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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr HUI Yiu-man 許耀文牙科醫生 (Reg. No. D04211)

Date of Hearing: 5 December 2024

Present at the Hearing

Council Members: Dr LEE Kin-man, JP (Chairman)
Dr KO Hay-ching, Brian
Prof. LEUNG Wai-keung
Dr LIU Wai-ming, Haston
Dr CHOW Ming-chung

Legal Adviser: Mr Stanley NG

Legal Representative for the Defendant: Ms Jennifer LEE, Messrs. Johnson Stokes & Master, Solicitors

Legal Officer representing the Secretary: Mr Raymond LAM, Government Counsel

The Charge

1. The Defendant, Dr HUI Yiu-man, is charged that:-

"In or about November 2021, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient, Miss [redacted] ("the Patient") or otherwise neglected your professional duties to the Patient in that you failed to ensure that Amoxicillin would not be prescribed and/or dispensed to the Patient, who was known to be allergic to Augmentin.

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 5 August 2016. His name has never been included in the Specialist Register.

3. On 7 November 2021, the Patient attended the Defendant's clinic for the first time and was a new patient. The Patient registered with the clinic by filling out a registration form. On the registration form, the Patient wrote down that she was allergic to Augmentin.

4. During the consultation, the Patient complained to the Defendant of pain over 2 teeth (28, 38). The Defendant performed oral examination, and noted pericoronitis over the 2 teeth with redness and swelling. The Defendant then arranged an OPG to examine the surrounding nerves. After the OPG, the Defendant explained the diagnosis and suggested extraction of the 2 teeth. The Patient agreed to the extraction, which was carried out on the same day.

5. After the extraction, the Defendant prescribed the Patient with Paracetamol, Ibuprofen, Amoxicillin, Metronidazole, Arcoxia and Lyzozyme.

6. On 12 November 2021, the Patient returned to the Defendant's clinic for removal of sutures. The Patient reported pain over the left side of her mouth. The Defendant prescribed the same medications to the Patient.

7. On 13 November 2021, the Patient started to have rashes on her skin and sought medical treatment at Hong Kong Adventist Hospital. The Patient was diagnosed to have drug allergy.

8. On 15 November 2021, the Patient again sought medical treatment of her drug allergy problem at Hong Kong Adventist Hospital.

9. Between 16 and 22 November 2021, the Patient was hospitalized at Princess Margaret Hospital for her drug allergy.

10. On 23 November 2021, the Patient lodged a complaint against the Defendant with the Dental Council.

Burden and Standard of Proof

11. We bear in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. We also bear 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.

12. There is no doubt that the allegation against the Defendant here is 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 the disciplinary charge against him carefully.

Unprofessional Conduct

13. 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

14. The Defendant admits to the facts of the charge. However, it remains for us to consider and determine whether he is guilty of unprofessional conduct.

15. Prior to consultation on 7 November 2021, the Patient had clearly made known in the registration form, which was provided by the Defendant's own clinic, that she was allergic to Augmentin. There is no dispute and in fact it is expectant to be known to every registered dentist that Amoxicillin is an active ingredient of Augmentin.

16. It was clearly a clinical contraindication for the Defendant to prescribe and/or dispense Amoxicillin on both dates (i.e. 7 and 12 November 2021) to the Patient, who was known to be allergic to Augmentin.

17. The Defendant should have ensured that he had knowledge of the Patient's allergy to Augmentin when he prescribed and/or dispensed Amoxicillin to the Patient, but he had failed to do so. The Defendant's failure was a grievous and elemental failure.

18. 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. We therefore find the Defendant guilty of the charge.

Sentencing

19. The Defendant has no previous disciplinary record.

20. The Defendant does not contest the charge at today's inquiry. We will give the Defendant credit for his admission.

21. We bear 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.

22. According to the Defendant's submission to the Preliminary Investigation Committee ("PIC") of the Council dated 6 January 2023, the Defendant said that his usual practice was to look at the registration form and check for any drug allergy before prescribing medications. He however said that on 7 November 2021 he had inadvertently forgotten to review the registration form, resulting in the prescription of Amoxicillin. He said he could not explain why he had failed or forgotten to check the registration form on that day.

23. We find it hard to believe that if it was really due to inadvertence that the Defendant had failed to check for known allergy from the registration form on 7 November 2021, why would he again not check the registration form or his medical record on 12 November 2021 for any drug allergy. The Defendant had omitted to check not once, but twice. Prescribing and dispensing medications to patients who are allergic to them are very dangerous, and in some cases, can be life-threatening. The offence committed by the Defendant was very serious.

24. The Defendant told us that since the incident he has taken a number of remedial steps, including highlighting in yellow the allergy on the registration form; writing down the allergy at the Past Medical History section of the consultation record and highlighting the same, as well as putting a red circular label at the top right hand corner of the record; regularly reminding clinic nurses and educating new nurses of the clinic practice; personally checking the registration form for

every consultation and follow-up consultations for drug allergy; and verbally asking the patients for drug allergy prior to prescription of any medication. We must stress that these are merely very basic steps which every dental practitioner should have put in place at all times.

25. The Defendant submitted to us his CME record from 9 February 2023 onwards, which was subsequent to the incident. The Defendant confirms to us that he had no CME record between 2016 when he first became a registered dentist up to 8 February 2023. From the CME record provided, we are not satisfied that the Defendant had sufficient knowledge on clinical usage and drug safety.

26. Having regard to the gravity of the case and the mitigation submitted by the Defendant, the Council makes the following orders in respect of the charge:

(a) the name of the Defendant be removed from the GR for a period of one month;

(b) the operation of the order for removal be suspended for a period of 12 months; and

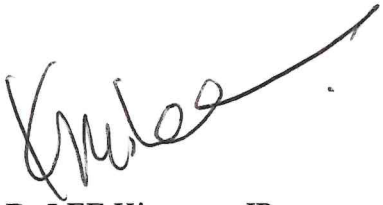
(c) during the suspension period of 12 months, the Defendant shall at his own expense satisfactorily complete a total of 10 hours of continuing education in courses relating to clinical usage and drug safety, which has to be pre-approved by the Chairman of the Council, and every such pre-approval of intended courses which the Defendant wishes to take has to be sought from the Chairman of the Council one month in advance.

Remarks

27. The Council stresses that the following remarks form no part of the decision on findings and sentencing above.

28. The Defendant had provided to the PIC his dental record of the Patient. The dental record was written in manuscripts. The handwriting was totally illegible. We wish to bring to the attention of the Defendant that legibility of dental record is very important as dental record is formal documentation, which will be relied upon by other professional colleagues.

29. We also note that as soon as the Patient complained to the Defendant or to his nurse about the allergy problem, there seemed to be a complete absence of advice or follow-up with the Patient. This was totally unprofessional. The Defendant should pay due attention in the future.



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