Milerman v General Dental Council

[2019] EWHC 2378 (Admin)

Queen's Bench Division, Administrative Court (London)

Murray J

9 September 2019

Judgment

Mr Nicholas Peacock (instructed by **RadcliffesLeBrasseur**) for the **Appellant**

Mr Sandesh Singh (instructed by **Capsticks Solicitors LLP**) for the **Respondent**

Hearing date: 14 March 2019

- -

Approved Judgment

Mr Justice Murray :

Introduction

1. The appellant, Dr Marjana Milerman, appeals against an order made on 1 November 2018 by the Professional Conduct Committee ("PCC") of the respondent, the General Dental Council ("GDC"), that her registration should be suspended for six months. She appeals by right pursuant to section 29 of the Dentists Act 1984.

2. Dr Milerman qualified as a dentist in 2003 in Estonia. She was first registered as a dentist with the GDC in 2004. At all material times she practised dentistry at a practice based in London known as CitySmile ("the Practice").

Background

3. Patient A, as a National Health Service (NHS) patient, attended a number of appointments with Dr Milerman at the Practice during the period from April 2007 to October 2013. Dr Milerman treated her for periodontal disease. During this period, Patient A also attended appointments with the hygienist at the Practice for private periodontal care and/or treatment.

4. On 9 August 2013 Patient A wrote a letter to Dr Milerman in which, among other things, she said the following:

"I am writing to share my concern as to the treatment I am receiving from you.

I appreciate that I have gum disease and that both you and the hygienist have been diligent in providing treatments to deal with this.

…

I am concerned as to the fact that I am being asked to pay such amounts on a regular basis. The British Health Foundation and NHS England have advised me that deep cleaning is available from my dentist under the NHS. If these treatments are clinically necessary then you need to provide the treatments under the NHS and I would like to be reimbursed for the deep cleaning that I have been made to pay for privately with you."

5. By letter dated 23 August 2013 Dr Milerman responded to Patient A's letter, acknowledging her dissatisfaction and explaining the approach that Dr Milerman had taken to treating her, including her recommendation that Patient A see a dental hygienist on a regular basis. She continued:

"I sympathize with your circumstances and as a gesture of goodwill I can refund you the money that you have paid for private deep cleaning, *but all your hygienist visits were necessary and they are not available on the NHS here at CitySmile, therefore cannot be refunded.*" (emphasis added)

6. On 13 June 2014 Patient A made a complaint against Dr Milerman to the GDC. The GDC undertook an investigation of Dr Milerman's practice, during the course of which the GDC identified a number of clinical failings by Dr Milerman in respect of a number of other patients over a period of years, as well as allegations of dishonesty in respect of her dealings with Patient A. We are principally concerned with the latter on this appeal.

The proceedings before the PCC

7. After a series of adjournments by the GDC's Investigation Committee in 2015 and 2016 and a Preliminary Hearing in July 2017, the PCC commenced a hearing 16 July 2018 that was listed for 10 days. The hearing was to consider a lengthy set of allegations involving 12 patients, set out in 38 heads of charge ("HoC"). The panel of the PCC conducting the hearing was comprised of a dentist, who acted as Chair, and two PCC members, one a dental care professional and the other a lay member. The PCC was assisted by a Legal Adviser. A Committee Secretary was also in attendance.

8. HoC 1 to 26 concerned Patient A, while the remaining HoC concerned the other 11 patients. Of the charges in respect of Patient A, HoC 20 and 22b and HoC 24 and 26b alleged dishonesty, while HoC 25 alleged a failure by Dr Milerman to obtain Patient A's informed consent.

9. Following a pre-hearing meeting between the GDC's expert witness, Dr David Igoe, and Dr Milerman's expert witness, Dr Sharon Caro, a number of charges were withdrawn at the start of the hearing, and Dr Milerman admitted a large number of the remaining allegations.

10. Dr Milerman appeals only against:

i) the PCC's findings of dishonesty in relation to HoC 20, 22b, 24, 25 and/or 26 relating to Patient A; and

ii) the consequential determinations made by the PCC, including:

a) its finding that Dr Milerman's fitness to practise was impaired; and

b) its imposition of the sanction of six months' suspension.

11. I have set out HoC 19 to 26 in the Annex to this judgment.

12. In relation to these HoC, the GDC's case against Dr Milerman was that Patient A, being an exempt NHS patient, was entitled to a “non-contributory” (that is, free) NHS treatment option for all treatment that was considered clinically necessary, but, as a result of Dr Milerman's failure to provide Patient A with that option, which was both misleading and dishonest, Patient A paid for treatment by the hygienist at the Practice (HoC 20 and 22b) and she paid for some deep cleaning by Dr Milerman privately (HoC 24 and 26). In addition, the GDC alleged that Dr Milerman also failed to obtain Patient A's informed consent in relation to the periodontal care or treatment carried out privately by the hygienist (HoC 21) and failed to obtain her informed consent in relation to the deep cleaning carried out by Dr Milerman privately (HoC 25).

13. In relation to HoC 19 to 22, Dr Milerman accepted that Patient A was entitled to free dental treatment for clinically necessary treatment. She did not claim to have offered Patient A, as an NHS patient, free hygienist or other treatment. She admitted that she had not made such an offer. The question for the PCC was why she had not done so. The GDC invited the PCC to conclude that her omission was deliberate and therefore dishonest. Dr Milerman's position was that she had misunderstood the relevant NHS regulations.

14. In relation to HoC 23 to 26, Dr Milerman did not accept that she had not given Patient A an NHS option. She relied on a record she made on 20 November 2012 where she had made the following note in relation to her treatment of Patient A: “to have deep clean in pract[ice] or hospital (NHS)”. The issues for the PCC were whether Dr Milerman had omitted to advise Patient A of an NHS option and, if so, why.

15. Stage1 of the proceedings before the PCC involved its assessing the factual and expert evidence in order to make findings of fact. Stage 2 of the proceedings involved:

i) its decision on whether the facts found amounted to misconduct;

ii) if so, whether Dr Milerman's fitness to practise was impaired; and

iii) if her fitness was impaired, what the appropriate sanction should be.

16. During stage 1 of the proceedings, the PCC considered a large amount of documentary material, including patient records and expert reports. Patient A did not attend to give evidence. The PCC heard oral evidence as to matters of fact from Mr Leo Mashensky, the owner of the Practice, and from Dr Milerman. It also heard oral evidence from the expert witnesses, Dr Igoe and Dr Caro.

17. Mr Mashensky prepared a witness statement dated 11†August 2017 for the PCC proceedings. Among other documents, he exhibited to his witness statement two versions of each of two Practice Protocols, one dealing with periodontal care and one with referrals to a hygienist. In each case, he produced the version of the Practice Protocol that was in effect between 2007 and 2013 and the version current at the time of his witness statement. It was suggested to the PCC on Dr Milerman's behalf that the later versions had been drafted to clarify the issue that had arisen between Dr Milerman and Patient A, supporting her contention

that she had simply misunderstood that the NHS Regulations required Patient A to be given an NHS option.

18. The PCC found Mr Mashensky's evidence to be unreliable, evasive and inconsistent, but also not directly relevant to the issues which it had to consider. The PCC noted that he had given evidence about when the different Practice Protocols became effective within the Practice. The PCC noted that the Practice Protocols "simply reflected what was required of those working in the practice under NHS regulations in force at the time".

19. In relation to the evidence of Dr Milerman, the PCC said the following in in its stage 1 findings:

"The Committee considered your evidence carefully. It bore in mind that this is the first time your fitness to practise has been called into question and took this into account in your favour both in terms of your propensity to act as alleged, and in terms of your credibility as a witness. Having done so, however, it concluded that your oral evidence was of limited assistance and particularly lacked credibility. For example, in your evidence you explained to the Committee that you carried out a full assessment of probing depths for every patient at every examination using a Williams probe, and then converted this into a BPE score. Given the time that this would take to complete, the Committee considered this evidence to be incredible.

The Committee noted that most of your answers appeared to be based on what you said you would normally do in clinical practice, as opposed to what actually happened in each patient's case. This suggested to the Committee that you did not have a good recall of events. Further, in some instances, the Committee noted that you appeared to change your explanation or rationale for the treatment provided. On occasions you appeared to amend your evidence to align with the evidence of the expert witnesses. You also gave oral evidence which was not consistent with your written evidence. The Committee was also concerned that you claimed to remember all the details of consultations where you had seen a patient for a short period of time, many years ago and in a busy NHS practice. For all these reasons the Committee found you not to be a credible or reliable witness."

20. The PCC found both experts to be helpful and thorough, but on the whole preferred the evidence of Dr Igoe, which they considered more balanced, considering that the evidence of Dr Caro was at times "over generous" to Dr Milerman. The experts each prepared reports, as well as a joint report, and there was substantial agreement between them.

† 21. On 23 July 2018, which was day 6 of the stage 1 proceedings, the taking of evidence was completed. Mr Sandesh Singh, representing the GDC, as he does on this appeal, then made closing submissions to the PCC, followed by Mr Nicholas Peacock, representing Dr Milerman, as he, too, does on this appeal. The Legal Adviser gave her legal advice to the PCC, dealing with burden and standard of proof, the test for dishonesty, the proper approach to expert evidence and other relevant matters. The hearing was then adjourned so that the PCC could begin its deliberations in camera.

† 22. The hearing briefly reconvened in open session on 27 July 2018 to indicate that the PCC would need more time to complete its deliberations and that therefore the hearing would not reconvene in open session until the end of October 2018.

23. On 30 October 2018 the hearing was reconvened, and the PCC handed down its stage 1 findings of fact. At the reconvened hearing, the GDC was represented by Mr Gareth Thomas and Dr Milerman by Mr Peacock. It found proved the allegations in respect of dishonesty set out in HoC 20 and 22b and in 24 and 26b as well as the allegation in respect of failure to obtain informed consent set out in HoC 25.

24. On 31 October 2018 the PCC proceeded to stage 2, considering further documentary material provided on behalf of Dr Milerman and various reports that Dr Igoe had prepared dealing with Dr Milerman's remediation of the areas of her clinical practice where she had admitted or been found to have clinical failings. Mr Thomas for the GDC and Mr Peacock for Dr Milerman each made submissions in relation to the stage 2 issues. The Legal Adviser then gave the PCC advice on the law applicable to allegations of dishonesty against a professional in regulatory proceedings.

25. On 1 November 2018 the PCC announced its determination that Dr Milerman's fitness to practise was impaired and suspended her registration for six months. The PCC decided that the suspension would not take effect immediately, but instead only once any appeal had been determined or otherwise 28 days after it was handed down.

26. Dr Milerman filed her Appellant's Notice on 26 November 2018, which was in time, and therefore the suspension has not yet come into effect.

The legal framework and principles to be applied

27. There is no disagreement as to the legal framework that applies to the determination of this appeal under the Dentists Act 1984. The core principles were helpfully summarised by Haddon-Cave J in *Wasu v GDC* [2013] EWHC 3782 (Admin) at [16]-[18] and can be found in other recent authorities. In *Monibi v GDC* [2014] EWHC 1911 (Admin) at [4] to [12], Stuart-Smith J adopted the summary of principles in *Wasu* and made helpful additional observations. A key point to note is that an appeal pursuant to section 29 of the Dentists Act 1984 is by way of rehearing, albeit on constrained grounds. I have not heard any evidence afresh. The evidence that I have reviewed includes a full transcript of the hearing below.

28. The question for this appeal is whether the decision of the PCC in relation to the allegations of dishonesty against Dr Milerman was wrong. This involves a rehearing amounting to a review of the material and evidence before the PCC. As the PCC's findings of fact depend on its judgment about the reliability and truthfulness of witnesses who gave evidence to it, those findings should be accepted unless material errors are shown: *Wasu* at [8].

29. As noted by Stuart-Smith J in *Monibi* at [9], the burden upon the appellant and the standard to be applied by the appellate court in an appeal of this kind was set out by Leveson LJ in *Southall v GMC* [2010] 2 FCR 77 at [47]:

"… findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, are virtually unassailable (see *Benmax v Austin Motor Co Ltd* [1955] AC 370); more recently, the test has been put that an appellant must establish that the fact-finder was plainly wrong (per Stuart-Smith LJ in *National Justice Cia Naviera SA v Prudential Assurance Co Ltd (The Ikarian Reefer)* [1995] 1 Lloyd's Rep 455 at 458). Further, the court should only reverse a finding on the facts if it 'can be shown that the findings … were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread' (per Lord Hailsham of St Marylebone LC in *Libman v General Medical Council* [1972] AC 217 at 221F more recently confirmed in *R (Campbell) v General Medical Council* [2005] 1 WLR 3488 at [23] per Judge LJ)."

30. I also bear in mind that where the question is what inference is to be drawn from specific facts, as the appellate court I am under less of a disadvantage relative to the PCC, and I may draw any inferences of fact that I consider are justified on the evidence: *GMC v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438 (Divisional Court) at [40(iv)]. I also bear in mind that dishonesty is a matter of inference from primary findings of fact, in relation to which the degree of deference I need to show to the PCC's findings is diminished: *Jagjivan* at [40(vi)].

31. The GDC bore the burden of proof in the proceedings before the PCC. The standard of proof was the civil standard, namely, the balance of probabilities.

32. I bear in mind for purposes of this appeal the need for the tribunal to give adequate reasons, consistent with the principles set down by Lord Brown of Eaton-under-Heywood in *South Buckinghamshire DC v Porter* [2004] UKHL 33, [2004] 1 WLR 1953 (HL) at [36]. The case concerned a planning decision, but the principles set down by Lord Brown are clearly capable of applying more broadly.

33. As noted by Stuart-Smith J in *Monibi* at [12], the GDC's published Guidance for the PCC at paras 43 to 45, where it deals with the need for the PCC to give adequate reasons, is consistent with the principles set down by Lord Brown. Although there was no evidence on the point (presumably because it did not give rise to any disputed point), it is reasonable to assume that the PCC Guidance in effect at the time of the PCC proceedings concerning Dr Milerman was substantially the same as the Guidance set out in *Monibi* at [11].

34. Mr Singh cited additional authorities that are consistent with the authorities I have already mentioned, including *Lavis v NMC* [2014] EWHC 4803 (Cobb†J) at [17] (fact-finding is a multifactorial process, evaluating evidence is essentially impressionistic and the fact-finding tribunal has a significant advantage over an appellate court) and *Antony v NMC* [2018] EWHC 2796 (Lambert J) at [18].

35. In relation to reasons for decisions given by a professional disciplinary committee, Mr Singh referred to *Lavis* at [22] to [24] (the parties should know why they have won or lost but there is no need for the committee to refer to every piece of evidence or argument advanced) and *Jenyo v NMC* [2016] EWHC 1708 (Admin) (Andrews J) at [44] to similar effect.

36. As to whether a practitioner's fitness to practise is impaired, Mr Singh referred to *Bawa-Garba v GMC* [2018] EWCA Civ 1879 at [60] to [67] (Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Lady Justice Rafferty). Relying on these passages in *Bawa-Garba*, Mr Singh submitted that a professional disciplinary committee's decision on the question of a practitioner's fitness to practise is an “evaluative decision” that should only be overturned if there was an error of principle or the evaluation was “wrong” in the sense that it fell outside the bounds of what the committee could properly and reasonably decide.

37. As to the role of a professional disciplinary committee such as the PCC, Mr Singh referred to *Council for the Regulation of Health Care Professionals v GMC and Ruscillo* [2004] EWCA Civ 1356, where Lord Phillips of Worth Matravers MR noted at [80] that:

“The disciplinary tribunal should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and that the relevant evidence is placed before it.”

38. Mr Peacock did not disagree with this, but noted that the proceedings nonetheless remain adversarial, and it is no part of the PCC's role to take on the functions of a prosecutor. He made this point in relation to part of the PCC's reasoning in respect of HoC 24. I will come back to this point in due course.

39. Finally, in relation to the assessment of impairment of fitness to practise, Mr Singh outlined the following principles:

i) the over-arching objective of the GDC is the protection of the public: section 1(1ZA) of the Dentists Act 1984;

ii) in pursuing the over-arching objective, the GDC has the following more specific objectives under section 1(1ZB) of the Dentists Act 1984:

"(a) to protect, promote and maintain the health, safety and well-being of the public;

(b) to promote and maintain public confidence in the professions regulated under this Act; and

(c) to promote and maintain proper professional standards and conduct for members of those professions";

iii) when assessing whether fitness to practise is impaired, it will be necessary to consider not only whether any misconduct is easily remediable, has been remedied and the likelihood of its being repeated, but also the wider public interest, namely, whether public confidence in the profession would be undermined if a finding of impairment were not made: *Council for Healthcare Regulatory Excellence v NMC and Grant* [2011] EWHC 927 (Admin) (Cox J) at [66] to [74] and endorsing at [76] the factors outlined by Dame Janet Smith DBE at para†25.67 of her Fifth Report on the Shipman Enquiry (9 December 2004); and

iv) the disciplinary tribunal must consider the wider public interest regardless of whether the alleged misconduct is clinical or non-clinical, and even where clinical failings have been remediated, it is open to the tribunal to conclude that the clinical failings were so serious that even the accepted remediation is not enough to enable it to uphold the public interest without a finding of impairment: *Odoi-Asare v NMC* [2014] EWHC 1151 (Admin) (Supperstone J) at [46] to [47].

40. I do not understand Mr Peacock to have disagreed with these submissions on the law, which I note and accept.

41. An important change in the law since the decisions in *Monibi* and *Wasu* was made by the Supreme Court in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67, [2018] AC 391 where the second limb of the two-limb test of dishonesty that was set out in *R v Ghosh* [1982] QB 1053 (CA) was disapproved. In the judgment of Lord Hughes (with which all the other JSCs agreed) at [74]:

"When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."

42. The PCC in its original findings of fact, in relation to the objective part of the test, judged the honesty or dishonesty of Dr Milerman's conduct by the standards of "ordinary and honest members of the dental professions" rather than the standards of "ordinary decent people".

43. At the beginning of the stage 2 proceedings, Mr Gareth Thomas, who represented the GDC at the stage 2 proceedings, submitted that the PCC had applied the wrong test by judging Dr Milerman's conduct by the standards of "ordinary and honest members of the dental professions" rather than the standards of "ordinary decent people". Mr Peacock, for Dr Milerman, remained neutral on the point.

44. The legal adviser to the PCC expressed the view that the decision in *Ivey* did not obviate the need for the PCC, as a professional disciplinary body, to judge Dr Milerman's conduct by the standards of fellow dental professionals, but agreed that it would be a practical way forward if the PCC considered whether it would come to a different view applying the standards of

"ordinary decent people". The PCC then reconsidered its factual findings in that light and reached the view that its conclusions as to the relevant charges would not be different on the alternative test.

The grounds of appeal

45. The grounds of appeal are that:

i) the PCC was wrong to find dishonesty proved against Dr Milerman on HoC 20, 22b, 24, 25 and/or 26 (or gave inadequate or incorrect reasons for doing so); and

ii) the PCC was wrong to find that Dr Milerman's fitness to practise was impaired on the basis of the clinical allegations against her (or gave inadequate or incorrect reasons for doing so).

46. Dr Milerman says that, having made these incorrect findings, the PCC's consequential determinations, including imposing the sanction of suspension of her registration, were therefore wrong.

47. Mr Peacock made clear in his submissions that Dr Milerman did not appeal against any other findings of the PCC, including its decision as to her clinical failings in respect of patients other than Patient A. He also made clear that there was no free-standing appeal against the PCC's decision in relation to sanction, should Dr Milerman not succeed on her appeal against the findings of dishonesty.

Was the PCC wrong to find dishonesty proved against Dr Milerman?

HoC 20 and 22b

48 HoC 20 and 22b concern Dr Milerman's provision of periodontal care to Patient A during the period from April 2007 to October 2013. HoC 24, 25 and 26 concern Dr Milerman's providing deep cleaning to Patient A on a private basis on each of 20 November 2012 and 31 May 2013.

49. Mr Peacock submitted that there were a number of critical weaknesses in the PCC's reasoning in support of its finding of dishonesty in relation to HoC 20 and 22b, such that the PCC's conclusion cannot stand. First, the PCC stated in its finding in relation to HoC 20 that:

"The Committee did not accept that discussions had taken place with Patient A about an NHS option because had you done so Patient A would not have had reason to complain."

50. According to Mr Peacock, this showed "an almost complete absence of comprehension of the issues which the PCC had to consider". Dr Milerman had never asserted that she had had any discussion with Patient A during which Patient A was offered non-contributory hygienist treatment. The whole premise of her case was that no such discussion had taken place, the issue being *why* there had been no such discussion. Furthermore, given that Patient A had not attended to give evidence, it was unwise to speculate on her reason for complaining and then to rely on that speculative reason. In any event, Mr Peacock submitted, a more natural inference as to her reason for complaining could be drawn from the agreed fact that Patient A paid for treatment when she was entitled to free treatment. Even if Patient A had complained on the basis that she had not been offered an NHS option, it would have provided weak support for the GDC's case. Patient†A could simply have forgotten what was discussed.

51. Although HoC 20 does not itself need to be challenged or overturned, Mr Peacock noted that the reasoning above was also relied on by the PCC in reaching its conclusion that Dr Milerman had acted dishonestly. In its findings in relation to HoC 22(b), the PCC said:

“Further the Committee did not accept that discussions took place with Patient A about an NHS referral to the hospital, or NHS treatment at the practice on any date, because had this been the case, Patient A would not have had reason to complain.”

52. Mr Peacock submitted that this flawed reason was an important link in the PCC's chain of reasoning. Mr Peacock noted that the PCC then stated that it had concluded that Dr Milerman must have been aware that periodontal treatment was available on the NHS at the Practice as she had provided it to Patient A on three occasions referred to in its findings on HoC 20, namely, 30 June 2010, 21 July 2010 and 8 September 2010. He submitted that it is unclear how this can possibly have informed the PCC's findings as to dishonesty. HoC 19 to 22 concerned referral of Patient A to a hygienist over a period from 2007 to 2013. Even Dr Igoe had conceded that the tasks undertaken by a dentist and a hygienist are not identical. The hygienist can spend more time with the patient.

53. Mr Peacock submitted that the PCC's reliance on the referral to the hygienist being of financial benefit to Dr Milerman “albeit that this benefit was modest” gives the “regrettable impression” that the PCC simply wished to make an adverse finding against Dr Milerman rather than consider the actual evidence. The evidence was that a referral to the hygienist at the Practice generated a referral fee to the dentist of £11, payable only once however many times the patient saw the hygienist. Dr Igoe had noted in his evidence that a referral to the hygienist also conferred a benefit on Dr Milerman in freeing up time for her to treat other patients and therefore generate more income, although it appeared to be common ground that the financial benefit to Dr Milerman of this was, at best, marginal.

54. Mr Peacock also criticised the PCC for apparently giving no consideration to any possibility other than that Dr Milerman's failure to advise Patient A of her NHS option was deliberate. The PCC, for example, failed properly to consider the Practice Protocols and that they had required correction and clarification, and the PCC failed to consider Dr Milerman's own evidence that she had misunderstood that the NHS Regulations required Patient A to be given an NHS option.

55. Mr Peacock concluded that the reasoning supporting the PCC's conclusion of deliberate dishonesty in relation to 22(b) was deficient and should be overturned.

56. Mr Singh responded to these submissions by, first, noting the very high bar, set by the relevant case law, that Mr Peacock was required to surmount when challenging the factual findings of the PCC. He also noted that the only factual evidence called following the close of the GDC's case was Dr Milerman. Mr Singh further noted that the PCC had made a clear finding that it did not find her to be credible, referring to the passage in the stage 1 findings that I have set out at [19] above.

57. Mr Singh agreed that the PCC's reliance on the fact that Patient A had complained “takes the matter little further”, and he noted that this reason was not advanced by the GDC at the hearing. He submitted, however, that any error by the PCC in this regard was not material. The PCC had given sufficient reasons, without reliance on this point, for its conclusion on HoC 22(b) that Dr Milerman had been deliberately dishonest.

58. Mr Singh noted that it was common ground that Dr Milerman had failed in her duty to provide Patient A with an NHS option for the periodontal treatment that was provided privately by the hygienist at the Practice between 2007 and 2013. It was also common ground that Patient A was entitled under NHS regulations to receive any necessary periodontal treatment at no cost to her. This was confirmed by the expert evidence of Dr Igoe. Mr Singh also noted that Dr Milerman admitted that her failure to provide Patient A with an NHS option for periodontal

treatment meant that she had failed to obtain Patient A's informed consent (HoC 21) and that her failure was misleading to Patient A.

59. Mr Singh submitted that, given the conclusion reached by the PCC as to Dr Milerman's credibility, it was entitled to reject her explanation that she did not appreciate that she was required to provide an NHS option to Patient A. Having rejected that explanation, it was open to the PCC to conclude that her omission was deliberate. The PCC noted in its findings of fact that the clinical records showed that she had carried out periodontal treatment (root surface debridement) on the NHS for Patient A on 30†June 2010, 21 July 2010 and 8 September 2010, which was evidence that Dr Milerman was aware that periodontal treatment was available on the NHS at the Practice. Accordingly, although periodontal treatment was not available on the NHS with the hygienist at the Practice, Dr Milerman could have provided the NHS option to Patient A herself. He submitted that the PCC was entitled to take this into account as supporting its view that her explanation that she had misunderstood the need to provide an NHS alternative to Patient A was not credible.

60. Mr Singh noted that in her evidence during cross-examination, Dr Milerman had agreed that the periodontal treatment carried out on Patient A was necessary. He also noted that he had put it to her during cross-examination that she knew that she could have carried out the periodontal treatment on the NHS, because she had, in fact, done so, and that she had accepted that.

61. Mr Singh accepted that the financial benefit to Dr Milerman in referring a patient to the hygienist privately was modest, but there was nonetheless a benefit. The PCC was entitled to rely on this as providing an incentive for Dr Milerman not to explain to Patient A that the periodontal treatment that was needed could be provided on the NHS by her or another practitioner at the Practice. Mr Singh submitted that, in any event, it was not necessary for any motive to be proved and even the absence of a motive would not have precluded a finding of dishonesty by the PCC: *Alam v GMC* [2015] EWHC 854 (Morgan J) at [9(7)].

62. In relation to the Practice Protocols produced by Mr Mashensky, the PCC was not bound to accept that this evidence provided material support for Dr Milerman's account, particularly given her evidence that she had not seen the Practice Protocols until they were disclosed to the GDC for purposes of the proceedings.

63. In relation to HoC 20 and 22(b), I have to accept that Mr Peacock has not managed to surmount the high hurdle that he must surmount challenging factual findings of a professional disciplinary tribunal on appeal. I agree with Mr Singh that while the PCC's reference to the fact that Patient A complained does not take the matter forward, the PCC provided sufficient reasons for its conclusion that Dr Milerman's failure to provide Patient A with an NHS option was deliberate and therefore dishonest, by the standard of ordinary and honest members of the dental profession (and of ordinary decent people). I reject Mr Peacock's submission that the PCC's reference to the fact that Patient A complained is an essential link in the PCC's reasoning such that, without this reason, their determinations in HoC 20 and 22(b) cannot stand.

64. While this will be of scant comfort to Dr Milerman, I was somewhat uneasy with the relatively short treatment in the PCC's stage 1 findings of the question of the benefit to her of her conduct alleged in these HoC, given the paltry financial advantage to Dr Milerman. I accept, however, that the PCC is not required to establish Dr Milerman's motive before reaching a conclusion on dishonesty (*Alam* at [9(7)]). Had there been a striking lack of a motive, that might have been a point in Dr Milerman's favour, although not, of course, determinative. Bearing in mind the significant advantage that the PCC had over this court in relation to fact-finding (*Wasu* at [17], *Lavis* at [17] and *Antony* at [18]) and the standard that I must apply as the appellate court (*Southall* at [47], but bearing in mind *Jagjivan* at [40(iv) and (vi)]), and despite the

attractive submissions of Mr Peacock, who in my view made the strongest possible case for Dr Milerman given the evidence and the findings of the PCC, I cannot conclude that the conclusion reached by the PCC in relation to HoC 22(b) is plainly wrong.

65. For the reasons given above, I must uphold the PCC's findings on HoC 20 and 22(b).

HoC 24, 25 and 26

66. As to HoC 24, Mr Peacock submitted that the PCC's reasoning was deficient. Once again, the PCC relied on the fact that Patient A had complained as undermining Dr Milerman's evidence that she had had a discussion with Patient A about referral to an NHS hospital or treatment at the Practice on the NHS. This was not part of the GDC's case, and there was no evidence from Patient A on which to base any conclusion as to her motivation for complaining. It was in this regard that Mr Peacock suggested that the PCC was potentially crossing the line from conducting a proper adversarial proceeding to an improper inquisitorial proceeding.

67. Mr Peacock also criticised the PCC's analysis of the record that Dr Milerman had made of her discussion with Patient A on 20†November 2012, in particular her note “to have deep clean in pract[ice] or hospital (NHS).” The PCC concluded that these words, by virtue of their phrasing, supported its conclusion that there was no discussion by Dr Milerman with Patient A on 31 October 2012 or 20 November 2012 regarding an NHS option for deep cleaning. In its stage 1 findings on HoC 24, the PCC said that these words “clearly [do] not refer to a discussion about treatment already given”.

68. Mr Peacock submitted that it was never put to Dr Milerman by the GDC or by the PCC itself as to what that record could have meant if it did not refer to a discussion between Dr Milerman and Patient A. The GDC had not suggested that the entry was itself dishonest or other than contemporaneous. Dr Milerman's case was that her failure to record a reference to such a discussion on 31 October 2012 was due to her poor record-keeping. Dr Milerman's poor record-keeping was a large part of the GDC's case against her in respect of clinical failings. As Dr Milerman noted in her evidence, these only began to be remedied after Dr Milerman had long since ceased to treat Patient A. Mr Peacock submitted that the PCC did not give adequate consideration to her explanation.

69. Mr Peacock criticised the following passage in the PCC's stage 1 findings of fact in respect of HoC 24:

“In addition, in your letter to Patient A, dated 23†August 2013, you wrote: 'I can refer you to the hospital if you prefer or can continue treating you here at CitySmile. The choice lies with you.' The Committee noted that there was no mention of a previous discussion regarding referral to the hospital in your letter or the fact that the patient had declined this option. The Committee was aware that you knew you could have completed this treatment for Patient A on the NHS, as you had done so previously.”

70. Mr Peacock said that this was not part of the case against Dr Milerman and it was not put to her. He also criticised the words “as you had done so previously”, saying that the reference to what she “had done … previously” was unclear. Dr†Milerman had not considered or discussed referring Patient A to hospital before. She was discussing referral now because the treatment that she had attempted was not bearing fruit. The PCC appears to have ignored this evidence and argument. In his skeleton argument at para 29.3, Mr Peacock asked rhetorically: “if the words 'had done so previously' refer to something else, then what?”

71. Mr Peacock noted that the finding in respect of HoC 25 is based on the finding in respect of HoC 24 and subject to the same criticisms. As to HoC†26(a) and 26(b), Mr†Peacock's submissions were:

i) the factual premise for the finding of dishonesty in HoC 26(b) is the PCC's finding as to HoC 24, so that if HoC falls away, then so does the finding of dishonesty;

ii) the finding of dishonesty in HoC 26(b) is flawed for the same reasons that the finding of dishonesty in HoC 22(b) is flawed; and

iii) the PCC chose not to apply its mind to the agreed expert evidence that where a patient declined an NHS referral option, a dentist could legitimately treat the patient on a private basis.

72. Responding to these submissions, Mr Singh noted first that it was common ground, supported by the expert evidence, that if a specialist referral to an NHS hospital was justified in relation to Patient A and if Patient A refused such a referral, then Dr Milerman was entitled to go on to provide the necessary treatment privately. Dr Milerman gave evidence that this was her understanding of the relevant NHS regulations at the time. While the experts agreed with this principle, they disagreed as to whether the threshold for referral had reasonably been reached in Patient A's case, Dr Igoe considering that it had not been reached and Dr Caro considering that it had.

73. Mr Singh noted that the PCC expressly rejected Dr Milerman's evidence that she had offered an NHS referral to Patient A on 31 October 2012 and each subsequent appointment, which Patient A declined. The PCC noted that Dr Milerman made no mention of such a discussion in her notes for the appointments of 31†October 2012 and 31 May 2013 and had said “to have deep clean in pract or hospital (NHS)” in her notes for the appointment on 20 November 2012, which could not, in the PCC's view, be interpreted as referring to a discussion of an NHS referral that had been had prior to the deep cleaning given by Dr Milerman on that occasion, much less as supporting Dr Milerman's evidence that she had offered an NHS referral on the prior occasion, 31 October 2012, or on the subsequent occasion, 31 May 2013.

74. Mr Singh noted that there is no mention in the notes for any of those three dates of Patient A having refused a referral. He also noted that the PCC expressly rejected Dr Milerman's explanation that her failure to record that discussions concerning an NHS referral had occurred on 31 October 2012 was due to her poor record-keeping, which the PCC was entitled to do in view of the conclusion it had drawn as to her credibility as a witness. He also submitted that the PCC had given a sufficient reason for rejecting Dr Milerman's explanation that the note she made on 20 November 2012 supported her case that she had discussed an NHS referral with Patient A on that date. It was reasonable for the PCC to conclude from the wording of the note that it did not refer to a discussion that had already been had.

75. Mr Singh accepted once again that the PCC's reliance on the fact of Patient A's having complained to support its conclusion regarding that Dr Milerman had not had discussions on any of the three dates with Patient A about an NHS referral did not take the matter further, and he noted that this was not part of the GDC's case. But he submitted that the error, if it was one, was not material, and the PCC's other reasons were sufficient to justify their conclusion on HoC 24. Mr Singh submitted that the PCC was entitled to rely on the letter of 23 August 2013 that Dr Milerman had written to Patient A and the absence in that letter of a reference to her having offered either an NHS option for deep scaling in the Practice or of a specialist referral to an NHS hospital.

76. Noting that Dr Milerman's challenges to HoC 25 and 26(a) rely on its criticisms of HoC 24 (there being no free-standing ground of appeal in relation to either of them), Mr Singh submitted in relation to the finding of dishonesty in HoC 26(b) that it was clear that the words “you had done so previously” in the PCC's reasoning on HoC 26(b) (in the excerpt that I have set out at [69] above) referred to Dr Milerman have previously carried out deep scaling treatment on Patient A on the NHS on a number of occasions. It was not a reference to discussions concerning referral to an NHS hospital.

77. Mr Singh submitted that the PCC was entitled to conclude that Dr Milerman was “fully aware” that the necessary periodontal treatment could be carried out at the Practice on the NHS because she had provided the treatment herself to Patient A previously. The PCC was entitled to conclude that, despite that knowledge, she provided the treatment to Patient A privately. Taking into account the PCC's view of Dr Milerman's credibility and its rejection of her evidence that she had discussed an NHS referral with Patient A, it was open to the PCC to conclude that Dr Milerman's failure to discuss an NHS option with Patient A in respect of the treatment provided on 20 November 2012 and on 31 May 2013 was deliberate and therefore dishonest, applying the test in *Ivey*.

78. In relation to the PCC's conclusions on HoC 24 and 26(b), I am satisfied that the PCC has given adequate reasons for reaching its conclusion that Dr Milerman failed to offer Patient A an NHS option for deep cleaning at the Practice, for rejecting Dr Milerman's account that she did discuss an NHS referral with Patient A on any of the three dates considered by the PCC in relation to these HoC (namely, 31 October 2012, 20 November 2012 and 31 May 2013) and for concluding that Dr Milerman's failure to obtain Patient A's informed consent to deep cleaning on the NHS on each of 20 November 2012 and 31 May 2013 was deliberate and therefore dishonest by the standards of ordinary and honest members of the dental profession (and of ordinary decent people).

79. As to the words “had done so previously” in the PCC's stage 1 findings of fact on HoC 24, I agree with Mr Singh that the words clearly refer to Dr Milerman's having previously provided periodontal treatment to Patient A on the NHS rather than to a discussion of referral to an NHS hospital or some other matter. Mr Peacock had submitted that the finding of dishonesty in HoC 26(b) was flawed for the same reasons that the finding of dishonesty in HoC 22(b) was flawed. Just as I have rejected those reasons and upheld the finding in HoC 22(b), I find, contrary to Mr Peacock's submissions, that I cannot say that the PCC's conclusion on HoC 26(b) is plainly wrong. I accept that the reliance on the fact that Patient A complained does not, in fact, provide material support for the PCC's conclusions, but I find that the other reasons given by the PCC are sufficient to justify their conclusions on HoC 24 and 26(b), bearing in mind the standard that I must apply at this appellate stage. As the conclusions in HoC 25 and 26(a) rely on the HoC 24, it follows that I uphold those findings as well.

80. Mr Peacock confirmed in his skeleton argument that there was no free-standing appeal against sanction should the findings of dishonesty be found proved. Accordingly, I turn to the remaining issue.

Was the PCC wrong to find that Dr Milerman's fitness to practise was impaired on the basis of her clinical failings?

81. Arguably this issue is academic given that I have upheld the PCC's findings of dishonesty. However, as it was fully argued and has some relevance to the sanction imposed, I consider that it may be useful to address it.

82. Having made its stage 1 findings in which, in addition to the HoC that are the subject of this appeal, Dr Milerman admitted and/or had proved against her numerous clinical failings, in relation a number of patients, the PCC went on to make its stage 2 findings in relation to matters of misconduct, impairment and sanction. The PCC reminded itself of the following principles:

“The Committee reminded itself of the GDC's overarching objective to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession.

The Committee considered the well-known comments of Lord Clyde in the case of *Roylance v GMC (No 2)* [2000] 1 AC 311 where he said that misconduct was 'A word of general effect involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.' The Committee reminded itself that any breach of the standards must be serious.

The Committee considered what constitutes DPP [deficient professional performance] and bore in mind the decision of Jackson J in *Calheam v GMC* [2007] EWHC 2606 (Admin) where he stated that deficient professional performance connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the professional's work."

83. The PCC assessed the HoC relating to clinical failings by reference to the GDC's *Standards for Dental Professionals* published in 2005 on the basis that the vast majority of the HoC fell to be considered under those standards. The PCC considered that the clinical failings admitted or found proved were wide-ranging, related to multiple patients and occurred over a significant period of time.

84. The PCC found that a number of the relevant standards had been breached, with the expert witnesses finding that Dr Milerman's clinical practice fell "below" or, in some cases, "far below" the standard expected in a number of areas. The failures were considered to have caused harm to her patients and to have had the potential to cause "further risk of significant harm" to her patients. The PCC noted that both expert witnesses agreed that Dr Milerman's clinical failings considered cumulatively amount to a significant departure from the standard expected. The PCC accepted this conclusion and determined that Dr Milerman's clinical failings were so serious as to amount to misconduct. Having reached that conclusion, the PCC noted that her clinical failings were therefore also capable of amounting to DPP.

85. The PCC then noted in its stage 2 findings the steps taken by Dr Milerman to remedy her misconduct in respect of her clinical failings. In this respect, the PCC had regard to three reports prepared by Dr Igoe dated 24 March 2017, 27 July 2017 and 2 November 2017, respectively, commenting on the extensive steps taken by Dr Milerman to remediate the deficiencies in her past clinical practice. In his report dated 27 July 2017 Dr Igoe stated that "the standard of remediation evidenced in the bundle is of a very high standard", and in his final report dated 2 November 2017 Dr Igoe stated that "there are no concerns that these changes have not been embedded in her clinical practice" and that the outstanding concerns he had identified in an earlier report had been addressed.

86. As a result of this evidence, the PCC concluded that Dr Milerman had taken sufficient steps to remedy her misconduct in respect of the clinical failings, having engaged in focused and targeted remediation. The PCC was satisfied that she had remedied the deficiencies, that there was little risk of repetition and there was no need for the PCC to make a finding of current impairment on the grounds of public protection in relation to her admitted and proven clinical failings.

87. The PCC did, however, conclude that it was nonetheless necessary to make a finding of impairment of fitness to practise in order to uphold standards in the profession. The PCC's conclusion was as follows:

"The Committee considered that the nature of your clinical failings were basic, wide-ranging, persisted over a significant period of time, resulted in patient harm and put patients at risk of further harm. In these circumstances it concluded that a finding of impairment was required,

despite your complete remediation, to declare that your serious failings were not acceptable and to uphold standards in the profession."

88. Mr Peacock submitted that the PCC was wrong to find that Dr Milerman's fitness to practise was impaired given its acceptance that, through her own extensive efforts, as confirmed by Dr Igoe, she had completely remediated those failings and embedded the necessary changes in her clinical practice. The matters the PCC referred to as support for their finding of impairment were obviously relevant to a finding of misconduct or DPP, but as Dr†Milerman's clinical failings were completely remediated, the only justification for a finding of current impairment is the public interest.

89. Mr Peacock submitted that *Chaudhary v GMC* [2017] EWHC 2561 (Admin) supports the proposition that the various elements of the public interest (as set out in section 40A(4) of the Medical Act 1983, which corresponds fairly closely to section 1(1ZB) of the Dentists Act 1984, which applies in this case) should at least be weighed equally in the balance, whereas the PCC appears not to have done that. Instead, the PCC decided that the perceived need to declare and uphold proper standards appears to have outweighed the exceptional nature of the remediation work undertaken by Dr Milerman in this case.

90. In response to Mr Peacock's submission that *Chaudhary* supports the proposition that the various elements of the public interest should be weighed equally in the balance, Mr Singh submitted that what Jay J held in that case is simply that "a proper balance of all three elements of the tri-partite public interest must be undertaken". The reference to the "tri-partite public interest" is to the three objectives set out in section 40A of the Medical Act 1983, which, as I have noted above, correspond to the three objectives for the GDC set out in section 1(1ZB) of the Dentists Act 1984.

91. I agree with Mr Singh. The weight to be given to each of these elements is a matter for consideration by the relevant tribunal having regard to the particular circumstances of the case. The PCC determined in this case that despite the exceptional nature of the remediation work undertaken by Dr Milerman (for which she is to be commended) and despite the PCC's conclusion that there was little risk of repetition of her past clinical failings such that no issue of public protection arises, nonetheless Dr Milerman's misconduct meant that it could not uphold the public interest without a finding of impairment.

92. In my view, there was nothing wrong with the approach taken by the PCC to the issue of whether Dr Milerman's fitness to practise was impaired, and therefore there is no ground on which I can or should interfere with the PCC's "evaluative decision" in this regard.

Conclusion

93. For the reasons given above, Dr Milerman's appeal is dismissed.

Annex†1

Extract from the PCC's stage 1 determination in relation to Dr Milerman (HoC 19 to 26)

19.	You referred Patient A to a hygienist at the Practice for periodontal care and/or treatment to be provided on a private basis between approximately April 2007 and October 2013. **Admitted and Found Proved**

20.	You failed to provide Patient A with an NHS option for the periodontal care and/or treatment referred to at paragraph 19 above at the Practice. **Admitted and Found Proved In Part** Patient A received private hygienist appointments at the Practice between April 2007 and October 2013, having been referred by you. On 9 August 2013, the patient wrote a letter of complaint to you questioning why the periodontal treatment she had been undergoing had not been made available from you on the NHS. You responded to her letter in a letter dated 23 August 2013, stating that: "I sympathize with your circumstances and as a gesture of goodwill I can refund you the money you have paid for private deep cleaning, but all your hygienist visits were necessary and they are not available on the NHS here at CitySmile, therefore cannot be refunded." The Committee had sight of the clinical records and noted that on 30 June 2010, 21 July 2010 and 8 September 2010, you carried out periodontal treatment on the NHS for Patient A. Nevertheless, you continued to refer Patient A to the hygienist on a private basis. This indicated to the Committee that you were aware that periodontal treatment was available on the NHS at the practice, as you had already provided it. During cross examination, you agreed that "on those three dates, I provided root surface debridement on the NHS." In your written evidence you stated that: "At the time, when I was treating Patient A between 2007 and 2013 and now, the Practice had a hygienist. She always worked privately. The Practice did not hold an NHS contract for a hygienist. Referrals to the hygienist were made either because the patient requested one, or it was the dentist's recommendation following discussion with the patient. It was always made clear to the patient that any treatment by the hygienist would need to be paid for on a private basis. Although Patient A was an NHS exempt patient, following our discussions, she was willing to pay for private hygienist treatment to help with her periodontitis. I accept that had I been aware of my obligation to offer an NHS option at the time, her decision may have been different." The Committee did not accept that discussions had taken place with Patient A about an NHS option because had you done so Patient A would not have had reason to complain. The Committee concluded that while the hygienist at the practice was only available on a private basis, you yourself could have provided the periodontal care and/or treatment to Patient A on the NHS at the practice and you had done so previously. In your written statement you accepted that you failed to provide Patient A with an NHS option save for the three dates identified above and this was clarified during your cross examination. Accordingly, the Committee determined that you had a duty to provide Patient A with an NHS option for periodontal care and you failed to do so save for the three dates identified above. The Committee therefore found this head of charge proved in part.
21.	In the circumstances set out above you failed to obtain Patient A's informed consent for the periodontal care and/or treatment provided by the hygienist on a private basis for some or all of the period between approximately April 2007 and October 2013. **Admitted and Found Proved**
22.	Your conduct at paragraph 20 above was:
(a)	Misleading; **Admitted and Found Proved**
(b)	Dishonest, in that you deliberately failed to inform Patient A of an NHS option for the

	periodontal care and/or treatment referred to at paragraph 19 above at the Practice; **Found Proved** The Committee was referred to and applied the test for dishonesty as set out by the Supreme Court in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. As advised by the Legal Adviser, the Committee first asked itself whether your failure to provide Patient A with an NHS option for periodontal treatment at the practice was deliberate. The Committee noted your written statement regarding hygienist referrals within the Practice, which is quoted at charge 20 above. However, the Committee did not accept that discussions had taken place between you and Patient A about an NHS option for periodontal treatment, as had you done so, Patient A would not have had reason to complain. Further, the Committee concluded that you must have been aware that periodontal treatment was available on the NHS at the practice as you had provided such treatment to Patient A on the three occasions detailed at charge 20. The Committee noted that a referral to the hygienist was of financial benefit to you, albeit that this benefit was modest. For these reasons, the Committee concluded that it was more likely than not that your failure to offer Patient A an NHS option for her periodontal treatment was deliberate. The Committee then went on to ask itself whether this deliberate failure would be considered dishonest by the standards of ordinary and honest members of the dental profession. The Committee was of the view that it is more likely than not that ordinary and honest members of the dental profession would expect that a patient being treated under the NHS would be offered all NHS treatment options available, and a deliberate failure to do so would be dishonest. The Committee therefore concluded that your actions in charge 20 were dishonest and accordingly found this head of charge proved.
23.	On each of 20 November 2012 and 31 May 2013 you provided deep clean/cleaning to Patient A on a private basis. **Admitted and Found Proved**
24.	You failed to provide Patient A with an NHS option for the deep clean/cleaning referred to at Paragraph 23 above at the Practice. **Found Proved** The Committee had sight of the clinical records and noted: ∑†††† 31.10.12 – UL6, UL7 = 8mm 46-6mm pockets ∑†††† 20.11.12 – Local anaesthetic solution Rixocaine. UL6, UL7 deep clean. UL6 is mobile – pocket 8mm 35 – pocket – 6mm. Dentisolon to use interdental brushes. To have deep clean in practice or hospital NHS. ∑†††† 31.5.13 – Local anaesthetic solution lignospan. UL6, UL7 deep cleaning. Dentisolon. TCA 1 x 5 review in 8 days. According to your written statement, Patient A was charged privately for the appointments on 20 November 2012 and 31 May 2013. In your written evidence you stated that: “On 31 October 2012 and at each subsequent appointment Patient A was offered a referral to a periodontal specialist at the hospital (NHS option). This was declined. A record was made on 20 November

	2012. I therefore offered the option of treatment with me, on a private basis, as I understood I was able to do so when a patient refused an NHS option." During cross examination, the reason you gave the Committee for not recording your discussion with Patient A on 31 October 2012, was due to your poor record keeping. However, the Committee did not accept that this discussion took place on 31 October 2012 or 20 November 2012 because of the way in which the record is phrased "to have deep clean in pract or hospital (NHS)" clearly does not refer to a discussion about treatment already given. Further the Committee did not accept that discussions took place with Patient A about an NHS referral to the hospital, or NHS treatment at the practice on any date, because had this been the case, Patient A would not have had reason to complain. In addition, in your letter to Patient A, dated 23 August 2013, you wrote: "I can refer you to the hospital if you prefer or can continue treating you here at CitySmile. The choice lies with you." The Committee noted that there was no mention of a previous discussion regarding referral to the hospital in your letter or the fact that the patient had declined this option. The Committee was aware that you knew you could have completed this treatment for Patient A on the NHS, as you had done so previously. The Committee therefore concluded that it was more likely than not that you did not provide Patient A with an NHS option for the deep clean/cleaning on 20 November 2012 and 31 May 2013. Accordingly, the Committee determined that you had a duty to provide Patient A with an NHS option on 20 November 2012 and 31 May 2013 and that you failed to do so. The Committee therefore found this head of charge proved.
25.	In the circumstances set out above you failed to obtain Patient A's informed consent for deep clean/cleaning to Patient A on a private basis on each of 20 November 2012 and 31 May 2013; **Found Proved** The Committee found in charge 24 above, that Patient A had not been given an NHS option for the treatment completed on 20 November 2012 and 31 May 2013. It therefore concluded that Patient A was consenting to private treatment but not on an informed basis as an NHS treatment was available. Accordingly, the Committee determined that you had a duty to gain Patient A's informed consent for the treatment completed on 20 November 2012 and 31 May 2013 and was satisfied on the balance of probabilities that you failed to do so. The Committee therefore found this head of charge proved.
26.	Your conduct at paragraph 24 above was:
(a)	Misleading; **Found Proved** Having found charge 24 above proved, the Committee found that your conduct in failing to give Patient A an NHS option for deep cleaning treatment was, even if not deliberate (which the Committee considers below), misleading.
(b)	Dishonest, in that you deliberately failed to inform Patient A of an NHS option for the deep clean/cleaning referred to at paragraph 23 above at the Practice. **Found Proved** The Committee was referred to and applied the test for dishonesty as set out by the Supreme

	Court in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. As advised by the Legal Adviser, the Committee first asked itself whether your failure to provide Patient A with an NHS option for the deep clean/cleaning provided to Patient A on 20 November 2012 and 31 May 2013 on a private basis was deliberate. The Committee noted your written statement with regards to your alleged referral of Patient A to an NHS periodontal specialist at the hospital as quoted in charge 24 above. However, the Committee did not accept that discussions took place with Patient A about an NHS referral to the hospital for the reasons set out in paragraph 24 above. The Committee was also aware that you knew you could have completed this treatment for Patient A on the NHS, as you had done so previously. Having determined that you did not discuss an NHS option for deep cleaning treatment with Patient A and that you were clearly aware that you could provide this treatment on the NHS having done so previously, the Committee was satisfied on the balance of probabilities that your failure to offer an NHS option for deep cleaning treatment on 20 November 2012 and 31 May 2013 was deliberate. The Committee then went on to ask itself whether this deliberate failure would be considered dishonest by the standards of ordinary and honest members of the dental profession. The Committee was of the view that it was more likely than not that ordinary and honest members of the dental profession would expect that a patient being treated under the NHS would be offered all NHS treatment options available, and that a deliberate failure to do so would be dishonest. The Committee therefore concluded that your actions at charge 24 were dishonest and accordingly found this head of charge proved.