HEARING HEARD IN PUBLIC

BALSAI, Tamas

Registration No: 102860

PROFESSIONAL CONDUCT COMMITTEE

SEPTEMBER 2016 – FEBRUARY 2017

Outcome: Erased with immediate suspension

Tamas BALSAI, a dentist, DMD Semmelweis University 1991, was summoned to appear before the Professional Conduct Committee on 19 September 2016 for an inquiry into the following charge:

Charge (amended on 20 September 2016)

"That being registered under the Dentists Act 1984:

1) At all material times you were a United Kingdom registered Dental Practitioner in practise at Ghauri Dental Centre, Wormholt Road, Shepherds Bush ('the Practice') and Budapest.

Patient A

2) You did not provide an adequate standard of care to Patient A between January 2012 to February 2014 in that you:

   a) did not appropriately examine the donor or recipient site of the bone graft;

   b) advised Patient A, via an approved intermediary, to travel to Budapest for treatment having not undertaken an appropriate prior clinical examination;

   c) did not adequately assess Patient A's periodontal status;

   d) did not advise Patient A on the risks of smoking;

   e) did not explain to Patient A the risks of the proposed treatment prior to its commencement;

   f) did not advise Patient A of appropriate alternative treatment options;

   g) in relation to the Dental Treatment Plan:

      (i) you prepared the plan having not examined Patient A;

      (ii) did not provide Patient A with sufficient information within the Dental Treatment Plan;

3) The relevant information that was available was only provided to Patient A in Budapest, which was an inappropriate time-scale and setting.

4) As a result of the conduct detailed in 2c) to 2f), 2(g) (ii) and 3, both individually and collectively, you failed to obtain appropriately informed consent from Patient A for any or all of the treatment provided to her.

5) At the appointment on or around 28 April 2012, you allowed an unregistered person to carry out a radiograph on Patient A.

6) You failed to adequately respond to Patient A's complaint regarding having the implants removed.

7) You failed to respond to a written request from Patient A's solicitors for her dental records to be provided by correspondence dated:

   a) 24 November 2014;

   b) 11 December 2014;

   c) 20 January 2015.

Patient B

8) You did not provide an adequate standard of care to Patient B between November 2010 to November 2011 in that you:

   a) failed to carry out adequate pre-treatment investigations;

   b) failed to prepare a report on the radiograph taken on or around 8 May 2011;

   c) provided implants that were inadequate at LR5, LL5 and LL6, which led to the implant crowns having large overhangs and becoming bulbous;

   d) failed to explain to Patient B the risks of treatment;

   e) failed to inform Patient B of the possibility that the outcome to the treatment may be compromised.

9) As a result of the conduct detailed in 8d) and 8e), you failed to obtain Patient B's adequately informed consent to the treatment.

10) In respect of the veneers provided on the teeth stated in Schedule 1, you failed to provide an adequate standard of care as you:

   a) removed excessive buccal and occlusal enamel;

   b) increased the risk of iatrogenic damage being caused;

   c) failed to provide veneers that were sufficiently long-lasting.

11) The conduct described in 10), both individually and collectively, increased the risk to Patient B's future periodontal health.

12) You failed to provide full dental records within a reasonable time following correspondence from Patient B's solicitors, The Dental Law Partnership, dated 8 November 2012.

13) You failed to appropriately co-operate with your indemnifier, Dental Protection, regarding the Letter of Claim dated 13 October 2014 sent to them by The Dental Law Partnership.

Patient C

14) You did not provide an adequate standard of care to Patient C between November 2011 to August 2012 in that you:

   a) failed to adequately advise Patient C as to improving his oral hygiene;

   b) failed to take a complete medical history of Patient C.

15) The document entitled 'Dental Treatment Plan' did not include:

   a) options for care including a lower part denture;

b) risks of care related to poor oral hygiene;

c) the consequences of failing to maintain appropriately the dentition and restorative work;

d) the risks involved from advanced restorative work related to increased complexity and difficulties in cleaning and home care;

e) the risks and benefits involved in implant treatment.

16) Further, you failed to explain verbally to Patient C the information stated in paragraph 15.

17) As a result of the conduct in paragraphs 15 and 16, you failed to obtain informed consent from Patient C of the treatment undertaken.

18) You forged, or allowed someone to forge, Patient C's signature on the Implant Guarantee Form.

19) In respect of the Implant Guarantee Form, you allowed your legal representative to put forward a representation to Patient C's solicitors that you knew, or should have known, was false.

20) The conduct described in paragraphs 18 and 19 was:

a) misleading;

b) dishonest.

Failure to co-operate with the GDC

21) You failed to co-operate with an investigation by the GDC by not appropriately replying within an appropriate time to correspondence dated:

a) for Patient A:

(i) 10 June 2015;

(ii) 3 July 2015;

(iii) 14 October 2015.

b) for Patients B and C:

(i) 17 February 2015;

(ii) 9 March 2015;

(iii) 11 March 2015;

(iv) 25 March 2015;

(v) 15 April 2015;

(vi) 5 May 2015;

(vii) 14 October 2015

Implant Guarantee Form

22) You represented, or allowed persons to represent, to Patients B and C that your practices in London and Budapest were insured by a UK based insurer including on the Implant Guarantee forms that you had "full insurance for his practice with the

Medical Protection Society, UK" when in fact Medical Protection Society; UK did not insure your practice in Budapest.

23) The conduct described in paragraph 22 was:

a) misleading;

b) dishonest.

Record Keeping

24) You failed to maintain an adequate standard of record keeping for Patient B

in that you failed to record:

a) adequate details of the pre-treatment investigations that were carried out;

b) what risks of treatment were advised to Patient B;

c) discussions of your advice to Patient B regarding the outcome of the treatment being possibly compromised;

d) in respect of the treatment that started on 8 May 2011;

(i) the results of the examination on 8 May 2011;

(ii) a report on the radiograph taken on 8 May 2011;

(iii) the clinical justification for removing excessive buccal and occlusal enamel;

(iv) WITDRAWN

25) You failed to maintain an adequate standard of record keeping for Patient C in that you failed to record appropriate details of:

a) the advice provided to Patient C regarding improving his oral health;

b) all appointments that you had with Patient C.

AND, by reason of the facts stated, your fitness to practise as a dentist is impaired by reason of your misconduct."

On 26 September 2016 the Chairman made the following statement regarding the finding of facts:

"Dr Szoke

You are present at this hearing and are representing Mr Balsai, who is not present at this hearing, as his friend. Mr Guy Micklewright of Blake Morgan solicitors presents the case for the General Dental Council (GDC).

Amendments to the heads of charge

At the commencement of the hearing Mr Micklewright applied to amend by way of withdrawal the schedule of charge in accordance with Rule 18 of General Dental Council (Fitness to Practise) Rules 2006 ('the Rules'). He applied to amend the wording of heads of charge 4, 8a and 20. Subsequently, during the course of the hearing, Mr Micklewright applied to amend Head of Charge 24 (iv) by way of its deletion

You on Mr Balsai's behalf did not oppose the applications. The Committee decided to accede to the applications to amend on the basis that doing so would not cause any injustice to the parties. The schedule of charge was duly amended.

Admissions

Mr Balsai made a number of admissions in his signed written statement which was handed in as the defence evidence.

Background to the case and summary of allegations

The allegations that Mr Balsai faces relate to the standard of his conduct whilst in practice at the Ghauri Dental Centre, Shepherds Bush and Budapest.

The GDC has raised allegations about Mr Balsai's care and treatment of three patients, referred to for the purposes of these proceedings as Patient A, Patient B and Patient C in the period between November 2010 and August 2012. Their treatment was planned in London, however, the significant proportion of the treatment was provided in the alternative premises in Budapest. All three patients, dissatisfied with the care they received from Mr Balsai, sought to take civil action against him. They subsequently made a complaint to the GDC.

In respect of the three patients for whom Mr Balsai provided treatment, the GDC alleges that, he failed to carry out pre-treatment investigations, provide adequate advice and assessments, a failure to discuss treatment options, and a failure to obtain informed consent. In respect of Patient A, the GDC also alleges that Mr Balsai failed to appropriately examine the donor or recipient site of the bone graft. In respect of Patient C, it is further alleged that Mr Balsai forged or allowed someone to forge Patient C's signature on the Implant Guarantee Form.

It is also contended that Mr Balsai failed to recognise and co-operate with complaints made by all three patients. The GDC also alleges that his record-keeping was of an inadequate standard, as he did not record details of treatment and discussions with the patients.

During the investigation, the GDC raised heads of charge in relation to an alleged failure to co-operate with the GDC and also that he falsely represented to patient's B and C that his practice in Budapest was insured in the United Kingdom for all treatment to be carried out.

Evidence

The Committee heard oral evidence from Patients A, B and C. The Committee heard oral evidence from a hand-writing expert, Witness 4.

The Committee found Patient A very credible and clear in her evidence. Her recollection of events was good. The Committee found Patient B was confused as to her recollection of events. However, the Committee found her evidence to be honest and credible. The Committee found Patient C's evidence to be credible, honest and reliable. He had a good recollection of his treatment. The Committee also heard evidence from a hand-writing expert, who understood his role as an expert, and gave clear and concise evidence.

The Committee also heard oral evidence from the expert witness for the GDC, Professor Ian Brook, who was quite clear that the standard he was applying was not the "gold standard", but that of an "acceptable" standard".

The Committee was provided with Professor Brook's written expert report, various witness statements and copies some of the dental records of Patient A, Patient B and Patient C for the treatment they received. You, on Mr Balsai's behalf, submitted a signed written witness statement from Mr Balsai as the only defence evidence. The Committee also received signed witness statements from Witnesses 1,2, and 3 as neither you nor the Committee had any questions on their evidence which related to communications with Mr Balsai after the treatment.

Committee's findings of fact

The Committee has taken into account all the evidence presented to it, both oral and written. It has also considered the submissions made by Mr Micklewright on behalf of the GDC and those made by you on behalf of Mr Balsai.

The Committee has accepted the advice of the Legal Adviser. The Committee has been reminded that the burden of proof lies with the GDC, and has considered the heads of charge against the civil standard of proof, that is the balance of probabilities.

The Committee has considered each head of charge separately, although its findings will be announced collectively.

I will now announce the Committee's findings in relation to each head of charge:

1.	Admitted and found proved. Mr Balsai has expressed in previous correspondence that he was working at the address alleged. The Committee are satisfied, having heard the three patients and seen Mr Balsai's written statement, that he was also practising in Budapest at all material times.
2.	This allegation is clearly talking about January to February 2012 so the Committee concluded that its reference to February 2014 was a mistake and determined to amend the stem to read "between January 2012 to February 2012", considering that there was no injustice because it merely corrected the obvious mistake.
2. (a)	Proved in part (just the recipient site). The GDC has not adduced any evidence that Mr Balsai personally should have examined the donor site of the bone graft. However, the Committee does accept that to have devised a treatment plan without the examination by Mr Balsai of the recipient site in the patient's mouth was inappropriate. That examination did not take place until the following month.
2. (b)	Proved. The Committee accepts Professor Brook's evidence was that it was necessary for Mr Balsai to undertake a full medical and dental history and also an examination prior to Patient A travelling to Budapest in order to ascertain whether Patient A was suitable for this extensive proposed treatment. Patient A stated that Person 4 was the intermediary who spoke to her on behalf of Mr Balsai and advised her to travel to Budapest for treatment. The Committee considers that on the balance of probabilities that Mr Balsai did advise Patient A via Person 4, but that he had failed to undertake a prior clinical examination. Accordingly, the Committee finds this charge proved.
2. (c)	Proved. The Committee accepts the evidence of Professor Brook who stated that an assessment was necessary. Mr Balsai accepted in his witness statement that he had not assessed Patient A's periodontal condition before her visit to Budapest in March 2012.
2. (d)	Proved. The Committee notes that Patient A was recorded as a smoker. Mr Balsai in his written statement states that he had given this advice in Budapest. The treatment

	plan of 6 February 2012 did not contain any mention of advice on the risks of smoking. The Committee accepts the evidence of Professor Brook that this is one of the necessary aspects of treatment planning. The Committee is satisfied that Patient A needed to be advised of those risks, but she was not.
2. (e)	Proved. (see 2.(f) below)
2. (f)	Proved. Patient A confirms in her witness statement that she was not advised of the risks involved nor was she given alternative options. The Committee considers that Patient A needed to be informed of what the risks of failure were. Professor Brook in his report states why it is necessary for a patient to be informed of the possible risks, and that there were alternative options for treatment and they needed to be offered as well. The Committee considers that alternative options could have been provided by Mr Balsai but they were not. Therefore, the Committee finds this charge proved.
2. (g) i	Proved (see 2.(g) below).
2. (g) ii	Proved. The Committee notes from Patient A's oral testimony that she was not examined prior to the treatment plan being given to her. The Committee notes that the treatment plan did not include alternative options or contain details of relevant risks. Professor Brooks in his report states that time is needed for reflection on the treatment being offered. Mr Balsai admitted in his written statement that the treatment plan did not include all of the information.
3.	Proved. Professor Brook stated in oral evidence that the patient required time for reflection. The Committee considers that discussions should have taken place prior to Patient A travelling to Budapest to undergo the treatment.
4.	As amended - Proved Patient A said in oral evidence that none of the following were discussed, among others: - was not given the option of a denture; - leave alone; - no discussion about nerve damage to the leg; - the risks of the graft to the jaw; - poor aesthetics; - bone levels after the graft; - recession of the gum (goes together with poor aesthetics). The Committee accept Patient A's evidence on this point as opposed to Mr Balsai's witness statement. The Committee notes the evidence at paragraph 31 of Professor Brook's report that if Patient A did not get adequate information and adequate time for proper reflection then the consent would not be properly

	informed. The Committee is satisfied that Mr Balsai could not have obtained informed consent if he did not advise Patient A of all these items as detailed in charges 2c) – 3. Accordingly, the Committee finds this charge proved.
5.	Admitted and found proved. Professor Brook's evidence confirmed that he had previously undertaken a check to see whether person 9, who had taken the radiograph, was on any UK register which would have authorised person 9 to take the radiograph, and person 9 was not on any such register at the relevant time. The Committee noted the written statement of Patient A that correspondence sent to her was indicative of Person 9 being a member of administrative staff only. The Committee consider that by taking a radiograph, person 9 would fall within prohibition on the practice of dentistry by lay persons in section 38(1) of the Dentists Act 1984.
6.	*Not proved.* Patient A confirmed in her witness statement that she made a complaint orally to Mr Balsai and then made another complaint to Person 4. The Committee notes that Patient A's email of 16 May 2014 does not make a specific complaint but she clearly has concerns about her treatment. Mr Balsai replied 4 days later in an email stating "if you have more questions I would be happy to answer them". The Committee is satisfied that Mr Balsai's response in his email dated 20 May 2014 was not inadequate and therefore finds this charge not proved
7. (a)	Proved. (see 7.(c) below)
7. (b)	Proved. (see 7.(c) below)
7. (c)	Proved. The written statement of Witness 1 (Patient A's solicitor) confirms that no response was received from Mr Balsai to his firm's letters of the dates in question. Mr Balsai does not contest the allegation but he gives an explanation in his written statement, that according to Hungarian regulations, he was unable to respond unless he had written consent, otherwise he would face legal consequences. He maintains that he did not have consent from the patient. However, the Committee noted that the letter of 24 November 2014 enclosed Patient A's form of authority permitting the release of her records. The Committee considers that Mr Balsai, in accordance with the GDC's Standards for Dental Professionals (May 2015) Standards 1.1 and 1.2, should have responded to these written requests from Patient A's solicitors but failed to do so on any of these dates.
8. (a)	Proved. Patient B states that the first consultation lasted only 10 minutes and investigations did not take place prior to treatment. Mr Balsai in his written statement states that the examination was adequate but admits that his records were brief. Professor Brooks sets out in his report what is necessary for treating planning and the

	necessary standards a dentist must follow. The Committee notes that there was a complex treatment plan, and taking this into account, the Committee considers that it would not be possible to undertake an adequate pre-treatment examination in ten minutes.
8. (b)	As amended – Admitted and found proved. The Committee has had sight of a radiograph which was taken on 8 or 9 May 2011. However, the Committee has not had sight of any report which is a requirement of the Ionising Radiation (Medical Exposure) Regulations 2000 and Directive 97/43 Euratom, which applies across the whole of the EU. Mr Balsai in his statement admits that he failed to prepare a report.
8. (c)	Not proved. Professor Brook did not criticise the implant at LR5 in his oral evidence. Professor Brook's report states that the implants at LL5 and LL6 are in the LL4 and LL5 sites and are not ideally positioned. He states that the coronel part of the LL5 and LL6 is too close, resulting in a restoration that is difficult to clean and maintain. However, Professor Brook stated that this was not unacceptable. Mr Balsai states in his written statement that if Patient B had not cancelled her treatment, he could have corrected them. The Committee therefore finds this charge not proved.
8. (d)	Proved. Patient B in oral evidence stated that no risks were explained to her. The Committee notes that no risks were set out in her treatment plan, nor are there any clinical notes of any discussions taking place. The Committee accepts the oral evidence of Patient B and finds this charge proved.
8. (e)	Proved. The evidence of Professor Brooks is that if Mr Balsai was aware that the outcome of the treatment of Patient B would inevitably be compromised, then he was duty bound to inform her. The Committee accepts Patient B's evidence that she was not informed of this.
9.	Proved Given the Committee's finding at charges 8 d) and 8 e) above, – there could not be informed consent as Mr Balsai did not discuss the risks of treatment, and also failed to explain that the treatment may be compromised.
10. (a)	Proved. In her oral evidence, Patient B stated that "4 or 5" of her upper teeth already had veneers before she saw Mr Balsai. Those were replaced by Mr Balsai and new veneers were provided to a total of 16 teeth. The Committee noted documentation from the subsequent treating dentist that recorded his view that excessive buccal and occlusal enamel had been removed. This view was supported by Professor Brook from his examination of the radiographs and photographs available. The Committee is satisfied that 11 or 12 of the 16 teeth in Schedule 1 were overly prepared by Mr Balsai, but that 4 or 5 of them had been treated previously by a

	different dentist to an unknown extent.
10. (b)	Proved. Professor Brook in his written report states that over preparation increases the risk iatrogenic damage. The Committee therefore finds this charge proved.
10. (c)	Proved Patient B in her oral evidence confirmed that she had experienced problems with the veneers within 6 months of these being fitted. The evidence of Professor Brook states that the radiographs taken on 30 November 2012, show that the veneers on LR2, LR3 and LL3 are missing, and that the remaining veneers showed evidence of needing adjustment. He also states that most had ledges or overhangs at the gingival margin. The Committee is satisfied that on the balance of probabilities, Mr Balsai failed to provide sufficiently long-lasting veneers.
11.	Proved Professor Brook's report stated that Patient B's future periodontal health was put at risk because the treatment provided by Mr Balsai were not long-lasting and introduced the risk of iatrogenic damage.
12.	Proved. The statement of Witness 2 (Patient B's solicitor) sets out the efforts made in order to obtain the clinical records on behalf of Patient B. Some copies were provided on 12 February 2013. However, it wasn't until 2 August 2013 that full records were obtained. The Committee noted the GDC Standards in place at that time, 1.3, 1.5, 4.4 and 4.6. Having taken these into account, the Committee is satisfied that Mr Balsai failed to meet these requirements.
13.	Not proved. The Committee had sight of letters exhibited to Witness 2's statement which confirms that, despite various attempts made by Dental Protection, Mr Balsai failed to appropriately co-operate with his indemnifier. A letter dated 28 October 2014 from Dental Protection to Patient B's solicitors confirmed that they were without instructions. A further letter from Dental Protection dated 23 December 2014 confirmed that they had re-established contact with Mr Balsai's representatives in Hungary. The Committee noted that contact had been established with Mr Balsai within 2 months of the letter of 28 October 2014 and therefore considered that this did not establish a failure by Mr Balsai to appropriately co-operate with his indemnifier.
14. (a)	Not proved. The evidence of Professor Brook is that Patient C needed to be informed, prior to treatment commencing, that improved oral hygiene was required because of the extensive restorative work needed. Patient C, during his oral testimony, did mention that Mr Balsai had mentioned cleaning, brushing and flossing. The Committee is satisfied that Patient C had been given some form of oral hygiene advice in the treatment plan by its reference to there being a "requirement for cleaning to clear tartar build up and cure gum disease". Stage 1 of the treatment plan included deep cleaning. That, together with Patient C's evidence

	satisfies the Committee that Mr Balsai had advised Patient C on how to improve his oral hygiene.
14. (b)	Partially admitted and found proved. The evidence of Professor Brook is that it is a requirement for a dentist to take a full medical history. Patient C in oral evidence said that he was never asked if he had any blood pressure or heart problems. Mr Balsai admits in his written statement that the recorded medical history is brief. Taking all of this into account, the Committee is satisfied that Mr Balsai did not take a full medical history as required.
15. (a)	Proved.
15. (b)	Not proved. As stated in 14(a) above, improved oral hygiene was referred to, and was part of, the treatment plan.
15. (c)	Proved.
15. (d)	Proved
15. (e)	Proved The Committee considers that based on its examination of the treatment plan, charges 15 (a), (c), (d) and (e) have been proved but not 15(b).
16.	Proved in respect of charges 15(a), (c), (d) and (e). Not proved in respect of charge 15(b). Patient C in oral evidence stated that at no point were those matters, except oral hygiene, discussed prior to the treatment commencing. Professor Brook states in his report that Mr Balsai should have given Patient C a full explanation of the proposed treatment and risks. If these aspects of care were not discussed, then informed consent could not have been obtained and would fall below standards 1.1 - 1.5 and 2.2 of 'Principles of Patient Consent'. The Committee accepts that this was not done in respect of 15(a)(c)(d) and (e).
17.	Proved in respect of charges 15(a), (c), (d) and (e). Not proved in respect of charge 15(b). The Committee notes that a consent form was signed by Patient C but was mistakenly dated 23 May 2012. Given the absence of the matters referred to in 15(a), (c), (d) and (e) above from the treatment plan, the Committee is satisfied that informed consent could not have been given as Mr Balsai did not discuss the risks and treatment prior to the commencement of the treatment.
18.	Not proved. Patient C stated in oral evidence that the signature on the implant guarantee form is not his. He stated that the original document in his possession did not contain his signature. Witness 4, a hand-writing expert only examined the signature, and stated that there is "strong evidence" that Patient C did not sign the implant guarantee form. The Committee can be satisfied that Patient C did not sign the form, however the Committee has not been provided with any actual evidence to support this charge.

	Mr Balsai in his witness statement denies ever having forged a signature or ever allowing anyone to do it. The Committee is not satisfied, based on the balance of probabilities, that Mr Balsai either forged the signature or allowed someone to forge it.
19.	Not proved. The Committee has had sight of your letter dated 2 January 2015 which accompanied a copy of the Implant Guarantee Form, when you were acting as Mr Balsai's Lawyer. That form purported to be signed by Patient C. Mr Balsai states in his written statement that he does "admit my general responsibility for this unfortunate incident…and deeply sorry for this occurrence. The Committee is not satisfied that the GDC has provided evidence of actual knowledge, nor indeed any evidence, that he should have known it was a false document. The Committee therefore finds this charge not proved.
20. (a)	Not proved having found charges 18 and 19 not proved.
20. (b)	Not proved having found charges 18 and 19 not proved.
21. (a) i	Admitted and found proved.
21. (a) ii	Admitted and found proved.
21. (a) iii	Admitted and found proved
21. (b) i	Admitted and found proved.
21. (b) ii	Admitted and found proved.
21. (b) iii	Admitted and found proved.
21. (b) iv	Admitted and found proved.
21. (b) v	Admitted and found proved.
21. (b) vi	Admitted and found proved.
21. (b) vii	Admitted and found proved. The statement of Witness 3 (a GDC Coordinator) sets out the train of correspondence and the lack of response by Mr Balsai with regards to patient A, B and C. The Committee is satisfied that Mr Balsai failed to co-operate in a timely manner with the investigation by the GDC by not replying to that correspondence.
22.	Proved. The treatment plan sent to Patient B stated 'Our dentists have full insurance for their practice with the Medical Protection Society, UK'. The treatment plan sent to Patient C stated 'all our dentists have full insurance for their practice with the Dental Protection Society. Whether you are treated in Budapest or in the UK, you will receive complete dental care.' The Implant Guarantee forms given to both Patient B and Patient C contained the representation 'Dr Tamas Balsai has full insurance for his practice with the Medical Protection Society, UK; Member

	Number: 390419.' The Committee is satisfied that those representations amounted to a statement that both Mr Balsai's London and Budapest practices were covered by a UK indemnifier. All three patients stated in evidence that they assumed that appropriate insurance was in place. This was set out in their treatment plans. The Committee is satisfied from the correspondence between Dental Protection (part of the Medical Protection Society) and the solicitors for Patient B and Patient C, that the Medical Protection Society did not insure the work Mr Balsai undertook in Budapest. Mr Balsai does not suggest that the Medical Protection Society did insure his Budapest practice.
23. (a)	Proved. The Committee is satisfied that when construed objectively the representations in Charge 22 was misleading. That interpretation would not have been made if there had been a clear statement that the London practice was insured by the Medical Protection Society, UK, and the Budapest practice was covered by a Hungarian insurer.
23. (b)	Proved. The Committee applied the two stage test for dishonesty. The Committee found that reasonable and honest people would consider that Mr Balsai had acted dishonestly by stating that his practices in London and Budapest were both insured in the UK when Mr Balsai knew they were not. The Committee next considered the second stage of this test, of whether he must have realised that what he was doing was, by those standards, dishonest. The Committee took into account Mr Balsai's written statement which states that the patients were covered by Hungarian insurance. However, the Committee notes that he failed to inform the patients of this. The Committee is satisfied that Mr Balsai must have known that those statements made, and allowed to be made, were dishonest. The Committee does not accept that Mr Balsai did not understand that the words used would be interpreted as meaning both London and Budapest were covered by UK insurance. The absence of any reference to Hungarian insurers at all must have been deliberate. The patients found it comforting to read that UK insurance was in place if they were treated in Budapest and the Committee is satisfied that the representations must have been intended to give that comfort to UK patients.
24. (a)	Proved. The Committee is satisfied that there is no adequate record of the details of the pre-treatment investigations carried out by Mr Balsai.
24. (b)	Admitted and found proved. The Committee can find no record of the advice regarding the risks of treatment, and the Committee is satisfied that Mr Balsai should have recorded it.
24. (c)	Admitted and found proved. The Committee can find no record of those discussions, and the Committee is satisfied that Mr Balsai should have recorded it.

24. (d) i	Admitted and found proved. The Committee can find no record of it, and is satisfied that Mr Balsai should have recorded it.
24. (d) ii	Admitted and found proved. The Committee can find no record of it, and is satisfied that Mr Balsai should have recorded it.
24. (d) iii	Proved. No clinical justification was recorded for this, and the Committee is satisfied that Mr Balsai should have recorded it.
24. (d) iv	WITHDRAWN
25. (a)	Admitted and found proved. There is no note in the dental records detailing the advice given about improving oral health as there should have been.
25. (b)	Admitted and found proved. The Committee finds that not all appointments have been recorded as they should have been.

We move to Stage Two."

On 26 September 2016, the hearing was adjourned and resumed on 20 February 2017.

On 21 February 2017, the Chair announced the determination as follows:

> "Having announced its finding on all the facts, the Committee heard submissions on the matters of misconduct, impairment and sanction.
>
> Mr Micklewright, on behalf of the GDC, referred the Committee to a written determination produced in 2016 by a different Committee of the Professional Conduct Committee. Mr Balsai received an indefinite suspension in respect of a previous fitness to practise investigation. He further referred the Committee to documentation relating to criminal convictions received by Mr Balsai for unlawful practice of dentistry and unlawfully carry on the business of dentistry. These offences were committed whilst he was suspended from the register.
>
> Mr Micklewright submitted that the facts found proved amount to misconduct. He explained that it is clear from the authorities that any misconduct must be serious. Mr Micklewright identified the standards, which in his submission, have been breached. He also referred the Committee to the relevant sections of the *Principles for Dental Team Working*, and *Principles of Patient Consent*, as published by the GDC.
>
> Mr Micklewright then moved on to the issue of current impairment, and addressed the Committee on the factors that it must consider, including Mr Balsai's level of insight and any remediation. He also addressed the Committee on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the GDC as a regulatory

body. Mr Micklewright referred the Committee to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). He submitted that Mr Balsai's fitness to practise is currently impaired by reason of misconduct.

Mr Micklewright addressed the Committee on the matter of sanction and submitted that the Committee must have regard to the current indefinite suspension order on Mr Balsai's registration when determining the workability of any sanction, particularly when considering conditions. However, Mr Micklewright invited the Committee to consider whether this is a case where nothing short of erasure would be appropriate. He referred the Committee to the specific matters for consideration as set out in the *'Guidance for the Practice Committees'* as published by the GDC in October 2016.

Dr Szoke, on behalf of Mr Balsai, submitted that he does not believe that the GDC has jurisdiction over the matters relating to treatment provided in Hungary. Further, serious professional misconduct cannot be proved in this case and erasure would be disproportionate.

Dr Szoke submitted that the 'other case', where Mr Balsai was indefinitely suspended, was not relevant for this Committee to consider and it must solely focus on the issues in this case. He submitted that there was no chance of providing the treatment, described as complex and invasive, without consent. Further, there is no evidence that Mr Balsai didn't follow the standards. He also submitted that Mr Balsai did not tell any of his patients anything that was untrue.

Dr Szoke informed the Committee that Mr Balsai worked hard to comply with the conditions imposed on his registration in respect of the other case. However, he was not able to get a supervisor, as the GDC does not have a list of approved supervisors. He also stated that the treatment Mr Balsai provided during his conditional registration was ongoing treatment that the patients wanted finished, and not a new course of treatment.

The Committee fully considered all the evidence in this case as well as the submissions made by Mr Micklewright and Dr Szoke. It accepted the advice of the Legal Adviser, which included the factors relevant to the considerations of the Committee and relevant case law.

Decision on whether the facts found proved amount to misconduct:

When determining whether the facts found proved amount to misconduct the Committee had regard to the terms of the relevant professional standards in force at the time of the incidents.

The Committee, in reaching its decision, had regard to the public interest and accepted that there was no burden or standard of proof at this stage.

The Committee has concluded that Mr Balsai's conduct was in breach of each of the standards as set out below.

Standards for Dental Professionals (2005)

***1.1** Put patients' interests before your own or those of any colleague, organisation or business.*

***1.4** Make and keep accurate and complete patient records, including a medical history, at the time you treat them. Make sure that patients have easy access to their records.*

***2.2** Recognise and promote patients' responsibility for making decisions about their bodies, their priorities and their care, making sure you do not take any steps without patients' consent (permission). Follow our guidance 'Principles of patient consent'.*

2.4 *Listen to patients and give them the information they need, in a way they can use, so that they can make decisions. This will include:*

- *communicating effectively with patients;*
- *explaining options (including risks and benefits); and*
- *giving full information on proposed treatment and possible costs.*

5.4 *Find out about laws and regulations which affect your work, premises, equipment and business, and follow them.*

6.1 *Justify the trust that your patients, the public and your colleagues have in your by always acting honestly and fairly.*

Standards for the Dental Team (2013)

Standard 4.4

You must ensure that patients can have access to their records

4.4.1 *Although patients do not own their dental records, they have the right to access them under Data Protection legislation. If patients ask for access to their records, you must arrange for this promptly, in accordance with the law.*

Standard 9.4

You must co-operate with any relevant formal or informal inquiry and give full and truthful information

The Committee appreciated that the above breaches do not automatically result in a finding of misconduct. However, the Committee was of the view that the breaches in this case are wide-ranging, occurred over a protracted period of time, are serious and fundamental to the profession. The Committee concluded that Mr Balsai's conduct was a significant departure from the standards expected of a registered dentist. The Committee considered that treating patients without informed consent is a serious matter, particularly in circumstances where the treatment was complex and invasive. The failures identified in his treatment planning and pre-treatment assessments had the potential to put Mr Balsai's patients at significant risk of harm. Further, allowing an unregistered member of his staff to take radiographs was wholly inappropriate and in breach of the regulations.

The Committee was of the view that the findings of inappropriate, misleading and dishonest conduct represented a wholesale departure from the standards expected of a dental professional. The Committee concluded that this conduct would be considered deplorable by fellow professionals.

The Committee considered that Mr Balsai's conduct, individually and collectively, fell significantly below the standards expected of a registered dentist and amounted to misconduct.

Decision on impairment:

The Committee proceeded to decide whether, as a result of this misconduct, Mr Balsai's fitness to practise is currently impaired.

The Committee recognised that the clinical failings in this case could be remediated. However, it had no information from Mr Balsai that he has taken any steps to remedy his conduct or that he had any recognition that his conduct was inappropriate. Further, there appears to be no appreciation by Mr Balsai of the seriousness of his misconduct. There is no

information before the Committee as to what, if any, insight Mr Balsai has into the failings identified by the Committee and no evidence of any remorse for his misconduct. Given the complete lack of information from Mr Balsai regarding any remediation or insight, the Committee could not be satisfied that the risk of repetition is highly unlikely.

The Committee considered that Mr Balsai has demonstrated poor professional judgment through his conduct and his lack of engagement and cooperation with the GDC. The Committee was aware that dishonesty is an attitudinal matter and therefore harder to demonstrate remediation than clinical failings. However, there is nothing from him to show that he has an understanding of why his actions were inappropriate and any assurance that he had learned from these proceedings and would not repeat his misconduct. There has been no evidence from Mr Balsai of any remorse for his actions or anything to show that he appreciates that his conduct was wrong. The Committee also considered that he has demonstrated a cavalier attitude towards his regulator and the standards that are expected of a professional.

The Committee has borne in mind that its primary function is not only to protect patients but also to take account of the wider public interest, which includes maintaining confidence in the dental profession and the GDC as a regulator, and upholding proper standards and behaviour.

Dental professionals occupy a position of privilege and trust in society and must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. In this regard the Committee considered the judgment of Mrs Justice Cox in the case of Grant.

The Committee considered that the misconduct found had the potential to place patients at unwarranted risk of harm. It also considered that there is an ongoing risk to patients as well as the public interest if Mr Balsai were permitted to return to practise without restriction. The Committee was of the view that Mr Balsai's conduct, including his dishonesty, brought the profession into disrepute and breached fundamental tenets of the profession.

The misconduct identified in this case was, in the view of the Committee, sufficiently serious to warrant a finding of impairment. Further, public confidence in the profession would be significantly undermined were the Committee not to make a finding of current impairment, which would effectively amount to a full acquittal.

Having regard to all of this the Committee has concluded that Mr Balsai's fitness to practise is currently impaired by reason of misconduct.

Decision on sanction

The Committee next considered what sanction, if any, to impose on Mr Balsai's registration. It recognised that the purpose of a sanction is not to be punitive, although it may have that effect, but rather to protect patients and the wider public interest.

The Committee has taken into account the GDC's *'Guidance for the Practice Committees: Including Indicative Sanctions Guidance'*. The Committee applied the principle of proportionality, balancing the public interest with Mr Balsai's interests. The Committee has considered the range of sanctions available to it, starting with the least serious.

The Committee considered that there were no mitigating circumstances present in this case. The aggravating factors included: the risk of harm to patients; Mr Balsai's misleading and dishonest conduct; his a wilful disregard for the GDC standards and guidance; Mr Balsai's lack of insight; previous findings made against him; breach of trust; and repeated and persistent misconduct. The Committee also considered that the convictions for illegal

practice and the determination of the PCC in December 2016 are matters that this committee consider to be aggravating factors in this case when considering the likelihood of Mr Balsai complying with any sanction that it may impose.

In the light of the findings against him the Committee has determined that it would be wholly inappropriate and irresponsible to conclude this case without taking any action or with a reprimand, as neither would restrict Mr Balsai's registration, address the lack of insight and risk of harm to patients and the wider public.

The Committee next considered whether a period of conditional registration would be appropriate in this case. The Committee was mindful that any conditions imposed must be proportionate, measurable and workable. The Committee considered that, in order for conditions to be workable, there would need to be insight, a measure of positive engagement and co-operation from Mr Balsai, all of which are absent in this case. In any event, the Committee determined that it would not be possible to formulate appropriate and practical conditions which would address the dishonesty in this case. Further, there was evidence that Mr Balsai had previously breached conditions imposed on his registration and he worked as a dentist while suspended by the GDC for which he was convicted on three counts. The Committee concluded that conditions would not be appropriate, workable or proportionate in the circumstances of this case.

The Committee then considered whether a suspension order would be proportionate and appropriate in this case. The Committee is in no doubt that Mr Balsai's misconduct, including his breach of trust and his dishonesty was wholly unacceptable and seriously damaging to the reputation of the profession and to the public's confidence in the dental profession. The Committee had nothing before it to show that Mr Balsai has any insight into the seriousness of his actions or the potential consequences. Mr Balsai has not provided any assurance to this Committee that his misconduct would not be repeated and there is evidence that he has wilfully disregarded the previous opportunities given to address his failings and demonstrate that he is willing to engage with the GDC to return to safe practise.

The Committee then considered whether the issues identified are fundamentally incompatible with Mr Balsai remaining on the Register.

The Committee considered the guidance in relation to considering imposing a sanction of erasure.

The ability to erase exists because certain behaviours are so damaging to a registrant's fitness to practise and to public confidence in the dental profession that removal of their professional status is the only appropriate outcome. Erasure is the most severe sanction that can be applied by the PCC and should be used only where there is no other means of protecting the public and/or maintaining confidence in the profession.

Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust;*
- *serious dishonesty, particularly where persistent or covered up;*

- *a persistent lack of insight into the seriousness of actions or their consequences.*

In all the circumstances of this case the Committee concluded that Mr Balsai's behaviour is fundamentally incompatible with him being a registered dentist. The Committee concluded that the only proportionate sanction is that of erasure.

The Committee considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standards of conduct required of a registered dental professional at all times.

The Committee was aware that the effect of this order is that Mr Balsai will be prevented from working as a registered dental professional using a GDC registration. This could result in financial hardship, though the Committee was aware that he is already under the imposition of an indefinite suspension and therefore unable to work as a dentist in the UK in any event. However, in applying the principle of proportionality, the Committee determined that Mr Balsai's interests in this regard are outweighed by the need for public protection and protection of the wider public interest."

Decision on Immediate Order:

"Having directed that Mr Balsai's name be erased from the register, the Committee had to consider whether to impose an immediate order to cover the appeal period, or until any appeal against the outcome is heard.

The Committee has considered the submissions made by Mr Micklewright that an immediate order should be made on the grounds that it is necessary to protect the public and is otherwise in the public interest. He submitted that there is an ongoing risk to the public based on the Committee's findings and Mr Balsai's lack of insight. Further, this risk is sufficiently serious that the imposition of an immediate order for protection of the public is warranted. Mr Micklewright submitted that if there was a period where a suspension order was not in place this would undermine the public confidence in the profession and in the GDC as the regulator, particularly given the Committee's conclusion that Mr Balsai has demonstrated a wilful disregard for the role of the GDC.

Mr Micklewright submitted that any immediate order would run concurrently with the indefinite suspension already in place for separate matters. He applied for an immediate order to cover to cover the eventuality of the current indefinite suspension order being lifted.

Dr Szoke submitted that there was no need for any immediate order given that Mr Balsai was already suspended by another Committee. He further submitted that there was nothing to suggest that Mr Balsai was a risk to the public and therefore there was no necessity to suspend him again.

The Committee accepted the advice of the Legal Adviser.

The Committee was satisfied that, notwithstanding the indefinite suspension imposed by a different Committee, an immediate order of suspension was necessary for the protection of the public and it was otherwise in the public interest. The Committee concluded that given the seriousness and the nature of its findings and its reasons for the substantive order of erasure, including Mr Balsai's lack of insight and the identified risk of repetition, to direct otherwise would be inappropriate. The Committee considered that, given its findings, if an immediate order were not made in the circumstances, public confidence in the profession

and in the GDC as its regulator would be undermined. The Committee was satisfied that this order was necessary to cover the eventuality of the current indefinite suspension being lifted.

If, at the end of the appeal period of 28 days, Mr Balsai has not lodged an appeal, this immediate order will lapse and will be replaced by the substantive direction of erasure. If he does lodge an appeal, this immediate order will continue in effect until that appeal is determined.

Unless Mr Balsai exercises his right of appeal, his name will be erased from the register 28 days from the date upon which this decision is deemed served on him.

That concludes this case."