Record of Determinations - Seychelles Medical and Dental Council

Dentist: SAT-07-20-2-M-5

Date: 10 November 2016

Primary Dental Qualification: Bachelor of Dental Surgery,
The Tamil Nadu Dr. MGR Medical University

Summary of outcome: Serious professional misconduct
Suspension, 12 months
Mandatory training in Health Care Ethics
Mandatory upgrading of knowledge and skills in Oral Surgery

Investigating Committee: The Council convened as the Investigating Committee with the following members present

Dr. Bernard Valentin	Medical Practitioner	Chair
Dr. Susan Fock Tave	Medical Practitioner	Registrar
Dr. Harold Pothin	Dentist	Member
Dr. Velmurugan Chetty	Dentist	Member
Mr. Victor Pool	Layperson	Member
Father Danny Elizabeth	Layperson	Member

In attendance: Ms Maypaule Gallante, Assistant Registrar

Allegations and Finding of Facts

1. That being registered under the Medical Practitioners and Dentists Act 1994, SAT-07-20-2-M-5 performed a tooth extraction on Patient LF, whereby SAT-07-20-2-M-5

    a) Failed to explain the nature of the procedure and the possible complications; **Admitted and proven**
    b) Failed to explain what exactly happened during the procedure; **Proven**
    c) Did not refer Patient LF to a specialist in a timely manner; **Proven**

Procedures

2. (1) The inquiry into the complaint was conducted pursuant to the provisions of the Medical Practitioners and Dentists (Disciplinary Inquiries) Regulations 1995. The Council informed SAT-

07-20-2-M-5 of the complaint in a letter dated 30 August 2016, wherein the substance of the complaint was detailed for SAT-07-20-2-M-5's response.

(2) The complaint as well as SAT-07-20-2-M-5's response were put to the Council for consideration on Thursday 6 October 2016. Based on the evidence supporting the complaint and the determination that the complaint had substance, the Council decided to proceed and to have the matter put before an Investigating Committee pursuant with Section 5(a) of the Medical Practitioners and Dentists (Disciplinary Inquiries) Regulations 1995.

The committee met on Thursday 10 November 2016 in the presence of SAT-07-20-2-M-5, to conduct the inquiry.

Approach

3. In order for the Council to come to a determination, the Council considered each allegation in light of all evidence adduced in this case, including SAT-07-20-2-M-5's own oral and written evidence, the patient's narrative of his experience, his dental records and the report of the internal inquiry of the dental services of Seychelles Hospital.

General Background.

(1) The allegation is related to SAT-07-20-2-M-5's treatment of LF in February 2016.
(2) Mr. Harold Pothin, a senior dentist, took the lead on technical questions.
(3) The Council noted that SAT-07-20-2-M-5 is an experienced dental officer originally from Chennai, India. SAT-07-20-2-M-5 has 22 years' experience as a dentist, having qualified in 1994. SAT-07-20-2-M-5's first appointment in Seychelles was in 2007 for Praslin and La Digue. SAT-07-20-2-M-5 subsequently left Seychelles and came back in 2012. SAT-07-20-2-M-5 has not been involved in any disciplinary procedures previously.
(4) Patient LF presented to the English River Health Centre on 11th February 2016, complaining of tooth ache. SAT-07-20-2-M-5 identified tooth number 26 as the cause of the pain, SAT-07-20-2-M-5 placed a dressing and advised the patient to come back if symptoms persist. Patient LF came back the next day with the same symptoms. SAT-07-20-2-M-5 told the Council that Patient LF was adamant that a tooth extraction be effected and that SAT-07-20-2-M-5 agreed to perform an extraction because he had insisted.
(5) During the course of the extraction the tooth broke and SAT-07-20-2-M-5 had to revert to a surgical extraction, which in turn led to the creation of an oro-antral communication.
(6) Following that incident, SAT-07-20-2-M-5 admitted that he did not refer Patient LF to the Oro-Maxillofacial Surgeon for specialised management. It was only on the second review, eight days, later that SAT-07-20-2-M-5 did refer Patient LF, but only on the his insistence.
(7) Patient LF was still having tooth ache after the oro-antral communication had been successfully attended to. It was later discovered that tooth number 25 was badly caried with pulpal involvement. Endodontic treatment of tooth 25 was carried out by another dentist.
(8) Patient LF is subsequently asymptomatic.

The Council's Decision

4. (1) Upon conclusion of the Inquiry, the Council convened for deliberation and determination of the allegations as levelled against SAT-07-20-2-M-5. After careful deliberation taking into account all the evidence as cited supra at para.3, the Council came to the determination that on 12th February 2016 SAT-07-20-2-M-5

    a) Failed to explain the nature of the procedure and the possible complications; **Admitted and proven**
    b) Failed to explain what exactly happened during the procedure; **Proven**
    c) Did not refer him to a specialist in a timely manner. **Proven**

(2) Furthermore, the Council finds that there is no documented indication for extracting tooth number 26. In SAT-07-20-2-M-5's oral evidence SAT-07-20-2-M-5 stated that on opening the old filling on 11th February, SAT-07-20-2-M-5 found the tooth was quite strong. This is corroborated by SAT-07-20-2-M-5's documentation in the dental records that the cavity was not deep and there was no pulpal involvement. In fact, on questioning, SAT-07-20-2-M-5 denied that there was apical periodontitis, which according to an Oro-Maxillofacial Surgeon on the panel, Dr. Velmurugan Chetty, is a result of a deep carious lesion affecting the root and periapical region, as opposed to generalised periodontitis, which is associated with ageing and degeneration of the periodontal fibres.

(3) Both dentists on the panel, (Dr. Velmurugan Chetty and Dr. Harold Pothin) pointed out that apical periodontitis in a neighbouring tooth could have been the cause of the pain. This could have been confirmed or ruled out by percussion of the neighbouring teeth. Percussion of the affected tooth would have caused a patient to "jump out of the chair in pain" as explained by Dr. Chetty.

(4) SAT-07-20-2-M-5 did not convince the Council that SAT-07-20-2-M-5 was certain that that particular tooth was the source of the pain or that SAT-07-20-2-M-5 performed the necessary investigation to so determine. SAT-07-20-2-M-5 said the previous visits were all related to that particular tooth and even the previous dentist had also treated Patietn LF for the same tooth. SAT-07-20-2-M-5 said he therefore had no reason to doubt that it was the cause of the pain. It is clear to the Council that SAT-07-20-2-M-5 did not at any time consider any other possible cause of the pain.

(5) The Council is concerned that a radiograph had not been done prior to the extraction to aid in the diagnosis and to better plan the management. SAT-07-20-2-M-5 said that had Patient LF not been so adamant SAT-07-20-2-M-5 would have considered a radiograph. In fact, SAT-07-20-2-M-5 said that the Patient LF never gave SAT-07-20-2-M-5 a chance to consider or offer any alternative. SAT-07-20-2-M-5 however failed to document all of this in the dental records.

(6) Dr. Pothin indicated that the standard procedure after a crown fracture, where only the roots are left, is to get a radiograph to assess bone structure, the root pattern, the relationship of the roots to the sinus before proceeding with surgical extraction. SAT-07-20-2-M-5 did not contest that assertion.

It is obvious that SAT-07-20-2-M-5 did not realistically or professionally assess the situation. SAT-07-20-2-M-5 had been wrongly confident that he would be able to complete the surgery without complications.

(7) From SAT-07-20-2-M-5's documentation on the 11th February it is evident that SAT-07-20-2-M-5 had advised the dental extraction if symptoms persist. This is in line with the Patient LF's version of events and contrary to SAT-07-20-2-M-5's statements to the Council as per para. 4(3) supra.

(8) In SAT-07-20-2-M-5's written response SAT-07-20-2-M-5 stated that

> *"Dental EXTRACTION being a basic dental procedure, a common practice among the dental service is to inform the patient ONLY in the event of a crown breakage about the surgical intervention it may require to complete the extraction."*

SAT-07-20-2-M-5 therefore did not find it necessary to explain Patient LF prior to the procedure of any possible complications.

(9) In SAT-07-20-2-M-5's opinion, the tooth broke not because of SAT-07-20-2-M-5's technique, but probably because the cavity had made it structurally weaker. Yet SAT-07-20-2-M-5 did not consider alternative techniques to avoid the possible complication of crown breakage following a conventional extraction, as according to him, he had, in his long career completed more complicated extractions without crown breakage. SAT-07-20-2-M-5 had no reason, therefore, according to him, to modify his approach.

(10) From SAT-07-20-2-M-5's written response and his oral deposition it is clear that SAT-07-20-2-M-5 did not communicate with the patient. SAT-07-20-2-M-5 stated:

> *"Hence, only after the crown breakage, I informed my DSA (Dental Surgery Assistant) that this should be surgically removed which was conveyed to the patient."*

It is evident that SAT-07-20-2-M-5 did not communicate directly with Patient LF, but with the Dental Surgery Assisstant, who then passed the information on to Patient LF. SAT-07-20-2-M-5's usual practice, according to him, is to communicate with the Dental Surgery Assisstant, who is the better person to convey information to patients. SAT-07-20-2-M-5 said he finds it more convenient to communicate with the Dental Surgery Assisstant, even when patients understand English.

(11) The Council noted that SAT-07-20-2-M-5's documentation did not reflect the fact that the treatment had started out as a simple tooth extraction, which was converted to a surgical extraction because the tooth broke. The fact that SAT-07-20-2-M-5 simply wrote surgical extraction done, implies that SAT-07-20-2-M-5 had planned and started with a surgical extraction. Yet that was not the case. Further, there is no mention of the crown fracture.

(12) SAT-07-20-2-M-5 did not record the fact that an oro-antral communication had been created. Neither did SAT-07-20-2-M-5 document what measures SAT-07-20-2-M-5 had taken

to remedy the situation nor SAT-07-20-2-M-5's instructions to Patient LF. SAT-07-20-2-M-5 did not confirm by clinical tests that there was an oro-antral communication.

(13) SAT-07-20-2-M-5 was not able to clearly explain to the panel how he repaired the defect. On closer questioning SAT-07-20-2-M-5 stated he had approximated the buccal and palatal flaps after placing Surgicel (absorbable gel foam) in the cavity, and placed some sutures. This is contrary to the procedure SAT-07-20-2-M-5 described to the panel as appropriate treatment of an oro-antral communication, namely raising a buccal flap and rotating it to cover the defect. SAT-07-20-2-M-5 was not able to tell the panel what kind of sutures SAT-07-20-2-M-5 used. SAT-07-20-2-M-5 referred to catgut sutures, which SAT-07-20-2-M-5 used because silk, SAT-07-20-2-M-5's first choice, was not available. Catgut, however, has been removed from use in the Ministry of Health since more than ten years. SAT-07-20-2-M-5 was unable to state what sutures SAT-07-20-2-M-5 used instead. Neither did SAT-07-20-2-M-5 document the type and calibre of suture used.

(14) SAT-07-20-2-M-5 admitted that SAT-07-20-2-M-5 did not refer Patient LF to the specialist that day because SAT-07-20-2-M-5 was satisfied he had done a good job since he had succeeded in completely removing the tooth.

(15) On 15 February 2016 SAT-07-20-2-M-5 reviewed Patient LF. He reported nasal dripping on and off when leaning forward, but no pain. In SAT-07-20-2-M-5's response to the allegations, SAT-07-20-2-M-5 wrote

> *"The nasal discharge was an expected consequence as the wound cannot heal in just two days of time and also the sutures were still intact at the extraction site."*

During the interview with the panel, SAT-07-20-2-M-5 said SAT-07-20-2-M-5 did not refer Patient LF because he did not appear to be complaining of anything major.

(16) SAT-07-20-2-M-5 saw Patient LF on 19 February 2016. SAT-07-20-2-M-5 stated before the panel, that the extraction site was healing, that there was no inflammation and no objective reason to refer him to the specialist. SAT-07-20-2-M-5 only referred Patient LF to the Yellow Roof Dental Unit, because he insisted on a second opinion from the specialist.

(17) The Council retains from SAT-07-20-2-M-5's response that SAT-07-20-2-M-5 had not referred Patient LF to the specialist because he felt he had taken care of the complication in a way he felt was appropriate at the time. SAT-07-20-2-M-5 stated that although oro-antral communication is a common complication of extraction of 26 and 27, he had never had such a complication before.

(18) In his statement to the Dental Unit's internal Inquiry Panel, a maxillofacial surgeon, DED-99-20-2-M-57, stated that no sutures were present when he examined Patient LF on 19 February 2016. He further stated that suturing was not the adequate management of what he described as a clinically obvious oro-antral communication. This assessment concurs with that of the two dentists present on the Council's panel.

(19) Together with SAT-07-20-2-M-5's response to the Council, SAT-07-20-2-M-5 also handed over other documents. These included copies of articles downloaded from the internet to illustrate SAT-07-20-2-M-5's point that both crown fracture and oro-antral communication are common complications of tooth extraction. SAT-07-20-2-M-5 also included copies of the dental chart of a patient, who SAT-07-20-2-M-5 has never treated and who is totally unrelated to the case of Patient LF. SAT-07-20-2-M-5 admitted that his wife, who works as a dentist in the same dental service, had given him the notes. SAT-07-20-2-M-5 had submitted a copy of the dental records to prove to the Council, that oro-antral communication is, in fact, a common complication and that it has happened to other dental officers.

(20) After definitive management of the oro-antral communication by the Oro-maxillofacial surgeon, Patient LF was still complaining of pain. Clinical examination by another dental officer, as well as radiographs, confirmed that tooth 25 had dental caries with pulpal involvement, extending subgingivally. Root canal treatment was done. Patient LF has been asymptomatic since then.

Determination on misconduct

5. The Council first considered whether SAT-07-20-2-M-5's actions amount to professional misconduct. Professional misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour. The Council considered each of the allegations found proven in this case to determine whether it amounts to serious professional misconduct.

<u>Failure to explain the nature of the procedure and possible complications</u>

(1) (i) From SAT-07-20-2-M-5's statement that

"Dental EXTRACTION being a basic dental procedure, a common practice among the dental faculty is to inform the patient ONLY in the event of a crown breakage about the surgical intervention it may require to complete the extraction."

it is clear that SAT-07-20-2-M-5 did not advise Patient LF on the procedure before starting the dental extraction and SAT-07-20-2-M-5 further stated that complications are never foreseen before the procedure has finally been performed and completed. This is in direct contradiction to the numerous articles SAT-07-20-2-M-5 submitted in SAT-07-20-2-M-5's defence, which all give crown breakage and formation of an oro-antral fistula as common complications.

(ii) Informed consent is an essential component of a patient's right to autonomy. It is the duty of the practitioner to explain to the patient why he is considering any procedure, the risks involved and whether there are any alternatives. Common complications are to be anticipated and the patient should be informed accordingly before any intervention. It is only after such a discussion that the patient can exercise his right to decide and choose a treatment option. The Council finds that SAT-07-20-2-M-5 denied Patient LF of this right by

not engaging in such a discussion before the procedure. This amounts to serious professional misconduct.

Failure to explain what happened during the procedure

(2) (i) From SAT-07-20-2-M-5's oral and written depositions it is clear that SAT-07-20-2-M-5 did not communicate directly with Patient LF at all during that incident. All communication was directed at the Dental Surgery Assistant, who in turn communicated with the Patient LF. In fact, SAT-07-20-2-M-5 admitted that this is how SAT-07-20-2-M-5 does things because the Dental Surgery Assistant is best placed to convey information patients.

(ii) The Council has taken into account that in accepting to treat a patient SAT-07-20-2-M-5's professional relationship is with the patient and not with the Dental Surgery Assistant. As such all communication should be directed to the patient. The Dental Surgery Assistant should only step in to translate if the patient demonstrates that he does not understand. Failure to talk directly to the patient constitutes professional misconduct.

Failure to refer to a specialist in a timely manner

(3) SAT-07-20-2-M-5 confirmed to the Council that he was confident that his management of the case was correct. SAT-07-20-2-M-5 therefore did not find it necessary to refer Patient LF. Evidence before the Council suggests however that normal practice would have been to close the defect by rotating a buccal flap and not merely approximate the buccal and gingival flaps. If SAT-07-20-2-M-5 did not have the expertise to do so, then SAT-07-20-2-M-5 should have referred Patient LF to a colleague with the necessary knowledge and expertise. The Council therefore concludes that the care SAT-07-20-2-M-5 delivered to Patient LF falls far below the standard expected from a dentist of SAT-07-20-2-M-5's experience and constitutes serious professional misconduct.

Other considerations that were not part of the original allegations

(4) (i) Evidence before the Council also strongly suggests that SAT-07-20-2-M-5 had extracted the wrong tooth. It is evident that SAT-07-20-2-M-5 did not take steps to confirm SAT-07-20-2-M-5's diagnosis or eliminate other possible causes for Patient LF's pain. At no point before initiating the tooth extraction, did SAT-07-20-2-M-5 consider taking a radiograph. The fact that symptoms persisted after extraction of tooth 26 and resolved after endodontic treatment of tooth 25 strongly suggests that tooth 25 was the cause of Patient LF's symptoms. Proper diagnosis at the onset would have averted the extraction which triggered a series of unfortunate events for Patient LF. Although the evidence for this is only circumstantial, the Council considers this to be a serious misconduct.

(ii) Every patient has the right to be treated with dignity and this includes his right to privacy. By copying the dental records of a patient and handing them over to a third party (the Seychelles Medical and Dental Council) without the patient's authorisation, SAT-07-20-2-M-5 has breached basic tenets of health care ethics. That in itself constitutes serious professional misconduct. The Council also finds that SAT-07-20-2-M-5's wife has also breached these same ethical principles by procuring the dental records.

The Council's conclusion on misconduct

6. Having taken into account all the instances of misconduct it identified in SAT-07-20-2-M-5's treatment of Patient LF, the Council finds that SAT-07-20-2-M-5's conduct fell well below what is expected of a dental officer of SAT-07-20-2-M-5's experience. The Council was satisfied that SAT-07-20-2-M-5's actions were serious departures from what is accepted as good clinical practice and amounted to serious professional misconduct.

The Council's decision on disciplinary measures

7. (1) Having satisfied itself that the grounds laid out in the complaint have been established, the Council then deliberated on disciplinary measures specified in paragraphs A, B, C, D or E of section 10 (1) of the Medical Practitioners and Dentists Act 1994.

(2) In taking its decision, the Council took into consideration SAT-07-20-2-M-5's twenty-two years' experience in the profession. The Council took note that on repeated occasions SAT-07-20-2-M-5 shifted the blame for SAT-07-20-2-M-5's shortcomings in dealing with the complications onto the patient.

(3) The Council finds in this case that there is a clear need to remove SAT-07-20-2-M-5 from clinical practice in the interest of patient safety, to uphold standards of behaviour and to maintain public confidence in the profession.

(4) The Council has decided to suspend SAT-07-20-2-M-5's registration for a period of twelve months. In deciding on this period of time, the council took into consideration the seriousness of SAT-07-20-2-M-5's actions, the need to protect patients and to clearly demonstrate that SAT-07-20-2-M-5's conduct was unacceptable. The twelve-month period will also provide SAT-07-20-2-M-5 with the opportunity to take steps to remediate SAT-07-20-2-M-5's shortcomings.

(5) The council decided that SAT-07-20-2-M-5 should undergo training in medical ethics.

(6) While recognising that it may prove difficult to upgrade SAT-07-20-2-M-5's practical skills in oral surgery while removed from the Register, the Council nevertheless determines that SAT-07-20-2-M-5 must find a way to undergo formal retraining in basic and complicated tooth extraction as expected to be done by a dentist of SAT-07-20-2-M-5's level of training.

(7) The Council will conduct a review hearing in SAT-07-20-2-M-5's case before the end of the suspension period to make a determination on SAT-07-20-2-M-5's restoration to the register. SAT-07-20-2-M-5 will need to submit to the Council evidence of SAT-07-20-2-M-5's participation in the re-training activities stipulated above.

(8) These are the final collective decisions of the majority of the members of the Council after the findings of the Investigation Committee were circulated to all members and all members were given ample oppportunity to maintain or alter any aspect of the draft decision.

End of Decision - 09/12/2016

Member	Signature	Date
Joseph Bistoquet	_____	_____
Josie Chetty	_____	_____
Velmurugan Chetty	_____	_____
Danny Elizabeth	_____	_____
Susan Fock Tave	_____	_____
Kenneth Henriette	_____	_____
Winnie Low Wah	_____	_____
Harold Pothin	_____	_____
Dereck Samsoodin	_____	_____
Valentina Seth	_____	_____
Bernard Valentin	_____	_____