit of hearing from the Practitioner directly, and Mr Waalkens' submissions on his behalf, that there will be no repetition of this behaviour, and that the Practitioner does not present an ongoing risk to the public.

23. Having considered all of the available options in terms of a penalty as set out in s101 of the Act, which range from the imposition of a censure through to an order

cancelling the Practitioner's registration, the considerations referred to in paragraphs 19 – 22 above suggest that the Tribunal can discharge its obligations to the public and the profession by censuring and fining the Practitioner.

24. In relation to the principle of consistency in the imposition of penalties, both Ms Cooke and Mr Waalkens cited a large number of previous decisions in order to provide the Tribunal with some assistance in relation to the range of fines within which we might wish to focus our consideration.

25. The Tribunal has considered all of the cases referred to us. Without meaning any disrespect to the submissions made on behalf of the parties, we do not think it would be helpful laboriously to refer to every one of these case. In the end, every case is unique, and must be decided on its own facts.

26. The cases which the Tribunal regards as being particularly relevant here are the following:

26.1 *Molloy* (April 2003)[10] where a dentist was found to have failed to keep adequate records and failed properly to inform a patient as to treatment options, and the Tribunal censured the practitioner and fined him $3,000.

26.2 *Gibson* (November 2004)[11] where a dentist was found to have failed adequately to inform a patient as to treatment options, and the Tribunal censured the practitioner and fined him $2,500.

26.3 *Zimmerman* (December 2005)[12] where a dentist was found to have failed adequately to inform his patient before embarking on a risky procedure and to keep adequate records. There was also a serious issue as to the adequacy of his treatment. The Tribunal censured the practitioner.

26.4 *Krishnayya* (1 June 2007)[13] where a surgeon was found to have failed to provide a patient with adequate information about a proposed surgical procedure and explain the risks, and the Tribunal fined the practitioner $5,000 and imposed conditions on his practising certificate.

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[10] No reference available
[11] No reference available
[12] 26/Den/05/05D
[13] 114/Med06/46D

26.5 *Rodrigues* (June 2011)[14] where an osteopath was found to have failed to keep adequate clinical records and adequately inform his patient, and the Tribunal censured the practitioner.

26.6 *N* (May 2013)[15] involved a surgeon who failed adequately to inform a patient of the risks associated with surgery. He also failed to deal with complications and the outcome for the patient was seriously adverse. The Tribunal censured the Practitioner and fined him $8,000 and imposed conditions on his practising certificate.

27. Having regard to those cases, all of which have features in common with the present case, and having regard also to the fact that the range of available fines increased over the relevant period, it appears to the Tribunal that an outcome here could not be regarded as being inconsistent with them if it included a fine within a range of $1,000 to $5,000.

28. Having regard to all of the evidence (including the Practitioner's statement to us) the Tribunal's conclusion is that the least punitive penalty it can impose in this case is a censure and a fine of $3,000. There will also be an order that this decision of the Tribunal be published in the usual way.

29. In our judgment, this penalty is sufficient to mark the seriousness of the Practitioner's professional misconduct, and discharge the important obligations that the Tribunal has in relation to the protection of the public and the maintenance of professional standards, whilst, at the same time, recognising the points that can be made on the Practitioner's behalf.

Costs

30. The Director seeks costs. Costs are always a matter for the Tribunal's discretion (although that discretion must of course be exercised in a principled way). Furthermore, costs are a difficult issue in professional disciplinary proceedings because the judgment being made is as to the proportion of the costs which should be borne by the profession as a whole and the proportion which should be borne by the Practitioner who, at least in a case where an allegation of serious misconduct is made out, is, by definition, responsible for them being incurred in the first place.

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[14] 384/Ost11/173P
[15] 535/Med/12/225D

31. On behalf of the Director Ms Cooke submitted that the Tribunal should order the Practitioner to pay 40% of the costs of the proceeding, the 10% reduction on what is generally regarded as the starting point of 50% being to recognise the level of the Practitioner's cooperation in this case. The contention made by Mr Waalkens on the Practitioner's behalf was that the percentage should be lower than that. He submitted that 30% was the appropriate level.

32. When one gets down to a 10% difference between the parties' submissions, the judgments become very fine indeed. It is fair to record in this case that the Respondent has cooperated with the Director from the outset. The practical outcome of that is not only that the costs have been kept to a minimum, but also that neither the patient nor his parents were required to give evidence, and such expert evidence as we received was put in by consent.

33. In the exercise of our discretion, we have concluded that the appropriate order in this case is that the Practitioner contribute 30% of the costs.

Suppression

34. The Director seeks permanent orders pursuant to s95(2)(d) of the Act suppressing the patient's name, and those of his parents. That application is supported by the Practitioner. Such an order will follow.

35. The Tribunal directs that a copy of this decision and a summary of it be published on the Tribunal's website. The Tribunal further directs that a notice stating the effect of the Tribunal's decision be published in the newsletter of the Dental Council (section 157 of the HPCA Act).

Dated in Wellington this 23rd day of July 2015

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Kenneth Johnston
Chairman
Health Practitioners Disciplinary Tribunal