General Dental Council | protecting patients, regulating the dental team

HEARING HEARD IN PUBLIC

GUIRGUIS, Kareem

Registration number: 193829

PROFESSIONAL CONDUCT COMMITTEE

DECEMEBER 2019

Outcome: Conditions imposed for 12 months with immediate conditions (with a review)

Kareem GUIRGUIS a dentist, BDS Lond 2010, was summoned to appear before the Professional Conduct Committee on 2 December 2019 for an inquiry into the following charge:

Charge (as AMENDED by joinder on 2 December 2019)

"That, being a registered dentist and at all material times practising dentistry at 31 Harley Street, London, W1G 9QS ('the Practice'):

1. On or around 20 September 2017 you saw Patient A (who is identified in the attached Schedule[1]) at the Practice and discussed the provision of orthodontic treatment including upper and lower aligners ('the proposed orthodontic treatment').
2. You failed to provide Patient A with any or any adequate treatment plan.
3. You failed to provide Patient A with any or any adequate information regarding:
   a. The available treatment options;
   b. The risks and benefits of the available treatment options.

3A. You told Patient A that you were an orthodontist and/or a specialist.

3B. Your conduct at paragraph 3A above was:
   a. Misleading, in that you were not on any GDC specialist list (in relation to orthodontics or otherwise);
   b. Dishonest, in that you knew that you were not on any GDC specialist list (in relation to orthodontics or otherwise).

4. AMENDED TO READ: As a consequence of paragraphs 3 and/or 3A and/or 3B(a) and/or 3B(b) above, Patient A was not in a position to provide his valid consent for the proposed orthodontic treatment.
5. On or around 29 September 2017 Patient A paid £2400 in respect of the proposed orthodontic treatment.

5A. On or around 29 September 2017 you filed one or more of Patient A's upper teeth without obtaining his valid consent.

[1] Please note the Schedule is a private document which cannot be disclosed

6. Thereafter you failed to complete the proposed orthodontic treatment in a timely manner.

7. On 14 November 2017 you told Patient A that you had the aligners and would post them to him (or words to that effect).

8. At around 08.32am on 15 November 2017 you told Patient A that you had posted the aligners and/or that you had been in too much of a hurry to post the aligners that you did not take down the tracking number (or words to that effect).

9. Your conduct at paragraphs 7 and/or 8 above was:

   a. Misleading, in that the information you provided to Patient A was inaccurate.

   b. Dishonest in that you knew that the information you provided to Patient A was inaccurate.

10. You failed to make a copy of Patient A's records before posting them to your defence organisation.

11. You failed to make a copy of Patient B's records before posting them to your defence organisation.

And that, your fitness to practise is impaired by reason of your misconduct."

Mr GUIRGUIS was not present and was not represented. On 4 December 2019 the Chairman announced the findings of fact to the Counsel for the GDC:

"Mr Guirguis was neither present nor represented at the hearing.

On behalf of the GDC, Mr Singh of counsel instructed by Capsticks submitted that the notification of hearing had been served on Mr Guirgius in accordance with the General Dental Council (Fitness to Practise) Rules 2006 and that the hearing should proceed in his absence.

Service and absence

The notification of hearing dated 31 October 2019 was sent the same day by Special Delivery to Mr Guirguis at his registered address. Royal Mail tracking records that the item was returned undelivered on 4 November 2019. A copy of the notification of hearing had also been sent to Mr Guirguis on 31 October 2019 by email and was also copied to Mr Guirguis's then representative, Oliver Al-Falah of Eminence Consultants Ltd.

By email to Capsticks on 22 November 2019 at 14:13, Mr Al-Falah stated of this hearing:

> No Counsel has been instructed and I do not expect Mr Guirguis to attend, albeit I understand he is currently preparing a short submission document which will be forwarded to you in due course.

As the Committee understands it, Mr Al-Falah subsequently came off the record for Mr Guirguis.

On 26 November 2019 Capsticks emailed Mr Guirguis directly at 10:30 to state:

> It is my understanding that Oliver Alfalah [sic] has come off the record as acting for you, and in light of this I am contacting you directly about your upcoming Professional Conduct Committee hearing next week.

> […]
>
> 3. We understand that you are not attending the hearing and that you will not be represented. Please let me know if that is not correct. We presume that you are not intending to make any application to postpone the hearing? If you are, please can you notify me of this immediately.
>
> Now you are unrepresented, please do let me know if you feel like you require any assistance with anything, as you know, I am unable to provide you with any advice, however, if you need assistance with sending documents onwards to the Committee and other such tasks I am more than happy to help you. I will also notify the GDC's witness liaison officer that you are unrepresented and she may call you to check if you need any assistance.

Mr Guirguis replied the same day to state: "…*I am not intending to make applications to postpone the hearing. I am not attending and will provide written submissions for the committee.*" Those written submissions were subsequently received by the Committee.

The Committee accepted the advice of the Legal Adviser on the requirements for service and proceeding in the absence of the respondent.

The Committee was satisfied that the notification contained the required information under Rule 13 of the Rules, including the time, date and venue of this hearing; and that it had been served on Mr Guirguis in accordance with Rule 65 by virtue of it being posted to his registered address.

The Committee next considered whether to exercise its discretion to proceed in the absence of Mr Guirguis. This is a discretion which must be exercised with the utmost care and caution.

The Committee was satisfied that the GDC had made all reasonable efforts to notify Mr Guirguis of this hearing. He is aware of this hearing, as is self-evident from the email correspondence from both him and his former representative discussing whether he will be attending the hearing.

Mr Guirguis made clear that he would not be attending this hearing and that he would be providing written submissions for the Committee. He confirmed that he makes no application for a postponement. There was nothing before the Committee which would otherwise suggest that a postponement or adjournment would make Mr Guirguis's attendance at a future hearing any more likely. In the Committee's judgment he has made an informed decision not to attend, having been provided in the notification of hearing with information that he could attend the hearing in person or remotely via telephone or video-link and that non-attendance might be prejudicial to his case:

> You should be aware that if you decide not to attend the hearing (either in person, by telephone or by video-link), the Committee may proceed and make a decision in your absence as this is permitted under the rules. If you are not present then obviously you will not have an opportunity to cross-examine the witnesses on any points in their statements that you do not agree with, or be able to adduce from them any other matters that you may consider are relevant that they have not already said. You will also not have the opportunity to give your own evidence in relation to the allegations. As a result, if you do not attend the hearing this is likely to be severely prejudicial to your case and may lead to a more severe sanction being imposed by the Committee.

Having regard to all the circumstances, the Committee determined that postponing or adjourning the hearing would serve no purpose and that to do so would result in a considerable waste of resources and would only delay matters, which is not in the interests of the witnesses who have been warned, nor would it likely be in Mr Guirguis's own interests.

The Committee determined that there was a strong public interest in the expeditious disposal of the proceedings and that it would be fair to proceed with the hearing, notwithstanding the absence of Mr Guirguis. The Committee drew no adverse inference from his decision not to attend the hearing.

Joinder

The Committee allowed an application under Rule 25 to join further allegations to those already contained in the notification of hearing. The Committee was satisfied that the further allegations were founded on the same alleged facts and were of a similar kind to the allegations already before the Committee. The allegations involve the same patient, the same practice, the same timeframe and the same course of treatment. Mr Guirguis was put on notice of the application for joinder and has not objected to the further allegations being joined. In the Committee's judgment it was fair and in the interests of justice to allow the joinder, as it could identify no prejudice to either party in allowing the application and as joining the charges would avoid the need for the further allegations to be determined at a second hearing.

Thereafter the charge was amended and renumbered to include the further charges as 3A, 3B(a)-(b) with a corresponding amendment to the wording of charge 4 to incorporate the further allegations into the conduct alleged under that charge.

The factual inquiry

The Committee heard oral evidence from Ms H, a dental technician based in Italy, and from Patient A, who gave his evidence via Skype. The witness statement of Ms H. Dominguez, a GDC Registration Casework Manager, was taken as read. Although he did not formally admit the contents of her statement, Mr Guirguis did not object to the statement being admitted as hearsay. Moreover, he does not contest Ms Dominguez's evidence, which simply establishes that he was not on any GDC specialist list: a point which he accepts in his own written submissions.

The Committee also heard evidence from Mr G. Bellman, a specialist in orthodontics instructed by the GDC for his expert opinion, and had regard to his report dated 5 September 2019.

The Committee heard the submissions made by Mr Singh in opening and closing and had regard to the written submissions provided by Mr Guirguis.

The Committee accepted the advice of the Legal Adviser. The burden is on the GDC to prove each charge on the balance of probabilities.

The Committee found Ms H to be clear and focused. She gave her evidence frankly and openly. Although English is not her first language the Committee did not consider there to be any language barrier. It did not appear to the Committee that Ms H had any malice towards the registrant or that she was seeking to discredit him. The evidence she gave was consistent with other evidence before the Committee.

The Committee found Patient A to be an intelligent, honest and credible witness who assisted the Committee to the best of his recollection. Whilst there were some inconsistencies between his witness statement and his oral evidence, the Committee concluded that this was likely to be due to the passage of time. Whilst this might affect the accuracy of some of his specific recollections, the Committee did not consider that it undermined his overall credibility.

The Committee accepted the uncontested statement of Ms Dominguez.

The Committee found Mr Bellman to be a well-qualified expert witness with very high standards who gave his opinion in a fair and balanced way.

It is regrettable that Mr Guirguis was not present to challenge the witnesses through cross examination, the evidence called against him and to give his own evidence. That was his choice and the Committee drew no adverse inference against him. From his written submissions he comes across as a person with integrity, acknowledging some of his shortcomings. Mr Guirguis has no previous adverse findings recorded against him and the Committee accepted the submission of Mr Singh and the advice of the Legal Adviser that he is to be treated as a person of good character.

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

1.	*On or around 20 September 2017 you saw Patient A (who is identified in the attached Schedule) at the Practice and discussed the provision of orthodontic treatment including upper and lower aligners ('the proposed orthodontic treatment').* **Proved.** Mr Guirguis does not dispute that he saw Patient A on or around 20 September 2017 and that he discussed the provision of orthodontic treatment including upper and lower aligners. There was clear and uncontested documentary and oral evidence before the Committee in support of this charge.
2.	*You failed to provide Patient A with any or any adequate treatment plan.* **Not proved.** A document headed "Proposed Treatment Plan" was provided to Patient A on 21 September 2017. It refers to the provision of "Upper and Lower Clear Aligners (including bonded retainers, and free home whitening)" and quoted a price of £2,700.00 for the treatment. The opinion of Mr Bellman was that a treatment plan needed to include the objectives of the treatment in order to be adequate, as stated in his report dated 5 September 2019 and confirmed by him orally in evidence: The form headed Proposed Treatment Plan dated 23 January 2018, for Patient A is not a treatment plan which should include the objectives of treatment and a plan of how these objectives are to be achieved. All the proposed Treatment Plan form states is that clear aligners are to be used followed by retainers and a costing for this treatment. Therefore, this document is not a treatment plan and I am critical of the registrant for not producing an adequate treatment plan. The Committee finds that the treatment plan provided to Patient A by Mr Guirguis was the most basic of treatment plans. The Committee took account of the minimum requirements described in Standard 2.3.7 of *Standards for the Dental Team* (September 2013): Whenever you provide a treatment plan you must include:

	• the proposed treatment; • a realistic indication of the cost; • whether the treatment is being provided under the NHS (or equivalent health service) or privately (if mixed, the treatment plan should clearly indicate which elements are being provided under which arrangement). As to the last point, although the treatment plan did not expressly state that the treatment would be provided privately, the Committee accepted that Patient A was attending Mr Guirguis at a Harley Street clinic for elective orthodontic work to improve the appearance of his smile and was given a quote of £2,7000.00. It would have been obvious to Patient A that he was being quoted for private work. He is an intelligent man and an informed patient who was already clear about the type of orthodontic work he wanted to receive. He had carefully researched the treatment over the internet before consulting with a range of practitioners, including Mr Guirguis. His evidence was that he decided to be treated by Mr Guirguis, as Mr Guirguis gave the cheapest quote for the work out of those he had consulted. The Committee does not consider the document entitled "Proposed Treatment Plan" to be adequate in itself. However, the Committee noted that between 21 and 29 October 2017 there was further email correspondence between Patient A and the Practice Manager regarding the treatment plan and estimated outcome, including the provision of an information leaflet. Therefore, in context, the Committee is not satisfied that Mr Guirguis had gone so far as to fail in a corresponding duty by not providing a more detailed treatment plan, as alleged under this charge. Accordingly, the Committee does not find the charge proved.
3.	*You failed to provide Patient A with any or any adequate information regarding:*
3.(a)	*The available treatment options;* **Not proved.** Mr Guirguis recorded the treatment options he says he discussed with Patient A on the Orthodontic Assessment Form. What was recorded would have been an adequate discussion of the treatment options in the opinion of Mr Bellman, albeit more treatment options could have been discussed with Patient A if a higher standard were to be applied. Patient A does not recall being informed of other treatment options, although he recalls being told of the option of no treatment. It is therefore for the Committee to decide whether the record made was accurate. Applying the burden of proof, the Committee finds that this charge is not proved. There is a contemporaneous note recording what would on the GDC's expert evidence be an adequate discussion on treatment options. Patient A attended Mr Guirguis's Practice with the clear intention of having aligners: he may not have been receptive to any discussion on other treatment options, as such options are likely to have been less appealing to him than the treatment he had already researched and was intending to receive. He may therefore have not recalled any discussion which took place on other treatment options.

	Accordingly, the Committee finds this charge not proved.
3.(b)	*The risks and benefits of the available treatment options.* **Proved.** Patient A's evidence was that the benefits of the proposed treatment were discussed but not the risks. He stated that he had asked Mr Guirguis about risks but Mr Guirguis did not address that question. Mr Bellman identified a range of risks which he considered needed to be discussed. The Committee accepted Patient A's evidence and found that the risks had not been discussed. Although the likelihood of adverse consequences was small, Mr Guirguis was under a duty to discuss those risks with Patient A and he failed to do so. Accordingly, the Committee finds this charge proved.
3A.	*You told Patient A that you were an orthodontist and/or a specialist.* **Not proved.** The allegation was no longer positively pursued by the GDC so far as it referred to Mr Guirguis telling Patient A that he was a specialist. This was in light of Patient A's oral evidence, where (departing from the terms of his witness statement) he stated that he could not recall that Mr Guirguis had in fact told him that he was a specialist. Patient A was however clear in his evidence that Mr Guirguis had referred to himself as an orthodontist. Patient A stated that he recalls this clearly, as he did not know exactly what an orthodontist was. Patient A referred to Mr Guirguis as an orthodontist when emailing the Practice the day after Mr Guirguis allegedly told him that he was an orthodontist. The Committee was satisfied that Patient A genuinely considered that Mr Guirguis had said to him that he was an orthodontist. The GDC's *Guidance on Advertising* (September 2013) states: If you are a dentist and you are not on a GDC specialist list you must not use titles which may imply specialist status such as Orthodontist, Periodontist, Endodontist etc. … If you are not on a specialist list you must not describe yourself as 'specialising in…' a particular form of treatment but may use the terms 'special interest in..', 'experienced in..' or 'practice limited to..'. Mr Guirguis was not on any GDC specialist list and would not therefore have been entitled to refer to himself as an orthodontist. The issue before the Committee is whether he did in fact tell Patient A he was an orthodontist or whether Patient A may have misunderstood or incorrectly recalled the actual words he had used. Mr Guirguis's response is that he only refers to himself as a dentist with a special interest in orthodontics and that he explains to patients the difference between a general dental practitioner and a specialist, a point which he had

	noted in Patient A's records ("DISCUSSED GDP VS SPECIALIST"). There is no other corroborating evidence provided by the GDC in support of this charge (such as accounts from colleagues or other patients that Mr Guirguis refers to himself as an orthodontist or of that title being used by him in his correspondence or advertising). The Committee, applying the burden and standard of proof, determined that Patient A may genuinely but mistakenly have thought Mr Guirguis had said he was an orthodontist when in fact Mr Guirguis had said only that he had a special interest in orthodontics. Patient A may have inadvertently conflated the title of 'orthodontist' with reference to having a special interest in orthodontics. Accordingly, the Committee was not satisfied to the required standard that Mr Guirguis told Patient A that he was a specialist or an orthodontist. The Committee therefore finds this charge not proved.
3B.	*Your conduct at paragraph 3A above was:*
3B.(a)	*Misleading, in that you were not on any GDC specialist list (in relation to orthodontics or otherwise);* This charge fell away as the Committee found charge 3A above not proved.
3B.(b)	*Dishonest, in that you knew that you were not on any GDC specialist list (in relation to orthodontics or otherwise).* This charge fell away as the Committee found charge 3A above not proved.
4.	AMENDED TO READ: *As a consequence of paragraphs 3 and/or 3A and/or 3B(a) and/or 3B(b) above, Patient A was not in a position to provide his valid consent for the proposed orthodontic treatment.* **Proved.** What remains under this charge is 3(b), as the other charges referenced here have been found not proved. The issue is therefore whether Mr Guirguis's failure to explain the risks of the proposed orthodontic treatment meant that Patient A was not in a position to provide his valid consent to that treatment. The proposed orthodontic treatment was a course of expensive treatment over 12 months which, if successful, would have changed the configuration of Patient A's mouth and would have required him to thereafter wear a retainer in order to maintain the change in configuration. Patient A should have been told of the risks so that he could make an informed decision on whether to go ahead with such treatment. Although the material risks may have been small in this case, Patient A should have been informed of them so that he could give valid consent to the treatment. As Patient A was not informed of them the Committee was satisfied that he was not in a position to provide valid consent. Accordingly, the Committee finds this charge proved.
5.	*On or around 29 September 2017 Patient A paid £2400 in respect of the proposed orthodontic treatment.*

	Proved. The records before the Committee and the evidence of Patient A confirm that this amount was paid (and subsequently refunded). It is a point which is not disputed by Mr Guirguis.
5A.	*On or around 29 September 2017 you filed one or more of Patient A's upper teeth without obtaining his valid consent.* **Proved.** Patient A had corresponded with the Practice Manager about having his upper teeth smoothed and was informed by her that this could be done without additional cost. Patient A's evidence was that two of his upper teeth were filed by Mr Guirguis and that there had been no prior discussion about exactly what was going to happen. He described being given some glasses, being put back in the dental chair, the use of an electric tool and experiencing a burning unpleasant smell whilst the teeth were being filed. He stated he was not given any information before the procedure occurred or told what to do if he felt uncomfortable. The Committee accepted Patient A's account. The detailed way in which Patient A describes the filing of his teeth to have been carried out by Mr Guirguis suggests that it was done rapidly and without prior discussion. Mr Guirguis does not address this allegation in his written submissions. He refers to discussion on Inter Proximal Reduction (IPR) in his submissions, but this was a different procedure in respect of different teeth. There is no allegation against Mr Guirguis in respect of IPR. On the evidence before the Committee, the Committee finds that, although Patient A had requested the filing of his teeth, there was no prior discussion with him about what was going to happen. In those circumstances the Committee was satisfied that he did not give his valid consent to having his teeth filed. The Committee therefore finds this charge proved.
6.	*Thereafter you failed to complete the proposed orthodontic treatment in a timely manner.* **Not proved.** In reality the delay was in the commencement (rather than completion) of the treatment. Ultimately, there was a breakdown in the relationship between Patient A and Mr Guirguis. Patient A decided not to complete the treatment with him and he was refunded the cost in full. It cannot be said in those circumstances, and on the way in which the charge is worded, that Mr Guirguis failed to complete the treatment.
7.	*On 14 November 2017 you told Patient A that you had the aligners and would post them to him (or words to that effect).* **Proved.** The Committee accepted the account given by Patient A and supported by the chain of text messages between Patient A and Mr Guirguis.
8.	*At around 08.32am on 15 November 2017 you told Patient A that you had posted the aligners and/or that you had been in too much of a hurry to post the*

	aligners that you did not take down the tracking number (or words to that effect). **Proved.** The Committee accepted the account given by Patient A that Mr Guirguis stated to him over the phone at 08:32 that the aligners had been posted but that he had not taken down a tracking number.
9.	*Your conduct at paragraphs 7 and/or 8 above was:*
9.(a)	*Misleading, in that the information you provided to Patient A was inaccurate.* **Proved.** The Patient was clearly misled, as the information given to him was not accurate. On the evidence of Ms H, the retainers had been posted from Italy in the afternoon of 14 November 2017. It is highly improbable that Mr Guirguis could have had them in his possession in the United Kingdom and then posted them on to Patient A by 08:32 the following morning.
9.(b)	*Dishonest in that you knew that the information you provided to Patient A was inaccurate.* **Proved.** In his written submissions, Mr Guirguis explains that: The aligners were delayed from the laboratory. The way our process worked was that we relied on a delivery date from […] that was provided on a web portal. When we saw a date had been provided we gave it to the patient. This date then changed on the portal, which is then why we informed the patient it had not arrived. Sadly this update was made after the patient had left (without his aligners) and only after we queried it with [Ms H] who then queried it with the lab. The patient was refunded in full and I sincerely apologised because we had clearly been disorganised in our dealings with him. Despite the lab making a mistake in shipping dates, we ultimately let him down with aligner delivery. "*If I am not contacted by 9am today (15 Nov 2017) to arrange, I will immediately escalate with GDC, DCS and also refer to the fraud police for investigation*." - Despite this being a threat, I willingly refunded the patient immediately because I felt that it was honestly due and we had let him down, albeit with the lab letting us down, we still should have communicated with him in a better fashion and been more organised. After this refund and apology the patient still continued to verbally berate myself and the practice and defame me online. Regardless of this fact, I believe the following regarding this case : 1. I acted honestly and did not intend to mislead the patient in any way. I put his best interest before any gain of the practice or my own. 2. None withstanding [sic] point 1, we were extremely disorganised and even if we have a lab delay we should have communicated a lot more effectively and bluntly with the patient, instead of trying to appease the situation we made it worse. The Committee finds that the context of the delay in receiving the aligners and

	then sending them on to Patient A was the result of poor administration within the Practice and delayed payment to the dental laboratory. Mr Guirguis was essentially trying to 'buy time' by fobbing off Patient A with an explanation that the aligners were in the post to him. Knowingly giving false information to a patient that their orthodontic appliance had been posted to them when in fact it had not yet even been received by the Practice is clearly conduct which would be regarded as dishonest by the ordinary standards of reasonable and honest people. The Committee finds that Mr Guirguis acted dishonestly. The Committee acknowledges in context that the dishonestly is likely to have arisen through panic and embarrassment, rather than its being pre-meditated or manipulative.
10.	*You failed to make a copy of Patient A's records before posting them to your defence organisation.* **Proved.** The facts alleged under this charge were not in dispute. As to whether there was a duty to have made a copy of the patients' records before posting them to the defence organisation, the Committee accepted the opinion of Mr Bellman that the duty arises under the record keeping standards described in *Standards for the Dental Team*. The Committee finds that Mr Guirguis had failed in that duty. Further, in respect of Patient A at least, common sense should have compelled him to have made a copy of the records, as the patient was complaining about him: that is why he was posting the records to the defence organisation.
11.	*You failed to make a copy of Patient B's records before posting them to your defence organisation.* **Proved.** As above."

On 5 December 2019 Chairman announced the determination as follows:

> "On 20 September 2017 Patient A attended Mr Guirguis's practice for an initial consultation relating to the provision of orthodontic treatment, including upper and lower aligners. Mr Guirguis failed to explain to Patient A the risks of the proposed treatment and Patient A was therefore not in a position to give his valid consent to the treatment. Patient A decided to proceed with the treatment. On 29 September 2017 he made a payment of £2,400.00 for the treatment and was advised by Mr Guirguis that it would take approximately two weeks for the aligners to be manufactured. Patient A was advised that once the aligners were received at the Practice a further appointment would be scheduled for the aligners to be fitted.
>
> On 29 September 2017 Mr Guirguis filed two of Patient A's upper teeth without obtaining his valid consent: although Patient A had requested the treatment, there was no prior discussion with him about what was going to happen and therefore he could not have given his valid consent for Mr Guirguis to file his teeth.

Towards the end of October 2017 Patient A started to chase the aligners with the Practice. On 10 November 2017 he attended an appointment for the aligners to be fitted but when he arrived at the Practice he was advised that the aligners were yet to be delivered.

Another appointment was scheduled for 14 November 2017 but was cancelled on the day by the Practice. When Patient A spoke to Mr Guirguis over the phone that day, Mr Guirguis stated that he had the aligners in his possession and that he would personally take them to the post office to post and that once he had done so he would send the tracking number by SMS and would also arrange for a partial refund to be issued in light of the delay.

At around 08.32am on 15 November 2017 Mr Guirguis told Patient A over the telephone that he had posted the aligners. When asked by Patient A for the tracking number, he stated that he had been in too much of a hurry to post the aligners and that he did not take down the tracking number.

In fact, the aligners were posted to the Practice from the dental laboratory in Italy, during the afternoon of 14 November 2017. This delay was the result of poor administration within the Practice and late payment from Mr Guirguis to the dental laboratory.

The Committee found as fact that Mr Guirguis did not have the aligners in his possession on 14 November 2017, nor would he have received and then posted them onto Patient A by around 08:32am the following morning. Mr Guirguis's statements to Patient A were dishonest. However, the Committee acknowledged that in context the dishonesty was likely to have arisen out of panic and embarrassment, rather than there being a more pre-meditated or manipulative element to the dishonest conduct.

Later on 15 November 2017 Patient A decided to withdraw from the treatment and requested a full refund, which he received.

In response to a complaint from Patient A, Mr Guirguis posted Patient A's records with the records of another unrelated Patient (B)) to his defence organisation. He did not make any copy of the records, which have now been lost, before posting them.

The Committee heard the submissions made on behalf of the General Dental Council (GDC) by Mr Singh and had regard to the written submissions made by Mr Guirguis following the announcement of the findings of fact, which were sent electronically to Mr Guirguis on 4 December 2019.

The Committee accepted the advice of the Legal Adviser.

The Committee had regard to the *Guidance for the Practice Committees, including Indicative Sanctions Guidance* (October 2016).

Misconduct

Misconduct is a serious departure form the standards reasonably expected of a dental professional. The Committee considered that the findings of fact could be categorised into the following areas: (i) the failure to obtain valid consent in respect of the proposed orthodontic treatment (charges 3(b) and 4) and in respect of the filing of Patient A's teeth (charge 5A); (ii) the dishonesty in respect of the aligners (charges 7 to 9(b)); and (iii) the record keeping failure in respect of failing to make a copy of the records of Patients A and B before sending those records in the post (charges 10 and 11).

In assessing whether the facts found proved amount to misconduct, the Committee had regard to the following principles from *Standards for the Dental Team* (September 2013):

1.3 You must be honest and act with integrity

1.3.1 You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.

1.3.2 You must make sure you do not bring the profession into disrepute.

2.2: You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care

2.3: You must give patients the information they need, in a way they can understand, so that they can make informed decisions

3.1: You must obtain valid consent before starting treatment, explaining all the relevant options…

3.2: You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

4.4: You must ensure that patients can have access to their records

The failure to obtain valid consent was serious in the Committee's judgment and meets the threshold for misconduct. Obtaining valid consent is fundamental to clinical practice. There were risks associated with the proposed orthodontic treatment and Patient A should have been informed of them in order to be in a position to give his valid consent. Likewise, Mr Guirguis should have advised him about what he was going to do, prior to using an electric tool to file two of Patient A's upper teeth.

Dishonesty is clearly a serious breach of professional standards. The public must be able to place its trust in dentists. Integrity and probity go to the heart of the profession and any lapse from that is likely to cross the threshold into misconduct. The Committee finds that the dishonesty in this case, although towards the lower end of scale of seriousness, does meet the threshold for misconduct.

As to the record keeping failing under charges 10 and 11, the Committee considered that this was an error of judgement. It was a negligent failure which has unfortunately meant that Mr Guirguis's records for the two patients are no longer available, owing to the loss of the original records which were posted. No culpability is alleged against Mr Guirguis in respect of the posting and loss of those original records: his failure was in respect of not making a copy of the records before they were posted. This isolated matter, although it is a breach of standards, is not in the Committee's judgment so serious as to meet the threshold of misconduct.

Accordingly, the Committee finds that there have been significant breaches of the above standards in respect of its findings under charges 3(b), 4, 5A and 7 to 9(b) only and that these matters each amount to misconduct.

Impairment

The Committee considered whether Mr Guirguis's misconduct is remediable, whether it had been remedied and the risk of repetition. The Committee also had regard to the wider public

interest, which includes the need to uphold and declare proper standards of conduct and behaviour, so as to maintain confidence in the dental profession and this regulatory process.

The Committee has no clear evidence of any endeavours made by Mr Guirguis to learn fully from what has happened. There is no evidence of any course he has attended to address the concerns raised in these proceedings. There are few expressions of reflection and remorse. There are some signs of insight but they are not fully developed.

On 18 March 2015 the Investigating Committee (IC) issued Mr Guirguis with advice in respect of concerns relating to his clinical care and treatment of a patient. On 2 June 2015 the IC issued him with advice in respect of his clinical care and treatment of another patient. The advice given by the IC includes advice relating to the obtaining of patient consent. The giving of advice by the IC is a neutral act which does not constitute an adverse finding, as no findings of fact are made by the IC but it does put a registrant on notice of particular areas of his practice to which he needs to pay particular care. Mr Guirguis has had ample opportunity to reflect upon and learn from that advice, but he does not appear to have fully learnt in respect of giving Patient A the information needed for the purpose of giving valid consent.

In the Committee's judgment, the matters relating to valid consent are easily remediable through training and reflection. As there is no corresponding evidence of remediation, the Committee cannot therefore be satisfied that the risk of repetition is low and therefore there remains a risk to the public. As to the dishonesty which the Committee has found proved, this is a matter which is more difficult to remedy, as it goes to character. However, in context, the Committee considers the dishonesty to have been isolated and to have stemmed from Mr Guirguis's sense of panic and embarrassment in respect of the delayed delivery of the aligners (for which he subsequently issued Patient A with a full refund). In the Committee's judgment, the dishonesty in this case falls towards the lower end of the scale of seriousness and is unlikely to be repeated. Dishonesty is however seriously damaging to the reputation of the profession and the dishonesty here occurred in context of Mr Guirguis's practice as a dentist, where he misled a patient as to the location and delivery of the orthodontic appliances for which the patient had paid. Public confidence in the profession would be seriously undermined if no finding of impairment were made to mark that dishonesty.

Accordingly, the Committee finds that Mr Guirguis's fitness to practise as a dentist is currently impaired by reason of his misconduct in relation to his failures to obtain valid consent and his dishonesty.

Sanction

The purpose of a sanction is not to be punitive, although it may have that effect, but to protect the public and public confidence in the profession and this regulatory process. The Committee considered each sanction in ascending order of severity.

The Committee gave due regard to aggravating and mitigating factors. In particular, the Committee noted that Mr Guirguis is of previous good character; the dishonesty was not pre-meditated; that when he filed Patient A's teeth it had been a well-intentioned act, albeit that there had been too little prior explanation of what would happen for the purposes of gaining valid consent; and the misconduct relates to one patient. In relation to aggravating features, the Committee identified that the misconduct included dishonesty.

To conclude this case with no further action would be wholly inappropriate in light of the Committee's findings and the lack of remediation and insight demonstrated by Mr Guirguis.

The Committee considered that a reprimand might be indicated if Mr Guirguis had shown full remediation and insight. However, he shows only limited insight and has not demonstrated any remediation to this Committee.

The Committee next considered whether to direct that Mr Guirguis's registration be made subject to his compliance with conditions. Mr Singh submitted that conditions would be neither proportionate nor workable. As to workability, he referred the Committee to the order for interim suspension to which Mr Guirguis is currently subject.

The interim suspension was imposed for a period of 18 months from 1 February 2019 in response to the matters before this Committee and to other matters (the details of which the Committee is unaware). Although the interim order would ordinarily be revoked upon the announcement of this determination so far as it relates to the allegations before the Committee, the practical effect is that the interim suspension shall continue (subject to any further review by the Interim Orders Committee) owing to the other outstanding matters to which the interim order relates.

Mr Singh submitted that conditions of practice would be unworkable whilst Mr Guirguis's registration remains subject to an order for interim suspension. Mr Singh submitted that the appropriate sanction in this case is that of suspension. Mr Guirguis, in his written submissions, argues that the Committee should not confine any consideration on sanction to suspension simply because he is currently subject to an interim suspension order.

The Legal Adviser advised the Committee that there was no bar in law in imposing conditions of practice, provided the Committee was satisfied in its judgment that such a sanction is proportionate and workable.

Each case must be decided on its own facts. In the Committee's judgment, the shortcomings in this case are not so serious that suspension is indicated. Having regard to all the circumstances, the Committee decided that suspension would be disproportionate and potentially punitive in the circumstances. Mr Guirguis has engaged in these proceedings to some degree. He has in his representations expressed a willingness to undertake further training and to work to conditions of practice. In the Committee's judgment, conditions are in all the circumstances workable and proportionate.

The Committee reached its decision by first formulating conditions and then measuring the adequacy and proportionality of these against a direction for suspension. In formulating the conditions, the Committee considered any risk which might arise if Mr Guirguis's interim suspension were to be lifted. The Committee did not identify any clinical risk to patients which would require him to work under supervision. The required learning here is not about techniques in clinical practice. It is about the importance of understanding the standards to which the Committee has already referred and understanding the underlying importance behind those standards. That is extra learning which can be acquired within the framework of conditions requiring reflection and learning with the support of a Postgraduate Deanery.

Accordingly, the Committee directs that Mr Guirguis's registration be made subject to his compliance with conditions, which will appear against his name in the Register as follows:

1. He must notify the GDC promptly of any professional appointment he accepts and provide the contact details of his employer or any organisation for which he is contracted to provide dental services and the Commissioning Body on whose Dental Performers List he is included or Local Health Board if in Wales, Scotland or Northern Ireland.

2. He must allow the GDC to exchange information with his employer or any organisation for which he is contracted to provide dental services, and any Postgraduate Dental Dean/Director, reporter, workplace supervisor or educational supervisor referred to in these conditions.

3. At any time he is providing dental services, which require him to be registered with the GDC, he must agree to the appointment of a reporter nominated by him and approved by the GDC. The reporter shall be a GDC registrant.

4. He must allow the reporter to provide reports to the GDC at intervals of not more than three months and the GDC will make these reports available to any Postgraduate Dental Dean/Director, workplace supervisor or educational supervisor referred to in these conditions.

5. He must inform the GDC of any formal disciplinary proceedings taken against him, from the date of this determination.

6. He must work with a Postgraduate Dental Dean/Director (or a nominated deputy), to formulate a Personal Development Plan, specifically designed to address the deficiencies in the following areas of his practice:

    - obtaining and recording of valid consent;
    - effective communication (including discussion and recording of risks and benefits of treatment);
    - a reflection on the impact of his misconduct on Patient A and the reputation of the profession.

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7. He must forward a copy of his Personal Development Plan to the GDC within 3 months of the date on which these conditions become effective.

8. He must allow the GDC to exchange information about the standard of his professional performance and his progress towards achieving the aims set out in his Personal Development Plan with the Postgraduate Dental Dean/Director (or a nominated deputy), and any other person involved in his retraining and supervision.

9. He must meet with the Postgraduate Dental Dean/Director (or a nominated deputy), on a regular basis to discuss his progress towards achieving the aims set out in his Personal Development Plan. The frequency of his meetings is to be set by the Postgraduate Dental Dean/Director (or a nominated deputy).

10. He must inform the GDC if he applies for dental employment outside the UK.

11. He must inform promptly the following parties that his registration is subject to the conditions, listed at (1) to (10), above:

    • Any organisation or person employing or contracting with him to undertake dental work

- Any locum agency or out-of-hours service he is registered with or applies to be registered with (at the time of application)
- Any prospective employer (at the time of application)
- The Commissioning Body on whose Dental Performers List he is included or seeking inclusion, or Local Health Board if in Wales, Scotland or Northern Ireland (at the time of application)

12. He must permit the GDC to disclose the above conditions, (1) to (11), to any person requesting information about his registration status.

The period of conditional registration shall be for 12 months to allow Mr Guirguis sufficient time to demonstrate remediation. The conditions shall be reviewed prior to their expiry.

The Committee now invites submissions on the question of an immediate order."

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06 December 2019

"The Committee is satisfied that it is necessary for the protection of the public and is otherwise in the public interest to order under section 30(2) of the Dentists Act 1984 that Mr Guirguis's registration be made subject to his compliance with the above conditions forthwith. There is a risk of repetition in relation to valid consent and it would also be inconsistent with the decision the Committee has reached on the wider public interest not to make an immediate order.

The effect of this order is that Mr Guirguis's registration shall be made conditional forthwith. Unless he exercises his right of appeal, the substantive 12 month period of conditional registration will commence 28 days from when notification of this decision is served on him. Should he exercise his right of appeal, this immediate order shall remain in force pending the disposal of the appeal.

Mr Guirguis's registration is already subject to an interim order of suspension made in relation to matters which are not before the Committee as part of these proceedings. The interim suspension therefore continues in force so far as it relates to those other matters. This Committee decided that the fact that an interim suspension order remains in place does not alter the requirement for the immediate conditional registration. The interim suspension order may be reviewed by a separate Committee.

That concludes the hearing."