Neutral Citation Number: [2021] EWHC 3230 (Admin)

Case No: CO/1831/2021

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/12/2021

Before :

THE HON. MR JUSTICE LANE

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Between :

The Professional Standards Authority for Health and Social Care	**Appellant**
- and –	
General Dental Council	**1st Respondent**
-and-	
Mohamed Amir	**2nd Respondent**

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Mr D Bradly (instructed by **Browne Jacobson LLP**) for the **Appellant**
Mr I Hare QC (instructed by **the General Dental Council**) for the **1st Respondent**
The second respondent, in person, assisted by Ms M Gay as a McKenzie Friend

Hearing date: 9 November 2021

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Approved Judgment

Mr Justice Lane :

1. This is an appeal brought by the Professional Standards Authority for Health and Social Care under section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("2002 Act"), against the decision made by the Professional Conduct Committee ("PCC") of the General Dental Council on 17 March 2021 to suspend the registration in the Dentists' Register of Mr Mohammed Amir for a period of three months, subject to a review prior to the expiry of that period. The appellant has referred the decision to the High Court because it considers that that decision is not sufficient for the protection of the public.

A. BACKGROUND

2. For a period up to 22 January 2019, the second respondent made claims to the public via his website that asthma, ataxia, allergies, sciatic nerve pain, breathing problem, Chrohn's disease, coeliac disease, depression and anxiety, fibromyalgia, infertility, arthritis, learning difficulties, migraine, multiple sclerosis and heart palpitations could be attributable to a dysfunctional jaw joint, a condition which, as a dentist, the second respondent was able to treat.

3. As a registered dentist, the second respondent was under a professional obligation to "provide good quality care based on current evidence and authoritative guidance" (paragraph 7.1 of first respondent's *Standards for the Dental Team,* 30 September 2013). The PCC found that there is no current evidence or authoritative guidance to support the second respondent's claims to be able to address those medical conditions through dental treatment.

4. Patient A had been diagnosed in 2011 with Spinocerebellar Ataxia Type 3 ("Sca3"), a rare incurable hereditary degenerative condition, the symptoms of which include loss of co-ordination and problems with movement. These progressively deteriorate over time and do not improve, according to the evidence given to the PCC by Dr Jonathan Rohrer, a consultant neurologist.

5. According to Patient A's witness statement, by January 2016 his mobility had become poor and he needed to have someone walking with him. Patient A's wife described him as having become increasing anxious about admission to hospital for tests for his Sca3, with Patient A experiencing low mood after hospital admission, as well as showing signs of anxiety and depression, not sleeping and expressing suicidal thoughts to their son. When Patient A consulted the second respondent in December 2015, Patient A was in a vulnerable condition. As he told he PCC in oral evidence, he was "very desperate at that point to find a solution for his problem".

6. The evidence of Dr Rohrer is that there is no known association between Sca3 and disfunction of the tempero-mandibular joints.

7. The evidence of Patient A included an account that at his first appointment with the second respondent, the latter did not conduct an examination inside his mouth but rather asked him to walk and observed him walking. The second respondent asked Patient A to raise his left hand, with and without his mouth open. The second respondent did not

answer Patient A's questions but told him that the doctors he had seen had wanted to label him as having Sca3 and that the second respondent could help. Patient A was told by the second respondent about the cases of other patients whom the second respondent had treated. According to the PCC's decision, the second respondent had informed Patient A that the second respondent could perhaps improve Patient A's cerebellar ataxia or stop it from deteriorating further. The PCC found it was likely that the second respondent told Patient A that his treatment might slow or improve Patient A's symptoms, such as walking and balance issues.

8. Patient A agreed to the only treatment which the second respondent offered; namely, an appliance which the second respondent claimed would expand Patient A's upper maxillary arch, at a cost to Patient A of £8,000.

9. The PCC found that this treatment was not clinically justified; and that the second respondent provided it to Patient A without performing an adequate examination of Patient A's jaw joints; without undertaking diagnostic assessments and special investigations required for an assessment of those joints; without obtaining Patient A's informed consent to the treatment (including by failing to provide any treatment options or explain any risks); and without making adequate clinical records.

10. A central element of the appeal to this court is the assertion that the PCC approached the second respondent's conduct as having two discrete elements; that is to say, (i) the statements which the second respondent had made on his website and to Patient A; and (ii) the deficiencies in the second respondent's care and management of Patient A. The appellant says that the PCC undertook no inquiry into the relationship between these two concerns, which went to the crucial issue of the reasons why the second respondent had failed in his care and management of Patient A. Accordingly, the PCC did not address the issue of whether the second respondent had abused his position as a dentist in relation to a vulnerable patient. That issue was, in effect, crucial to deciding upon the second respondent's fitness to practise.

11. Furthermore and in any event, the appellant contends that the second respondent's misconduct amounted to widespread breaches of relevant professional standards and was, thus, very serious. Since the second respondent proved incapable of demonstrating any insight into those serious deficiencies, the appellant submits that an order suspending the second respondent's registration for a period of three months is wholly insufficient to meet the public interest in protecting patients, maintaining public confidence in the profession and promoting standards within the profession.

B. LEGAL FRAMEWORK

12. Section 1 of the Dentist Acts 1984 ("1984 Act") makes continued provision for the existence of the first respondent, conferring upon it the overarching objective, in exercising its functions, of the protection of the public. That involves protecting, promoting and maintaining the health, safety and wellbeing of the public, promoting and maintaining public confidence in the profession of dentistry, and promoting and maintaining proper professional standards and conduct for members.

13. Section 2 of the 1984 Act contains statutory recognition of the PCC. By section 27B, the PCC must investigate an allegation referred to it by the Investigating Committee and determine whether the fitness to practise as a dentist of the person referred to the PCC is impaired.

14. By Section 27B(6), if the PCC determines that a person's fitness to practise as a dentist is impaired, they may, if they consider it appropriate, direct that the person's name be erased from the register; that registration therein be suspended for a period not exceeding 12 months; that registration be conditional upon compliance with conditions specified by the PCC; or that the person concerned be reprimanded.

15. Section 29 of the 2002 Act makes provision for the appellant to refer to this court a direction of the PCC, following a determination of a person's fitness to practise as a dentist is impaired. Section 29(4) provides that the power to refer arises when the appellant considers that the decision of the PCC is not sufficient, whether as to a finding or a penalty or both, for the protection of the public. Section 29(4)(A) provides that consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient to protect the health, safety and well-being of the public; to maintain public confidence in the profession; and to maintain proper professional standards of conduct for members of that profession.

16. In the event of a referral, section 29(7) requires this court to treat the reference as an appeal against the relevant decision, even though the Professional Standards Authority was not a party to the proceedings which resulted in the decision. The body which made the relevant decision, as well as the person to whom the decision relates (the second respondent) are expressly made respondents to the deemed appeal (section 29)(7)(b)).

17. Section 29(8) provides that the court may dismiss the appeal; allow it and quash the relevant decision; substitute for the relevant decision any other decision which could have been made by the PCC; or remit the case to the PCC.

C. CASE LAW

18. The treating of a reference to this court as an appeal means that Part 52 of the Civil Procedural Rules applies. By reason of CPR 52.21(3), the court will allow an appeal where the decision of (here) the PCC was "wrong"; or "…unjust because of a serious procedural or other irregularity in the proceedings...".

19. Although decided under different (albeit comparable) legislation, the judgment of the Court of Appeal in Council for the Regulation of Healthcare Professionals v General Medical Council and Ruscillo [2005] 1WLR 717 remains authoritative. The Court's role is to consider whether the penalty imposed is appropriate, having regard to the relevant statutory considerations of public safety and public confidence in the profession. In considering whether a penalty is unduly lenient, the test is whether the body imposing it could reasonably have imposed the penalty, having regard to the material facts and the object of the proceedings. If the penalty is correct, this court must dismiss the appeal, even if it concludes that some of the findings of the body were inadequate (paragraph 70). In deciding whether to disturb the determination of the PCC, this court must place weight on the expertise of that body (paragraph 78).

20. The issue of the weight or deference to be afforded by this court to the expertise of (here) the PCC was addressed by the Divisional Court in General Medical Council v Jagjivan and another [2017] 1 WLR 4438. The Divisional Court held that an appeal court must be extremely cautious about upsetting a conclusion of primary fact, particularly when findings depended on the assessment of the credibility of witnesses. Whilst the same caution did not apply to inferences drawn from such facts, the Divisional Court nevertheless held that an appellate court will not have the professional expertise of the tribunal of fact. This meant that the court should approach with diffidence the conclusions of such a tribunal about whether conduct was serious misconduct or impaired a person's fitness to practise; and about what is necessary to maintain public confidence and proper standards. There may, however, be matters such as dishonesty or sexual misconduct, where the court can draw conclusions more easily for itself and, accordingly, attach less weight to the expertise of the tribunal (paragraph 40).

D. THE HEARING

21. At the hearing on 9 November 2021, I heard oral submissions from Mr Bradly, for the appellant, and from the second respondent, who was assisted by Ms Gay as a McKenzie friend. On the appellant's unopposed application, I admitted a witness statement of Matthew Alderton, with exhibits, in order to inform the court of the outcome of the review mentioned in paragraph 1 above.

22. The material filed by the second respondent in connection with the hearing comprises a statement prepared by the second respondent, to which he spoke, extracts from the second respondent's website, graphs concerning the alleged alleviation of the symptoms, as recorded by patients of the second respondent, and a document written by the second respondent, which refers to Roger Sperry, a Nobel Prize winner, who is quoted as saying that more than 90% of the energy output of the brain is used in relating to the physical body in its gravitational field. The more mechanically distorted a person is, the less energy is available for thinking, metabolism and healing. This meant that "the most important treatment for any illness has to be the achievement of the symmetry of the cranial dental and skeletal complex to remove mechanical distortions". The second respondent says "I discovered how to bring that about. Roger gets a Nobel Prize. I get suspended. This is what we call institutionalised racism".

23. The second respondent also filed a statement from Ms Gay, describing the second respondent's work with her daughter. Ms Gay works in the NHS and is extremely supportive of the second respondent. I allowed Ms Gay to speak to this statement and also to read some of the second respondent's position statement, when he encountered difficulties in doing so during his oral submissions. The second respondent also provided, at the hearing, printouts of expressions of support for the second respondent. After the hearing, the second respondent sent in a document said to have been prepared by his supporters, reiterating their support for his "unique treatment", which "could halve the NHS budget if taken up more widely".

24. Mr Hare QC informed me that the first respondent adopted a neutral stance regarding the appeal. He made no oral or written submissions.

25. In reaching my decision, I have taken all the oral submissions and written materials into account.

E. DISCUSSION

Ground 1

26. Ground 1 submits that the PCC found that the second respondent had made misleading claims regarding the efficacy of his modality of dental treatment for a large range of medical conditions. Given that Patient A was a vulnerable patient and that the PCC found that the treatment Patient A received was without clinical justification, the public interest required an effective inquiry into the impact of the representations made to Patient A by the second respondent about the efficacy of his treatment. It also required an effective inquiry into the second respondent's motives for making those representations.

27. Ground 1 continues by challenging the appropriateness of charges 6(a), (b) and (c). These respectively alleged that the second respondent had told Patient A that "the treatment you were able to provide would slow Patient A's symptoms of spinocerebellar ataxia, or words to that affect"; that the treatment "would improve Patient A's symptoms of spinal cerebella ataxia or words to that effect;" and that the second respondent said Patient A's "symptoms were caused by a dysfunctional jaw joint and not spinal cerebellar ataxia or words to that effect". The PCC found that these charges were not proved. That led to the findings that the conduct alleged by charge 6 was not misleading or dishonest.

28. The appellant's criticisms of how charge 6 was framed are based on the fact that the written evidence was not accurately reflected by the charge. The written evidence of the son of Patient A was that the second respondent "said that he could not guarantee [a cure], but the mouthguard would definitely help. He was confident that the mouthguard would improve my dad's physical symptoms to some degree". The son further said that second respondent told Patient A his treatment "might not" get Patient A back to work,

> "but it would definitely help or improve or slow down the deterioration of the symptoms. I felt like he was being honest [the second respondent] did not say that the mouthguard would not work altogether; he said it would make an improvement. He also said that he could not guarantee what scale the improvement would be".

29. In his written response, the second respondent said he had informed Patient A and Patient A's son that he could "perhaps improve his cerebellar ataxia or stop it from deteriorating further."

30. As a result of the failure accurately to reflect the evidence of Patient A and his son, the appellant contends that the PCC failed to make findings as to whether the representations which were recorded in that evidence were misleading and/or dishonest. In finding charge 6(a), (b) and (c) not proved, the PCC held that the word "would" in

charge (a)(b) fell to be contrasted with "may or might", with regard to the slowing or improvement of Patient A's symptoms. Similarly, charge 6(c) was not proved because the PCC found that the second respondent did not say that Patient A symptoms "were" caused by dysfunctional jaw joint.

31. In his oral and written submissions, the second respondent takes issue with the findings of the PCC concerning the inadequacy of the treatment and care provided by him to Patient A. The second respondent has not, however, appealed against the first respondent's decision concerning impairment and sanction. I understood him to say that this was because he lacked the financial means to do so. The second respondent regards the charges as "trumped up". They are, he says, the result of "medieval thought patterns by the existing system of dental conduct". The second respondent denied treating Patient A or indeed anyone else for the purposes of financial gain. In 2019, he said that his profits, as disclosed to Her Majesty's Revenue and Customs, were only in the region of £10,000. The second respondent told me he considered the allegations made regarding Patient A were the result of animosity on the part of patient A's ex-wife.

32. The PCC found that the second respondent failed to provide an adequate standard of care to Patient A by not carrying out sufficient diagnostic assessments, including failing to take an adequate history of Patient A's presenting condition; not undertaking any or any adequate clinical examination of the jaw joints, muscles of mastication, occlusion; and failing to undertake dental charting, intraoral examination, soft tissue examination, basic periodontal examination and radiographic examination. Nor did the second respondent adequately consider all potential diagnoses prior to commencing treatment. He did not provide Patient A with any or any adequate treatment plan or appropriate treatment options. He did not inform Patient A of appropriate advantages and disadvantages for appropriate treatment options, or of the material risks of the proposed treatment. According to Professor Brook, formerly Head of the Unit of Oral and Maxillofacial Medicine and Surgery at the University of Sheffield, who gave evidence to the PCC, wearing the appliance supplied by the second respondent carried the risk to Patient A of gum disease and tooth decay via plaque accumulation, as well as mobility of the teeth. By contrast, the second respondent's evidence to the PCC was that there were no risks associated with the treatment that he proposed to provide to Patient A.

33. I agree with Mr Bradly that the PCC was wrong and/or committed a serious procedural irregularity in failing to make any proper connection between, on the one hand, the long list of medical conditions set out on the second respondent's website, which the PCC found he was attributing to a dysfunctional jaw joint; and the failings that occurred in respect of the treatment and care of Patient A. The evidence before the PCC, graphically confirmed by the second respondent's written and oral submissions to me, is that the second respondent is so committed to his theories and so disparaging of anyone who disagrees with them, that he simply saw no need to go through a process that is demanded of any professional dentist.

34. This important matter is, as we shall see, relevant to certain of the other grounds advanced by the appellant.

35. The second aspect of Ground 1 concerns the framing of charge 6. The use of the words "would" and "were" in charge 6 was plainly an inaccurate attempt to reflect the written evidence relied on by the PCC. By finding charge 6 not proved on this basis, the PCC therefore failed to consider the thrust of that written evidence, which was, on its own

terms, problematic. The statements made by the second respondent, as recorded in his evidence and that of Patient A's son, required to be considered in the context of them being made to a vulnerable patient who was desperate for a solution to (or at least the alleviation of) his very serious medical condition and its effects. I agree with the appellant that, even without the degree of certainty imported by the use of the words "would" and "were", these statements were such as to raise serious concerns that the second respondent was abusing his position as a registered dentist. It is unarguable that the evidence of Patient A's son was that the second respondent was envisaging the possibility of helping Patient A with his mobility problems stemming from Sca3.

36. For these reasons, I am entirely persuaded that both elements of Ground 1 are made out. The first respondent's decision on these matters was wrong.

Ground 2

37. Ground 2 contends that the PCC's decision to suspend the second respondent's registration for a period for three months was a serious procedural or other irregularity because there needed to be an effective inquiry into the reasons why the second respondent had failed in offering proper treatment and care to Patient A, providing him with only one treatment option and failing to inform Patient A of the risks of that option.

38. The terms of the charge did not include particulars which addressed the reasons for the second respondent's failure in respect of Patient A. As can already be seen, those reasons involved an approach to dentistry by the second respondent which rendered diagnosis and/or informed consent irrelevant, so far as he was concerned. They also involved a conscious refusal by the second respondent to accept the need for an evidence base for dental treatment; the need for diagnostics assessments; and the need for a patient's informed consent.

39. For the reasons I have given in respect of Ground 1, I agree with these criticisms. Even leaving aside the problems with the approach to charge 6, the PCC's "compartmentalised approach", as Mr Bradly describes it, meant it failed to afford adequate weight to the seriousness in the deficiencies of the second respondent's treatment and care of patient A. These did not fall to be viewed in isolation but as part of the second respondent's advertised belief that a large number of unrelated medical conditions can be attributed to a dysfunctional jaw joint. This flawed approach meant that the reasons why the second respondent acted as he did towards Patient A remained unresolved by the PCC.

40. Ground 2 is made out.

Ground 3

41. Ground 3 concerns the second respondent's statement on his website that "cranial-dental symmetry aims to restore balance to bodily systems, bringing about a permanent and lifelong improvement in health and well-being". The PCC found that this statement was not misleading. The PCC told the second respondent it was merely "a simple declaration of your aims, and was not controversial or contentious, and it follows that

the reader would not be likely to be misled". That conclusion is challenged by the appellant.

42. Even applying deference to the expertise of the PCC, this inference about what the public would understand is, I find, simply wrong. Anyone reading the second respondent's website, including the list of medical conditions said to be attributed to a dysfunctional jaw joint, would see the statement not merely as a declaration of aims, but as part of an exercise in persuasion. The ordinary reader would assume that the second respondent is, at least, strongly suggesting that the aim can be achieved.

43. There is, however, no recognised evidence base for that claim. The second respondent does not, indeed, point to any such thing. He told me that there are only a small handful of professionals who share his views. He is, nevertheless, convinced that he is right and that orthodox professional opinion, such as that of Professor Brook, is quite simply wrong.

44. The second respondent also points to the testimonials in his support, such as those of Ms Gay and the others recorded in the document handed to me at the hearing. I am in no doubt as to the genuineness of the views held by Ms Gay and those ex-patients of the second respondent who have written in his support. The stark reality is, however, that the form of professional regulation under which the second respondent operates, as a registered dentist, must be informed by objective scientific criteria. However strongly held, the second respondent's views, and those of his lay supporters, cannot be permitted to trump the first respondent's obligation to have proper regard to the views of relevant experts, such as those who gave evidence to the PCC.

45. Although the PCC, did, in important respects, give the evidence of those experts proper consideration, it failed to recognise the full implications of their evidence. These implications included the fact that the second respondent's website is designed to encourage the public to come to him in the hope (if not expectation) that their medical problems can be resolved by his heterodox treatment. There is no scientific basis for this encouragement, which must therefore be categorised as misleading.

46. Ground 3 is made out.

Ground 4

47. Charge 9(b) alleged that the second respondent was dishonest, in that he knew there was no reasonable body of evidence to support his statement and that cranio-dental symmetry aims to restore balance to bodily systems, bringing about a permanent and lifelong improvement in health and well-being (charge 8(a)); and that the list of medical conditions which I have set out in paragraph 2 above can be attributed to a dysfunctional jaw joint.

48. Because of its erroneous conclusion in respect to charge 8(a), the PCC found that it had not been proved that the second respondent was dishonest as regards the "aims to restore" passage from his website.

49. I shall begin with charge 8(b). So far as this was concerned, the PCC purported to apply the test set out by the Supreme Court in Ivey v Genting Casinos (UK Ltd) t/a Crockfords [2017] UKSC 67. What the PCC had to decide, first, was the second respondent's actual state of knowledge or belief as to the facts. It then had to apply the objective standards of ordinary and decent people in order to determine whether the second respondent's conduct was dishonest by those standards.

50. The PCC said this:-

> "The Committee first considered your actual state of your knowledge and belief as to the facts. The Committee considers that you held a genuine belief that the statements you made as set out at head of charge 8(b) and its sub-particulars were accurate. The Committee considers that the evidence presented to it demonstrates that your belief in your treatment is deeply-held, and that you did not consider that there was no reasonable body of evidence to support those statements. The Committee considers that you genuinely believe that you had a reasonable body of evidence to support those statements in the form of positive patient experiences and outcomes.
>
> The Committee also considers that your conduct would not be considered dishonest by reference to the standards of ordinary and decent people, as they would consider that you genuinely believed that a reasonable body of opinion existed to support your statements.
>
> For these reasons, the Committee finds that the facts alleged at head of charge 9(b) not proved in respect of head of charge 8(b)".

51. The appellant submits that, in reaching this conclusion, the PCC failed to take account of the first respondent's guidance standards, which set out the standards of conduct, performance and ethics that govern a dental professional. The standards also set out what patients expect from such professionals.

52. Core Principle 1 required the second respondent to put patients' interests first. Core Principle 3 required him to obtain valid consent, whilst Core Principle 7 required him to maintain and develop his professional knowledge. Standard 1.1.1 required the second respondent to discuss treatment options with patients. Standard 1.3.3 required him to ensure that any advertising, promotional material, and other information was accurate and not misleading. Standard 1.4.2 required him to provide appropriate oral health advice following relevant clinical guidelines. Standard 2.3 provided that patients needed to be given the information required to make informed decisions. Standard 4.1 required making accurate patient records. Standard 7.1 required good quality care based on current evidence and authoritative guidance. Standard 7.1.1 required the second respondent to find out about current evidence and best practice, whilst Standard 7.1.2 required him to record the reasons for deviating from established practise guidance.

53. None of this found any expression in the conclusions of the PCC on the issue of dishonesty. I remind myself that, when it comes to this issue, this court may feel it can

assess what is needed to protect the public or maintain the reputation of the profession more easily for itself (Jagivan above).

54. I consider that the PCC fell into error in answering the last part of the Ivey test as it did. I consider the objective standards of ordinary and decent people must involve the expectation that registered dentists will have at least some regard to the professional standards under which they are required to operate, pursuant to a system of regulation that is designed to protect the public. Ordinary and decent people would, in particular, not conclude that a registered dentist could flout the first respondent's professional standards, merely because the dentist has reached the conclusion that he knows better than those responsible for his regulation. There was no reasonable body of opinion that, for example, holds that the second respondent's dental device can treat multiple sclerosis.

55. The implication of the PCC's conclusion, if correct, is therefore profound. The conclusion would operate to diminish public confidence in the regulation of the profession, by assuming that "ordinary and decent people" will accept standards of behaviour and conduct from dentists that fall significantly below the standards set by those entrusted with the operation of the regulatory regime, merely because the dentist refuses – in the face of objective scientific evidence - to accept there is any need for him to comply with those standards.

56. In all circumstances, the only reasonable conclusion that could be drawn was that the second respondent was dishonest, in respect of the statements, covered by charge 8(b).

57. I have already held that the only reasonable inference that could be made from the "aims to restore" statement covered by charge 8(a) is that it was in reality a statement that the aim could be achieved. That misleading statement plainly falls foul of relevant professional standards, including to provide "good quality care based on current evidence and authoritative guidance" (standard 7.1, as well as the requirements at 7.1), to "find out about current evidence and best practise which affect your work... and follow them". 7.1.2 requires the dentist to "record the reasons why" he or she has deviated "from established practice and guidance" and to "be able to justify your decision". The standards of ordinary and decent people would, I find, be to expect the second respondent to act in accordance with those standards, which are completely at variance with the "aims to restore" statement on his website.

58. Accordingly, the second respondent was guilty of dishonesty in respect of charge 8(a).

Ground 5

59. Ground 5 is essentially covered in the earlier grounds, concerning the PCC's erroneous compartmentalisation of the conduct of the second respondent. In all circumstances, I agree with the appellant that the following assessment by the PCC of the second respondent's misconduct fails to reflect its seriousness:-

> "Your clinical failings relate to basic and fundamental aspects of the safe practise of dentistry. The Committee was further concerned by the misleading statements that you made on your website about your treatment modality, given the importance of ensuring that published information is accurate and reliable."

Ground 6

60. Ground 6 contends that even on the basis of the facts which it did find approved, the PCC's consideration of the extent to which the second respondent's fitness to practise as a dentist is impaired was inadequate.

61. I find this challenge well-founded. In the light of all the evidence, which made it clear beyond all doubt that the second respondent was convinced that his view of cranio-dental symmetry was correct and that all contrary professional views were misguided or worse, it is remarkable that the PCC concluded follows:

> "The Committee finds your fitness to practise is currently impaired. The Committee considers that you have not produced sufficient evidence of your insight into, and remediation of, your misconduct. The Committee considers that your misconduct is remediable, relating as it does to basic and fundamental aspects of the safe practise of dentistry, with particular regard to the areas of assessment, examination, informed consent and recordkeeping. The Committee also finds that the misleading statements on your websites are, similarly, easily remediable".

62. Having identified a "lack of reflective learning" on the part of the second respondent, which "is damaging to your fitness to practise", the PCC concluded that "your insight and remediation, then, can only properly be described as being at an early stage…". It then noted that the second respondent had made only a few minor changes to his website, which did "not appear to fully address the Committees findings against you". The website continued to "to suggest an associative relationship between specific health conditions and a dysfunctional jaw joint."

63. The only area in which the second respondent acknowledged that some change needed to be made was with regard to his record keeping.

64. In assessing whether the PCC could rationally conclude the second respondent had some prospect of remediating his behaviour, it is necessary to examine the evidence before the PCC. This contained the second respondent's statements that the recommendations from the British Society for Oral Medicine for the treatment of jaw problems, were "wishy washy" and "utter nonsense"; that every dentist and maxillofacial surgeon in the country was "pushing splints into the patient's mouths and injuring all of them"; that he did not need to take a radiograph of the teeth of Patient A because, having regard to Patient A's ethnicity and having looked at his teeth, he could tell that Patient A "had strong teeth"; that most outcomes at most hospitals are "zilch, zero, nada"; that multiple sclerosis is "the biggest fraud perpetrated on society for the last fifty years"; and that the medicine for MS is "no better than absolute rubbish"; that the second respondent needs no independent scrutiny of the evidence upon which he relies to support his claims; and that any concerns about his website could be addressed by substituting the word "conditions" with the word "symptoms".

65. In the light of this, it was simply not possible to categorise the second respondent's insight as being at an early stage. Apart from the relatively minor matter of record-keeping, it was non-existent.

66. As I have already said, I admitted into evidence the witness statement of Matthew Alderton, with exhibits. There was no objection by the respondents. The evidence concerns the first respondent's review decision, which took place on 25 June 2021.

67. The outcome of that decision was to extend an order of suspension on the second respondent for a further period of 12 months. In so deciding, the PCC was concerned by the second respondent's lack of insight. Far from accepting the criticisms made of him, he had, amongst other things, posted a blog, complaining that the "GDC does not like the idea that I am whistle-blowing, exposing their impotent governance of the profession". The PCC found that the second respondent's "website continues to discredit the GDC and its functions". The second respondent's blog appeared to the PCC "to demonstrate that [the second respondent] has a deep-seated attitudinal issue. The Committee is of the view that an informed member of the public would be shocked and surprised if an order of suspension were not made given the circumstances of this case…".

68. The decision of June 2021 serves only to confirm the appellant's criticisms of the PCC's conclusions on insight in its earlier decision. There was, in truth, no evidence before the PCC that could begin to show that the second respondent would remediate his behaviour.

69. The second respondent's position at the hearing further demonstrated this point. Amongst other things, he told me that he can "tell on day one if [the patient's jaw] has anything to do with their problems" and "I don't need to take radiographs". As to whether he was deviating from established practice and guidance, the second appellant said that it was the established practice and guidance that were "way out". The second respondent had written some forty articles on multiple sclerosis and had shown that surgeons at St Bartholomew's Hospital were "deceiving patients". He knew much more than the neurologists about these matters.

70. The second respondent said that he wanted the GDC to look at his work. He described multiple sclerosis as "a scam". He had also exposed fibromyalgia as a "fabricated illness". It was, in fact, a jaw problem that was treatable. The charges against him were "all made-up nonsense". The specialists "hijacked" patients into believing in non-existing disease.

Ground 7

71. The seventh and final ground is that the PCC was wrong to consider that a direction for the suspension of the second respondent's registration for a period of three months was sufficient for the protection of the public.

72. It follows from what I have already held that I am compelled to agree. Suspension for three months failed completely to reflect the gravity of the second respondent's misconduct.

73. Paragraph 5.18 of the first respondent's "Guidance for the Practice Committees including indicative sanctions guidance" (October 2016; last revision, December 2020) provides at paragraph 5.18 that the PCC will consider whether there are any aggravating features, in deciding sanction. These features include actual harm or risk of harm to a patient or another; dishonesty; financial gain; the involvement of a vulnerable patient or other vulnerable individual; blatant or wilful disregard of the role of the GDC and the systems regulating the profession; and lack of insight.

74. So far as these features are concerned, the respondent's actions in respect of Patient A carried a risk of harm, as described by Professor Brook. As I have held, the second respondent's actions involved dishonesty. The evidence is equivocal as to whether there was financial gain on the part of the second respondent. Strikingly, there was a blatant or wilful disregard of the role of the GDC and the systems regulating the profession. As I have also held, there was no basis for the PCC to conclude otherwise than that there was a lack of insight on the part of the second respondent.

75. The Guidance says mitigating factors include the evidence of the circumstances leading up to the incident in question; evidence of good conduct following the incident; evidence of previous good character; evidence of remorse shown/insight/apology given; evidence of steps taken to avoid repetition; no financial gain on the part of the registrant; the fact that the incident was a single, isolated event; and the time elapsed since the incident.

76. Of these mitigating factors, the only ones that are potentially relevant are the respondent's good character; insight into his poor record keeping; and the fact that he may not have been motivated by financial gain.

77. Under paragraph 6.28 of the Guidance, suspension is suggested as being appropriate for more serious cases but, significantly for our purpose, this is where "there is no evidence of harmful deep-seated personality or professional attitudinal problems (which might make erasure the appropriate order)". As I have held, there is abundant evidence of such professional attitudinal problems in the present case.

78. At Paragraph 6.34, under the heading "Erasure", we find that erasure will be appropriate where the behaviour is fundamentally incompatible with being a dental professional. Amongst the factors which, alone or collectively, might point to such a conclusion are serious departures from the relevant professional standards; where continuing risk of serious harm to patients or other persons is identified; the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons; and a persistent lack of insight into the seriousness of actions or their consequences.

79. Having regard to the Guidance, there is, in my view, no doubt whatsoever that the PCC's sanction of three months suspension was wholly inappropriate. Furthermore and in any event, the sanction of suspension failed to accord with the statutory objective of protection of the public, both in its physical sense and in the sense of promoting and maintaining public confidence in the profession of dentistry.

80. The findings of the PCC cannot stand. The question for me is whether I should remit the matter for a rehearing; or whether I should substitute the sanction of erasure from the register. The appellant's primary position is that I should do the latter.

81. This court must be cautious before substituting erasure for a lesser penalty. Such a course is, however, appropriate, where, after applying the requisite deference, the court is satisfied that the only appropriate sanction which the PCC could impose, on remittal, is erasure.

82. I am conscious that, in respect of certain of the grounds, I have accepted the appellant's case that the PCC failed to take a holistic view of the second respondent's conduct, with the result that it failed to investigate the reasons lying behind the inadequate treatment given by the second respondent to Patient A. Such a conclusion might be said to point towards remittal, rather than substitution of a sanction. However, as is evident from my findings in respect of those grounds, had the PCC not fallen into error in this regard, the only conclusion that it could reasonably have reached was that the treatment of Patient A stemmed directly from the intensely problematic professional stance adopted by the second respondent, as articulated on his website, and in his evidence to the PCC.

83. Overall, even without the finding of dishonesty which I have made, I am in no doubt that the only reasonable regulatory response to the facts of this case is that the second respondent should be erased from the register. There is, accordingly, no purpose to be served by remittal. The position might have been otherwise, had I been in any doubt of the possibility of the second respondent achieving insight. For the reasons I have given, I am in no such doubt. The second respondent's position is fixed.

84. I reach this conclusion with regret. The second respondent has worked as a dentist for many decades. He has, however, brought himself to a position which is fundamentally incompatible with his continuing to be registered as a dentist.

85. My decision will, I know, disappoint not only the second respondent but also those who consider they have benefited from his treatment.

F. DECISION

86. The appeal is allowed. I substitute for the decision of the PCC a decision that the respondent's name be erased.

87. The appellant seeks costs against the first and second respondents. If that is pursued, the order which gives effect to this judgment (which I invite the Mr Bradly to prepare) should give seven days from the date of the order for the first and second respondent, respectively, to respond in writing, following which the appellant has seven days in which to make any written reply.