香港牙醫管理委員會
The Dental Council of Hong Kong

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr CHUNG Kwai-hung 鍾桂洪牙科醫生 (Reg. No. D02973)

Date of hearing: 1 December 2022

Present at the hearing

Council Members: Dr LEE Kin-man, JP (Chairman)
Dr CHEUNG Tat-leung
Dr LIU Wai-ming, Haston
Dr TUNG Sau-ying, MH

Legal Adviser: Mr Stanley NG

Defendant: Represented by Mr Chris HOWSE of Messrs Howse Williams, Solicitors

Legal Officer representing the Secretary: Mr Edward CHIK, SGC (Ag)

The Charge

1. The charge against the Defendant, Dr CHUNG Kwai-hung, is as follows:-

> "In and about September 2017, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient, [redacted] ("the Patient") or otherwise neglected your professional duties to the Patient in that, you –
>
> (i) failed to inform the Patient of the risks and complications of the implant treatment before the implant treatment in the mandible;
>
> (ii) failed to carry out adequate pre-operative assessments or investigations before the implant treatment;
>
> (iii) failed to devise a proper implant treatment plan; and/or

(iv) failed to carry out the implant treatment at tooth 37 site properly on or about 27 September 2017;

and that in relation to the facts alleged you have been guilty of unprofessional conduct."

Facts of the case

2. The name of the Defendant has been included in the General Register ("GR") since 7 February 1994. The name of the Defendant has never been included in the Specialist Register.

3. The Patient visited the Defendant's practice from January 2013 to July 2017 for wisdom tooth surgery and orthodontic treatment. On 30 August 2017, the Patient attended the Defendant's clinic again for consultation of pain from the lower left second molar (i.e. tooth 37) which was previously restored by the Defendant because of caries. After initial consultation, clinical and radiographic examination (periapical radiograph), she was diagnosed with pulpitis in tooth 37. Treatment options were given and the Patient decided to have extraction of tooth 37 to be later replaced with prosthesis. The Defendant extracted tooth 37 on the same day. The procedure was uneventful.

4. The Patient returned to the Defendant on 27 September 2017 (28 days after extraction) for follow up on the healing of tooth 37 extraction site. The Defendant advised her to replace the missing tooth 37 so that over-eruption of the opposing upper left molar (i.e. tooth 27) could be prevented. Different prosthetic options were discussed including removable partial denture, three-unit fixed cantilever bridge and dental implant. The Patient decided to opt for dental implant. The Defendant suggested her to receive surgery immediately (i.e. 27 September 2017).

5. The Defendant planned the implant surgery basing on a periapical radiograph taken on 30 August 2017, an orthopantomogram (OPG) taken on 11 May 2017 and the study model taken on 26 July 2017. An implant 4.3 x10mm was placed under local anaesthesia on the same day (i.e. 27 September 2017). During the operation, the Defendant discovered that the bone in tooth 37 site was soft, and he had to place the implant deeper to achieve primary stability.

6. On 29 September 2017, the Patient consulted the Defendant and complained of persistent numbness in the lower left lip. The Defendant took an OPG and the implant in site 37 was found touching the superior border of inferior dental (ID) canal. The Defendant suggested the Patient to observe two weeks for recovery, and removal of the implant would be considered if numbness persisted.

7. On 7 October 2017 (more than 10 days after the implant surgery), the Patient returned to the Defendant with no improvement in the lower lip numbness. The Defendant removed the implant because he suspected there was compression of the ID nerve by the implant and vitamin B was prescribed after the operation. The Defendant also referred the Patient to Dr YIP, Specialist in Oral and Maxillofacial Surgery for management of her neurosensory deficit.

8. The last time the Defendant reviewed the Patient was on 24 March 2018 and the Patient reported that the paraesthesia had improved but not fully recovered.

9. On 31 May 2019, the Patient lodged a complaint with the Dental Council against the Defendant.

Burden and Standard of Proof

10. The Council bears in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. The Council also bears in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

11. There is no doubt that the allegations against the Defendant here are serious. Indeed, it is always a serious matter to accuse a registered dentist of unprofessional conduct. Therefore, we need to look at all the evidence and to consider and determine each of the disciplinary charges against him separately and carefully.

Unprofessional Conduct

12. According to section 18(2) of the Dentists Registration Ordinance, Cap. 156 ("DRO"), "unprofessional conduct" means an act or omission of a registered dentist which would be reasonably regarded as disgraceful or dishonourable by registered dentists of good repute and competency.

Findings of Council

13. The Defendant admits the factual particulars of the disciplinary charges against him but it remains for us to consider and determine on the evidence whether he has been guilty of unprofessional conduct.

Charge (i)

14. Being informed of risks and complications is an important part of informed consent.

15. The Council gratefully adopts as its guiding principles the following statements of the law on informed consent as expounded in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11:

> *"87. ... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or*

should reasonably be aware that the particular patient would be likely to attach significance to it.

90. ... the doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible ..."

16. The Patient wrote in her complaint letter that the Defendant had not informed her of the risks and complications of the implant surgery.

17. In the clinical notes, nothing was written regarding the informed consent on the risks and complications of the implant surgery.

18. In fact, the Defendant admitted in his submission to the Preliminary Investigation Committee that he had not explained to the Patient the risks and complications of the implant surgery, including the possibility of nerve damage leading to temporary/permanent numbness of the lip.

19. The possibility of nerve damage leading to temporary/permanent numbness of the lip is a material risk. Informed consent has to be obtained. We have no doubt that the Defendant had failed to inform the Patient of the risks and complications of the implant treatment before the implant treatment of the mandible.

20. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

21. We therefore find the Defendant guilty of charge (i).

Charge (ii)

22. Before embarking on implant surgery, a dentist should always consider, including but not limited to (i) if the bone structure of the implant site is suitable both qualitatively and quantitively to receive the implant fixture; (ii) the relationship of the intended implant fixture with the other vital structures, such as the ID nerve and blood vessels; (iii) the architecture of the soft tissues of the socket site, such as how thick or thin they are, and particularly in this case to check if there is still inflammation after the extraction; and (iv) the position of the intended prosthesis and its relationship with the opposing tooth or teeth such as occlusion and loading.

23. In this connection, an adequate pre-operative assessment and investigation would invariably require a dentist to perform clinical examination, taking updated radiographic imaging, taking study cast, and estimating bone width such as by way of bone mapping or three-dimensional imaging as indicated. All these are very basic and elemental.

24. However, in this case, the Defendant had done none of these assessments and investigations. The Defendant did not even bother to update the radiograph prior to the implant surgery. The Defendant's implant planning was simply based on the OPG taken on 11 May 2017, the periapical radiograph taken on 30 August 2017 and the study model taken on 26 July 2017. These radiographs and model were all taken before the extraction of tooth 37 which were not suitable and could not reflect the real situation of the intended implant site. We agree with the Secretary's expert that there could be vertical and horizontal bone resorption in the extraction site during healing, which would result in remarkable reduction of ridge bone width and height. Therefore, the bone height measured by the Defendant from pre-extraction OPG could not reflect the true bone height in tooth 37 alveolar ridge.

25. In our view, the pre-operative assessments and investigations performed by the Defendant were clearly inadequate.

26. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

27. We therefore find the Defendant guilty of charge (ii).

Charge (iii)

28. To devise a proper implant treatment plan, a dentist should always decide on, including but not limited to (i) the position of the intended implant fixture; (ii) the appropriate choice of implant fixture in terms of diameter and length in relation to the implant recipient bone site; (iii) the mode of wound healing, such as primary closure or transmucosal healing; (iv) the timing of loading of the implant fixture to the implant placement; and (v) the design of the fixture and prosthesis.

29. However, in this case, the Defendant had done none of these. The Defendant had failed to devise a proper treatment plan.

30. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

31. We therefore find the Defendant guilty of charge (iii).

Charge (iv)

32. To properly carry out the implant procedure, a dentist should always, including but not limited to (i) ensure that the implant structure could be properly inserted into its intended position; (ii) that there is primary stability of the implant fixture; (iii) assess immediately post-operatively if the implant fixture is properly inserted as intended and whether or not it has impinged on other vital structures i.e. ID nerve and blood vessels; and (iv) ensure that the patient will be properly treated when complications arise in accordance with the protocol.

33. During the implant surgery, the Defendant discovered that the bone in tooth 37 site was soft and hence primary stability could not be maintained. If there was lack of good primary implant stability, a proper reassessment of the implant site is mandatory before any further

operative procedures. In this case, clinician could use either a larger diameter implant if the width of the ridge allowed, or submerged the implant to allow undisturbed osteointegration, instead of torqueing the implant deeper to risk the ID nerve. However, the Defendant had torqued the implant apically. In the post-implant OPG taken on 29 September 2017, the dental implant in 37 site was found 7mm apical to the crest of the ridge and the ID canal was disrupted which led to nerve injury.

34. What is even more unbelievable is that the Defendant did not bother to take any post-operative radiograph to assess if his implant surgery was successful. Taking a post-operative radiograph is very basic and elemental; otherwise how would a dentist know if his surgery is successful. The Defendant only took a two-dimensional post-operative radiograph on 29 September 2017, which was not enough to diagnose the actual position of the fixture in relation to the vital structures when the Patient complained of numbness of the lower left lip for two days. This was unacceptable.

35. Further, when the Defendant found out from the post-operative radiograph taken on 29 September 2017 that there was complication i.e. the implant had disrupted the superior border of the ID canal, he did not seem to have any protocol to handle the situation. Instead of removing the implant immediately, which according to the Secretary's expert should be removed within 36 hours post-surgery to prevent permanent damage, he asked the Patient to wait for two more weeks. Again, this was unacceptable.

36. Clearly, the Defendant had failed to carry out the implant treatment at tooth 37 site properly.

37. We are satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

38. We therefore find the Defendant guilty of charge (iv).

Sentencing

39. The Defendant has no previous disciplinary records.

40. The Council gives credit to the Defendant's cooperation and admission to the facts of the charges.

41. The Council bears in mind that the purpose of a disciplinary order is not to punish the Defendant, but to protect the public and maintain public confidence in the dental profession.

42. In mitigation, the Defendant told us that he has since the incident taken courses and studied publications and articles relating to implant surgery.

43. The Defendant said he is remorseful and has learnt a hard lesson.

44. The Defendant said he has made effort to improve in the area of implant surgery.

45. The gravity of the offences in this case is serious. This case is a treatment case which heavily relied on the clinical competency of the operating dentist. By competency, this Council expects adequate knowledge and skill. Meticulous attention to pre-operative

assessment and investigations, peri-operative and post-operative management is essential for the safety of the Patient. The Defendant lacked competency in many respects, from the beginning till the end. On gravity alone, we are of the view that a removal order is appropriate.

46. Given our acceptance that the Defendant is remorseful, has taken courses and studied publications and articles relating to implant surgery and other related areas, and has taken remedial measures to ensure that the risk of re-offending is low, we are minded and is prepared to suspend our removal order.

47. We therefore make a global order in respect of all charges (i) to (iv) that the name of the Defendant be removed from the General Register for a period of 1 month. We further order that the operation of the removal order shall be suspended for a period of 6 months. Our orders shall be published in the Gazette.

Dr LEE Kin-man, JP
Chairman
The Dental Council of Hong Kong