NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

Level 24, AON Building,
1 Willis Street, Wellington 6011
PO Box 10509, The Terrace,
Wellington 6143, New Zealand
Telephone: +64 4 381 6816
Website: www.hpdt.org.nz

BEFORE THE HEALTH PRACTIONERS DISCIPLINARY TRIBUNAL
TARAIPUINARA WHAKATIKA KAIMAHI HAUORA

HPDT No	**1242/Den 20/497P**
UNDER	the Health Practitioners Competence Assurance Act 2003 ("the HPCA Act")
IN THE MATTER	of a disciplinary charge laid against a health practitioner under Part 4 of the HPCA Act
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE OF THE DENTAL COUNCIL OF NEW ZEALAND** **Applicant**
AND	**SAAD ABDUL-HASSAN ALI AL-MOZANY**, registered dentist and orthodontic specialist, formerly of Auckland **Practitioner**

Hearing:	19 & 20 July 2021; 4 October 2021; 9 March 2022
Tribunal:	Mr R D C Hindle (Chair) Dr H Trengrove, Dr C Corcoran, Dr S Salis & Ms A Kinzett (Members); Ms K Davies (Executive Officer)
Stenographer:	Ms H Hoffmann
Appearances:	Ms A Miller & Mr T Morrison for the Professional Conduct Committee No appearance by or for the practitioner on 19 July 2021 Practitioner in person on 20 July and 4 October 2021 and 9 March 2022

DECISION OF THE TRIBUNAL

Preliminary

[1] Dr Saad Al-Mozany ('the practitioner') is charged with failure to meet various professional standards in the 2018 calendar year, including that he did not put the interests of his patients first; that he put their care at risk; and that he did not communicate with them in an open and/or transparent way.

[2] The Tribunal finds all particulars of the charge to be established. More than that, it considers the case to be sufficiently serious to warrant orders cancelling the practitioner's registration, for censure, and requiring him to pay costs including costs assessed at 90% of the actual costs incurred in the matter since July 2021.

[3] Two factors have contributed to the length of this decision:

(a) cancellation of a practitioner's registration is amongst the most significant penalties available to the Tribunal. The order for cancellation in this case depends in large part[1] on the accumulation of evidence against the practitioner: taken separately, individual incidents might not reach the level of seriousness justifying cancellation.[2] It follows, however, that it is necessary to set the evidence out in some detail in order to explain the outcome; and

(b) secondly, the case has had an unusual procedural history. The papers were served, and the substantive hearing commenced, without any indication that the practitioner would take part. On the second day of the hearing, the practitioner contacted the Tribunal secretariat from Australia. He said that he had only just become aware of the matter as a result of publicity in the New Zealand media that had been relayed to him by a relative. That led to an adjournment, a separate hearing in respect of the procedural issues raised, and timetabling of steps to be taken by the practitioner before the resumption of

[1] Although not completely. Another significant consideration in this case arises out of the practitioner's stated intention not to practice in New Zealand again. That aspect is considered in more detail below, in the context of the discussion of penalty.

[2] If viewed in isolation, some might not reach the threshold of misconduct that warrants a disciplinary sanction.

the substantive hearing. For reasons which follow, the Tribunal was satisfied that the papers to be served on the practitioner before the substantive hearing had been served in accordance with the relevant provisions of the Health Practitioners' Competence Assurance Act 2003 ('the **Act'**). The Tribunal also found that – despite his assertions to the contrary - the practitioner had been aware of the matter before the substantive hearing. He had the opportunity to defend the charge, but chose not to do so until publicity about the matter caused him to reconsider that decision. In the circumstances, the Tribunal regards the costs that were incurred in the matter after July 2021 as having been entirely unnecessary. It has therefore taken the unusual step of requiring the practitioner to pay 90% of all costs incurred in the prosecution of the case, and by the Tribunal, after July 2021. That conclusion demands a reasonably detailed account of the way the matter unfolded.

[4] The hearing took place in three parts:

(a) the hearing was convened in person in Auckland on 19 and 20 July 2021 (the '**July hearing'**). There was no appearance by or for the practitioner on 19 July 2021. The applicant ('the **PCC**') opened its case, and called evidence supporting the charge. Then on the morning of 20 July 2021 the practitioner contacted the Tribunal's executive officer. He later attended the hearing by AVL. The upshot was that the hearing was adjourned at a point at which the evidence for the PCC had all but been completed, but before any submissions as to liability had been made;[3]

(b) on 4 October 2021 the Tribunal heard what was in effect an application by the practitioner for an order which – had it been made - would have brought the matter to an end at that point (the '**October hearing'**).[4] This hearing was conducted by AVL. For reasons set out below, the Tribunal did not accept the

[3] In fact, one of the witnesses to be called by the PCC had not given evidence at that point, but there were logistical difficulties because the witness was in the United Kingdom at the time. In the result, the PCC produced the evidence of the witness in the form of a sworn statement, and the witness was not called.

[4] By then the entirety of the PCC's case had been made available to the practitioner, and he had acknowledged receipt.

practitioner's application. It directed that the hearing would continue from the point at which it had ended on 20 July 2021. A timetable was set to enable the practitioner to file any evidence in reply;

(c) the third part of the hearing took place on 9 March 2022 (the '**March hearing'**). It was an AVL hearing. The practitioner attended throughout. He began by making an application for adjournment on the basis that he had been unable to secure legal counsel. The application was supported by an unsworn statement, with some attachments.[5] The Tribunal did not accept the application. It was satisfied that the practitioner had had the time and opportunity to put his case together if he had chosen to do so. The hearing then proceeded, and was completed that day.

[5] When the practitioner appeared at the March hearing, he said that he agreed with a lot of the points raised by the PCC. He added that there were reasons for what had happened, and that issues about the continuity of care and transferring patients had been out of his hands.[6]

[6] With respect to the evidence relied on by the PCC to establish professional misconduct, however, the practitioner has chosen not to file evidence to contest the case against him. For all practical purposes the evidence presented by the PCC to establish the charge was unchallenged.

The practitioner

[7] The practitioner is registered as a general dentist and specialist orthodontist in New Zealand and Australia.[7]

[8] In or about 2015 he acquired a general dental practice located in downtown Auckland. His intention was to continue that practice, and to add his specialist orthodontic services

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5 This was focussed on the issues of legal representation, and did not bear on any of the substantive matters.

6 He also had other things to say in relation to the penalty that might be imposed.

7 It may be that his registration has since been revoked in Australia. The Tribunal does not know, although it is clear that the practitioner has not held a practicing certificate in Australia for some years.

to it.[8] He started practicing in both countries, with visits to Auckland roughly every 4 weeks. He styled his orthodontic practice as 'The Orthodontic Institute'. He practiced under that banner in Auckland until late in 2018.

[9] By October 2018 the Dental Council had received a number of complaints about the practitioner. On 31 October 2018 it declined his application to renew his annual practicing certificate, and directed that a number of conditions designed to ensure that his responsibilities to his patients be met before an annual practising certificate would be issued. There is no evidence that the practitioner has ever made any real attempt to meet those conditions. He has not held a practicing certificate in New Zealand since.

[10] He is, however, still registered in New Zealand as a general dentist and specialist orthodontist.

The charge

[11] The practitioner is charged as follows:

> *"Pursuant to s 82(1) of the Act, the Professional Conduct Committee lays a charge that between on or around January 2018 and December 2018, Dr Al-Mozany conducted himself in an inappropriate and/or unprofessional manner in relation to the patients named in Appendix one in that he:*
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> *1. Did not put the interests of his patients first by failing to:*
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> *(a) attend scheduled patient appointments and/or*
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> *(b) provide ongoing care to patients; and/or*
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> *(c) provide orthodontic plates paid for by patients and/or*
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> *2. Put patient care at risk by failing to:*
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> *(a) regularly monitor orthodontic treatment; and/or*
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> *(b) provide dental records when requested; and/or*
>
> *(c) respond to patient enquiries; and/or*

[8] Practitioner letter dated 26 October 2018 to the Dental Council.

3. *Did not communicate with patients in an open and transparent way by failing to:*

   (a) communicate when he was not available to see patients; and/or

   (b) respond to phone calls and/or emails from patients regarding their treatment and/or appointments.

In acting in the manner alleged, Dr Al-Mozany breached his professional and ethical obligations including (without limitation) the Dental Council's Standards Framework for Oral Health Practitioners. The conduct alleged above separately or cumulatively amounts to professional misconduct pursuant to s 100(1)(a) and/or s 100(1)(b) of the Act."

The evidence

[12] The PCC adduced evidence and materials to establish the charge as follows.

(a) an affidavit of Mr M A Rodgers sworn on 30 April 2021. Mr Rodgers is the Registrar of the Dental Council ('the **Council'**). The purpose of his evidence was to provide the Tribunal with copies of relevant complaints and other correspondence relating to them. Amongst the documents referred to in his affidavit were three complaints made by former patients of the practitioner. They are conveniently designated as patients or complainants 1, 2 and 3 in this decision.[9] None gave evidence to the Tribunal, but the PCC relied on their complaints as part of its case against the practitioner;

(b) an affidavit sworn by Dr P M Huitema on 27 April 2021. Dr Huitema is Chair of the PCC that was appointed by the Council to investigate the complaints against the practitioner. The purpose of Dr Huitema's affidavit was to produce documents relevant to the correspondence (such as it was) with the practitioner during the PCC's investigation;

[9] The Tribunal has made orders prohibiting publication of the names and/or any identifying details in respect of all patients whose dealings with the practitioner are referred to in this case. The patients/complainants are identified only by the document control number that was allocated to their statements by the Executive Officer. As explained, these first three did not give evidence in person. There is no patient 4 (or patient 12, for that matter). The next patient in sequence after patient 3 is patient 5 (who did give evidence to the Tribunal at the hearing).

(c) a bundle of relevant standards, including the Standards Framework for Oral Health Practitioners;[10] the Standards for Patient Records and Privacy of Health Information;[11] a description of the entry level competencies for dental specialties as issued by the Dental Council of New Zealand / Dental Board of Australia (effective July 2016, and including a statement of the entry level competencies for orthodontics); and the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996;

(d) an affirmation by Sharon Finlayson affirmed on 22 June 2021 as to the delivery of the PCC's statements of evidence and other documents in the case to the practitioner in Australia; and

(e) statements of evidence of patients/complainants designated as 5 to 14.[12]

[13] The evidence may be summarised as follows:[13]

(a) **Complainant 1:**[14] This complaint relates to a 14-year-old patient who began orthodontic treatment with the practitioner in February 2017.[15] The cost of the treatment ($8,000.00) was paid in full at the outset. There is no complaint about attendances in 2017, but the practitioner cancelled a scheduled appointment in March 2018 on the basis that there was an illness in his family. The appointment was not re-scheduled. The patient's mother then telephoned and emailed the practice to enquire, but without any response. She then went to the practice only to find the doors shut. She wrote to the Council on 31 May 2018 expressing concern that her daughter's treatment was not complete. She

[10] Issued by the Council, effective 15 August 2015.

[11] As issued by the Council on 1 February 2018.

[12] Patients/complainants 5, 6, 8, 9, 10, 11 and 13 all gave evidence at the hearing on 19 July 2021 (complainant 13's evidence was given by AVL). Patients 7 and 14 gave their evidence as affirmations (patient 14 was to have given evidence by AVL, and would have done so, but for the events that unfolded on the morning of 20 July 2021).

[13] What follows are only summaries of the statements that were given.

[14] Patent 1 did not give evidence at the Tribunal hearing, but her letter of complaint was included amongst the materials produced to the Tribunal by Mr. Rodgers, the Registrar of the Dental Council. It is effectively unchallenged.

[15] The complainant is the mother of the patient.

noted that the treatment had been paid for up front, and said that they did not have any money to pay for another orthodontist.[16]

(b) **Patient 2:** Patient 2 paid the practitioner $9,000.00 for a full Invisalign treatment which started in or about the beginning of 2016. She describes how aligners were routinely delivered late. There is also an account of her arriving for a confirmed appointment[17] to be told that neither the aligners she was expecting nor the practitioner were at the practice. The receptionist who was at the premises said that the practice did not have a contact number for the practitioner. As it happened, in or about April 2018 the patient moved to Sydney. She would have been willing to complete her treatment by the practitioner there. The practitioner responded to an emailed enquiry from the patient, saying that he would be happy to do that. However, when the patient asked for the location of his practice in Sydney, she got no response. She said:

> *"I have also emailed and called the Orthodontic Institute over 50 times in May-August yet no reply. For a few days the phone went to voicemail mentioning the practice would be closed until the following week due to renovations. I called back numerous amounts, and now the phone just rings, no voicemail."*[18]

Significantly, by October 2018 the patient was asking the practitioner to provide her with a full copy of her Invisalign records so that she could see another orthodontist. The records have never been provided. When spoken to by the PCC in February 2019 she said that she had not had any refund, any dental records, [19] or any further response from the practitioner.

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[16] The Council referred the matter to the practitioner by email to his Gmail address (the significance of which will emerge below) on 31 May 2018. He responded to the Council the same day saying he had employed a new receptionist and that he would in any event contact the patient's mother that day as well. There is no evidence that he did so. Again, as will be explained below, the practitioner elected not to give evidence on these matters.

[17] It is not altogether clear, but it appears from the context that this event occurred in 2018 and was part of the sequence of events the patient described in relation to her move to Sydney.

[18] Complaints to the Council and the Health & Disability Commissioner (HDC) dated 10 September 2018. The HDC complaint was later referred by the HDC to the Council.

[19] There is evidence that the practitioner responded to the Council's correspondence in September 2018 and the HDC's correspondence in or about October 2018 but his response did not provide any information that might have allowed her to find him in Sydney, and it said nothing about providing her dental records.

(c) **Patient 3:** This is another patient who paid for orthodontic treatment at the outset.[20] Amongst other things, her complaint dated 8 October 2018 to the Council was that:

> *"I have complained in person, over the phone and by email for the past few months I have not been able to reach anyone. I have gone to the practice on scheduled appointments to find it closed on multiple occasions with no acceptable explanation or communication from an employee. …. The last I have heard from the company was a text sent on Monday 10th September stating 'Due to family circumstances, Dr Saad has had to go back to Sydney earlier. Could we please reschedule your appointment to the same time on the 24th September.' When I showed up to this scheduled appointment, the practice was closed."*

(d) **Patient 5:**[21] The evidence establishes that:

(i) this patient first attended the practitioner's clinic in Auckland on or about 19 June 2016. At some point between then and 2 October 2017, she paid the practitioner $8,470.00 for Invisalign treatment;

(ii) aligners that the complainant had been expecting to arrive in early February 2018 were not provided;

(iii) on 23 April 2018, the complainant received an email from the practitioner's receptionist in respect of a scheduled appointment advising that the practitioner had been called away to a 'family emergency'. Another appointment for 21 May was suggested;

(iv) the complainant sent an email asking where the aligners were that had been expected. The email makes it clear that at that point the aligners that the patient was using had deteriorated and no longer fitted her. There was no reply to her email;

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[20] Her complaint notes that she worked hard to achieve that, as she was 16 at the time treatment started. The practitioner did not respond to her complaint.

[21] Unlike patients 1 to 3, this patient and all others referred to below gave statements of evidence to the Tribunal (in some cases the evidence was given by a caregiver rather than the patient in person).

(v) the patient then says:

> *"I arrived at my next appointment on 21 May 2018 to find the practice was closed with no prior warning or attempt to contact me. There was a note on the door to say it was closed with a phone number to call. I called the number and it did not connect. I attempted to reach the practice to express my concerns, including leaving numerous messages and sending emails."*

(vi) the patient complained to the Council on 27 May 2018. Of some concern is that, in the course of responding to that complaint, the practitioner has described services that he claimed to have provided for the patient. There is a note of a consultation at 4.30pm on 23 April 2018 *"retake U/L PVS impressions (distortion)".* The patient says that this did not occur; in fact, as set out above, the appointment was cancelled. Instead, she was still wearing the aligners supplied in late January, and which she had understood were only intended to have been worn for two weeks or so;

(vii) the practitioner's response referred to the patient's failure to attend an appointment on 19 June 2018. The complainant says that is incorrect;

(viii) the practitioner's response also asserted that the patient had received all refinement aligners on 13 August 2018. The patient says that is untrue – she said that these have never been received;

(ix) all contact with the practitioner came to an end in October 2018;

(x) the patient has since sought treatment with another orthodontist. There has, however, been no reimbursement of the money she paid the practitioner for the work that he commenced but did not complete. The patient now has concerns about the long-term effect that his failure to treat her will have for her teeth. She has been informed that her gums

have receded, likely because of the prolonged wearing of the incorrect aligners.

(e) Patient 6:

(i) this complainant had a first consultation with the practitioner for Invisalign treatment in February 2017. The first aligners and a treatment plan were received at some time between May and July 2017. The patient was asked to pay $1,500.00 upfront, with the remainder of the cost to be by way of instalments;

(ii) there were regular appointments between July and the end of 2017 to get new aligners. From February 2018, however, there were a number of appointments that were cancelled, often with no prior notice. Sometimes rescheduled appointments would themselves be cancelled with no prior notice. Despite a number of failed appointments, the patient says that between February and around November 2018, she was only able to see the practitioner on two or three occasions, with seven or so more appointments cancelled (or where the practitioner simply did not appear);

(iii) the patient's evidence is as follows:

> *"For the first couple of cancellations, Dr Al-Mozany gave an explanation. I remember him saying that his wife was pregnant and there were dangerous complications. Or his house was broken into in a burglary. He looked so calm when he said this. No reasons were given for cancellations later in the year. I would receive a text confirming the date and time of my appointment, then when I went to the practice the door would be locked and no staff would be there."*

(iv) appointments were cancelled again in September 2018. There appears to have been an appointment on 8 October 2018 that went ahead. On 13 November 2018, however, the patient went to the clinic but there was no one there. The practitioner then offered to see the patient on

26 November. When she arrived at the clinic, however, a different practitioner was there, who said that he would be attending to the patient instead of the practitioner. There was no explanation as to why the practitioner was not there. The patient was reassured that in future there would be no more cancellations;

(v) however, when the patient went for the next appointment in December 2018, the doors of the clinic were locked and there was no one there;

(vi) the patient's treatment was ultimately completed by a different practitioner. Although that practitioner was willing to offer a discount, there was still a further charge of $4,000.00 to complete the Invisalign treatment;

(vii) it is also relevant that the practitioner's notes record that he had performed an inter-proximal reduction as part of the patient's treatment. The patient said that he had not. Nonetheless, the aligners that the practitioner had been providing were all made on the assumption that an inter-proximal reduction had been carried out. The patient says it meant that the aligners were always quite tight, and that they could not be placed on the teeth properly. Her evidence is that it was painful to wear the aligners and that, in due course, she felt her teeth were in worse condition than before she started treatment. When the new practitioner later embarked on the work, an inter-proximal reduction was carried out. After that the patient no longer had any pain when wearing the aligners;

(viii) in all, patient 6 paid the practitioner $4,300.00 for treatment. She then had to spend another $4,000.00 to have the work completed by another practitioner. In addition, although the treatment initially proposed was to have finished in 2018, as a result of all of the delays and having to find a new practitioner, in fact it was not completed until 2020. Even then, the patient considers that there is a visible imbalance in her face.

She says that the posterior bite cannot fully recover or be as good as it was when she embarked on treatment with the practitioner.

(f) Patient 7:

(i) patient 7's treatment by the practitioner began in September 2017. The patient was looking for treatment because his upper and lower front teeth were crooked. He says that the practitioner took photographs of his teeth, but did not take any x-rays or moulds. He recalls that the practitioner briefly explained the treatment, and a plan to fit braces, but did not mention any risks or problems that might occur;

(ii) the practitioner advised that the treatment would take 14 months and that it would cost $7,000.00. The patient paid $1,500.00 upfront and agreed to make monthly payments of $229.00 after that;

(iii) the braces were fitted on the upper teeth first, and then on the lower teeth;

(iv) from around January or February 2018, the practitioner began to cancel appointments:[22]

> *"On two or three occasions, I was told by his receptionist in advance that my appointment would be cancelled and when I asked him why my appointment was cancelled, he made excuses, including saying that he was busy with his family. He was saying that they had a new baby, and he had some other family commitments."*

(v) there had been seven or eight appointments after the initial appointment in 2017. The patient became concerned about slow progress;

[22] The patient was aware that the practitioner was travelling to Auckland from Sydney for his appointments.

(vi) in June or July 2018, the patient attended the practitioner's clinic but it appeared to have been shut down. There was no one there. The patient says that he emailed the practitioner several times to try and sort out his treatment, but the practitioner did not respond;

(vii) there was then an appointment at a different clinic in November 2018. The practitioner was present with another dentist. The practitioner said that the other dentist was helping him with his patients temporarily. That was the last occasion on which the patient saw the practitioner;

(viii) the patient was advised by the other dentist towards the end of 2018 that Dr Al-Mozany's licence had been suspended.[23] The patient emailed the practitioner to ask why he had left the treatment without advising him (the patient). There was no reply;

(ix) the new practitioner treating this patient advised him in February 2019 that the work done by the practitioner had been incorrect, because the brackets for the patient's braces had been put in the wrong position. The braces were removed, and treatment started from the beginning again. The total price of the replacement treatment was $5,500.00, and it was not completed until March 2021.

(g) Patient 8:

(i) patient 8 first saw the practitioner for orthodontic treatment in or about the middle of 2017. She contacted his clinic, then attended at his practice and met with him. He took a photograph of her teeth, but no x-rays. He also took impressions which the patient understood were to be sent to Invisalign, so that the aligners would be supplied from the United States in due course;

[23] This being a reference to proceedings which the Tribunal understands were unfolding in Australia.

(ii) the practitioner told the patient that the treatment cost would be $8,000.00, reduced to $7,200.00 if paid in full upfront. The patient paid $7,200.00;

(iii) there was some delay before the aligners (a set of 15 pairs) arrived. Again, the patient saw the practitioner when she had completed using the first set. For some reason, the second set was for her bottom teeth only, even though the practitioner had taken impressions from both top and bottom arches.

(iv) the patient knew that the practitioner was based in Australia, so that she would only be able to see him every four weeks when he travelled to New Zealand. She found, however, that her appointments were never any longer than about five minutes. She says:

> *"After a couple of months, Dr Saad started postponing his appointments, so every time I met him it was after more than a month. This started from around July or August 2018. Dr Saad would arrange an appointment, then kept giving excuses to cancel or delay them. For example, "family matters", or his house was burgled. There was one day I went for the appointment, but I was told my time was double booked so I had to wait there until he had time.*
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> *At one point the clinic started repeatedly postponing and rearranging my appointments every time it was close to my appointment date, so I hadn't seen Dr Saad for a while. One day I went to the practice anyway to see if I could talk to someone. At this point I saw the door was closed. There were mails and the papers on the floor outside the door. It looked like no one had been there for a while."*

(v) the patient complained to the Dental Council in September 2018. A couple of days later the practitioner contacted her by text message. He arranged an appointment, and the patient says he did attend her two or three more times after that. But at that point the appointments were being arranged by text message, not email;

(vi) the last appointment was on 26 November 2018. Although the practitioner was present at the clinic, in fact the patient was checked by a different orthodontist. The practitioner told the patient that the other orthodontist would be available when he (the practitioner) was not. After that, the practitioner stopped replying to the patient's texts;

(vii) The patient was only about halfway through her treatment. The patient has not seen the practitioner since November 2018, and has not finished her treatment elsewhere.

(h) Patient 9:

(i) Patient 9 first attended the practitioner in September or October 2016. She was asked to pay $6,900.00 for treatment that was to be provided – again, being Invisalign treatment. After the patient had received some 26 or so aligners, from February 2018 the practitioner stopped supplying new aligners. The complainant says:

> *"He lied to me, saying my aligner was on the way but it wasn't. He used a lot of excuses to make me believe my aligners were on the way. He said my aligners had not arrived yet. He attended the appointments just to look at my teeth and said you need more aligners. After three months of him not giving me any treatment I asked him for a refund."*

(ii) the consequence was that the practitioner proffered a document to record that he would refund monies paid for her treatment but only if she [the patient] would agree not to follow through with *"… any further claims to the respective bodies, on the basis that the Orthodontist agrees to refund the monies paid for her treatment";* [24]

(iii) the patient signed the document and returned it to the practitioner. At some point she also was asked for a bank account number so that the

[24] He also asked the patient to remove any *"disparaging or negative comments on social media".*

practitioner could make payment, and she provided it. But there was no payment, nor has there ever been any payment since;

(iv) the patient kept a list of phone calls to the practitioner's number in Australia in her attempts to reschedule her appointments. By October 2018, she had made email contact with the Council, and had also tried to contact the practitioner through his practice in Australia. Her calls went unanswered, but she was advised by the practice in Australia that the practitioner had been suspended, and was under investigation in Australia;

(v) the treatment for this patient has not been finished. The patient is concerned that her teeth are going back to their original condition (she says they look 'horrible and not straightened'). She has seen another dentist, but *"… I didn't have any treatment with him because I had a baby to look after during that time."*

(i) Complainant 10:

(i) evidence in respect of patient 10 was given by his father. The patient's father had been involved in all of the orthodontic treatment for his son from October 2017 onwards. He explained that the treatment provided by the practitioner began with the extraction of two bicuspids. The sum of $4,000.000–$5,000.00 was paid for the initial phase of treatment, which included the extractions and Invisalign aligners;

(ii) in late April 2018, the patient was the subject of a violent attack, leaving him with traumatic brain injury and multiple skull fractures. It was for that reason that his father started driving him to all of the treatments with the practitioner;

(iii) the evidence is that:

> *"From April 2018, we were faced with repeated situations in which emails were sent advising of appointments but when we drove in from West Auckland to attend, the premises were closed. The receptionist was in attendance on three occasions when we attended for an appointment, so the failure to reply or to notify us that the email appointment had been cancelled was dysfunctional in the extreme.*
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> *When we finally got an appointment there were no aligners. Dr Al-Mozany promised to post the aligners, because* [the patient's] *treatment was lapsing both from the injury and from the failure from April through to maybe July to get further aligners. This needed to be continuous treatment and you can't interrupt it. His teeth were slowly slipping back to their original position."*

(iv) the evidence also describes a number of other attempts to make contact with the practitioner, and appointments which the practitioner did not attend. New aligners were not provided. When the patient and his father attended the clinic in November or December 2018, there was someone else in attendance who would not identify themselves. An attempt to attend an appointment in January 2019 revealed that the clinic had been closed;

(v) the complainant's evidence is that his son has had two entirely healthy teeth removed, and yet has received effectively no treatment for around two years, leaving him with permanent gaps in his smile. He is also several thousand dollars out of pocket, and the aligners that could have been used were not provided to him;

(vi) in due course, another orthodontic practice examined the patient for restorative follow-up. They advised that the solution to achieve the originally intended results would have involved a jaw fracture and surgical repositioning, and that it was unlikely that the Invisalign treatment on its own would ever have achieved the desired result. The complainant expresses considerable concern that his son has been put

to the time, inconvenience and cost of a treatment that was never likely to have been effective;

(j) Patient 11:

(i) patient 11 began seeing the practitioner at his clinic in Auckland in around August 2017. It was suggested that he needed to have upper braces, and that the treatment would take about six months. Between $2,500.00 to $3,000.00 was paid upfront;

(ii) for a while, the patient saw the practitioner "every few weeks" but later it was every month. The patient says that there were "lots of cancellations". On one occasion the practitioner said that he had been broken into, on another occasion the patient was told that the practitioner had some family issues. There were times when the patient would attend for an appointment and find that there was no one there;

(iii) the braces were taken off on 18 June 2018. The patient was then advised that he would need a retainer and a wire put into the back of his teeth. The mould for the retainer was made, but it was never received. The patient emailed and called the reception to follow up, but he describes the communication as being "very poor". By that time his teeth had returned to their pre-treatment state. The patient was extremely concerned. He provided photographs to demonstrate the issues;

(iv) there was then some treatment. Appointments on the 4th and 16th July 2018 took place. The patient was reassured by the practitioner that the gap in his teeth would close once the retainer was in. Nonetheless, the patient was concerned that the practitioner had not put a wire at the back of his teeth immediately after removing his braces, and that the retainer would not move his teeth back to the state that they were in after the braces had been removed;

(v) The retainer eventually arrived on 26 July 2018 and was fitted by the practitioner's receptionist. But it did not fit, so a new mould was needed. The receptionist suggested that the patient should go to a different practice to have the retainer made;

(vi) from August 2018, the patient made a number of attempts to contact the practitioner and raise his concerns. A new retainer finally arrived about two months after his braces were taken off, but it did not fit. He was told to keep trying to "squeeze it on". This was painful. After about a month, he did notice some movement in his teeth. There were some further appointments (with some further postponements and cancellations). His teeth did not move back to the position that they were in after the braces were removed;

(vii) at an appointment on 31 October 2018, the patient asked the practitioner for money back, since he had not provided the treatment that was promised. The practitioner promised that he would pay half the money back and finish the treatment. By email dated 13 November 2018, the practitioner even told the patient that he had transferred the money into his account. That was not true. The patient has never received a refund;

(viii) before the next appointment, the practitioner's receptionist contacted the patient to advise that the appointment had to be cancelled due to a gas leak in the building. The patient was given the details of another orthodontist;

(ix) overall, the patient does not consider that the practitioner has provided the service that was advertised, or that the treatment which ought to have been provided has been finished.

(k) Complainant 13:

(i) patient 13 is the daughter of the complainant who gave evidence at the hearing.[25] In her case, the practitioner began orthodontic treatment in July 2016. An 11-month course of treatment was paid for, (i.e., it was anticipated that the treatment would finish in June 2017). The amount paid in advance was $8,350.00. By October 2018, however, the treatment was still incomplete. In the meantime, the practitioner had failed to attend appointments, often without notice. For a period during this time, patient was left using the same retainer for approximately five months;

(ii) an appointment was scheduled for 24 September 2018. When the patient arrived, she found the clinic closed. Her position is that she was not told of the cancellation.[26] A similar thing occurred on 29 October 2018, but then on 30 October there was a text from the practitioner advising that an appointment would take place on 31 October 2018;

(iii) the practitioner did see the patient on 31 October 2018. She took the opportunity to give the practitioner a detailed letter of complaint, setting out the missed appointments and her concerns about the treatment she had received. She asked for a refund of $2,000.00. The practitioner agreed to pay it that same day. In fact, he did pay the agreed sum in the first week of November;[27]

(iv) the patient then completed her treatment elsewhere.

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[25] The evidence is hearsay to a significant extent, but the important correspondence that is referred to was attached. As already noted, the practitioner chose not to file any evidence of his own. The Tribunal considered it appropriate to receive the evidence, but keeping in mind that its weight might be compromised by the fact that the patient did not give evidence herself. As noted, in the end the practitioner did not file any contrary evidence. The Tribunal is satisfied that the evidence is probative of the facts set out.

[26] An email from the practitioner asserted that she should have had a text message.

[27] The complainant's father (who gave evidence) said that at least one reason the complainant did not give the evidence in person was that she still felt obliged to the practitioner by this arrangement.

(l) Finally, with respect to patient 14:[28]

(i) Invisalign treatment by the practitioner started in September 2017. The patient paid $8,000.00 for the course of treatments to be provided;

(ii) for a period of about six months, she was attended to by a colleague of the practitioner's. She said that she felt she was being well looked after, and was confident her money has well spent;

(iii) but that practitioner then left the practice. The patient was not told;[29]

(iv) it was then that the patient began experiencing difficulties. She was meant to have been seen every month (sometimes more often), but there were *'… constant appointment cancellations, and moving appointments without any prior knowledge".* For example, an appointment might be made for a time and day, only to be told it was changed even after she had made arrangements to attend. She described that as having become 'the norm';

(v) by June 2018 her treatment was at the stage of refinement aligners. Moulds were taken. She was told that the aligners would be received in 10 working days. They did not arrive. The patient went to the practice four times to check, but found that it was locked up and in the dark;

(vi) the patient complained to the Council on 24 September 2018. At that time, she was already seeing other dentists to try to resolve her dental issues. She said that her gums were bleeding due to having to wear the same aligners for several months;

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[28] Patient 14 provided a statement of evidence in writing. Arrangements had been made for her to attend the hearing by AVL from the United Kingdom, but those were overtaken by the way in which the practitioner intervened in the hearing on its second day. In the end, the Tribunal accepted her statement of evidence as evidence in the matter without her being called.

[29] The patient asked the practitioner why she had been seen by the colleague if she (the colleague) was not properly qualified. The patient says that no answer was given by Dr Al-Mozany.

(vii) she says that she heard back from 'someone' (presumably, at the Council) reporting that the practitioner had been 'tracked down'. She was told that it would be another ten days before her aligners would arrive. That seems to have been followed by a telephone call between the patient and the practitioner. The patient asked for a refund of part of what she had paid. She says that the practitioner agreed

(viii) there was then an appointment which the practitioner attended. He told the patient that new photographs were needed. The patient was frustrated, but evidently agreed to attend a further appointment on 13 November 2018. That too was 'pushed out". In the end, it took place on 26 November 2018, but there was a new practitioner in attendance. Dr Al-Mozany was not present;

(ix) In December 2018 the patient was told by the new practice manager that the practitioner had agreed to refund $1,200.00.;[30] But nothing eventuated. The patient continued treatment with the new practitioner. And then, on 16 January 2019, the patient was contacted by the practice manager who wrote:

> *"Apologies for not getting back to you sooner. There has been a lot going on. Just before Christmas … (Saad's ex-business partner) took over the lease of the practice and changed the locks. We are no longer allowed to access the building, your aligners or treatment notes. We are legally unable to provide you his contact details but my understanding is that he is in possession of what is currently at the practice. Since the lease was taken over, Saad has ignored all correspondence from myself and* [the practitioner who had seen the patient on 13 November 2018]. *So, we are now in the same position as you, in the dark and unable to obtain information to help you guys. We are sorry this is happening …"*[31]

[30] The evidence was that *"the new practice manager confirmed that Saad had signed the form that he would refund me $1,200, and that he would like me not to leave a formal complaint*".

[31] The patient was then referred to the possibilities of complaining to the HDC or the Council.

(x) the patient has not been refunded any money. Her treatment has been completed by another practitioner. The patient has not had her treatment records from the practitioner.

[14] In overview:

(a) this cohort of patients and/or their parents have all reported very similar behaviours by the practitioner, including failure to keep appointments and cancellation of appointments at the last minute;

(b) the practitioner communicated with his patients only as and when he chose to. All of the patients report many instances of trying to contact him without success. It is to be emphasised that this is not a case of one or two missed calls or appointments. The evidence establishes a pattern of behaviour by the practitioner involving a substantial number of patients and lasting over a period of many months;

(c) the majority of the patients paid for their treatment in advance, but the practitioner left many treatments uncompleted;

(d) refunds were promised in some cases but – save for one exception – were not paid;

(e) there are at least three incidents of efforts by the practitioner to discourage patients from bringing or pursuing complaints against him.[32] In doing so, he consciously prioritised his commercial interests over those of his patients, and sought to avoid investigation;

(f) in several cases, the treatment that was provided was not appropriate.[33] There are also cases where the treatment provided (and, more often, the treatment that was not being provided) had harmful consequences for patients who were

[32] Patients 9, 13 and 14.

[33] That is not the subject of the charge, but it does have relevance to the issue of practitioner/patient contact.

left for example with aligners that did not fit, or which should have been replaced much earlier than they were;

(g) by the end of 2018 the practitioner had abandoned his Auckland practice. He made no effective attempt to ensure that his patients would receive ongoing care, or that the treatment they were entitled to would be completed. To the contrary, several of the patients report unsuccessful attempts to obtain their treatment records. The patients were simply left to look after themselves without access to their treatment records.

Relevant standards

[15] Assessment of the evidence is informed by reference to a number of relevant ethical and professional standards. Counsel for the PCC drew attention to the following:

(a) The Council has issued a Standards Framework for Oral Health Practitioners ('the **Framework'**).[34] This sets out minimum standards of ethical conduct that the public are entitled to expect from oral health practitioners. It establishes five primary principles which practitioners must adhere to at all times. In no particular order of priority, oral health practitioners must:[35]

(i) put patients' interests first;

(ii) ensure safe practice;

(iii) communicate effectively;

(iv) provide good care, and

(v) maintain public trust and confidence.

[34] Effective from August 2015.

[35] The PCC draws attention to the fact that these obligations are mandatory, not discretionary.

[16] Each of these principles is supported by a number of professional standards, some of which include notes for the guidance of practitioners. So, for example, the principle that oral health practitioners must put patients' interests first includes accompanying standards that:

> *1. You must ensure the health needs and safe care of your patients are your primary concerns.*
>
> *Guidance*
>
> *…*
>
> *Care for your patients in a consistently safe and competent manner.*
>
> *2. You must put the interests of your patients ahead of personal, financial or other gain.*
>
> *3. You must treat patients with dignity and respect at all times.*
>
> *Guidance*
>
> *Be open and honest, courteous, empathetic and supporting in all your interactions with patients.*
>
> *Be sensitive to patients' preferences, needs and values."*[36]

[17] The obligation to ensure safe practice is supported by a standard that:[37]

> *You must practice within your professional knowledge, skills and competence, or refer to another health practitioner.*
>
> *Guidance*
>
> *Practice safely and competently to ensure you do not cause harm to your patients …"*

[18] Similarly, the ethical principle that oral health practitioners must communicate effectively is supported by standards as follows:[38]

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[36] Framework, p 7.
[37] Framework p 11.
[38] Framework pp 14 & 15.

"13. You must communicate honestly, factually and without exaggeration.

14. You must listen to your patients and consider their preferences and concerns.

Guidance

Treat patients as individuals. Take their specific communication needs into account and respect any cultural values and differences …

15. You must give patients the information they need or request, in a way they can understand, so that they can make informed decisions.

Guidance

Provide clear information to patients …"

[19] With respect to the obligation to provide good care, the relevant professional standards include that:[39]

"20. You must provide care that is clinically justified and based on the best available evidence.

Guidance

Clinical justification is the progressive evaluation of treatment outcomes as part of professional accountability; it is of particular importance when treatment occurs over an extended period of time.

Assess the outcomes of treatment at regular intervals to determine if treatment should continue or cease, or if, and when a patient should be referred to another health practitioner or specialist.

…

22. You must protect and promote the health of patients and the public."

[39] Framework pp 19 & 20.

[20] Finally, with respect to the obligation that oral health practitioners must maintain public interest and confidence, there are the following standards:[40]

> *"23. You must ensure your professional and personal conduct justifies trust in you and the profession. …*
>
> *24. You must be familiar, and comply, with your legal and professional obligations. …*
>
> *25. You must act with honesty and integrity at all times with patients, colleagues and the public. …*
>
> *…*
>
> *27. You must protect the interests of patients and colleagues from any risk posed by your personal issues or health, or those of a colleague.*
>
> *28. You must protect the interests of patients and colleagues from any risk posed by your competence or conduct, or that of a colleague or employee."*

[21] The Council also has a practice standard for patient records titled "Patient Records and Privacy of Health Information Practice Standard" (the **'Patient Records Standard'**).[41] The Patient Record Standard provides, amongst other things that an oral health practitioner must give patients access to their personal health information on request, and in the form the patient prefers where possible (except when withholding grounds under the Privacy Act 1993 apply).

[22] In addition to the Framework and the Patient Record Standards, there are also competency standards relevant to the provision of dental and orthodontic care. These are published by the Dental Council of New Zealand/Dental Board of Australia. Of particular relevance in this case, entry level competencies for orthodontics include 'professionalism' and 'communication and social skills. Orthodontists are expected to practice with personal and professional integrity, honesty and trustworthiness.[42] Communication and social skills include effective communication with patients, their families and carers which takes into account the age, intellectual development, social

[40] Framework pp 23 & 24.
[41] Effective 1 February 2018.
[42] Entry -level competencies: orthodontics, p3.

and cultural background of the patients; and the use of technological and telecommunication aids in planning and delivering specialist treatment.

[23] Last but by no means least in this list, the PCC's submissions also referred to relevant provisions in the Code of Health and Disability Services Consumers' Rights 1996 ('the **Code'**). These standards apply to all healthcare providers. Of relevance in this case are Rights 1(1) (the right to be treated with respect), 4.2 (the right to services of an appropriate standard, including services that comply with legal, professional, ethical and other relevant standards), 5(1) (the right to effective communication), and 6(1) & (3) (rights to be fully informed).

[24] At bare minimum, the professional and ethical obligations owed by the practitioner to his patients as their orthodontist included obligations to put the interests of his patients first – i.e., ahead of his own personal, financial or other gains;[43] not to put their care at risk posed by his personal issues and/or competence;[44] and to communicate with patients in honest, open and transparent way.[45] It is these obligations which form the basis of the charge in this case.

Professional misconduct: legal considerations

[25] As relevant here, s.100 of the Act provides:

> ***100 Grounds on which health practitioner may be disciplined***
>
> *(1) The Tribunal may make any 1 or more of the orders authorised by section 101 if, after conducting a hearing on a charge laid under section 91 against a health practitioner, it makes 1 or more findings that—*
>
> > *(a) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred; or*

[43] Ethical Principle 1 in the Framework ('Put Patients' Interests First').

[44] Framework Standards 27 & 28 associated with the ethical principle that practitioners must maintain public trust and confidence.

[45] Ethical Principle 3 ('Communicate effectively') and associated standards 13 – 18.

(b) the practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, has brought or was likely to bring discredit to the profession that the health practitioner practised at the time that the conduct occurred; or …

[26] The following may be noted:

(a) assessing professional misconduct involves a two-step process.

(b) the first step requires an objective analysis of whether or not the practitioner's acts or omissions in relation to their practice can reasonably be regarded as constituting:

(i) 'malpractice', in the sense of that which is immoral, illegal, or where there is conduct that is unethical or in neglect of professional duties;[46] and/ or

(ii) negligence, in the sense described in *Cole v Professional Conduct Committee*[47] at [42]:

"Whether or not, in the Tribunal's judgment, the practitioner's acts or omissions fall below the standards reasonably expected of a health practitioner in the circumstances of the person appearing before the Tribunal. Whether or not there has been a breach of the appropriate standards is measured against the standards of a responsible body of the practitioner's peers."

and /or

(iii) that which brings discredit to the profession:

[46] Section 100(1)(a); see *Cole v Professional Conduct Committee* [2017] NZHC 1178 at [41]; *Johns v Director of Proceedings* [2017] NZHC 2843 at para's [76], [77], [85] and [107] and the authorities referred to by Moore, J in that case including that *"… Negligence or malpractice may or may not be sufficient to constitute professional misconduct… there must be behaviour which falls seriously short of that which is considered acceptable and not mere inadvertent error, oversight or for that matter carelessness."* (Cited from Gendall J in *Collie v Nursing Council of New Zealand* [2001] NZAR 74, at [21[).

[47] Moore, J quoting Nuttall 8/Med04/03P at [62]. The focus here is still s.100(1)(a) of the Act.

> *"To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation of the … profession was lowered by the behaviour of the practitioner concerned."*[48]

(c) the second step is to consider whether the acts or omissions in question warrant a disciplinary sanction. Authorities such as *Martin v Director of Proceedings* [2010] NZAR 333, *Johns v Director of Proceedings* [2017] NZHC 2843 and *Ms E* 347/Nur10/159P establish that the threshold for imposition of sanctions should not be set too high, and the objectives in imposing sanctions include not only penalisation of the practitioner and protection of the public, but also to provide clarity to the profession, and even assistance to the practitioner through the imposition of conditions on practice.[49] At the same time, the conduct must be that which departs from acceptable professional standards in a way that is sufficiently significant to attract sanctions for the purpose of protecting the public[50]; a disciplinary response is not required for minor errors that inevitably occur in professional practice.[51]

[27] It is open to the Tribunal to find professional misconduct under both s.100(1)(a) and s.100(1)(b): see *Vohora v PCC* [2012] NZHC 507.

[28] The PCC's research had not located any cases that are directly comparable with the present, but with respect to the obligation to protect patients' interests by ensuring ongoing care the Tribunal was helpfully referred to:

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48 *Collie v Nursing Council of New Zealand* [2001] NZAR 74 at [28]. The Council referred to in the passage was the Nursing Council of New Zealand. Here, the focus is s.100(1)(b) of the Act.

49 See, e.g., *Mckenzie v Medical Practitioners Disciplinary Tribunal* [2004] NZAR 47.

50 E.g., *B v Medical Council* High Court, Auckland 11/96, 8 July 1996 (it is noted that this case pre-dates the 2003 Act).

51 *Martin v Director of Proceedings* [2010] NZAR 333 at [23].

(a) *Buckingham* (510/OPT12/217P) in which an optometrist was found guilty of professional misconduct when practices over which she had had control were placed into liquidation. She had not made arrangements for ongoing care of the patients, or to enable them to access their health records. An aspect of the evidence against the practitioner in the present case is that he too made no arrangements to protect his patients as he found it more and more difficult to conduct his Auckland practice from Australia, and then finally abandoned the Auckland practice in late 2018. The following observation by the Tribunal in Buckingham therefore has some resonance:

> *'As a registered health practitioner, she continued to have professional obligations, and following the liquidation these were simply not respected or honoured; throughout this matter she has not unfortunately, displayed any insight into the difficulties which had been caused to multiple patients. Fundamentally, there has been a lack of appreciation of the importance of patient records … Ms Buckingham has demonstrated no insight as to the effect of her actions on patients …"*

(b) *Baker* (562/Mid12/211P) in which a midwife was found to be guilty of professional misconduct by failing amongst other things to make adequate arrangements for hand-over of patients when she ceased practice; and

(c) *Kapua* (227/Mid08/103D), another case about inadequate handover of a patient to another midwife when the practitioner took indefinite leave.

The case against the practitioner

[29] The first element of the charge is that the practitioner did not put the interests of his patients first, in that he failed to attend scheduled patient appointments; failed to provide ongoing care; and/or failed to provide orthodontic plates even when they had been paid for by the patients.

[30] As to the practitioner's failure to attend scheduled patient appointments, the evidence summarised above is replete with examples. To a greater or lesser extent, all of the patients and complainants reported the unreliability of appointments made. With

respect to occasions on which the practitioner simply failed to attend, the PCC particularly relied on the evidence of patient 5, patient 6, complainant 10, patient 11 and patient 14.

[31] The Tribunal has no doubt that this aspect of the charge is established, and that it amounts to professional misconduct. This is not an isolated case of a practitioner who for some legitimate reason could not attend an appointment at short notice. The evidence establishes a sustained pattern of behaviour over a period of many months. The reality is that the practitioner had come to treat his obligation to attend to his patients as optional, and as such sub-ordinate to his own interests.

[32] As for the allegation that the practitioner failed to provide ongoing care, again the evidence has a large number of examples. It will suffice to mention just four to illustrate:

(a) Patient 5 describes how the practitioner ceased all contact with her from around October 2018. Her treatment had commenced in 2016 but was not complete. The only possible inference is that, when it became inconvenient for the practitioner to continue to treat her, and he simply abandoned her;

(b) The evident of Patient 8 was that she was initially told that she would be able to see the practitioner every four weeks (when he flew in from Australia). After a couple of months, however, the practitioner started postponing appointments, so that the interval between appointments was more than a month. The patient's evidence is that she last saw the practitioner in November 2018. At that time, she was only halfway through her treatment. When he abandoned the Auckland practice, she was left to make her own decisions about when she should change her aligners;

(c) Complainant 10 gave evidence about the impact of the practitioner's failure to provide aligners that his son needed:

> *"The end result is that* [his son] *had two entirely healthy teeth removed, received no effective treatment for around two years, and now has*

permanent gaps in his smile. He is also several thousand dollars out of pocket and the aligners that he could have been using while this situation was ongoing were somewhere in Auckland but hadn't been provided to him."

(d) Patient 14 also described significant consequences as a result of the practitioner's failure to attend to her. She had her first treatment for Invisalign aligners in June 2018, and moulds were taken for refinement aligners. She was told these would take 10 working days:

> *"They never arrived so I texted, called, emailed with no response. I went into the practice four times in total, and every time the place was locked up and dark.*
>
> *This is when I knew something very wrong was going on as a couple of months had passed and I still hadn't heard anything from the practice. I was concerned for how the treatment would be completed, and if I would get my money back."*

In the result, the patient wore the same aligners for several months, leaving her with bleeding gums. She also incurred the cost of seeing another oral health practitioner to identify what was happening with her treatment.[52]

[33] Again, the Tribunal finds this element of the charge to be established.

[34] The third allegation of particular 1 of the charge is that the practitioner failed to provide orthodontic appliances that had been paid for by patients. The majority of the patients who gave evidence and those who made complaints about the practitioner had paid for treatment at the outset, but the treatment was never completed by the practitioner. For example:

(a) Patient 5 paid $8,470 for Invisalign treatment. She did not receive any aligners between February and May 2018. She certainly did not receive what she had paid for;

[52] The patient did see the practitioner in or about late September 2018 (the exact date is not clear), but not after that.

(b) Similarly, Patient 14 paid $8,000 in advance for Invisalign treatment. She did not receive refinement aligners following her first round of completed treatment in June 2018. By December 2018, she had been to see another dentist and moulds were taken. It is clear the patient did not get what she had paid the practitioner for. Her evidence was that the practitioner had agreed to refund $1,200 to her but nothing was ever received;

(c) Patient 2 reported having been told by the practitioner at an appointment that a then missing set of Invisalign trays had inadvertently been sent to one of the practitioner's Australian practices, and that he would have them urgently sent to New Zealand. The complainant says that they were never received:

> *"There were a number of different excuses. I was very patient about the first few times, but I am sure as many would, I now consider this not to be suitable treatment and am so very disappointed, especially given I made full payment."*

(d) Complainant 1 paid $8,000 in advance for braces and Invisalign treatment for her daughter. Her daughter was still wearing braces in May 2018. Nothing was received in relation to the Invisalign treatment, and the patient's mother reported that she did not have any money to pay for another orthodontist;

(e) Patient 8 paid $7,200 in full for Invisalign treatment. It was her evidence that the second set of aligners was only for her bottom teeth but moulds were taken for both her upper lower teeth. Her last appointment with the practitioner was in November 2018 (at this time, another dentist was also present). She did not see the practitioner again, although she was only halfway through her treatment;

(f) Patient 3 said in her letter of complaint to the practitioner that she had:

> *"Paid for my treatment upfront … Not only is my treatment incomplete but I have received what was agreed* [sic] *… I paid for treatment when I was 16 years old and worked incredibly hard to afford … orthodontic service that you clearly have no interest in fulfilling to a level of acceptable quality"*

(g) Patient 9 paid $6,900 to the practitioner for Invisalign treatment but, as with other patients, the practitioner simply stopped supplying her with aligners. After three months without treatment, she asked for a refund, but none was ever received. Her treatment was never finished;

(h) Complainant 13 said the practitioner was paid $8,350 for an 11-month treatment plan for his daughter, that was to have been completed by June 2017. Thirty months later, the treatment plan remained incomplete, and she had been on … *"one alignment retainer for over five months, when the accepted standard in this respect is for two changes of retainer every month".* This patient did receive a $2,000 refund from the practitioner in November 2018, but that was many months after the treatment ought to have been provided. Refund of the payment does not in any event excuse the practitioner's failure to provide treatment in the circumstances.

[35] Overall, the evidence establishes a pattern of payments for treatments that were never completed. There is little evidence that the practitioner explained why, or volunteered any apologies unless pressed to do so.

[36] The Tribunal regards this as professional misconduct of a serious kind. There can be no doubt that it is behaviour that brings the profession into disrepute. It goes well beyond mere inadvertence or negligence. In the Tribunal' assessment, there is a lack of morality about it. Even assuming (in the practitioner's favour) that he genuinely believed he would be able to provide treatments when they were being paid for up-front, his conduct demonstrates a total failure of commitment to follow up and provide the treatments he had been paid for (or at least to ensure continuity of care by another suitably qualified orthodontist). [53]

[37] The practitioner repeatedly put his own commercial interests ahead of the health of his patients.

[53] The Tribunal observes that in a letter to the Council in 2018 the practitioner asserted that patients that had asked for refunds were given them in a timely and professional manner. On the evidence available to the Tribunal, that statement is simply untrue.

[38] The second particular of charge is that the practitioner put patient care at risk by failing to regularly monitor orthodontic treatment, in failing to provide dental records as and when requested, and/or in respect of the way he responded to patient inquiries.

[39] The Tribunal accepts the PCC's submission in all of these respects.

[40] With respect to the allegation that the practitioner failed to monitor orthodontic treatments regularly, much of the evidence referred to above is relevant. Given the scale at which the practitioner was failing to attend scheduled appointments, and cancelling or postponing scheduled appointments at very short notice, the only possible conclusion is that he has displayed a profound lack of commitment to his professional obligations to monitor the treatments he was providing to his patients regularly and appropriately.[54]

[41] Concerns in that respect are exacerbated by the fact that these were specialist oral healthcare services that were being provided. Clinical procedures involved in the insertion and maintenance of orthodontic prostheses are a restricted activity under the Act.[55] The practitioner's repeated failure to monitor orthodontic treatments was, as the PCC submits, an egregious breach of his professional responsibilities in the broader context of the dentistry he was practising.

[42] With respect to the dental records that were requested, there was evidence of at least three patients who had asked for copies of dental records but were not provided with them.[56] The Code and the Patient Records Standard make it clear that the practitioner had obligations to provide his patients with access to their health information on request.

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[54] As the PCC submits, it may be inferred from the fact that an appointment has been made that the practitioner considered that it was necessary. The Tribunal considers it clear that there is professional misconduct when a practitioner cancels or postpone appointments, or simply does not attend at the agreed times, and does so on such a repeated and sustained basis as in this case.

[55] See Health Practitioners Competence Assurance (Restricted Activities) Order 2005.

[56] Patients 14, 11 and 2 in particular.

[43] The third element of particular 2 of charge is that the practitioner failed to respond to patient inquiries. As the PCC submits this is a theme that runs through many of the accounts given by the practitioner's patients. Three examples will illustrate:

(a) Patient 5 reported a period of up to five months without any contact from the practitioner, despite repeated attempts to contact him by telephone, email and in person at the practice;

(b) Patient 14 reported many attempts to contact the practitioner including visits to the surgery when she found the place to be *"locked up and dark".* It was her evidence that, throughout her treatment, she was not given any idea as to how the treatment was tracking or as to the end result: *"I felt very in the dark about my own treatment"*;

(c) Patient 2 wrote in her complaint that she had emailed and called the practitioner's practice over 50 times between May and August 2018 with no reply.

[44] There is more to the detail of the evidence on this topic. Again, it suffices to say that the Tribunal accepts the PCC's submission that the practitioner's persistent failure to respond to inquiries from his patients was unacceptable and unprofessional, and demonstrates a profound disregard for patients' interests. There can be no doubt that his actions in this respect did put the health of these patients at risk.

[45] Furthermore, the culpability of this conduct must be assessed in context of correspondence received from the Council as early as mid-June 2018. Another orthodontic specialist had written to the Council to raise concerns about patients having trouble contacting the practitioner for continuation of their orthodontic treatment.[57] . A Case manager at the Council then emailed the practitioner to ask for his response. He answered saying (amongst other things) that he was embroiled in

[57] By then, the Council had already received some other patient complaints directly as well.

dispute with his business partners at the Auckland practice. The Case manager wrote back:

> *"We remind you that all practitioners are required to comply with Council's Standards Framework for Oral Health Practitioners, comprised of ethical principles, professional standards and practice standards set by Council.*
>
> *Failure to meet the professional and practice standards and adhere to the ethical principles could result in Dental Council involvement and may impact on a practitioner's practice.*
>
> *The ethical principles include putting patients' interests first. The professional standards require that you ensure the health needs and safe care of your patients are your primary concern, and that their interests be put ahead of any personal, financial or other gain.*
>
> *The Dental Council should not be required to become involved in passing on communications from your patients to you, to ensure that your patients can contact you.*
>
> *Please ensure that you are, at all times, compliant with Council's standards framework; and please ensure that your patients are able to get in contact with you."*

[46] The warning was justified, and clear in its terms. The practitioner ignored it.

[47] The third and final particular of the charge is that the practitioner did not communicate with patients in an open and transparent way, in that he did not communicate when he was not available to see patients, and he failed to respond to phone calls and/or emails from patients regarding their treatment and/or appointments.

[48] This element of the charge is established on the evidence summarised above. The Tribunal has no hesitation accepting the submissions for the PCC that:

(a) the practitioner's repeated failure to communicate with patients was altogether at odds with his obligations to give patients the information they needed and requested, and to do so in a way they could understand; and

(b) his failures demonstrate a serious disregard for the interests of his patients.

[49] Taken as a whole, the evidence establishes that the practitioner had come to see his New Zealand patients as a source of revenue without concomitant responsibility. He routinely obtained upfront payments, but appears to have been oblivious to his obligations to protect and promote the interests of his patients. When it no longer suited him to provide treatment, he ignored them. It is not surprising that many of the patients reported feeling abandoned.

[50] The practitioner was able to make submissions on the issue of liability although, as noted, he did not file any evidence (not even his own). In his submissions, he drew attention to the fact that he had been excluded from the premises, and asserted that the practitioner he had been in business with would not allow him any access at all. He said that he could not communicate with patients after he was 'locked out'. There was, as noted, no solemnised evidence of any of these things. More than that, although the issue of timing was unclear it is apparent that the practitioner was still able to access the premises even in November 2018 because he was still seeing patients. Whatever it was about, his arguments with the other practitioner provide no explanation of any kind for his failures to communicate with patients in 2018. The practitioner's attempts to fix the other practitioner with responsibility for the practitioner's failings was unpersuasive to say the least.

[51] The Tribunal does not see the conduct that is at issue in this case as being mere negligence or inadvertence. The extent of the evidence is such that the practitioner must have been making deliberate choices, again and again, to prioritise his own concerns and interests over those of his patients. The Tribunal considers that to be conduct of a kind that falls within s.100(1)(a), in the sense that it was immoral, unethical and profoundly in breach of the practitioner's professional duties.

[52] In addition, and in any event, simply to state the evidence is to establish that it was conduct of a kind that was likely to bring the profession into disrepute: s.100(1)(b) is obviously also engaged here.

[53] The conduct is undoubtedly of a kind that is sufficiently serious to warrant a disciplinary response.

Conclusion as to liability.

[54] For these reasons, the Tribunal has concluded that:

(a) the charge is established in its entirety;

(b) the practitioner's conduct amounts to professional misconduct under both s 100(1)(a) and s.100(1)(b) of the Act; and

(c) the conduct is deserving of a disciplinary sanction.

Penalty: Introduction

[55] The PCC submitted that penalties should be imposed reflecting the seriousness of the practitioner's misconduct. It did not ask for the imposition of a fine. Instead, it submitted that the Tribunal should use the powers in s.101 (1) of the Act to order cancellation of the practitioner's registration,[58] for censure and to impose costs.

[56] Considerations in respect of penalty are set out in cases such as *Roberts v A Professional Conduct Committee of the Nursing Council*[59] and *Katamat v PCC*.[60] The considerations listed in *Roberts* include:

(a) what penalty most appropriately protects the public;

(b) the Tribunal's role in setting professional standards;

(c) the punitive element;

(d) any possible rehabilitation of the health professional;

(e) that any penalty imposed is comparable to penalties imposed on other health professionals in similar circumstances;

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[58] With conditions to apply on any application for re-registration.
[59] *Roberts v A Professional Conduct Committee of the Nursing Council* [2012] NZHC 3354.
[60] *Katamat v PCC* [2012] NZHC 1633.

(f) an assessment of the practitioner's behaviour against the range of sentencing options that are available (including to see that maximum penalties are reserved for worst offenders);

(g) the desirability of imposing the penalty that is least restrictive; and

(h) ultimately, whether the penalty proposed is fair, reasonable and proportionate in the circumstances of the particular case.

[57] As for comparable cases, the PCC referred again to the cases listed para [28] above as being those which come closest to the circumstances here:

(a) in *Buckingham*, the practitioner's registration was cancelled, she was censured, and she was required to pay 35% of the costs incurred.[61] In another passage that resonates with the facts here, the Tribunal observed that the practitioner

> *"… demonstrated no insight as to the effect of her actions on patients. For these reasons, it is not appropriate to consider any lesser option such as suspension."*

(b) in *Baker*, the practitioner was suspended for 6 months with conditions on return to practice for supervision for 18 months. She was also censured and a requirement to contribute to costs was fixed at 20%;

(c) in *Kapua*, the practitioner's registration was cancelled. The Tribunal made it clear that that was a function of the need to protect the public. The practitioner was censured, and was ordered to undergo a course of education if she ever sought to be re-registered. There was a costs order of $10,000, reflecting her limited financial circumstances. The Tribunal further recommended to Midwifery Council that, if she were ever to apply for re-registration, consideration should be given to the practitioner being supervised for a period of 18 months.

[61] Reduced from 40% because there was evidence of impecuniosity.

[58] The PCC also referred to the case of *Dr Kleszcz*:[62] This case concerned a doctor who had issued prescriptions written in the name of a patient for medicines intended for the doctor's use. The Tribunal noted that:

> *"… there appears to be a broader picture which requires comprehensive addressing and assessment. There is no guarantee that any period of suspension (and the maximum available is three years) would mean that there were any changes that could be assured to have occurred during that time.*
>
> *It is only by cancelling Dr Kleszcz's registration that, if Dr Kleszcz ever wishes to resume practice in New Zealand as a medical practitioner, she will need to take the appropriate steps for re-registration and have her position comprehensively and accurately assessed by the MCNZ; and in that way the Tribunal can ensure protection of the public*."

Cancellation or suspension?

[59] Against that background, the PCC sought an order for cancellation of the practitioner's registration. The submissions particularly referred to *Katamat v PCC*[63] and the importance of protection of the public as a primary consideration:

> *"… the case law reveals that several factors will be relevant to assessing what penalty is appropriate in the circumstances. Some factors, such as the need to protect the public and to maintain professional standards, are more intuitive in their application. Others such as the seriousness of offending and consistency with past cases, are more concrete and capable of precise evaluation. Of all the factors discussed, the primary factor will be what penalty is required to protect the public and deter similar conduct".*[64]

[60] The practitioner made submissions in relation to penalty to the effect that he had not caused any harm to any patients, and that communication with his patients was out of his control. He admitted that he had been out of his depth trying to run a practice in

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[62] *Dr Klesczc* 855/Med16/353P. The PCC also referred to several cases in which the practitioner had taken no part in the disciplinary hearing process: *Savage* (953/Nur17/389P); *Fernando* (860/Med16/352P), *Kurth* (651/Nur14/285D) and *Kora* (432/Nur11/192P). However, the practitioner here did take part – at least, after 20 July 2021.

[63] *Katamat v PCC* [2012] NZHC 1633.

[64] Ibid, at [53].

New Zealand from Australia: *"… it was not doable."* He added that he understood that the patients were angry with him and added that *"… I would like to apologise to each one personally and if need be pay them what they are out of pocket for when I can."*. He made it clear that he would accept a period of suspension, and supervision, but he resisted the suggestion that his registration might be cancelled.

[61] As the PCC submits, however:

(a) the practitioner has persistently breached the trust placed in him by his patients;

(b) his misconduct has been repeated, has involved breaches of fundamental aspects of professional practice, and took place over an extended period of a year. The practitioner has demonstrated a profound disregard for the interests of his patients and his professional obligations;

(c) there is nothing about his conduct that is likely to ensure public trust and confidence in the profession. Very much to the contrary;

(d) the practitioner's failure to have any proper regard to the complaints and concerns being raised by his patients during 2018 is troubling. Certainly, by no later than mid-June 2018, he was on notice of the concerns that had been raised because of the complaint that had been made to the Council by another practitioner. His behaviour did not alter;

(e) the practitioner has allowed his personal and business stressors to impact on his practice and the discharge of his professional obligations. He has repeatedly prioritised his personal interests over those of his patients; it is also of concern that – at least until this hearing was underway – the practitioner failed to take any meaningful part in the process of investigation that proceeded the laying of charges in the Tribunal. To the contrary, in June 2020 he sent an email to the Council saying that he no longer intended to practice in New Zealand. That appears to have been sent in an effort to stave off the disciplinary process.

[62] The Tribunal therefore accepts the PCC's submissions. It adds that, when he did appear at the Tribunal hearing (and to the extent that he elected to take part in it) the practitioner demonstrated no insight into the seriousness of his misconduct. He made and repeated a suggestion that what had happened was beyond his control because of the difficulties he had had with his business associates – as if those difficulties had somehow suspended his professional obligations, or rendered them ineffective. They did not.

[63] Perhaps of more concern, he made the submission that none of his patients had been harmed. In the Tribunal's assessment, he failed to understand what impact his misconduct has had for patients whose health and safety ought to have been his first concern throughout. The patients have all suffered significant inconvenience, stress, and (in some cases) actual harm through having to wear incorrectly fitting aligners or aligners that should have been replaced. The majority of the patients are also out of pocket, not to mention the delays they have suffered to get the treatment that the practitioner had promised them.[65]

[64] At the hearing on 9 March 2022, the practitioner said that if needed he would repay patients for work that had not been done (when he could). But it was an empty suggestion. He has had ample opportunity to make repayments before the hearing (including to patients to whom he promised reimbursement in 2018, but has made no payment). To effectively offer to refund money to patients at the hearing appeared to the Tribunal, in all the circumstances, to be rather more self-serving than real.

[65] There is a practical consideration as well. The practitioner lives in Australia. He has not held a practicing certificate in New Zealand since 2018. Realistically, if the Tribunal were to suspend his registration rather than cancel it, the period of suspension would be for a period of 18 months and quite likely longer. That would give rise to a break in practice of something like 6 years. It seems inevitable that there will need to be an

[65] In fairness, the PCC also submitted that none of the patients had suffered 'serious harm'. That is true if it means that none were injured or permanently disfigured (although in some cases, even that is not altogether clear). It is certainly not true if one considers wider factors such as delay in treatment, the stress of uncertainty, loss of money, and pain and discomfort suffered by those who either had the wrong treatment or aligners, or for whom the delays have meant that their condition is regressing.

assessment of his clinical competence, quite apart from any conditions required to address the conduct which is the subject of the charge.

[66] In the course of correspondence with the PCC while its investigation was under way, the practitioner asked the Council to de-register him on the basis that he was not planning to practice in New Zealand.[66] It is hard to see what burden there would be for the practitioner in ordering suspension, even if for a lengthy period and with strict conditions on return to practice. Nor does the Tribunal consider there are any obvious conditions that could be imposed (for example, in the nature of further education or retraining) that are likely to address the underlying lack of confidence in this practitioner's ability to meet his obligations to patients. There was nothing about the practitioner's engagement with the Tribunal process to reassure the Tribunal that the practitioner might be rehabilitated.

[67] It is difficult to identify any mitigating factors.

[68] Consistent with the approach in the *Kleszcs* case, the Tribunal considers the better course is to simply cancel the practitioner's registration and leave it to the Council to deal with any application to re-register – if and when it is made, and as the Council thinks appropriate. [67]

[69] As they apply in this case, none of the contrary considerations in *Roberts* outweigh the first and most important factor. The public is entitled to protection from this practitioner. The profession is also entitled to see its ethical principles and standards upheld and enforced.

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[66] At the hearing, he asserted that he did want to return to practice in New Zealand. If that is true, then making sure that he is fit to do so is all the more important.

[67] The PCC invited the Tribunal to impose limits under s 102 of the Act on any application by the practitioner for re-registration. The Tribunal does not consider that is necessary. It is confident that, if the practitioner were to apply for re-registration, the Council will be fully aware of this case and will be able to take steps required to ensure that, if the practitioner is to regain registration, there will be safeguards to ensure that the public is protected from any repetition of the conduct that has given rise to cancellation of his registration.

[70] The Tribunal has concluded that cancellation of the practitioner's registration is the appropriate disciplinary response in this case.

[71] Pursuant to s.101(1)(a) of the Act, the practitioner's registration is cancelled.

Censure

[72] The PCC also sought an order for censure of the practitioner under s 101(1)(d) of the Act. In the circumstances an order for censure is inevitable. There is an order accordingly.

Costs

[73] As discussed in *Cooray v Preliminary Proceedings Committee*,[68] the starting point for the assessment of costs in the Tribunal is usually 50% of the actual and reasonable costs incurred, although the Tribunal retains the discretion to increase or decrease that amount based on the particular circumstances of the case.

[74] Such information as the practitioner has given to the Tribunal indicates that he has or can obtain assets to meet costs.[69]

[75] For the period up to the end of the July hearing, the Tribunal considers it appropriate to order the practitioner to pay costs assessed at 40% of the actual and reasonable costs incurred by the PCC, and of the estimated costs in the Tribunal. That is consistent with (for example) the outcome in the *Buckingham* case. At least up until 20 July 2021, the criticism that could most obviously have been made of the practitioner's conduct in relation to the process was that he had failed to take any meaningful part in the investigative process, and that he had did not appear when the hearing commenced.

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[68] *Cooray v Preliminary Proceedings Commissioner* AP23/94, High Court, Wellington, 14 September 1995 (per Doogue J).

[69] The practitioner gave some financial information in the context of his application for adjournment made at the beginning of the day on 9 March 2022. If it is accurate, he appears to have assets although they may not be so easily liquidated. He did not, however, suggest that he would be unable to meet a costs award if made.

[76] The position changed on 20 July 2021. As set out above, the practitioner made contact with the Tribunal in the middle of the July hearing. He claimed to have had no knowledge of the matter. As a result, the hearing had to be adjourned. The October hearing then took place to deal with the practitioner's application for orders that would, if made, have effectively brought the matter to an end, and required the proceeding to start afresh (if at all).

[77] The focus of the October hearing was whether or not the practitioner had been aware of the matter before the July hearing commenced. Having heard from the PCC and the practitioner, the Tribunal decided that he was. It indicated that it would give its reasons for that conclusion in this decision.[70]

[78] The events that lead to the charge took place in 2018. By early 2019 the practitioner had abandoned the Auckland practice and was not in New Zealand. The evidence shows that he took no meaningful part in the PCC's investigation of the matter.[71] After a series of emails that were sent by the PCC to what the Tribunal will refer to as the practitioner's Gmail address, on 15 June 2020 the practitioner sent an email to the Council from that address under the subject line *"Email from the Dental Council"*. He wrote:

> *"I do not intend to practice anymore in NZ.*
> *Please remove me from the register.*
> *Kind regards*
> *Saad"*

[79] That email from the practitioner establishes that – at least at the point at which it was sent – the practitioner was using his Gmail address. It also establishes that the practitioner was aware of the fact that his practice was under investigation.

[80] The charge was sent by the PCC to the Tribunal on 30 October 2020. The PCC explained that it did not have a current address for the practitioner, but it did provide his Gmail

[70] The finding that the practitioner was aware of the case is relevant to the issue of costs, particularly those incurred after the July hearing. Some discussion of the communications that were sent to the practitioner before the July hearing is therefore unavoidable.

[71] Details of the attempts by the PCC to engage with the practitioner were given in the affidavit of Dr Huitema sworn on 27 April 2021.

address.[72] The Tribunal's Executive Office then made several unsuccessful attempts to locate the practitioner for the purpose of serving him with the proceedings.[73] Amongst other things, documents notifying the practitioner of the charge were sent to the practitioner's Gmail address on 3 November 2020. There was no bounce-back or other indication that the emails had not been received. There was no response from the practitioner either.

[81] In April 2021 the Executive Officer contacted the Australian Health Practitioner Regulation Agency. She was informed that on 31 December 2020 the practitioner had given the Agency a residential address in Alexandria, New South Wales (referred to in this decision as the practitioner's 'residential address').[74]

[82] On 3 May 2021, the Executive Officer posted a notice of the hearing[75] as well as the notice of proceedings and other related documents to the practitioner at that address.

[83] On 15 June 2021 the entirety of the PCC's case was posted to the practitioner at his residential address.[76]

[84] Nothing was heard from the practitioner.

[85] Quite apart from the posting of the proceedings to the practitioner at his residential address, all of the materials were provided to him at his Gmail address. There was (and is) no evidence that emails sent to that address have not been received. Although that address was not formally provided by the practitioner as an address for service of proceedings, there is no reason for the Tribunal to suspect that the materials that have been sent to that address have not been received at it.

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[72] And a telephone number, although the practitioner was not responding on that number by then.

[73] The details are set out in an affidavit filed by the Executive Officer sworn on 5 May 2021.

[74] The practitioner accepts that the address used by the Executive Officer is indeed his residential address.

[75] Which was by then set down to commence in Auckland on 19 July 2021.

[76] The materials were also sent on 31 May 2021. Postal records show that there were two attempts to deliver that package on 7 June 2021 but, when there was no-one to take the delivery and acknowledge receipt, the package was not left at the address. The package sent on 15 June 2021 was sent as an untracked parcel and was to be left at the address in the ordinary course.

[86] Section 156 of the Act governs the service of documents. Section 156(1)(b) provides that notice can be given to any person by pre-paid post to a last-known place of residence or business. Section 156(2) then provides:

> *"In the absence of proof to the contrary, a notice, document, or notification sent by post to a person in accordance with subsection (1)(b) must be treated as having been received by the person when it would have been delivered in the ordinary course of the post; and, in proving the delivery, it is sufficient to prove that the letter was properly addressed and posted."*

[87] The affidavit of the Executive Officer establishes that the documents that were posted to the practitioner on 21 April 2021 were posted to his residential address. As at 19 July 2021, there was nothing to suggest (must less establish) that they had not been received.

[88] The July hearing therefore commenced as scheduled. There was no appearance for the practitioner.

[89] The issue of name suppression was raised as a preliminary matter. At that time, an interim order had been in place prohibiting the publication of the name of the practitioner. The order had been made at an early stage in the proceedings on the grounds that it was appropriate to protect his anonymity until he had been served with the proceedings and had had an opportunity to engage in the matter. As noted, it seemed clear by the time of the hearing that he had chosen not to do so. The PCC submitted (and the Tribunal agreed) that there was no reason to continue the interim name suppression order in respect of the practitioner. The interim order ceased to have effect. No other orders were made preventing publication of the name of the practitioner and/or any identifying details.

[90] The case was widely reported in the New Zealand media on the morning of 20 July 2021. The New Zealand Herald, for example, led with a story about the case, with the practitioner named and a photograph of him prominent on the front page. The practitioner was in Sydney at the time. He was alerted to the publicity. He made contact with the Executive Officer. He subsequently attended the hearing by audio-visual link.

[91] The practitioner said that he had not received any of the documents that had been sent to him, and that he had been unaware that there was to be a hearing. He asked that the hearing be adjourned so that he could deal with matters. The application was opposed by the PCC, but in the circumstances the Tribunal considered that it was appropriate to allow the practitioner time to put forward any evidence to establish that he had not received any documents about the case (although, as noted, he accepted that the documents had been sent to his residential address).

[92] When asked about the documents that had been sent to his Gmail address, the practitioner said that, although that is and has been his email address, it had suffered intermittent interruptions such that documents sent to him at that address might not have been received. He explained that this was as a result of limitations put on his use of the account by Google. He said that he could and would provide evidence to prove what he was asserting. He added:

> *It* [the Gmail address] *was working for a period of time. It has been disabled twice because I haven't been able to pay for the upgrades to the storage with Google due to financial constraints. And with regards to it now, we have reactivated it but I can show the Tribunal the dates where the email was inactive. I need to go through all my emails. I need to go through my junk email. I need to go through my spam email. It's only been, I mean I found out about this whole Tribunal sitting down with this case, what, four or five hours ago, so I do need to go back and look at everything, …*

[93] The Executive Officer was asked to forward all documents in the case to the practitioner. When asked what email address to use for that purpose, the practitioner gave his Gmail address. It was only when the Executive Officer pointed out that he had been in touch that morning using a Hotmail address that the practitioner then gave his Hotmail address as the one to be used for future communications. He made no suggestion that the Gmail address had been discontinued.

[94] The need to establish that his Gmail address was inactive at material times was obvious and important. In its decision on the adjournment application,[77] the Tribunal said:

[77] Tribunal Minute No.6 dated 22 July 2021.

> *"In respect of the documents which have been forwarded to the email address* [i.e., the Gmail address] *he says that – while that has been and still is his email address – it has suffered intermittent outages (for want of a better description). He explains that this was a result of limitations put on his use of the account by Google. That presumably is something that he will be able to establish by documentary evidence in due course. He does not accept that documents sent to him at that address were received."*
>
> And later:
>
> *The practitioner is to have three weeks … to file anything that he wishes to put before the Tribunal on the limited question of whether or not he knew that the hearing was to proceed at 9.00 a.m. on 19 July 2021. The Tribunal observes that, if the practitioner wishes to persuade it that he was not aware of the hearing, then his evidence will need to be given by way of oath or affirmation (i.e., to be solemnised). The practitioner may also wish to put information about his Google account in front of the Tribunal, but that is for him.*

[95] The practitioner's application for an order that the matter not proceed[78] was heard by the Tribunal on 4 October 2021. Memoranda were filed in advance, including an unsworn statement by the practitioner in which he:

(a) asserted that he had never received the documents sent to his residential address; and

(b) said of his Gmail address that it *"… has been sporadically used since 2018 due to me switching to my Hotmail account … and my Gmail account being suspended due to it exceeding the storage limit and me not paying to upgrade my data with Gmail account"*.

[96] Beyond denying receipt, the practitioner did not offer any other evidence that might have helped the Tribunal to decide the matter in his favour. He did say that his post box at the current address is very small so that it might not have been possible to put a bulky envelope into it. He said that he had never had a card from the postal service in the box to notify him of a parcel to be uplifted. When questioned, he said that he could send a photograph of his post box at his address. As the PCC correctly pointed

[78] It was initially described as an application for adjournment but, in reality, it was an application that the hearing should be abandoned.

out, however, that was something he should have done in preparation for the October hearing. He did not take the opportunity to provide that evidence when he had it.

[97] Nor had the practitioner made contact with the Australian postal service to see whether or not it had any record of a parcel that it had not been possible to deliver to him because of the size of his post box.

[98] The Tribunal did not find the practitioner's denial of postal delivery of hardcopies to be persuasive. It concluded that the practitioner had failed to provide proof of non-receipt as contemplated by s 156(2).

[99] There was a second and independent reason for the Tribunal's conclusion that the matter should proceed. It relates to the Gmail address.

[100] Despite the discussion during the July hearing, and the wording of the Tribunal's subsequent minute, the practitioner did not put any information before the Tribunal to establish when his Gmail account was inoperative. When questioned at the October hearing, the practitioner repeated that he would be able to find the relevant records and put them before the Tribunal. But in the Tribunal's assessment he had been given ample opportunity to do so, and had failed to take it. Even allowing for the fact that he was not legally represented, the importance of establishing exactly when his Gmail address was not operating was obvious. The Tribunal's indication of the importance of that information could not have been misunderstood.

[101] As a result, and despite the practitioner's assertions to the contrary, the Tribunal was not willing to accept that his Gmail address was not receiving emails at the relevant times. The Tribunal did not accept that the practitioner had not received communications sent to him at that address.

[102] For those reasons, the Tribunal concluded the practitioner knew very well that the proceedings were taking place. He could and should have been ready for the July hearing.

[103] As a result, the Tribunal considers that all of the costs that were incurred after the July hearing were unnecessary. It is an exceptional situation.

[104] The Tribunal concluded that the appropriate response would be to require the practitioner to pay 90% of all of the costs that have been incurred in this matter after the end of July 2021.

[105] Fixing the costs after July 2021 at 90% is intended to provide a margin in favour of the practitioner so as to:

(a) recognise that – if the practitioner had not intervened on 20 July 2021 as he did – there would still have been some modest costs incurred to complete the July hearing;

(b) mitigate against the fact that some of the PCC's costs after July 2021 were incurred responding to inquiries made by other parties who became aware of the case because of the publicity; and

(c) ensure that there is no over-recovery of costs.

[106] The result is that the Tribunal has concluded that the practitioner must contribute 40% of the total costs incurred in the matter up to 31 July 2021, and 90% of the costs incurred thereafter.

[107] The PCC tabled a schedule of its costs and expenses. The Tribunal is satisfied that the costs claimed are reasonable. The total incurred for prosecution of the matter was $127,743.07. The Tribunal noted, however, that the estimate of costs for completion of the March hearing had allowed for two days of hearing, whereas only one day was required. Applying the approach of 40% of all costs prior to 31 July 2021, and 90% of costs thereafter[79] the Tribunal has concluded that the practitioner must pay the rounded sum of $57,500.00 in respect of the PCC's costs and expenses.

[79] But adjusting the estimate for the fact that only one day was required for the completion of the hearing.

[108] The Tribunal's estimated costs in the matter came to $85,427.11. Again, applying the approach of 40% to 31 July 2021 and 90% thereafter (and again adjusting the total amount for the fact that the March hearing was completed in only one day[80]), the Tribunal has concluded that the practitioner must pay the rounded sum of $41,500.00 in respect of the Tribunal's costs.

Name suppression

[109] Before the hearing took place interim orders had been made prohibiting publication of the names or any identifying details of:

(a) the patients or health consumers identified in the charge;

(b) the patients or health consumers named in the materials presented at the hearing; and

(c) the practitioner.

[110] When the question of name suppression was raised at the July hearing, the Tribunal put the orders which prohibit publication of the names and/or any identifying details of the patients or health consumers identified in the charge (and the patients or health consumers named in the materials presented at the hearing) on a permanent footing. That order continues to apply.

[111] As already explained, the interim order for name suppression in the case of the practitioner ceased to have effect at the commencement of the July hearing. There was then considerable publicity of his name. This was a matter of concern to him. By no later than 5 October 2021 he had asked for information as to the possibility of making an application for name suppression. It was not until the March hearing was underway, however, that he took the step of asking for another interim order to prevent publication of his name in connection with the proceedings.[81] The principal

[80] The adjustments are only in respect of the stenographer's and AV technician's time: all others are costs payable notwithstanding the shortened hearing.

[81] The practitioner made it clear he was asking for an interim order, not a permanent order.

reason he advanced was that publication of his name might be detrimental to family members. But there was only his assertion to that effect; no evidence was filed. In any event, the Tribunal could not ignore the publicity that had taken place in July 2021. It was not persuaded that the interests described could outweigh the importance of open justice in the circumstances.[82]

[112] The application for name suppression was declined.

Outcome

[113] For the foregoing reasons:

(a) pursuant to s 101(1)(d) of the Act, the practitioner is censured;

(b) pursuant to s 101(1)(a) of the Act, the practitioner's registration is cancelled;

(c) pursuant to s 101(1)(f) of the Act, the practitioner is ordered to contribute to the costs incurred by the PCC in the sum of $57,500.00;

(d) also pursuant to s 101(1)(f) of the Act, the practitioner is ordered to contribute to the costs incurred by the Tribunal in the sum of $41,500.00;

(e) the orders made the Tribunal at the July hearing pursuant to s 95(2) of the Act (prohibiting publication of the names or identifying details of patients or health consumers identified in the charge and/or named in the materials presented at the hearing) remain in effect.

[114] The Tribunal asks the Executive Officer:

(a) to publish this decision on the Tribunal's website; and

[82] The Tribunal referred to *Johns v Director of Proceedings* [2017] NZHC 2843 and *ANG v Professional Conduct Committee* [2016] NZHC 2949.

(b) to request the Council to publish either a summary of, or a reference to, the Tribunal's decision in its next available publication to members – in either case, including reference to the Tribunal's website so as to enable interested parties to access this decision.

Dated at Auckland this 7th day of June 2022

Royden Hindle
Chairperson
Health Practitioners Disciplinary Tribunal