DENTAL COUNCIL OF NEW ZEALAND
Te Kaunihera Tiaki Niho o Aotearoa

· DENTISTRY · DENTAL HYGIENE · CLINICAL DENTAL TECHNOLOGY · DENTAL TECHNOLOGY · DENTAL THERAPY ·

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DECISION NO: 02/DC08/01C

IN THE MATTER of the Dental Act 1995

-AND-

IN THE MATTER of disciplinary proceedings against **DR G** (name suppressed), Dentist, of XX

BEFORE THE DENTIST'S DISCIPLINARY TRIBUNAL

HEARING: 30 November 2009 to 4 December 2009, 7 December 2009

PRESENT: Dr Philip Coote (Chair)
Dr Warwick Ross, Dr Cathrine Lloyd, Ms Moana Avia (Members)

Mr John Upton QC (Legal Assessor)
Ms Gay Fraser (Executive Officer)

APPEARANCES: Mr Brent Stanaway and Ms Anne Toohey for Complaints Assessment Committee
Mr Harry Waalkens QC and Ms Aimee Credin for Dr G

INTRODUCTION

1. Dr G was at all material times a registered dentist.

2. On 27 May 2009 the Complaints Assessment Committee ("CAC") laid a disciplinary charge against Dr G with the Tribunal under the Dental Act 1988.

3. The charge alleges that Dr G excessively sedated and sexually abused three female patients while treating them.

4. It is expressed as follows:

> ***TAKE NOTICE*** *that a Complaints Assessment Committee established under section 45 of the Dental Act 1995 ("the Act") has reported to the Chairperson of the Dentists Disciplinary Tribunal under s 53(2) of the Act that in its opinion the complaints by* ***Ms N, Ms Y and Ms I*** *against Dr G should be considered by the Dentists Disciplinary Tribunal. The Complaints Assessment Committee has reason to believe that a ground exists entitling the Tribunal to exercise its powers under section 54 or section 60 of the Act.*
>
> ***Particulars of Charge***
>
> ***Dr G,*** *Dentist of XX, is charged as follows:*
>
> *1. In the course of his treatment of his patient, Ms N on 23 January 2001, in XX;*
>
> *1.1 Administered four 7.5 mg tablets of the sedative drug Hypnovel prior to administering a local anaesthetic, being twice the recommended maximum dose; and*
> *1.2 In administering the Hypnovel as particularised in particular 1.1;*
>
> *1.2.1 caused Ms N to fall asleep in his waiting room, which room was accessible to the general public; and in so causing, showed a total lack of respect for Ms N's feelings and/or dignity; and/or*
> *1.2.2 potentially endangered Ms N's wellbeing; and/or exposed Ms N to the risk of undesirable side-effects or consequences, including:*
> *while she was under sedation, inappropriately and with no clinical reason for doing so, on two occasions exposed his penis and then caused her right hand to touch or come into close contact with his penis; and on one occasion touched Ms N's right breast.*

The conduct alleged in Particulars 1.1, 1.2, 1.2.1 and 1.2.2 when each Particular is considered separately or two or more Particulars are considered cumulatively amounts to an act or omission in the course of or associated with the practice of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

2. In the course of this treatment of his patient Ms Y on 17 October 1984 at X:

2.1 On or around the time of her arrival at his surgery at approximately 5.00pm and when no nurse or other third party was present, administered 30mg of Valium intravenously, being well in excess of the average or recommended maximum dose; and/or

2.2 In administering the Valium as particularised in Particular 2.1 potentially endangered Ms Y's wellbeing and/or exposed her to the risk of undesirable side-effects or consequences including:
while she was under sedation, he inappropriately and with no clinical reason for doing so, caused her right hand to come into close contact with his penis.

2.3 Carried out the treatment or operative procedures in a room the door to which was locked and the curtains in which were drawn closed, and with no nurse or other third party present.

The conduct alleged in Particulars 2.1, 2.2 and 2.3 when each Particular is considered separately or two or more Particulars are considered cumulatively, either amounts to an act or omission in the course of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

3. In the course of his treatment of his patient Ms I on 28 September 1989 at XX:

3.1 Administered the sedative drug Hypnovel prior to administering a local anaesthetic, in a dose in excess of the recommended maximum dose; and/or

3.2 In administering the Hypnovel as particularised in Particular 3.1 potentially endangered Ms I's wellbeing and/or exposed Ms I to the risk of undesirable side-effects or consequences including:
while she was under sedation, he inappropriately and with no clinical reason for doing so, caused her right hand to touch and move over his penis.

The conduct alleged in Particulars 3.1 and 3.2 when each Particular is considered separately or two or more Particulars are considered cumulatively amounts to an act or omission in the course of or associated with the practice of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

LEGAL PRINCIPLES

Burden and Standard of Proof

5. The burden of proof lies with the CAC.

6. As to standard of proof, the appropriate standard is the civil standard, that is proof to the satisfaction of the Tribunal on the balance of probabilities, rather than the criminal standard. The degree of satisfaction called for will vary according to the gravity of the allegations.

7. In the decision of *Z v Complaints Assessment Committee*[1] the Court considered whether the standard of proof applying in criminal proceedings also applied to disciplinary proceedings. By a majority, the Court endorsed the flexibly applied civil standard of proof applied in recent years and found:

> *Balance of probabilities still simply means more probable than not. Allowing the civil standard to be applied flexibly has not meant that the degree of probability required to meet this standard changes in serious cases. Rather, the civil standard is flexibly applied because it accommodates serious allegations through the natural tendency to require stronger evidence before being satisfied to the balance of probabilities standard.*[2]

8. It went on to say that:

> *The natural tendency to require stronger evidence is not a legal proposition and should not be elevated into one. It simply reflects the reality of what judges do when considering the nature and quality of the evidence and deciding whether an issue has been proved to "the reasonable satisfaction of the tribunal". A factual assessment has to be made in each case. That assessment has regard to the consequences of the facts to be proved. Proof to a tribunal's reasonable satisfaction will, however, never call for that degree of certainty which is necessary to prove a matter in issue beyond reasonable doubt.*[3]

9. The Court considered whether the criminal standard of proof should apply to occupational disciplinary proceedings and concluded there was no good reason for

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[1] [2008] NZSC 55.
[2] Ibid at para 102.
[3] Ibid at para 105.

doing so.[4]

10. In this case, the charges are serious. As a result, the Tribunal has very carefully examined the evidence given that it must be sufficiently strong to satisfy the Tribunal to the appropriate level, especially particulars 1.2.2, 2.2, and 3.2.

Section 54 (1) Dental Act:

11. Section 54(1) of the Dental Act requires the Tribunal after conducting the hearing to determine whether it is satisfied that the dentist charged:

- has been guilty of any act or omission in the course of or associated with the practice of dentistry that was or could have been detrimental to the welfare of any patient or other person (s54(1)(b)); or
- has been guilty of professional misconduct (including, without limiting the generality of the foregoing, professional negligence) (s54(1)(c)).

12. There has not been a lot of discussion about the circumstances in which a dentist's acts or omissions will be conduct that is detrimental as opposed to professional misconduct. In *G v Dental Council*[5] Justice Morris held that:

> *A practitioner guilty of a negligent act detrimental to a patient may be found to have breached s54(1)(b). No element of misconduct need be established against him to support such a charge. To establish a charge under s54(1)(c) the element of misconduct must be established. It is this element which is the essential difference when a practitioner's conduct is being considered under the two subsections.*

13. Generally professional misconduct will be found in cases of serious and deliberate misconduct under 54(1)(c) such as fraud, sexual assault, or work of a very poor standard, or work of an extremely very poor standard[6] whereas less serious conduct such as careless or negligent practice has been found to be detrimental conduct under 54(1)(b) for example, omitting to tell a patient that a file had been lodged in a

[4] Ibid at para 118.
[5] *G v Dental Council*, HC Auckland, CP 58/95, Morris J, 4/3/96, at p9.
[6] *Director of Proceedings v Aladdin* 14/03/05.

root canal.[7]

Two stage approach

14. There are two steps involved in assessing what constitutes a breach of section 54(1)(b) or (c). The first step involves an objective analysis of whether or not the dentist's acts or omissions can be reasonably regarded by the Tribunal as constituting:

- an act or omission that was or could have been detrimental to the welfare of any patient or other person; or
- professional misconduct.

15. The second step requires the Tribunal to be satisfied that the dentist's acts or omissions require a disciplinary sanction for the purposes of protecting the public and/or warrant maintaining professional standards and/or punishing the health practitioner.

16. Not all acts or omissions made by a dentist will attract a disciplinary finding, "some alleged acts may, once the evidence has been put before the Tribunal, be so minimal or trivial as to not merit the sanction of the penalty provisions of the Act".[8]

Credibility

17. Credibility assessments are important in this case. This is because the only people that can give direct evidence about whether each incident happened are Dr G and each of the complainants. Therefore, it is very much the word of one person against that of the other in each instance.

18. What is involved in any test for "credibility" was articulated by a Canadian Appellate Court[9] which stated that the real test of the truth of the story of a witness

[7] *CAC v Gibson* CN01/163; 10 August 2004
[8] Supra at fn 5, at p 6.
[9] *Farynia v Chorny* [1952] 2 DLR 354 (BCCA)

is that it must be at harmony with the preponderance of the probabilities which are practical, and which an informed person would readily recognise as reasonable in that place and in those conditions**.**

19. So, the Tribunal, where relevant, must consider such factors as:

- The witness' manner and demeanor when giving evidence.
- Issues of potential bias – to what extent was evidence given from a position of self interest.
- Internal consistency – in other words was the evidence of the witness consistent throughout, either during the hearing itself, or with regard to previous statements.
- External consistency – in other words, was the evidence of the witness consistent with that given by other witnesses if any.
- Whether non advantageous concessions were freely tendered.

Propensity

20. The issue of propensity has arisen in this case. Where there are similarities in complaints which are sufficiently similar the Tribunal is entitled to take these into account when deciding whether the particulars are proved.[10] In this case the CAC says that the complainants and the offending are similar. In addition the number of complaints about Dr G is high when compared with other dentists. The Tribunal must consider the logical chain of reasoning by which the evidence on one charge may make the other charge more probable.[11]

21. The Tribunal is also mindful that propensity evidence is circumstantial evidence and should be examined alongside the other evidence when making a finding[12].

[10] Transcript at p 468, lines 10 – 13 (T 468/10-13).
[11] Cross on Evidence, at para EVA 43.5(c)
[12] Ibid.

INTERPRETATION OF PARTICULARS

Whether maximum dose must be proved to make findings on other particulars

22. The Tribunal considered the submission that Particular 1.1 needed to be proven in order to provide grounds for considering the next charge 1.2. The CAC is obliged under the Dental Act 1988 to communicate to the defendant the substance of the grounds believed to exist (s61(1)(b)). Therefore the charges must be sufficiently particularised.

23. There are two elements to particulars 1.1, 2.1, and 3.1. The first is the quantity of drug actually given in each case and the second is the strength of that dosage and whether or not they are "twice the maximum dose", "well in excess of the average or recommended maximum dose" or "in excess of the maximum dose" respectively.

24. In 1.2, 2.2, and 3.2 the charge reads "in administering the [relevant drug] *as particularised in particular 1.1 (or 2.1, 3.1)*" (italics added). The Tribunal considers that even if a dose in excess of the maximum is not proved, the Tribunal can then consider the subsequent particulars as long as the levels of dose set out in the particulars are proved. The Tribunal considers this meets the requirement that the charge has been sufficiently particularised.

Ms N's wellbeing

25. In closing submissions Mr Waalkens said that Dr G had not been charged with "other particulars of endangering wellbeing/undesirable side effects other than that as set out in the charge. Again the Act is very specific as are the obligations to do so in the charge".[13] Mr Waalkens went on to say that the Tribunal's decision of 16 November 2009 allowed evidence to be admitted from the experts' briefs of

[13] Closing submissions for Dr G at para 140, see s61(1)(b) Dental Act 1988.

evidence on the basis that the evidence either provided context or provided a modus operandi for Dr G[14] on the introduction of evidence.

26. It is true that the charge does not specify two matters that were discussed in the hearing: Ms N's breastfeeding, and the fact that Dr G was not at the premises when Ms A administered the Hypnovel.

27. However, the Tribunal considers that even though these matters are not set out in the particulars, the term "wellbeing" certainly encompasses the issues referred to in the preceding paragraph. In addition, the particular refers to "and/or" which the Tribunal interpreted as providing a wider field of enquiry than might otherwise have existed.

28. At a previous hearing on 30 October 2009, the Tribunal heard an application to exclude evidence from the witness briefs on a number of issues, including the effects of Hypnovel on breastfeeding. The Tribunal ruled that wellbeing could be interpreted to encompass these issues and so admitted that evidence.[15]

Ms N

Chronology of Events

29. Ms N saw Dr G on 7 November 2000 at his surgery at xx, XX. Dr G had treated Ms N previously. As she was a nervous patient and requested sedation, Ms N was sedated with four 7.5 mg tablets of Hypnovel (30 mgs) during her treatment at her next appointment on 13 November 2000.

[14] Ibid at para 141.
[15] 01Dec08/01C, 18/11/2009, at para 21.

30. Two days later, her treatment notes recorded that she did not recall the treatment or leaving the surgery, and that she was 'out for the whole afternoon', meaning that she was unable to function normally the afternoon after being sedated.

31. Ms N's next appointment was on 23 January 2001. She arrived at the surgery at around 9.00am that morning. She paid for the previous and current appointments at 9.05am.[16] At around that time Ms A, Dr G's assistant, gave her four 7.5mg tablets of Hypnovel. Dr G was not present at the time and arrived at the surgery about 9.15am.[17]

32. After being given the tablets, Ms N was seated in the waiting room. She then fell asleep.

33. Another patient Mr E came in to see Dr G. He required an adjustment to a previous restoration and passed through the waiting room on the way to the surgery (and presumably on his way out again).

34. Ms N was then assisted into the surgery. Ms A, Dr G's nurse, believes this was at about 9.35am. Dr G believes it was about 9.45am. Ms N was at that time very sleepy and had to be roused to be taken into the surgery. She was able to walk but needed the support of both Dr G and Ms A.

35. Once seated in the dental chair Dr G administered local anaesthetic by injection. Ms N was aware that this was happening. Dr G and Ms A report that she was disturbed during this procedure and required settling. Once Ms A settled Ms N, Dr G proceeded to attend to some paperwork and Ms A went into the reception area to make phone calls. Ms N was

[16] E 45.
[17] T 81/ 12-15.

aware of the calls being made. Ms A says that she moved out of the reception area twice into the surgery. She says her calls occupied her from 9.50am until 10.20am during which time she would have had a period of 10 minutes at some point when she was continuously in the reception area.

36. There were two allegations of sexual touching. The allegations arise from events which are said to have occurred before 10.23am, which is when Ms N telephoned her mother.[18]

37. Immediately following the second alleged touching of Dr G's penis, Ms N got out of the dental chair and accused Dr G of this. The commotion brought Ms A to the chair side. Ms N needed to be supported as she was still under some influence of the Hypnovel. She was restrained from leaving the premises for the same reason.

38. There is disagreement in the respective accounts about what happened immediately prior to Ms N getting out of the dental chair, and about events following the call she made to her mother.

39. Ms N alleges that Dr G had taken her hand and placed it on his exposed penis.

40. Ms N says that she "*began to come out of the sedative when I felt a warm sensation in my hand*".[19] She suspected that this was Dr G's penis, but does not recall how her hand came to be there.

41. In cross examination she said that she was aware and was trying to catch Dr G out.[20] She said in her evidence that the nurse left the room and that he had placed her hand on his penis again.[21] Ms N also stated a number of times that Dr G touched her right breast.[22] She refers to him pressing down on her breast, although was unsure if this amounted to the description of fondling.[23]

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[18] E 25.
[19] N brief, at p2.
[20] T 142/27.
[21] Supra at fn 19,at p3.
[22] Supra at fn 19, and T 141/4-13.
[23] Supra at fn 19, at p3 and T 141/15.

42. Ms N is not clear about when during the sequence of events the touching of her breast occurred. Ms N describes Dr G replacing her arm on the arm rest after the first contact with his penis when Ms A came into the room,[24] and then the second contact with his penis after Ms A left. She confronted Dr G immediately after the second contact. The parties do not remember the exact words she actually used at this stage, (and many of the actual words of most parties later) nor are they recorded.

43. Ms N then got up out of the chair. She and Dr G agree that she did this by herself. She stated that it was at about this time that she momentarily saw Dr G's penis. Ms N was unable to identify that it was indeed his penis but was adamant that she had seen a flash of flesh in the groin area.[25] Ms N states that Dr G said words to the effect that drugs can make a person believe she is being sexually assaulted. She stated that the nurse was not present at that stage and that Dr G immediately went into the other room to wash his hands as Ms N was getting out of the chair.[26]

44. Ms N does not remember the prop being removed from her mouth or the apron being removed. There is no record of how much time passed before Ms N went to the waiting area to call her mother.

45. According to Ms A's account of events she responded to noise in the surgery.[27] As she arrived there Ms N was getting out of the chair. She saw Dr G standing by the entrance to the sterilising room. She heard swearing but did not immediately know what had happened. Ms A does not remember the prop being removed from Ms N's mouth nor whether one had been placed in her mouth. Ms A says that Ms N asked permission to ring her mother, Mrs L, which Ms N then did.

46. Dr G denies that he twice placed Ms N's right hand on his exposed penis or that he

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[24] Supra at fn 19, at p3.
[25] T 146/30-31. 147/2-4.
[26] Supra at fn 19, at p4.
[27] A brief, at p4-6.

touched her right breast in any way.[28] He says that after assisting Ms N from the waiting room into the chair he and Ms A prepared her in what appears to be their customary way, including reclining the dental chair.

47. Dr G says he placed a prop in the left hand side of Ms N's mouth with some difficulty. While administering the local anaesthetic on the right hand lower region of Ms N's mouth, she became very upset.[29] Both Dr G and Ms A then calmed Ms N down. Dr G then repositioned the prop to the right hand side of her mouth, again with some difficulty. The remaining injections of local anesthetic were placed on the left hand side.[30]

48. Dr G said that Ms N was still a little weepy at this stage and Dr G and Ms A finally wiped her tears before Ms A left to make telephone calls. She returned to the chairside from time to time. Dr G reports that Ms A was engaged in her telephoning tasks from 10.00am until 10.15 am.

49. Dr G described a number of routine desk tasks he carried out, monitoring Ms N from time to time as he did so. He considered that her sedation was proceeding satisfactorily. The instrument tray remained over Ms N, that is, over her right shoulder.

50. He stated that at some stage he removed the mouth prop from the right hand side of the mouth and placed it on the left. As he did so Ms N "*suddenly woke and expressed anger and rage and was trying to say something*".[31] Ms N threw her arms about and struck Dr G on the forehead. He says he stood up from his stool and moved to the vicinity of the sterilizing room door to avoid being hit again. He signaled Ms A to come in to the surgery, although it appears that she was already on her way.

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[28] G brief, at paras 130-174 gives a detailed account of his recollection of events leading to the allegations.
[29] Exhibit 15, entry dated 23/01/01.
[30] Supra at fn 23, at para 144.
[31] Supra at fn 23, at para 154.

51. He said that Ms N had got herself out of the chair and was propped against the wall. Dr G states that Ms A removed the prop from Ms N's mouth. Ms N appears to have been unsteady and despite her efforts to leave she was restrained. Ms N declined to be seated until after the time that she made the call to her mother at 10.23am.

Findings

Particular 1: In the course of his treatment of his patient, Ms N on 23 January 2001, in XX:

Particular 1.1: [Dr G] administered four 7.5 mg tablets of the sedative drug Hypnovel prior to administering a local anaesthetic, being twice the recommended maximum dose.

52. The Tribunal considered this particular in two parts. First, the actual administration of four 7.5mg tablets of Hypnovel; and, secondly, whether or not the maximum dose had been exceeded.

Administration of Hypnovel

53. There is no dispute that the Hypnovel was in fact administered, which Ms A confirms in her brief.[32]

Whether the sedation administered was twice the recommended dose

54. The Tribunal notes that the particular refers to Dr G administering the Hypnovel. However, this is not the case, as Ms A gave Ms N the tablets to take. Nevertheless, as Ms A said in evidence she did not decide the level of dose given to each patient, as this was Dr G's decision.[33] Therefore, the Hypnovel administered by Ms A was, in effect, administered by Dr G as it was administered under his direction.

[32] Supra at 27, at p 3.
[33] T 50/31-33.

55. The Tribunal must first consider whether there is sufficient evidence to establish what a maximum dose of Hypnovel is for the purpose of conscious sedation. If so, then the Tribunal must determine whether Dr G administered Hypnovel at twice that dose.

56. On the first issue the Tribunal has based its findings on the literature available at the time of Ms N's treatment and the evidence of Drs Symes, Kruger, and Holden, all of whom have had extensive experience with sedation.

57. The most relevant literature is what was available at the time of Ms N's treatment: the 1999 Roche Data Sheet ("RDS")[34] and the Medsafe Data Sheet for health professionals of 25 August 2000("MDS").[35]

58. Under the heading "Intravenous Sedation, Adults" the RDS says, "Usual dosage range 2.5mg – 7.5mg as a total dose…..Dosages greater than 5.0mg are not usually necessary".. It must be borne in mind that the RDS relates to Hypnovel administered intravenously and that when Hypnovel is administered by tablet more is required because the bioavailability of Hypnovel in tablet form is significantly reduced. Nevertheless, the RDS does not specify a maximum. In addition, it refers to the *usual* dosage range as being up to 7.5mg and that a dose of 5.0 mg not *usually* being necessary (italics added). This must presuppose more than the upper range of 7.5mg can be exceeded and that more than 5.0mg will be used, even if only occasionally.[36] Therefore a dose of 7.5mg administered intravenously cannot be said to be a maximum level.

59. The Tribunal considered the information given about dosage levels in the MDS. This data sheet is aimed at health practitioners giving patients Hypnovel by tablet.

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[34] Exhibit 9.
[35] Exhibit 30.
[36] Supra at fn 34, p 2: patient information under the heading "How should Hypnovel be given" also refers to the usual adult dose being 5.0mg.

Of most relevance is the dosage levels specified under the heading "Dosage and Administration".[37] The standard dose for adults is in a range of 7.5mg to 15.0mg. The pamphlet goes on to say that; "[t]he maximum dose should not be exceeded because of the increased risk of CNS [central nervous system] adverse effects".

60. The Tribunal considers that the MDS implies a maximum dose of 15.0mg. However, the MDS is aimed at the treatment of insomnia or sedation in premedication before surgical or diagnostic procedures. Whether or not then the dosage levels can also imply a maximum dose for conscious sedation is something the Tribunal will discuss when it considers Dr Kruger's evidence on this point.

61. The Tribunal also considered the Roche Consumer Data Sheet of 15 July 1999 ("RDCS")[38] but considered it less relevant. First, it is not aimed at the health professional. Secondly, it did not refer to a maximum dose. Rather it referred to "normal dosage", which is 7.5 to 15.0mg for insomnia, and 15.0mg for premedication.

62. The Tribunal did not consider the Medsafe Data Sheets dated 17 September 2002[39] and 4 April 2008[40] to be relevant because neither was available in 2001. The Tribunal has not commented on the 1995 Roche data sheet as it had presumably been replaced by the 1999 data sheet. In any event, it also relates to intravenous administration and does not contain a maximum dosage.

63. The expert witnesses gave evidence on whether or not the literature specified a maximum dose. Dr Holden's view was that reputable authorities do not stipulate a maximum oral dose of Hypnovel.[41] Dr Symes, after some discussion on cross

[37] Supra at fn 35, p 3.
[38] Exhibit 31.
[39] Exhibit 8.
[40] Exhibit 32.
[41] Holden brief, at para 78

examination, conceded that the RDS and the MDS did not outline a maximum dose for Hypnovel.

64. Dr Kruger considered that the MDS implied a maximum dose for conscious sedation even though it was not written specifically for that purpose.[42]

65. The Tribunal finds that Dr Kruger's argument about an implied maximum has some force. According to the MDS, 15.0mg must be the maximum dose for the purposes of treating insomnia and premedication. Certainly, the Tribunal considers that in the absence of any other information on oral sedation by tablet, the maximum dose in the MDS may well be a guideline to what the maximum for conscious sedation should be. However, because the MDS was not written for conscious sedation, the Tribunal considers it is drawing too long a bow to find the MDS implies that 15.0mg of Hypnovel by tablet is the maximum dose for oral conscious sedation.

66. In conclusion, the Tribunal finds that Dr G administered 30mg of Hypnovel to Ms N. However, as it has not been proved what a maximum dose is, the Tribunal has no maximum dose on which to base a finding that Dr G administered twice that dose. Accordingly, particular 1.1 is not proved.

67. Having said that, the Tribunal makes comment on the level of dose given to Ms N. Dr Symes says that "*giving Ms N a single dose of 30mg of Hypnovel is clearly in excess of the manufacturer's recommendations and was unwise*".[43]

68. Dr Kruger in his evidence stated that the dose of 30mg of Hypnovel was "*many times more than the recommended dose for sedation*".[44] In line with the MDS he said that 15.0mg is an uncommon dose and would not be exceeded. He considered that the usual dose for oral sedation would be 7.5mg.[45]

69. It is clear that Dr Holden has administered larger doses of oral Hypnovel than either

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[42] T 223/22-33.
[43] Symes brief, at para 3.13.
[44] Kruger brief, at para 25.
[45] T 234/5.

Dr Symes or Dr Kruger. He says that he would use anything up to 20 mg orally.[46] Even so, Dr Holden agreed that the 30mg given to Ms N was extremely high.[47]

70. Although Dr Holden refers to a toxicology report prepared for Ms N which apparently stated that Ms N had received therapeutic levels of the drug,[48] the Tribunal does not give any weight to this statement as the report was not produced.

71. Dr Holden's comments that data sheets are often conservative and often not followed were considered by the Tribunal; however, the Tribunal prefers Dr Kruger's more measured approach where he said that manufacturers issue guidelines to ensure patient safety. In cross examination Dr Kruger said that clinicians "*learn to use guides, are expected to use them and do use them*".[49] Dr Kruger also said that in his own practice the guideline levels in the RDS were appropriate, and that he has never administered more than 15.0mg orally for conscious sedation.[50] Dr Symes said that keeping to within the manufacturer's recommended dosage reduces the risk of over sedation and undesirable effects[51].

72. The expert witnesses agreed that the bioavailability of Hypnovel is significantly reduced when administered orally. There was some discussion about whether bioavailability should be measured at 30% or 50%.[52] Certainly Dr G's evidence was that he estimated that when administering Hypnovel orally[53] about half of it or "maybe less" would be absorbed by the patient, which would indicate he worked on a bioavailability of about 50%.

73. If bioavailability of Hypnovel by tablet is calculated at 30%, this equates to just under 10.0mgs intravenously for a 55 kg person. This is higher than the RDS

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[46] T 366/3.
[47] T 368/18.
[48] T 379/31.
[49] T 253/31.
[50] Supra at fn 44, at para 29; T 234/5-8.
[51] Supra at fn 43, at para 3.12.
[52] T 261/14 – 262/14, also discussed in examination of Dr Kruger by Mr Stanaway at T 245/12-20.
[53] T 308/12 – 309/1.

guidelines for intravenous conscious sedation. The Tribunal considers this an omission bearing in mind that there is no opportunity for titration when the drug is administered orally.

74. Dr G stated that his usual dose of three or four tablets of Hypnovel was based on a number of factors: his knowledge of intravenous dosage levels, his experience of patients complaining of inadequate sedation with lower doses, patient factors including resistance or susceptibility to sedation, the type of procedure being undertaken, level of anxiety,[54] and an assessment of the patient's size by looking at them to determine whether they were small, medium or large.[55] Under cross examination, Dr G says that he did not particularly consider what a maximum dose might be.[56]

75. The Tribunal acknowledges there may be a wide variation in the doses practitioners administer. However, the Tribunal considers that a prudent practitioner would take steps to find out whether there are any guidelines available about a safe maximum dose and that any departure from those should be the exception rather than the rule. In 2001, those guidelines were available.

76. The Tribunal also notes that when Ms N was given the same dose at a previous appointment, two days after that treatment she reported that she had been "out" for the whole afternoon.[57]

77. In light of this, the Tribunal considers that the dose given to Ms N was unacceptably high.

Particular 1.2.1: In administering the Hypnovel as particularised in particular 1.1 [Dr G] caused Ms N to fall asleep in his waiting room, which room was accessible to the general public; and in so causing, showed a total lack of respect for Ms N's feelings and/or dignity.

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[54] Supra at fn 28, at para 44.
[55] T 318/34 319.
[56] T 309/30 – 310/11.
[57] Supra at fn 29, entry dated 15/11/00.

78. Ms N fell asleep in the waiting room.[58] There is some dispute as to whether or not she had lapsed into unconsciousness. Dr G believes she was not unconscious at the time. He says he and Ms A were able to wake her and that she walked albeit with some assistance into the surgery.[59] However, Dr Kruger considered that an oral dose of 30mg of Hypnovel would have rendered her unconscious while in the waiting room.[60] Whether or not Ms N was unconscious; there is no dispute that she did fall asleep in the waiting room, and this is how the particular is framed.

79. As a waiting room for patients, it is a room accessible to the general public. The Tribunal's visit to the premises confirmed this. As it happened, another patient, Mr E, accessed the waiting room while Ms N was there.

80. The evidence of Dr Symes and Dr Kruger was that allowing Ms N to fall asleep in the waiting area was a breach of Ms N's privacy[61] and dignity.[62] Dr Holden said while administering sedative drugs in waiting rooms was routinely done in the 1980s and 1990s, in 2009 this would be unacceptable practice. He said that by 2001 (the year of Ms N's treatment), he was not doing this.[63]

81. The Tribunal finds that allowing Ms N to fall asleep in the waiting area did not show total lack of respect for her feelings and/or dignity. The Tribunal considers that it is not best practice to allow this to happen. However, while it might show a degree of thoughtlessness, it falls somewhat short of showing the "total lack of respect for Ms N's feelings and/or dignity" as outlined in the particular.

82. In addition, the Tribunal notes that this was not of particular concern to Ms N.[64]

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[58] Supra at fn 28, at para 134.
[59] T 328/24 to 329/10.
[60] Supra at fn 44, at para 32 (b).
[61] Supra at fn 44, at para 32 (b).
[62] Supra at fn 43, at para 3.23; supra at fn 44, at para 32 (b).
[63] Supra at fn 41, para 80.
[64] T at p 155/10-15.

83. The Tribunal is also mindful that Dr G should be judged according to the standards of the time. The Tribunal was not referred to any rules, guidelines, or directions in force in 2001 on this issue.

84. Therefore this particular is not proved.

Particular 1.2.2: In administering the Hypnovel as particularised in particular 1.1, [Dr G] potentially endangered Ms N's wellbeing; and/or exposed Ms N to the risk of undesirable side-effects or consequences, including while she was under sedation, inappropriately and with no clinical reason for doing so, on two occasions exposed his penis and then caused her right hand to touch or come into close contact with his penis; and on one occasion touched Ms N's right breast.

85. The Tribunal considered this particular in two parts: firstly, whether Ms N's well being was potentially endangered by the administration of Hypnovel, and secondly whether it exposed her to undesirable consequences including the sexual touching.

Wellbeing endangered?

Administered sedative in the absence of Dr G

86. The Tribunal considered whether administering Hypnovel to Ms N in the absence of Dr G endangered Ms N's wellbeing. At the time Ms A administered the Hypnovel, Dr G was not at the surgery, arriving about 15 minutes later. Dr Symes said that because the clinician is responsible for administering the sedation and the welfare of the patient, the clinician should be on site when the sedation is administered.[65] This is relevant, for example to the possibility of an anaphylactic reaction to a drug. Just because Ms N had already been given that drug, does not make this event less likely when administered a second time.[66] Dr Symes went on to say that there is a risk of harm but that the risk was remote.[67]

[65] T 176 at 11-17.
[66] Ibid.
[67] T 176 at 19-20.

87. Dr Holden says that this criticism is harsh and unreasonable,[68] but ideally Dr G should have been present.[69]

88. The Tribunal finds that even if remote there was a potential risk to Ms N in administering the Hypnovel without Dr G present, particularly considering the unacceptably high level of sedative given. Therefore, on this point, this part of the particular is proved.

Administered Hypnovel while breastfeeding

89. At the time of the administration of the 30mg of Hypnovel Ms N was breastfeeding a baby.[70] The administration of Hypnovel to breastfeeding women is contraindicated[71] as the RDS states, "[s]ince midazolam passes into breast milk, Hypnovel should not be administered to breastfeeding mothers".[72] The MDS also makes the same point.[73]

90. Two of the experts addressed the issues of Hypnovel and breastfeeding. Dr Kruger says that Hypnovel can be administered to a breastfeeding mother provided care is taken: arrangements should be made to avoid breastfeeding for 6 hours after sedation, and the smallest doses should be used.[74] Dr Symes confirmed this but said that the patient should not breastfeed the infant for a minimum of 12 hours.[75] Dr Symes said that Ms N's baby would have received a dose of Hypnovel which could have been detrimental to the baby's health.[76] Dr Kruger states that Dr G used a dose high enough to expose the infant to unnecessary sedation[77].

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[68] Supra at fn 41, at para 81.
[69] Ibid at para 83.
[70] Supra at fn 44, at p5.
[71] Supra at fn 35, at p4, under "Pregnancy, nursing mothers".
[72] Supra at fn 34, at p3 under "Pregnancy and Lactation".
[73] Supra at fn 35, at p5 under "Pregnancy, nursing mothers".
[74] Supra at fn 44, at para 11, bullet point 4.
[75] T 178/20-25.
[76] Supra at fn 43, at para 3.15.
[77] Ibid.

91. Dr G agreed that if he had known Ms N was breastfeeding, he would not have administered Hypnovel to her.[78] It follows then that he cannot have known whether she was breastfeeding at the time. Dr G certainly accepted that he had a duty to know if a woman of child bearing age was breastfeeding.[79] Therefore, the Tribunal finds he should have ascertained whether or not this was the case.

92. The Tribunal notes that Ms N's treatment notes recorded that at one point she was having trouble finding a babysitter.[80] Even though this could relate to children who were not being breastfed, the mention of a babysitter should have alerted Dr G to the possibility.

93. As a result, the Tribunal finds that one of the consequences of the administration of Hypnovel to Ms N at an unacceptably high level is that it could have been detrimental to the baby that she was breastfeeding at the time.

94. However, the issue is does something that exposes Ms N's baby to potential harm, endanger Ms N's wellbeing?

95. Wellbeing encompasses both mental and physical considerations. The Midazolam will have passed into Ms N's breast milk and as a result her breastfeeding of the child placed the baby's wellbeing at risk. The Tribunal considers that any potential risk to the baby is necessarily a potential risk to the wellbeing of the mother. The Tribunal finds that Ms N's wellbeing was potentially endangered in such circumstances.

Risk of undesirable consequences including touching of Ms N's breast and placing Ms N's hand on Dr G's penis

96. The Tribunal is mindful that this is a very serious charge and has considered the

[78] T 323/33.
[79] T 324/7.
[80] Supra at fn 29. entry dated 21/11/00.

matter at length and with great care taking into account the fact that a high standard of evidence is required.

97. The Tribunal was required to consider the conflicting descriptions of events given by Ms N and Dr G. There was witness evidence from those who were there very shortly after the alleged events in question took place, Mrs L and Ms A, and police officers who investigated the alleged incident, Officers Power, Mitchell and Bermingham. Expert witnesses Drs Symes, Kruger and Holden have given evidence on the question of hallucination under the influence of benzodiapine drugs and a phenomenon known as emergence delirium.

Level of consciousness

98. The Tribunal considers that Ms N was sufficiently conscious at the time immediately before, during and immediately after the alleged incident to have an accurate recall of events.

99. Ms N had a good recall of what was going on around her, she remembered the nurse making phone calls[81], which was indeed the case.[82] Ms A recalls Ms N's eyes following her.[83]

100. Ms N recalls two episodes of sexual touching. At first she was not sure and so decided to wait to see if Dr G did it again. She recalls Ms A coming back into the room and her arm being moved back onto the arm of the chair.[84] She remembers the nurse going out and that her hand was on Dr G's penis moving in an up and down motion and that he had put his hand on top of her hand.

101. She immediately confronted Dr G. She also said in her brief that she saw his penis for a second, although under cross examination she conceded that what she saw was

[81] Supra at fn 19, at p 2.
[82] Exhibit 25.
[83] T 68/31-32, T 219/7-17.
[84] Supra at fn 19, at p 2.

a flash of skin in the groin area that she believed to be Dr G's penis.[85] This is in contrast to the other two complainants, who for whatever reason did not see anything. Even though Ms N made a concession, the fact remains she said that she saw a flash of skin in the groin area. It is hard to understand why and how she would have seen this under usual circumstances.

102. According to Ms A Ms N was slurring her words, but it was obvious to her that she was alleging something improper had happened.[86]

103. Immediately afterwards she remained comparatively lucid: she knew about the possibility of forensic evidence and told him he should not be washing his hands, and so was clear enough in her mind to be thinking about gathering evidence. She remembered flicking up Dr G's apron, which Dr G also recalls.[87]

104. Shortly afterwards, she was able to hold a conversation with her mother and a police officer. Ms N's mother described her as exacting, and appeared "with it"[88] compared to the previous time Ms N was treated where even though she had been given the same dosage, she had fallen asleep for a long period.

105. At the time, she asked Dr G, *"what the hell was that then?"* Although under cross examination she was asked if this indicated an element of uncertainty with her recollection[89], she was very clear that this was said sarcastically[90] rather than because she was uncertain.

106. Detective Sergeant Mitchell observed that while at the premises he spoke with Ms N. He said that she had a little difficulty in talking, but that she was quite lucid.[91] Certainly Ms N was less lucid later on at the police station[92] but she does say that

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[85] T 146/33, T 147/2-6.
[86] T 152/ 23-24.
[87] T 325/28.
[88] L brief, at p 2.
[89] T 149/9-10.
[90] T 149/3, 11.
[91] Mitchell brief, at p2.
[92] Bermingham brief, at p 2.

she felt sleepier there than in the period after the alleged assault where she felt more coherent.[93]

107. Dr Holden says that Ms N reported feeling dreamy when she felt Dr G touching her and that this is not consistent with a light level of sedation.[94] He concludes that this dreamy feeling together with the detailed description of an alleged assault means that it is likely that Ms N suffered from amnesia and there was a possibility of confabulation,[95] which the Tribunal understands to mean unconsciously replacing fact with fantasy in one's memory or giving a false account to fill a gap in a memory.

108. Ms N was sedated. However, even if she was "dreamy" her level of consciousness meant that she could also recall the nurse making phone calls and the nurse coming in and out of the room. These were specific memories that had nothing to do with the sexual touching. In the Tribunal's view this is consistent with Ms N being in a state of consciousness where she was aware of what was happening around her immediately before the assault. Her later actions are also consistent with being in the same state of consciousness.

109. This is not to say that Ms N remembered everything at the time. She did not remember the mouth prop.[96] However, it should be noted that Ms A did not remember the mouth prop when she was asked about it being moved earlier in the treatment.[97] Ms N also did not remember such things as the removal of the glasses or the apron.[98] However, the Tribunal does not consider that this weakens her evidence as a witness can be hard pressed to remember every detail. In any event,

[93] T 151/26.
[94] Holden brief, at para 78.
[95] Holden brief, at para 72.
[96] T 147/8, 148/13-14.
[97] T 68/23-25.
[98] T 147/19-26

what she did remember showed, in the Tribunal's view, that she was sufficiently alert at the time.

110. Certainly the effects of the sedation were noticeable earlier on when Ms N fell asleep in the waiting room and had to be led to the chair. She also had to be calmed a little later on when the local anaesthetic was administered.

111. However, in the Tribunal's view, she appeared to have a high level of consciousness and awareness immediately before and during the incident. She knew what was happening around her, including the nurse making telephone calls. She remembers one suspected incident where her hand came into contact with Dr G's penis. She waited to see if he would do it again, so that she could catch him out. She observed the same thing happening again, that she had her hand placed back on the penis and that her hand went up and down on the penis. Therefore, the Tribunal finds it highly unlikely that she was hallucinating at the time of the touching, in the same way it finds that her actions show that she could not have been in the same state afterwards.

112. On this basis the Tribunal finds at the time of the alleged touching that although she was sedated she was conscious and aware, and was not in the kind of altered state consistent with hallucination.

113. Ms N also related a pushing sensation on her breast. As the Tribunal considers that there is sufficient evidence to show that Dr G's penis came into contact with Ms N's hand, the Tribunal finds that it is more likely that this also happened.

114. It was put to her during cross-examination about whether an instrument tray could have come into contact with her breast.[99] However, the Tribunal considers that the instrument tray touching against her breast is not consistent with Ms N's description

[99] T 142/9-11.

of feeling as though Dr G was checking her glands.[100] Further Ms N says that she was "not just sure", but "very sure" Dr G touched her breast.[101]

Setting

115. The Tribunal considered whether the touching could have happened taking into account the setting, and whether it could be done in a way which could not be seen by others. The Tribunal considers that the setting in this case provided sufficient opportunity for the touching to have taken place.

116. The Tribunal visited the premises at xx and was able to obtain a better idea of the layout than the photographs provided.[102] The premises are smaller than the photographs suggest.

117. The surgery has a reception area partly separated from the surgery itself, by means of an angled dividing wall. This was as the result of alterations in 1993. At the other end of the surgery there is a separate sterilising room with a small window between the sterilising area and the surgery. The Tribunal also noted that a large window in the surgery overlooks a small carpark on the property adjacent to the footpath.

118. The patient's chair now there, was not there in 2001[103] and the current patient's chair is slightly to the right (as seen from the head of the chair) of the position of the chair that was there in 2001. This means the current patient's chair is less easily able to be seen from the reception area behind the angled wall than the previous patient's chair.

119. Ex-Detective Sergeant Bermingham was cross examined at length about the size of the rooms, and the Tribunal agrees with Sergeant Bermingham that the rooms are small and that in the normal course of the conduct of dental practice the staff and

[100] Supra at 19, at p3.
[101] T 142/13.
[102] Bundle of Documents ("BOD") Tab 1
[103] T 293/20.

patients would never be any great distance from each other.

120. The Tribunal considers that while sitting at the reception desk, the receptionist/dental assistant would not be able to see the patient's treatment chair in the surgery. The Tribunal came to this conclusion from its inspection. Although the patient's chair has been positioned slightly further to the right since Ms N's treatment; nevertheless, the Tribunal also considers that, unless the receptionist moved her chair back for at least a metre and looked around the corner of the angled wall she would not have seen the patient's chair in its original position. Mr Bermingham conducted a scene examination on the premises following Ms N's complaint. He noted that while sitting at the reception desk the receptionist/dental assistant would not be able to see the patient's chair in the surgery.[104] This is significant, because Ms A spent time in the reception area making telephone calls before Ms N's complaint.

121. The Tribunal concludes then that if Dr G was at approximately the waist level of Ms N (reclined or otherwise) and facing her, it would be physically possible for him to have Ms N's hand in his lap and for this to be not visible from the reception area or the waiting room.

122. Further, on the site visit, Dr G indicated that the door between the waiting room and the surgery would be shut when there was a patient in the chair.[105]

123. Ms A's evidence is that she would not have to roll her chair back to see the patient's chair,[106] however, the Tribunal does not accept this. It has already concluded that this is unlikely from its site visit[107] and is supported by Mr Bermingham's recollection.

124. Both Ms A and Mr Bermingham stated that the carpet would lessen the noise made

[104] Supra at fn 92, at p 6.
[105] T 342/9.
[106] T 64/2.
[107] See para 112.

by movement of the receptionist's chair. This suggests perhaps that the receptionist could come back into the surgery area with little warning. However, there are other ways that a person in the surgery would be alerted to the fact that someone might come into the surgery, such as, the time when the receptionist finishes a phone call.

125. Dr G said that he customarily plays music in his surgery, which can be heard over the drill.[108] This was confirmed by Ms A.[109] Presumably this level of sound means that Dr G may have been less able to hear people come in and out of the surgery. However, Ms N remembers hearing Ms A making telephone calls just prior to the touching, music playing or not.

126. The surgery's window which overlooks the adjacent car parking area, near the footpath means that people might be able to see into the surgery from outside. However, this also means that anyone in the surgery sitting in the dentist's chair on the patient's right would either be in a position to see out if they were adjacent to the patient, or alternatively, they would have their back to the window facing and still be seated to the right of the patient, which would obscure the view of anyone looking into the surgery.

127. The Tribunal noted that it was physically easy to move the dentist's chair from the head of the patient to the right of the patient. It may well have been easier during Ms N's treatment because the previous chair was further to the left. Further, in this position it is not difficult to move a patient's hand into the dentist's lap once the dentist has moved to the right of the patient. Detective Sergeant Power's examination of the scene also led him to that conclusion.[110] His conclusion was "*that placing a patient's hand on the vicinity of the surgeon's lap was a physical*

[108] T 294/33.
[109] T 64/17-21.
[110] Power brief at p 1.

possibility" and that *"a patient's hand could be moved into the position of the [dentist's] lap without great difficulty".*[111]

128. Certainly the Tribunal acknowledges that the setting posed a risk of discovery. The CAC submitted that this may have added an element of excitement. However, the Tribunal does not consider that this point should or can be taken any further, but rather confines itself to saying there was sufficient opportunity in the surgery setting for the touching to have taken place.

Time frame

129. The Tribunal also considers that the time frame that elapsed made the events outlined by Ms N more likely to have happened.

130. The Tribunal examined the Telecom call log[112] which records the minute but not the second at which each call is placed. The duration of each call is recorded to the minute and second. Ms N's treatment began at 9.05am and ended shortly before 10.23am, which is when she rang her mother. Ms A stated that she was on the phone at the time when she heard a commotion. This must have been at 10.20am as the call log records a call being placed at that time. There was no evidence given that this call was cut short in order for her to respond.

131. Ms N's evidence is that the disturbance followed the second alleged contact of her hand with Dr G's penis and that before that Ms A had been in the surgery. Ms A's previous call was at 10.15am and an unknown number of seconds, which lasted 2 minutes and 39 seconds. It follows that it was possible for Ms A to have been away from the phone and her desk for a period of between 1 minute and 22 seconds (had the call been placed at 10.15.59am) and 2 minutes and 21 seconds (had the call been placed at 10.15.00am). This period would be long enough for Ms A to perform

[111] Ibid.
[112] Supra at fn 18.

small tasks away from her desk and to have been seen by Ms N in the surgery. Before the 10.15am call Ms A had been on the phone for four and possibly five minutes with short intervals between each call. In any event, Ms A stated in re examination[113] that it might have been minutes between her having last looked at Ms N and the disturbance of Ms N getting out of the chair.

132. Therefore, the Tribunal considers that Ms N's version of events is chronologically consistent with the phone log, and Ms A's evidence.

Credibility

133. The Tribunal considered Ms N to be a credible witness, in particular she conceded freely at points during questioning, for example she said that she did not remember certain things happening such as the removal of the apron and glasses. She also conceded that she saw a flash of groin[114] which she believed to be the penis, even though she originally said that she had seen Dr G's penis. She was also happy to say that she did not take offence about being left asleep in the waiting room area, even though this formed one of the particulars in the charge.

134. The Tribunal did not have major problems with Dr G's credibility generally. However, the Tribunal considered that in the face of Ms N's evidence Dr G's evidence was less compelling. The Tribunal considered he was unwilling to concede things that were obvious if they were potentially adverse to him. For example in the 2002 criminal trial, the Tribunal heard that the defence was that high dosages of sedative might be more likely to cause hallucinations[115]. Dr G agreed with this[116]. However, under cross examination at this hearing he was hesitant about admitting that the doses were high saying that it was possible[117] and that he

[113] T 75/32.
[114] T 147/2-4.
[115] T 304/6-9.
[116] T 304/9/11/15.
[117] T 303/26/29, 304/5.

was not sure[118] if the high dose contributed to the allegations made by the complainants. The Tribunal considers this is because the charges in these proceedings addressed the level of dose.

135. The Tribunal also found Dr G's hesitation puzzling when questioned about the slightly less important matter of whether the dentist's chair in the surgery of the xx premises could be easily moved from the head of the patient to the patient's right. At first he said no a number of times[119] and explained why this was the case.[120] However, eventually Dr G said that the chair could be moved easily and that Mr Stanaway had not asked him that in the context of when he administered IV sedation.[121]

136. The Tribunal considers that regardless of the procedure being carried out either the dentist's chair could move position easily or it could not, and so the answer to the question must be straightforward. It was very obvious to the Tribunal from its inspection of the premises that the dentist's chair could be moved in that fashion, even though the current patient's chair was slightly further to the right than the previous chair.

Hallucination

137. Dr G's argument was that it was possible that Ms N suffered from a sexual hallucination. He said that hallucinations under Hypnovel could not be discounted, that they are not rare, and that they are underreported due to the discomfort many people have with the issue. It was suggested that the possibility of hallucination in this case was increased because women who are nervous are more likely to hallucinate. Some of the literature presented says that physical stimuli are thought

[118] T 303/33.
[119] T 321/6 - 313/1.
[120] T 313/3-4.
[121] T 314/29.

to induce hallucination. For example it may be that Dr G's placement of a mouth prop in Ms N's mouth just prior to her getting out of the chair may have triggered an hallucination. Ms N might have touched some cords, which could also have triggered an hallucination.

138. The Tribunal accepts that the phenomenon of hallucination under the influence of Hypnovel exists.[122] Some of these hallucinations are of a sexual nature. As a result the Tribunal should explore this possibility further.

Quality of literature presented

139. The Tribunal was given a number of articles about hallucinations, dreaming and fantasy involving anaesthetics and sedation. However, the Tribunal had some concerns about the overall quality of the articles presented.

140. A number of articles dealt with the issue of hallucinations, dreaming or fantasies of a sexual nature. Of those, certainly there are those articles that have been published in reputable medical journals. However, as the CAC submitted most of these are not based on clinical studies. They fall into the category of commentary such as letters to the editor in The Lancet by Brahams "*Medicine and the Law, Benzodiazepines and sexual fantasies*",[123] and "*Medicine and the Law, Benzodiazepines sex fantasies: acquittal of dentist*",[124] a general warning to clinicians to take necessary precautions when administering sedation and anaesthesia in the ANZCA Bulletin by Baker, "*Anaesthetists warned over patients and sexual hallucinations*",[125] and in a column headed "A Personal View" in the British Dental Journal, by Fields, "*Intravenous Sedation: The Risk to the Dentist*".[126] Having said this, the last article does report the results of direct research, although not a clinical study.

[122] For example, infra at fn 127.
[123] The Lancet, vol 335, 157.
[124] The Lancet, vol 335, 403.
[125] ANZCA (Australian and New Zealand College of Anaesthetists) Bulletin, December 2009, 28.
[126] British Dental Journal, 7 July 1990, 4.

141. One article that was more relevant in a reputable publication was by Balasubramaniam and Park, "*Sexual Hallucinations during and after sedation and anaesthesia*" in Anaesthesia,[127] to which the Tribunal will refer later. An article by Strickland and Butterworth entitled "*Sexual Dreaming during Anaesthesia*"[128] in Anaesthesiology is an historical review of the problem. This article is interesting more by way of background, as the phenomenon of sexual dreams and hallucinations is not a new issue for the medical profession regardless of the different drugs used. It does say patients can hallucinate when benzodiazepines are administered, which is something that the Tribunal has already acknowledged.

142. Some articles are not reported in reputable medical journals and so lack the rigour that reputable publications may require. For example, two articles submitted were published in the SAAD (Society for the Advancement of Anaesthesia in Dentistry) Digest: Dundee, "*Further Data on Sexual Fantasies During Benzodiazepine Sedation*" ,[129] and Reyes Guerra, "*Sexual Abuse under Dental Anaesthesia*".[130]

143. In particular, the Tribunal was concerned about the latter article, which it considered quite lightweight. For example the article cites the Salem Witch Trials as an instance of when the desire to participate in public events "can lead to false accusations and mass hysteria".[131] Support for another assertion in the article is sourced from the Phil Donahue Show,[132] an American day time talk show similar to shows such as "Dr Phil" and "Oprah". As a result, even though it is directly on the subject of sexual hallucinations under sedation, the Tribunal is hard pressed to give it any significant weight.

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[127] Anaesthesia 2003, 58, 549.
[128] Anaesthesiology 2007, 106: 1232-6.
[129] SAAD Digest, vol 7, no 7, July 1991, 171.
[130] SAAD Digest vol 11, nos 1 & 2, April 1994, 5.
[131] Ibid at p 6.
[132] Ibid at p 7, fn 18 of article.

144. Overall, the Tribunal considers that for whatever reason, whether due to underreporting and embarrassment about the subject matter as Dr Holden suggests, or as Drs Symes and Kruger would say, the rare incidence of sexual hallucination, there appears to be a paucity of quality information on the issue. Certainly Dr Holden refers to the literature as "low level scientific value"[133] but also says that it is all the literature that the profession has available to it.

145. The Tribunal considers it must work with what literature it has available to it. However, this does not mean that the literature should be elevated in relevance and importance merely because little else is available, unless its value merits it.

Problems of definition

146. The terms used to describe various incidents appear not to be consistent, which the Tribunal considered had the potential to cloud the issue. For example, Fields and Brahams use the words "fantasy and "hallucination" more or less interchangeably.[134] The Reyes-Guerra article includes the term "dreaming" as well as the other terms.[135] The Dundee article refers to fantasies only.[136] Dr Holden considered that dreaming and fantasy for example could be the same thing but also said that the terminology was very loose.[137]

147. Using three different terms throughout the literature presents problems of interpretation. Does this mean there three different phenomena, or one phenomenon with three names? The Tribunal considers this important because if the terms have different meanings then research about sexual dreaming under sedation for example, might not be as relevant, as research about sexual hallucinations.

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[133] T 363/18-22.
[134] Strickland and Butterworth, supra at fn 128. Brahams, supra at fn 124, although Brahams refers to fantasy only in the first of her articles, supra at fn 123.
[135] Supra at fn 130.
[136] Supra at fn 130.
[137] T 389/22.

148. Following on from that, only one article offers some definitions. The Baker article said "some definitions may be helpful" (a statement with which the Tribunal wholeheartedly agrees), and went on to say,

> *Patients who report hallucinations usually believe they were awake during the experience or at least aware of actual events occurring, and not in natural sleep or under anaesthesia or sedation. In contrast, patients who report dreaming usually believe that they were asleep and that the events were fanciful and not real.*[138]

149. To illustrate the problem, the Tribunal examined the article by Leslie et al, "*Dreaming during anaesthesia in patients at high risk of awareness*".[139] This is a study carried out on the incidence of dreaming during anaesthesia amongst patients who had a risk factor for awareness. The article is very credible as it was reported in a reputable medical journal and reports the findings of a double blind randomised controlled study. However, the dreaming described in the quotes from the study's subjects[140] refers to the Baker definition of dreaming not hallucination. For that reason, the Tribunal considers this study to be of more limited relevance to this case as the study makes no reference to hallucination, fantasy or dreaming of a sexual nature.

150. Of course the Baker definition is most helpful when the article in question makes that distinction, which the other articles do not. Nevertheless, the Tribunal has found the Baker definition useful because it follows that the most relevant information on this topic is information about patients having experiences of a sexual nature while under sedation or anaesthesia which they honestly believe they experienced, even if terms other than hallucination are used either in articles or by experts. When the Tribunal uses the term hallucination, this is what it refers to.

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[138] Supra at fn 125, at p 1.
[139] Anaesthesia 2005, 60, p 239-244.
[140] Ibid at 241

Incidence of sexual hallucination

151. The higher the reported incidence of hallucinations of a sexual nature during conscious sedation, the more possible it is that Ms N's experience was as the result of this. Therefore it is important to canvas this issue.

152. Dr Holden considered that there was an under reporting of sexual hallucination because of the discomfort that goes with the issue. He says that "dreaming during anaesthesia or sedation is widely reported but poorly understood" and that Midazolam can provoke erotic fantasies in susceptible patients that are so realistic that patients find it difficult to believe that it did not happen even when it could not have happened.[141] He goes on to say that there is absolutely no doubt that patients have complained of sexual events occurring under sedation.[142]

153. However, Dr Symes and Dr Kruger disagreed with Dr Holden. Dr Symes disputes that sexual dreaming is widely reported.[143] Dr Kruger says that hallucination under the effect of Hypnovel is possible; however, there is no good evidence to suggest that sexual hallucination is anything other than very rare.[144] He concludes this from his analysis of available literature. Further he said that he considers having a generalised fantasy is rare enough, it is even rarer for a patient to have a specific sexual hallucination of her hand on the practitioner's penis.[145]

154. Like Dr Kruger,[146] Dr Symes considers that while the possibility of hallucination can not be ruled out,[147] it is unlikely that Ms N had an hallucination of a sexual nature.

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[141] Supra at fn 41, at para 27.
[142] Ibid, para 28.
[143] T 174/4-6.
[144] Supra at fn 44, at para 21.
[145] Supra at fn 44, at para 23.
[146] T 244/31-34.
[147] T 209/25.

155. The Tribunal examined what the literature said about the incidence of hallucinations. Dundee reported three cases in 1986, ten out of 3000 (0.33%) who were sedated or anaesthetised, seven further cases, and also refers to 11 definite instances where sexual assault could not have happened. The second figure (10/3000) suggests that such incidents are rare. The first, third and fourth figures do not assist the Tribunal to determine the incidence of hallucinations, as there is no information about the proportion of patients who complained. Dundee also refers to a figure of 4/745 (0.54%), when higher doses were given.[148] This figure is higher but still less than 1%. There is no reference to the source of this figure.

156. Brahams refers to benzodiazepines "occasionally" producing sexual fantasies[149].

157. The Fields article refers to growing evidence that hallucination is a side effect and that the incidence is very difficult to assess due to the natural reluctance of patients to discuss this. Fifteen incidents of a sexual nature were reported after the author requested information from practitioners on the topic.[150]

158. However, the Tribunal agrees with Dr Kruger's view on this article[151]. First, there is nothing to say how many other patients the dentists had sedated and what proportion of patients had made these complaints. There were two tables of observation presented in the article[152] about sexual behaviour and complaints and comments. The first table consisted of nine observations by surgeons, and so are not hallucinations. In the second table six complaints are record, only two relate to Hypnovel, and only one could be called an hallucination.[153] While the article says that there is growing evidence that hallucinations are a side effect of

[148] Supra at fn 129, p 171.
[149] Supra at fn 123.
[150] Supra at fn 126, at p 4.
[151] T 272/1-20.
[152] Supra at fn 126, at p 4.
[153] T271/33-34, 272/1-9.

benzodiazepines,[154] and that the cases are "probably the tip of the iceberg", the Tribunal considers that these points are, as the heading of the article indicates, the author's personal view as these are not explained or substantiated in any way.

159. Reyes-Guerra refers to an early study by Litchfield of 16,000 cases where two with sexual connotations are mentioned. [155] This would seem to indicate that the incidence is very low at 0.0125%. However, if one reads about the same study in the Balasubramaniam article, of the 16,000 patients, 2,470 were given a questionnaire which indicated that hallucinations occurred in 1.3% of those patients that were surveyed. In any event, not all of the hallucinations were sexual.[156]

160. Of the Litchfield study, Reyes-Guerra states that there was a high incidence of psycologic reactions so "it is possible that many of the psycologic reactions that he [Litchfield] refers to were unrecognised sexual manifestations".[157] The Tribunal considers that the latter part of the sentence is the author's own opinion, also bearing in mind that "unrecognized sexual manifestations" may not necessarily mean sexual hallucinations. Both these points reinforce the Tribunal's view of the lightweight nature of the Reyes-Guerra article.

161. Reyes-Guerra cites another study where 15 out of 710 (2.11%) patients admitted to dreaming, hallucination, and sexual arousal[158] under the influence of various drugs, including valium. Without knowing what proportion of patients actually believed that another person had engaged in sexual touching, as opposed to a dream, or feeling sexually aroused this is not altogether helpful. There are other instances reported where a high incidence of sexual fantasies are reported, however, it is not clear whether this is about hallucination, and a private communication to the author

[154] Supra at fn 126, at p 4.
[155] Supra at 130, at p 5.
[156] Supra at fn 127, at p 550.
[157] Supra at fn 130, p5.
[158] Supra at fn 130, p5.

about an oral surgeon being accused of sexual abuse by eight women, but which is not explained any further.[159]

162. The Strickland and Butterworth article says that benzodiazepines have been implicated in sexual dreams,[160] without referring to what the incidence might be.

163. The Balasubramaniam article contains a more comprehensive account of an earlier article by Dundee, "*Fantasies during sedation with intravenous midazolam or diazepam*".[161] In this, it says that Dundee refers to a study of 600 patients undergoing oral endoscopies where two definite sexual experiences were recalled as well as two distressing non sexual experiences. The Tribunal considers that the two sexual experiences may not necessarily indicate hallucination, and if they did that proportion is about 0.33%, which is very low. Another study Dundee refers to is where during gynaecological procedures six out of 200 women reported pleasurable sexual fantasies.[162] It is not clear whether this means that these fantasies were something the patients thought actually happened.

164. Balasubramaniam also reports from the same article by Dundee specific incidents indicative of hallucination during dental and medical procedures. However, it does not give us an overall picture of what the incidence might be. According to Dundee, by 1989, 42 pending cases of sexual complaints had been made, but once again proportions are not referred to.[163]

165. The Balasubramaniam article refers to the Litchfield study saying that hallucinations occurred in 1.3% of patients but the proportion of hallucinations that were sexual is not reported.[164] It refers to two cases where there was a sexual element involved, but this does not help the Tribunal determine the overall

[159] Supra at fn 130, p5-6.
[160] Supra at fn 128, at p 1235.
[161] Supra at fn 127, at p 550 at fn 4 of the article.
[162] Supra at fn 127, at p 550.
[163] Supra at fn 127, at p 550.
[164] Supra at fn 127, at p 550.

incidence of sexual hallucination. The Balasubramaniam article also summarises a number of cases where such complaints have gone to court. Finally, the article makes the statement that when benzodiazepines are used for sedation, hallucinations occur between 1% and 3%.[165] Given that the references used are the Dundee[166] and Balasubramaniam[167] articles, it is doubtful whether these refer solely to hallucinations of a sexual nature.

166. The Baker article reported a study where out of 119 patients, 19 (15.96%) reported "sexual emotions although only five patients had sexual dreams – only one of which was serious".[168] This does not distinguish between dreaming and hallucination, despite earlier defining the terms and does not go onto to explain what "serious" meant. The Baker article also says that there are an increasing number of complaints of anaesthetists engaging in sexual activity, but this is "particularly in relation to propofol",[169] which is not related to Hypnovel.

167. Dr Holden's statement that *"dreaming during anaesthesia or sedation is widely reported but remains poorly understood"*[170] could be taken as meaning that the incidence of hallucination is widely reported. If this is the case then perhaps the incidence is not as low as one might think. However, the Tribunal does not consider that this can be what that statement means. The Tribunal considers that this is a paraphrasing of the first sentence of the summary of the Leslie article.[171] The article begins with the statement "[d]reaming during anaesthesia is widely reported but remains poorly understood".[172] Interestingly the sentence in the article does not include sedation. Secondly, the article does not discuss hallucination nor does it

[165] Supra at fn 127, at p 553.
[166] Supra at fn 127, at p 553, at fn 4 of the article.
[167] Supra at fn 127, at p 553, at fn 7 of the article.
[168] Supra at fn 125, at p 28.
[169] Supra at fn 125, at p 28.
[170] Supra at fn 41, at para 27.
[171] Supra at fn 139.
[172] Supra at fn 139, at p 239.

make any reference to hallucination or fantasies. The quotes from the study's subjects appear to refer to the state where people dream and know that they are asleep.[173]

168. Further there is no reference in the article to dreaming of a sexual nature. Therefore, whatever the incidence of dreaming is, this is of limited relevance when considering the incidence of hallucination, sexual or other wise. The study reports that some patients might find the experience of dreaming distressing, that they might confuse it with awareness and potentially suffer adverse consequences as a result.[174] However, this comment is not explored further or reflected in the study's conclusions.

169. In summary, the Tribunal concludes that the incidence of sexual hallucination is rare. There is little good quality evidence to suggest that the incidence of sexual hallucinations is anything other than very rare, and considerably less than the 1% referred to.

170. Supporting this is the experience of the three expert witnesses. Dr Symes said in his practice of 10 dentists and an oral surgeon where sedation is often administered, there has been no instance of any patient experiencing any hallucinations of a sexual nature.[175] Dr Kruger has never had any complaints of this nature. Dr Holden has sedated about 8000 patients during his career and has had one such complaint.

171. The Tribunal wishes to make comment on Dr Holden's statement that underreporting of sexual hallucinations takes place because of the nature of the subject, meaning that sexual hallucinations under sedation may not be a rare event. Firstly, the Tribunal has already found there is insufficient evidence to conclude that the incidence of sexual hallucinations is anything but rare. Secondly, if there was a

[173] Supra at 139 , at p 241
[174] Supra at fn 139, at p 239.
[175] Supra at fn 43, at para 6.2.

general underreporting of sexual hallucination (or dreaming or fantasy for that matter), the Tribunal does not see how this point is helpful to Dr G. This is because the Tribunal considers that as a matter of logic this underreporting would apply to all practitioners administering sedation, including Dr G.

Level of dose and incidence of hallucination

172. During the 2002 criminal trial Dr G's defence argued that the complaints arose because the complainants had been administered high doses of sedative, on the basis that there is a link between a higher dose of sedative and the higher incidence of hallucinations.[176] The Tribunal has considered this point and makes the following comments.

173. The Dundee article states that larger doses of benzodiazepams increased the incidence of hallucination.[177]

174. The Balasubramaniam article states that Litchfield found that psychological effects of sedation were dose-related.[178]

175. However, Dr Kruger, in examination in chief was adamant that there is no relationship. He had carried out particular research on the topic and reviewed his own experience. "*…it is very difficult to find evidence to support the fact that a higher or lower dose will be more likely to cause it [hallucination]".*[179]

176. Dr Holden disagreed with this and said that more hallucinations do occur at high doses.[180] Interestingly, although Dr Holden appears to have more experience of administering higher doses of Hypnovel to patients than Drs Symes or Kruger,[181] his incidence of complaints is very low at 0.0125%.

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[176] T 365/20-23.
[177] Supra at fn 129, at p 171.
[178] Supra at fn 127, at p 550.
[179] T 241/27-28.
[180] T 379/17-19, 30-31.
[181] T 353/16.

177. The Tribunal finds it possible that a link may exist between level of dosage and hallucinations. It cannot put it at higher than that because of the quality of the literature presented, the fact that Dr Kruger is very sure there is no relationship, and although Dr Holden professes that view, that is not his experience.

Mouth prop and cords as a stimulus for hallucination?

178. Dr G claims that repositioning a mouth prop in Ms N's mouth may have been the stimulus which roused Ms N and caused her to be disturbed. Dr Holden said that it is possible that placing a mouth prop in Ms N's mouth could have triggered an hallucination. He says that clinical experience shows that midazolam and words used can evoke powerful emotions in patients and that the stimulus of touch can also evoke sexual hallucinations[182].

179. Further, at paragraph 71 of his brief of evidence he says that *"positioning the prop can be a more stimulating experience than the surgery itself due to the stimulation of nerves associated with the temporomandibular joint"*[183].

180. The literature also refers to touch triggering sexual hallucination. Dundee provides a table which outlines various stimuli that might cause a particular complaint.[184] In the Reyes-Guerra article, it reports that the insertion of a mouth prop was one of the mental, physical and environmental factors that may contribute to a sexual interpretation.[185]

181. The Tribunal rejects the repositioning of a mouth prop was a catalyst for an hallucination. Firstly, Dr Holden's comments are refuted by Dr Symes' evidence when he said *"positioning or repositioning of the prop in my experience isn't a significantly traumatic experience at all"*[186].

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[182] Supra at fn 41, at para 30.
[183] Supra at fn 41, at para 71.
[184] Supra at fn 129, at p 172.
[185] Supra at fn 130, at p 6.
[186] T 176/4-6.

182. Secondly, the literature on this point is not strong enough: Dundee does not provide the evidence to support the conclusions he draws between the type of stimulation and the type of complaint[187]. He refers to it as *"a possible association"*. Although the table does not refer to a mouth prop, other stimulus in the mouth is referred to, the dental sucker and oral endoscopy. The Tribunal notes that Dundee's table shows a link between those stimuli and hallucinations of oral sex. Even presuming the link, this was not Ms N's complaint. Further, the stimulus said to produce induced masturbation was an instruction to squeeze the fist.[188] However, there was nothing in the evidence that suggested Dr G had asked Ms N to do this. In the Tribunal's view, this relegates any "possible association" to very unlikely.

183. According to the Dundee table a tight bra could possibly produce an hallucination of breast touching. No evidence was led about the tightness or otherwise of Ms N's bra. In relation to one incident cited in the Balasubramaniam article, a woman believed she had been "*molested in the upper part of her body"* during an operation. It also mentions "*the proximity of instruments to her chest and the fact that instruments are often wiped on the chest, [which] may have some bearing on the origin of these hallucinations".*[189] Once again the Tribunal considers that there is little to suggest a link other than the author's opinion.

184. The Reyes-Guerra article lists a number of factors considered to make hallucination more likely.[190] One of these is the insertion of a mouth prop. However, there is no reference to any research on which these statements might be based. As the Tribunal has already said it does not consider it ought to give this article very much weight, notwithstanding the relevance of the subject matter.

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[187] Supra at fn 129, at p 172.
[188] Supra at fn 127, at p 550 and 553.
[189] Supra at fn 127, at p 550.
[190] Supra at fn 130, at p 6.

185. The Tribunal does not consider Ms N's failure to recall the insertion of a mouth prop to be relevant. Firstly, Ms A did not remember a mouth prop, although Dr G says it was there. Secondly, even if a mouth prop had been inserted or moved, Ms N may understandably have been focused on the touching.

186. For similar reasons, the Tribunal rejects that touching cords may have induced a hallucination. Even without finding that Ms N was hallucinating, the Tribunal considered whether it was possible for Ms N to have misinterpreted the touching of a penis with touching cords. The Tribunal accepts Ms N's emphatic answer that the touch felt nothing like cords.[191]

Nervous women patients more prone to hallucination?

187. Certainly, there is some evidence in the literature to suggest that it is women who suffer from hallucinations, fantasies, and dreaming more than men. In the Leslie article, those more likely to experience intra-operative and post operative dreaming were more likely to be female, younger, and healthier[192], and had higher anxiety scores[193]. The Balasubramaniam article says that the Litchfield article found that hallucinations were up to 50% more common in females than in males in patients aged over 20.[194] The Reyes-Guerra article refers generally to complaints of sexual misconduct, which appear to be made by women.

188. Brahams in "Benzodiazepines and sexual fantasies" citing Dundee's work, says that "[an] unwanted effect of benzodiazepines to surface recently is the potential to induce sexual fantasies in women"[195] and considers why this might be so in "Benzodiazepines sex fantasies: acquittal of dentist".[196]

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[191] T 152/8-14.
[192] Supra at fn 139, at p 241
[193] Supra at fn 139, at p 242.
[194] Supra at fn 127, at p 58.
[195] Supra at fn 123, at p 157.
[196] Supra at fn 124,at p 404.

189. Fields' research shows that while dentists observed sexual behaviour in more male than female patients,[197] all those who made complaints about the behaviour of the dentist were women.[198] Baker says something similar, "dreams and/or hallucinations with propofol appear to be equally common in males and females"[199] although "complaints of sexual assault or indiscretion are much more common from females".[200] Fields theorises that the sex of the dentist and the sexual orientation of the patient might also be relevant[201].

190. The Strickland and Butterworth article says that all but one of the historical reports related to women and that the same phenomenon has been observed less commonly in men using current anaesthetics and sedatives.[202]

191. The literature says that women may be more likely to dream, and may have more hallucinations. Without even considering the fact that there may be problems with a lack of distinction between dreaming and hallucinations, and whether or not any hallucinations are sexual, the Tribunal considers that the incidence of hallucinations is very low generally. Assuming Ms N enjoys good health, the fact she is a woman, young and was nervous about treatment (although no evidence was led to suggest she was nervous generally) means she may fit the profile of someone who may be more likely to dream, fantasise or hallucinate while sedated. What this means is that Ms N's profile perhaps makes it slightly more likely that she may experience an hallucination while sedated.

192. However, given the rarity of hallucination the Tribunal finds this an extremely unlikely explanation, particularly when the Tribunal considers her evidence about her recall of events.

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[197] Supra at fn 126, at p 4 table I.
[198] Supra at fn 126, at p 4 table II
[199] Supra at fn 127, at p 28.
[200] Supra at fn 127, at p 28.
[201] Supra at fn 126, at p 4.
[202] Supra at fn 128, at p 1235.

193. Dr Holden also submitted that patients who require sedation have psychological and phobic personalities,[203] and that this type of patient is more likely to fantasise.

194. However, the Tribunal finds it difficult to accept that a nervous patient must also be someone who has a phobic personality or psychological problems. Further, no evidence was led to enable the Tribunal to conclude that Ms N had a psychological and phobic personality.

Likelihood of sexual hallucination

195. In light of the above the Tribunal finds it unlikely that Ms N was suffering a sexual hallucination. While there is a possibility that Ms N's profile and the high dosage may have increased the chance of hallucination, the Tribunal considers this only raises the likelihood from extremely unlikely to slightly less unlikely. In the Tribunal's view this is insufficient to conclude that hallucination was a possibility in this instance.

Emergence Delirium

196. Dr Holden said that emergence delirium could have explained what happened to Ms N. Emergence delirium is when a patient suddenly appears to emerge from the sedated or anaesthetised state.

197. Dr Holden said that reactions such as hallucinations, acute hyperactivity states, anxiety, rage, recent memory impairment, increased muscle spasm, and acute hyperactivity states either alone or in combination are termed emergence delirium[204], that it is implicated in the administration of midazolam and it is associated with high dose and overdose.[205]

198. Dr Kruger says that the classic signs of emergence delirium are where a patient is

[203] Supra at fn 41, at para 30.
[204] Supra at fn 41, para 53.
[205] Supra at fn 41, para 52.

restless and agitated, mumbles, pulls at lines. It lasts for some minutes and sometimes as long as one hour. The patient cannot remember what has happened or if the patient does he or she is extremely embarrassed about it. The patient does not interact with the practitioner. Dr Kruger also said that it would not be possible to have a conversation with them.[206]

199. Dr Kruger explained that many drugs have been implicated in emergence delirium, especially ketamine. He says that the reaction usually occurs after general anaesthetic and is more common in children.[207] He also says that emergence reactions after benzodiazapine administration only would be rare in the absence of other psychological or physiological abnormalities.[208]

200. Both Dr Holden and Dr Kruger agreed that an hallucination could be part of emergence delirium.[209]

201. Even if there is a link between emergence delirium and benzodiazepines, as Dr Holden suggests (although Dr Kruger disagrees), the Tribunal considers that Ms N's behaviour was not consistent with emergence delirium. First, once she had jumped out of the chair and was standing unsupported she cannot have been suffering from emergence delirium. This is because Dr Kruger says that a patient who can relate to the practitioner cannot be in this state, and Ms N was able to interact (albeit angrily) with Dr G once out of the chair. Further, Dr Holden acknowledged that once she was standing unsupported she could not have been suffering from emergence delirium.[210]

202. Ms N cannot have been suffering from emergence delirium before she attempted to jump out of the chair because she was lying in the chair and there was no suggestion

[206] T 244/16-25.
[207] T 243/29-34.
[208] T 244/5-8.
[209] Kruger, T 244/1-3; Holden, brief para 92.
[210] T 375/21-22.

at that time of showing any signs of emergence delirium. Therefore, if she did suffered from emergence delirium , it could only have been in the very short space of time between lying in the chair and standing unsupported, which is the time when she was trying to get out of the chair. However, the reason that she got out of the chair was to say the touching had already happened. Therefore this seems unlikely.

203. Given the confusion that the experts have attributed to patients suffering from emergence delirium, the Tribunal finds that her clear recall of events immediately leading up to the touching and at the time of the touching (as earlier outlined) is totally inconsistent with emergence delirium.

204. Dr Holden suggests that emergence delirium may have contributed to Ms N's drowsiness at the police station.[211] This is hard to reconcile with his statement that once Ms N emerged from the chair and was standing unsupported, she had moved from the emergence delirium as by then she was in the recovery stage of sedation.[212] In any event, the touching had already happened by then. Later on Dr Holden agreed that the drowsiness at the police station would more likely be attributable to the breakdown of the Hypnovel in Ms N's system.[213]

205. Ms N may have been emotional and angry after the incident; however, this does not mean that she was suffering from emergence delirium. On the contrary, the Tribunal regards this as a perfectly understandable reaction of someone who has been sexually touched in a dental surgery.

Conclusion

206. In summary, the Tribunal considers that despite the serious nature of this allegation and the resultant need for very strong evidence, the CAC has proved this particular. Although Dr G denies that the touching took place the Tribunal considers that the

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[211] Supra at fn 41, at para 92.
[212] T 375/16-27.
[213] T 391/11-19.

strength of Ms N's testimony as well as the evidence about the setting, and the timeframe, particularly in relation to the telephone calls made outweighs his evidence on the issue. The Tribunal considers that the explanations offered as an alternative of hallucination and emergence delirium are not sufficient for the Tribunal to conclude otherwise.

The conduct alleged in Particulars 1.1, 1.2, 1.2.1 and 1.2.2 when each Particular is considered separately or two or more Particulars are considered cumulatively amounts to an act or omission in the course of or associated with the practice of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

207. As only one of the particulars in respect of Ms N has been proved, even though it has two parts to it, there is nothing for the Tribunal to consider cumulatively.

Ms Y

Background

208. Dr G had a dental practice in X from 1983 to 1999, which was operated on a part time basis. Ms Y, who was living in X at the time, received dental treatment from Dr G, and according to her treatment notes, she first consulted him on 25 February 1984.[214]

209. Ms Y remembers little about her treatment apart from one occasion which was very probably 17 October 1984. On that morning Ms Y went to Dr G for dental treatment as she had a toothache.[215] It transpired that she had a large cavity in tooth 28 (upper left wisdom tooth); in effect, the tooth had collapsed. It appeared that the parties agreed it would be extracted but that it would take more time to carry this out than was available at that appointment. Dr G's appointment book showed that he had cancellations later that day. As a result an appointment was made for the end

[214] Exhibit 14.
[215] Y brief, at p 1.

of the afternoon to extract the tooth.

210. Ms Y believes the appointment was at 5.00pm. Dr G's appointment book records the appointment was at 4.45pm.[216] Given that the appointment book is a contemporaneous record the Tribunal finds it most likely that Ms Y's appointment was at that time.

211. Ms Y says that on her arrival, Dr G closed the side window curtains and locked the door. She also says there was no one else on the premises at the time.

212. Dr G says the curtains were partly closed to reduce glare and improve the quality of light illuminating Ms Y's mouth, that the door was not locked, and that a nurse was present during Ms Y's treatment.

213. The tooth was extracted under conscious sedation with intravenous Diazepam or Valium. Ms Y remembers that Dr G had difficulty in finding a vein for the injection site which had happened before in other situations when she had injections.[217] Ms Y says that while the Valium was being administered Dr G asked her to squeeze something. She then became aware of Dr G wiping liquid from her hand. At this point, Ms Y believed that she was squeezing Dr G's penis and that what he was wiping from her hand was semen.

214. Ms Y said that she thought about looking at Dr G to confirm that this was the case; however, she decided against it because she believed she was in a vulnerable position.

215. Dr G says that the touching of the penis and wiping semen away did not happen. He believes that due to difficulties in finding the vein, some of the valium leaked out. He considers it is likely this was the liquid that was wiped from Ms Y's hand.

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[216] Exhibit 43.
[217] T 112/29.

216. After the extraction, Ms Y's husband picked her up from the surgery. At the time, she mentioned to her husband what she thought Dr G may have done.

217. Ms Y says that she did not have any further treatment with Dr G. The Tribunal considers that it is likely she did. Her treatment notes record that she had a later appointment on 23 October 1984.[218] The date on the receipt of payment is 23 October 1984.[219]

218. Ms O was a dental assistant to Dr G in X from about 1983 to 1985. She gave evidence in writing. Her evidence was of a general nature about the work she did when working for Dr G. Ms O did not give any direct evidence that related to Ms Y's treatment on 17 October 1984.

Particular 2: In the course of this treatment of his patient Ms Y on 17 October 1984 at X:

Particular 2.1: On or around the time of her arrival at [Dr G's] surgery at approximately 5.00pm and when no nurse or other third party was present, [he] administered 30mg of Valium intravenously, being well in excess of the average or recommended maximum dose; and/or

219. There is no question that Dr G administered valium to Ms Y; rather the issue is whether the dosage alleged has been proved.

220. The treatment record is not clear on just what quantity was administered. It is expressed as "IV Val 30mg (20mg probably OK)"[220]. The CAC considers that it means that 30mg was actually administered, but Dr G recorded that 20mg would have been adequate for appropriate levels of sedation.[221] Dr G considers that when the valium was administered some of it leaked due to difficulties with finding Ms Y's vein. Because of this only 20mg was actually administered.[222]

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[218] Supra at note 214, entry dated 23/10/84.
[219] Exhibit 17.
[220] Supra at note 214, entry dated 23/10/84.
[221] T 317/27-31.
[222] Supra at fn 28, at para 60-62.

221. The Tribunal finds that Dr G's notes about the dosage administered to Ms Y can be interpreted either way. Either explanation makes sense. Although Dr G is not required to prove his explanation is the correct one, the Tribunal finds it has some force. Firstly, under questioning by Dr Coote, Dr G agreed that in 1984 he had been using a separate needle and syringe. It is possible that this method of administration may have led to a degree of spillage.[223] Secondly, this may well have been compounded by the fact that Ms Y remembers that Dr G had some difficulty in accessing the vein in her arm.[224] Ms Y confirmed that other medical professionals also had encountered problems when attempting to access the veins in her arm.[225]

222. As a result, the Tribunal concludes that it has not been proved that more than 20mg was administered.

223. The question that follows is whether 20mg was a dose being well in excess of the average or recommended maximum dose.

224. The Tribunal heard evidence about the appropriate dosage of valium and the availability of information for practitioners about dosage levels in 1984.

225. A document headed "Data Sheet" was produced during the hearing,[226] which gave dosage guidelines for valium. However, this document is not relevant to Ms Y's treatment in 1984 as it is dated 15 May 1990. Further, no dosage guidelines in force at the time were produced or referred to. On this basis alone there is insufficient evidence to conclude what a maximum recommended dose might have been.

226. The Tribunal went on to consider what the expert witnesses' evidence said about appropriate doses of valium for sedation for dental procedures.

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[223] T 340/10-13.
[224] T 112/29.
[225] Ibid.
[226] BOD, tab 10.

227. Dr Symes agreed under cross examination that given the data sheet, a 30mg dose of valium was an acceptable dose although it would be at the very upper end of the range.[227] By implication then, 20mg must be an acceptable dose.

228. Dr Holden quoted from a variety of manufacturers who agree that 20mg is an acceptable dosage and that adjustment to particular patient needs may be required.[228]

229. In the absence of any contemporaneous guidelines, and in light of both experts who gave evidence on this point, the Tribunal concludes that the level of valium administered to Ms Y is within acceptable limits. As a result, the level of valium administered to Ms Y cannot be considered to be well in excess of the average or maximum recommended dose. The Tribunal finds that particular 2.1 is not proven.

Particular 2.2: In administering the Valium as particularised in Particular 2.1 potentially endangered Ms Y's wellbeing and/or exposed her to the risk of undesirable side-effects or consequences including: while she was under sedation, he inappropriately and with no clinical reason for doing so, caused her right hand to come into close contact with his penis.

230. Because it has not been proved that the dose of valium was outside acceptable limits, the Tribunal finds that Ms Y's general wellbeing cannot have been compromised.

231. As the Tribunal outlined earlier, the allegations of sexual touching against Dr G are very serious. Therefore, the Tribunal must have strong evidence before it concludes that the allegation is proved on the balance of probability. The Tribunal considers that the CAC's evidence is not enough to prove the allegation made.

232. Ms Y said a number of times under questioning that she was not 100% sure about whether her hand had come into contact with Dr G's penis. In cross examination

[227] T 204/26-32.
[228] Supra at fn 41, at paras 119 – 121.

Ms Y said *"I never ever went to the police and complained because I was never 100% sure"*.[229] She went on to say that after an acquaintance had mentioned another case she came to believe that *"I was right all those years ago, I was right, that happened to me"*. Later her reply to the question about the reason the police brought no charge in relation to her allegations was: *"Because I was never 100% sure, I've always said I am not 100% sure"*.[230] When questioned by the Tribunal about how sure she was about her allegations, Ms Y said: *"I'm still not 100% sure, no. I'm sorry. There was still – there was always that doubt, you know"*.[231]

233. Ms Y did not consider that Dr G's penis might have been the object she was asked to squeeze until she felt him mopping up some liquid. It was then she concluded that the liquid was semen and that her hand had been on Dr G's penis.[232] However, given that there were difficulties accessing her vein and Dr G's notes about the dosage, the Tribunal accepts that there is another possible explanation, which is that the Valium had spilled and Dr G was mopping it up from her hand.

234. Further, Ms Y did not see actually see her hand on Dr G's penis. She said she elected not to look down as she thought that if she did Dr G could harm her by injecting her with more valium.[233] Certainly the Tribunal accepts that was her reason for not looking down. However, without seeing Dr G's penis, she cannot be and is not certain about what happened at that time.

235. Further, Dr G denies that this ever happened: *"I categorically reject the suggestion that I inappropriately or otherwise caused Ms Y's right hand to come into close contact (or any contact at all) with my penis. This is fanciful and simply did not happen"*.[234]

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[229] T 95/25
[230] T 109/6.
[231] T 128/19-20.
[232] T 127/10, 120/23.
[233] T 113, 13-15.
[234] Supra at fn 41, at para 78.

236. The Tribunal considered whether it should examine the issue of hallucination in relation to Ms Y's allegation arose as the result of an hallucination. Given the rarity with which the Tribunal considers hallucinations of a sexual nature take place, this is an unlikely explanation for what could have happened. In any event, as the evidence about the alleged sexual touching is not persuasive and could merely have been a mistaken assumption, the Tribunal does not consider it is required to go further.

237. The Tribunal has found that the particular in relation to the sexual touching of Ms N proved. In light of this, the Tribunal must consider the issue of propensity and whether this makes the sexual touching of Ms Y more likely.

238. According to the CAC, there are a number of relevant factors. Each of the three complainants was described by the CAC counsel as being, at the respective times of the alleged offending, petite, dark haired, and attractive. At the time of the complaints the patients were young, between the ages of 20 and 30 years. They were all sedated. Each patient alleged that she was made to touch Dr G's penis with her right hand.

239. There was mention of other patients during the hearing, however, without knowing more about those patients the Tribunal cannot take those into account when making a finding about propensity.

240. Dr G has had three complaints out of approximately 500 patients he has sedated. This is much higher than the experience of the expert witnesses. The President of the Dental Council, Robert Love gave evidence that he was aware of only two complaints against dentists of sexual misconduct under sedation.[235]

241. It may be as Dr Holden suggests that there are more patients in the community who believe that a dentist sexually assaulted them but have not reported it. However, the

[235] Love brief, at p 3.

Tribunal finds that this cannot help Dr G, because presumably a similar degree of under reporting would apply to any dentist including him. As a result the Tribunal finds that three out of about 500 is a very high number of complaints of sexual touching under sedation.

242. Certainly, the Tribunal finds that there are similarities in the complaints and the incidence of complaints against Dr G is high. However, as the allegations are very serious, the proof must be correspondingly strong. The propensity evidence makes the probability of Dr G offending against Ms Y higher than it otherwise would have been. However, the Tribunal finds that even allowing for the impact of propensity evidence, that evidence, even when combined with the other evidence is still not sufficiently strong to prove this particular to the required standard. Significantly, as the Tribunal has already noted, Ms Y said more than once in her evidence that she was not 100% sure that the touching happened.

243. The Tribunal finds that particular 2.2 has not been proved.

Particular 2.3: [Dr G] carried out the treatment or operative procedures in a room the door to which was locked and the curtains in which were drawn closed, and with no nurse or other third party present.

244. The Tribunal finds that the allegations in this particular are not as serious as those in 2.1 or 2.2. Therefore the strength of the evidence required is correspondingly less. Nevertheless, the principal evidence the Tribunal was required to consider is that of Ms Y and Dr G. Again then, the Tribunal must weigh the word of one person against that of the other.

245. Strictly speaking the wording of this particular requires all components to be proven for the particular as a whole to be proven because each of the elements is linked by the word “and”. However, the Tribunal has considered each allegation separately before making a finding about the allegation as a whole in respect of the:

- the locked door

- the drawn curtains, and

- the absence of a nurse or third party

246. The Tribunal notes that Ms Y had not been sedated before she observed whether or not the door was locked and the curtains drawn. Her observation about whether or not a third party was present was something she observed before and during her treatment.

Was the door locked?

247. Ms Y states that Dr G "*locked the door into the premises – the one near the bench seat"*.[236] In cross examination she said that she did not actually see the door being locked and that she relied on the fact that she heard it being locked.[237] The Tribunal considers that without seeing it, hearing a click is insufficient to prove that the door was locked. Further, Dr G denies that he locked the door.[238]

248. As a result it has not been proved that the door was locked.

249. The existence of the bench seat was discussed at length in cross examination. Ms Y said there was a bench seat in the waiting area and Dr G said that there was no bench seat there. The Tribunal makes no finding on the existence or otherwise of the bench seat. Even if Ms Y was mistaken it probably does not matter in the end. The Tribunal agreed with the CAC that recollection of facts central to the allegations is what matters,[239] and the presence of the bench seat is not one of these central facts.

Were the curtains drawn?

250. Ms Y claims that the curtains in surgery were drawn closed by Dr G. She said that this happened after the door was closed. Ms Y initially believed that this was to enable Dr G to perform the procedure uninterrupted.[240]

251. Dr G said that he would often draw the curtains closed towards the end of the day.

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[236] Supra at fn 215, at p 2.
[237] T 105/25.
[238] Supra at fn 41, at para 69.
[239] T 420/22-26.
[240] Supra at fn 215 at p 2.

The curtains would be pulled but only to a point where there was a small gap left. He said this was so that he could control the light coming into the surgery at that time of the day.[241] Google maps provided showed that the orientation of the window is south west.[242] The Tribunal accepts that pulling curtains partially closed might assist a dentist's vision of the mouth.

252. Ms Y said in her evidence that the curtains were blue. This is contradicted by Dr G. He says the curtains in 1984 were floral reddish orange,[243] which were then replaced in 1993 by brown curtains.[244] Although a 1995 video showed a dark blue curtain in a back room, Dr G said that there had never been blue curtains in the surgery.

253. Therefore, the Tribunal does not consider that Ms Y's assertion about the colour of the curtains has been proved. Because Ms Y did not prove that the curtains were blue, this casts further doubt as to her recollection that the curtains were fully pulled by Dr G.

Was treatment carried out in the absence of a nurse or third party?

254. Ms Y was unsure whether there had been a nurse present when she attended the surgery in the morning of 17 October 1984.[245] Her recollection of this point remained unclear during cross examination, but in re examination she was more certain.

255. Dr G was clear in his evidence that he always had a nurse present in X and that he did not remove teeth without an assistant.

256. Dr Holden and Dr Symes both said that it would be difficult to perform work on a collapsed wisdom tooth without assistance[246].

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[241] Supra at fn 28, at para 70.
[242] Exhibit 26
[243] T 298/5.
[244] T 287/28,29. Shown in a video of premises taken in 1995.
[245] T 110/3.
[246] T 222/32-34, 223/1-3; supra at fn 41, at para 129.

257. Ms O was a dental assistant with Dr G in X. The CAC presented a brief of evidence from her; however, the Tribunal received a letter from a person called a kenesiologist explaining that Ms O could not attend the Tribunal because she was unwell. Nevertheless, the Tribunal admitted Ms O's brief, at the same time acknowledging that Dr G did not have the opportunity to test the statements in her brief through cross examination.

258. As it happened the Tribunal did not find her brief to be of much assistance. She said that Dr G sometimes worked on his own, that she spent about a third of the time while the patient was there actually at the chairside, and that sometimes she left the building to run errands, also she stated that she thinks Dr G may have patients in the surgery after hours on occasion.[247] Even if the Tribunal accepts that this is the case, all this does is cast some doubt on Dr G's assertion that he did not perform extractions without an assistant. This could increase the possibility that Dr G might not have had an assistant on the day in question. However, in the face of a denial by Dr G this evidence cannot be taken any further than that. Ms O's general statement plus Ms Y's evidence is not enough to convince the Tribunal that Dr G performed the treatment without an assistant present.

259. This matter has not been helped by the period of time that has elapsed (some 25 years) since the alleged touching took place. The recollections of both Ms Y and Dr G are understandably uncertain given the length of time since the events in question.

260. Therefore the presence or otherwise of a nurse at Ms Y's treatment has not been proved.

261. The Tribunal finds this particular not proved.

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[247] O brief, at p 2.

The conduct alleged in Particulars 2.1, 2.2 and 2.3 when each Particular is considered separately or two or more Particulars are considered cumulatively, either amounts to an act or omission in the course of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

262. As none of the particulars have been proved, there is nothing for the Tribunal to consider cumulatively.

Ms S (NEE I)

Chronology

263. Ms I was a patient of Dr G's in his practice located at xx, XX. According to Ms I's dental records, Dr G treated her for about 10 years, the first appointment being on 30 March 1989 and the last on 21 February 2001.[248]

264. On 28 September 1989 Ms I had an appointment for treatment. Her treatment notes record that a number of teeth were filled and two wisdom teeth extracted.

265. Ms I was treated under conscious sedation with Hypnovel given intravenously. Her treatment notes record that she was given 1 vial of Hypnovel, which means either 5 or 15 mg was given to Ms I.

266. During the treatment Ms I says that she recovered consciousness and felt her hand on Dr G's penis. She said it lasted several seconds, and that she was not mistaken about what it was she was touching. She wondered if she might be imagining this. She was unsure whether it had actually happened or whether it was a fantasy. She did not open her eyes at this time.

267. She then remembered having one of her teeth pulled out.

268. Dr G denies that he made Ms I touch his penis. He says that it was impossible for a wisdom tooth to have been extracted at the time Ms I had a hand on his penis. This is because a wisdom tooth extraction requires him to be seated behind a patient

[248] Exhibit 13.

whereas he would have to be sitting on Ms I's right hand side for her hand to be on his penis.

269. After the treatment, Ms I was picked up by her mother. Ms I says that she told her mother about what she believed happened, and thinks it was straight away. She also told a friend about a year later. Because the friend had told her about a newspaper article about sexual hallucinations while under sedation, Ms I dismissed what she thought might have happened.

270. Ms I says that she felt so sick after the treatment that she said she would never have sedation again. Ms I's treatment notes record her as having sedation on 17 October 1989, about three weeks after the earlier appointment.

271. The premises were remodelled in 1993. At the time of Ms I's treatment, the reception desk was in the surgery where she was treated.

272. Years later, Ms I read an article in a XX newspaper that sounded like her experience and contacted the police.

273. Ms G, Dr G's wife, gave evidence about the day on which Ms I was treated. Ms G says that she was present during treatment and that Dr G did not engage in any inappropriate behaviour with Ms I.

274. Ms G also says that a new dental assistant, Ms K, started work on 17 October 1989, the day on which Ms I's dental records record that she was sedated a second time. She said that Ms K assisted Dr G during the second appointment.

Findings

Particular 3: In the course of his treatment of his patient Ms I on 28 September 1989 at XX:
Particular 3.1: [Dr G] administered the sedative drug Hypnovel prior to administering a local anaesthetic, in a dose in excess of the recommended maximum dose.

275. The Tribunal considered this particular in two parts. First, the actual administration of one vial of Hypnovel; and, secondly, whether or not the maximum dose had been

exceeded.

Administration of Hypnovel

276. There is no dispute that one vial of Hypnovel was in fact administered as Ms I's treatment records show.[249] However, it is not altogether clear whether Ms I received 5 or 15mgs as the vials came in two sizes.

277. The Tribunal finds it more likely that Dr G gave 15mgs of Hypnovel to Ms I. In the criminal trial, Dr G gave evidence that this was the dose he administered.[250] Although Dr G is uncertain now, the Tribunal prefers the certainty he showed at the criminal trial.

Whether the sedation administered was in excess of the recommended maximum dose

278. The Tribunal must first consider whether there is sufficient evidence to establish what a maximum dose of Hypnovel is for the purpose of conscious sedation. If so, then the Tribunal must determine whether Dr G administered Hypnovel in excess of that dose.

279. As with Ms N, the Tribunal has based its findings on the first issue on the literature available at the time of Ms I's treatment and the evidence of Drs Symes, Kruger, and Holden.

280. The most relevant literature is what may have been available at the time of Ms I's treatment. However, none of the literature put forward was current in 1989. Therefore, it cannot be said that there was any literature available at the time specifying a recommended maximum dose.

281. For the sake of argument, the Tribunal considered the data sheet closest in time, the 1995 Roche Data Sheet ("RDS2").[251] Under the headings "Conscious sedation,

[249] Exhibit 13, entry dated 17/10/89.
[250] T 311/18-21.
[251] BOD tab 9, first two pages.

Intravenous Conscious Sedation, Adults" the RDS2 says, "A total dose greater than 5mg is not usually necessary". However, as with the RDS, the RDS2 does not specify a maximum. In addition, if a dose of 5.0 mg is not "usually" necessary: this must presuppose that more than 5.0mg may be used, even if only occasionally. Therefore, 5.0mg administered intravenously cannot be said to be a maximum level. The other data sheets given were not considered as they were not available in 1989.

282. The expert witnesses gave evidence on whether or not the literature specified a maximum dose. Dr Holden's view was that reputable authorities did not stipulate a maximum oral dose of Hypnovel.[252] Dr Symes, after some discussion in cross examination, conceded that the literature did not outline a maximum dose for Hypnovel. Although Dr Kruger's evidence about the MDS implying a maximum dose for conscious sedation was useful in Ms N's case, it could not be considered in Ms I's case because the events in her case happened many years earlier.

283. Therefore, the Tribunal has no evidence about what was available in 1989 specifying a recommended maximum dose.

284. Although the Tribunal finds that Dr G administered 15.0mg of Hypnovel to Ms I, it has not been proved what a recommended maximum dose was at the time. Therefore, the Tribunal has nothing on which to base a finding that Dr G administered a dose in excess of the recommended maximum dose.

285. Accordingly, particular 3.1 is not proved. Nevertheless, the Tribunal makes comment on the level of dose given to Ms I.

286. Dr Symes said that 15mg dose of IV Hypnovel was a large dose to give to a young woman, but that it was at the very upper end of the acceptable dosage for Hypnovel.[253]

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[252] Supra at fn 41, at para 78
[253] Supra at fn 43, para 5.8.

287. Dr Holden has administered larger doses of intravenous Hypnovel than either Dr Symes or Dr Kruger, for example, he has administered 48mg of Hypnovel intravenously[254] while titrating.[255] Dr Holden's evidence was that in Ms I's case the dose is very high but that it is not excessive if it is titrated[256] because the dentist will titrate the Hypnovel until the signs of sedation are evident.[257] He also says that in 1989 this would not have been an unusual dose, and that as of 2009 he might have 30 cases a year that require titrating to that level.[258]

288. On this basis then, the Tribunal finds that the dose was high, but there is insufficient evidence to suggest that the dose was excessive.

289. There may appear to be an inconsistency between this finding and the previous finding in relation to Ms N on the same issue. There, the Tribunal found that the dose given to Ms N was too high, whereas here it has not found this to be the case. This is even though the dose given to Ms I was probably higher than the dose given to Ms N.[259] There are two reasons for this. The evidence the experts gave was, overall, that the dose given to Ms N was very high, whereas the evidence about the dose given to Ms I was not as certain. Further, Ms I's treatment with Hypnovel took place in 1989, when little or nothing in the way of guidelines was available. In contrast, Ms N's treatment took place in 2001, where more information was available. As Mr Waalkens said, each case must be judged according to the standards of the time.

290. As a result, the Tribunal does not find this particular proved.

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[254] T 366/27.
[255] Where the sedative is given over time until the desired state of sedation is reached.
[256] T 367/25-27. He also says in his brief that the dose is high but not inconsistent with some patients need for conscious sedation, at para 101, and T 365/26-27.
[257] T 367/17-20.
[258] Supra at fn 41, at para 101.
[259] This is not certain given the bioavailbility of oral Hypnovel.

Particular 3.2: In administering the Hypnovel as particularised in Particular 3.1 potentially endangered Ms I's wellbeing and/or exposed Ms I to the risk of undesirable side-effects or consequences including while she was under sedation, he inappropriately and with no clinical reason for doing so, caused her right hand to touch and move over his penis.

291. The Tribunal did not hear specific argument on how Ms I's general wellbeing might have been compromised and so does not find this part of the particular proved.

292. Given the seriousness of the allegations, the Tribunal must have strong evidence before it concludes that the allegation is established. The Tribunal considers that the CAC's evidence is not enough to prove the allegation made.

293. Ms I did not see what she was touching. She has previously said that she was not sure what happened. Although she told her mother soon after the treatment about the possible sexual touching, she also thought subsequently that she might have imagined it and at times in the years that followed she joked about it.

294. As with Ms Y, the Tribunal considered whether it should examine the issue of hallucination in relation to Ms I's allegation. Given the rarity with which the Tribunal considers hallucinations of a sexual nature take place, this is an unlikely explanation for what could have happened. In any event, as the evidence about the alleged sexual touching is not persuasive and could merely have been a mistaken assumption, the Tribunal does not consider it is required to go further on the topic of hallucination.

295. Mr Waalkens suggested to Ms I under cross examination that she may have touched some cords positioned near her right hand. Once again, this seems to the Tribunal to be a remote possibility, but does not rule out the possibility of mistaken assumption on Ms I's part

296. In 1989, the reception area in Dr G's premises was in the surgery. As a result, both Dr G and his receptionist would have been working in the same room. Accordingly, the Tribunal finds that the layout of the surgery made it less likely that any

inappropriate conduct took place on 28 September 1989.

297. Ms I's recollection is that she felt the penis and immediately afterward was aware that Dr G was behind her removing a wisdom tooth. The Tribunal is persuaded by Dr Symes' evidence that people under sedation can experience compression of time, so that while they do not remember things that happened in the right sequence they can remember what happened.[260] While that explains the dislocation in time, it does not assist the Tribunal to find that sexual touching took place.

298. The Tribunal has found that the particular in relation to the sexual touching of Ms N proved. Again, the Tribunal must consider the issue of propensity and whether this makes the sexual touching of Ms I more likely.

299. The same factors already discussed in relation to Ms Y's complaint apply: the similarities between the complainants, the circumstances of the offending, and the number of complaints faced by Dr G when compared to other practitioners.[261]

300. Once again, there are similarities in the complaints, and the incidence of complaints against Dr G is high. Certainly the propensity evidence makes the probability of Dr G offending against Ms I higher than it otherwise would have been. However, the Tribunal finds that even allowing for the impact of propensity evidence, that evidence, even when combined with the other evidence is still not sufficiently strong to prove this particular to the required standard.

301. As a result, the Tribunal finds that particular 3.2 has not been proved.

The conduct alleged in Particulars 3.1 and 3.2 when each Particular is considered separately or two or more Particulars are considered cumulatively amounts to an act or omission in the course of or associated with the practice of dentistry that was or could have been detrimental to the welfare of the patient and/or amounts to professional misconduct.

302. As neither of the particulars in respect of Ms I has been proved, there is nothing for

[260] T221/33.
[261] See paras 237 to 241.

the Tribunal to consider cumulatively.

PROFESSIONAL MISCONDUCT AND SANCTION

303. The charge brought against Dr G is upheld in respect of particular 1.2.2 but is not upheld in respect of any other particular.

304. The Tribunal has found all of particular 1.2.2 proved. Had only the first part of the particular relating to endangerment of Ms N's wellbeing been proved that on its own would have been a comparatively minor matter. The Tribunal would have needed to consider whether or not it was sufficient to warrant disciplinary sanction. It is likely that given the high dose of sedative administered to Ms N in Dr G's absence, the Tribunal would have found that it was sufficient to warrant a disciplinary sanction even if only at a lower level.

305. However, as noted above, the Tribunal has found the particular as a whole to be proved to the required standard Unwanted sexual touching is obviously a fundamental breach of a dentist's professional obligations to his or her patients. It does, without question, constitute professional misconduct under 54(1) (c) of the Act.

306. Given the serious nature of the breach the Tribunal is satisfied that Dr G's actions require a disciplinary sanction in particular for the purposes of protecting the public and punishing the health practitioner.

CONCLUSION

307. Accordingly, the Tribunal seeks submissions from counsel and from Dr G on penalty, costs, and name suppression according to the following timetable:

- The CAC to file and serve submissions within 14 days of receiving this decision, that is **Tuesday 11 May 2010**; and

- Dr G to file and serve submissions within 14 days of receiving submissions from the CAC.

DATED at Nelson this 22nd day of April 2010

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PAC Coote
Chair
Dentists Disciplinary Tribunal