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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr TONG Yat-him, Clement 唐逸謙牙科醫生(Reg. No. D03608)

Date of hearing: 26 October 2018

Present at the hearing

Council Members: Dr LEE Kin-man (Chairman)
Dr FOO Tai-chuen
Dr LAM Tak-chiu, Wiley, JP
Dr LAU Kin-kwan, Kenny

Legal Adviser: Mr Stanley NG

Legal representative for the Defendant: Mr Chris HOWSE, Messrs. Howse Williams Bowers, Solicitors

Legal Officers representing the Secretary: Mr Mark CHAN, APGC (Ag)
Ms Jess CHAN, SGC

The Charges

1. As set out in the Notice of Inquiry dated 19 June 2018, the charges against the Defendant, Dr TONG Yat-him, Clement, are as follows:-

> "From about September 2012 to April 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 the possible complications arising from the orthodontic treatment;

(ii) failed to carry out proper and adequate investigation when complications arose from the orthodontic treatment; and/or

(iii) failed to provide timely referral for the Patient when complications arose;

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

Facts of the case

2. On 23 September 2012, [redacted] ("the Patient") first consulted Dr TONG Yat-him, Clement, the Defendant, for clear aligners to fix the alignment problem and slight protrusion of her teeth. The Defendant diagnosed the Patient to have the following problems: (a) slight bimaxillary protrusion; (b) missing 46; and (c) lower midline shift to the right.

3. In the Defendant's clinical notes, two orthodontic treatment options were listed; but the definitive treatment finally adopted was the removal of four premolars (14, 24, 34 and 44), the alignment of teeth by a particular system of clear aligners in order to retract incisors and to close all spaces ("the Treatment Plan"). When the Defendant presented the Treatment Plan to the Patient, she queried if extraction at lower right could be avoided because there was space left from the loss of a lower right first molar. The Defendant informed the Patient that the treatment under the Treatment Plan would take around two years. At the end, the Patient agreed to the Treatment Plan.

4. The Defendant then proceeded with the Treatment Plan. The entire course of the treatment lasted from around 2012 to 2017, a period of more than four years, instead of two years as suggested at the beginning by the Defendant to the Patient.

5. The Treatment Plan could not be fulfilled. It ended up with a number of complications to the Patient's teeth.

6. The Patient then lodged a formal complaint to this Council. The Patient's complaints included loosening teeth and chewing difficulty, extended treatment time from 2 years to over 4 years; that the Defendant had deviated from the Treatment Plan by using braces/metal wirings; protrusion of wire end and removed by a dental assistant; and tooth 48 chipped after scaling.

7. At today's inquiry, the parties produce a Statement of Agreed Facts. The Defendant admits *inter alia* to the facts of all three charges.

Burden and Standard of Proof

8. 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.

Unprofessional Conduct

9. 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

Charge (i)

10. This case is an orthodontic treatment case with complications.

11. A complication occurs when a potential problem arises following, and is a result of, a procedure, treatment, or illness. It complicates the situation that makes a disease or condition more dangerous or harder to treat.

12. Proper and adequate diagnosis and treatment planning is essential in ensuring good clinical outcomes which fulfill the aesthetic and dental health need and demand of the patient within a planned and reasonable timeframe. In reality, complications do occur. Pre-operative diagnosis, continuous monitoring and post-operative maintenance are also important to predict and prevent complications from occurrence.

13. In this case, the complications which arose as a result of the treatment under the Treatment Plan were loosen lower teeth (in particular 45, 47 and 48 with further tipping); patient's complaint of mobility of the lower teeth and difficulty when eating. The Council agrees with the prosecution expert that according to the pre-treatment photos of the Patient, there was only slight lower centre line shift to the right side. Her gum health was normal and she had a good bite. However, when looking at the photos of the Patient taken on 5 November 2014, it clearly shows her lips retracted, her lower molars and premolars further tipped forward, and there was open bite in the posterior teeth. On 25 October 2015, the Defendant had diagnosed that teeth 45, 47, 35 had degree II mobility. The OPG taken on 26 November 2015 shows that there was moderate angular alveolar bone loss.

14. All these are possible complications which the Defendant should have informed the Patient at the very beginning, and before he started treatment according to the Treatment Plan. Time and again, the Council stresses the importance of obtaining informed consent from patients.

15. The Patient told the Council that the Defendant had never informed her, whether verbally or in any written form, that there would be any possible complication whatsoever for her case by following the Treatment Plan.

16. The Defendant admits that he had failed to inform the Patient of the possible complications arising from the treatment under his Treatment Plan.

17. The Council is satisfied that the conduct of the Defendant had seriously fallen below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

18. The Council therefore finds the Defendant guilty of charge (i).

Charge (ii)

19. According to the entry of the Defendant's clinical record of date "5 November 2014", the Defendant changed his treatment plan on this date by starting to use braces/metal wirings for the lower teeth, and maintaining to use aligner for the upper teeth. This was clearly a complication as at this stage in that his original predicted treatment goal could not be achieved as the teeth did not move to the originally planned positions. The Defendant was aware of this complication and he had done no investigation on this complication at all.

20. Further, the entry of his clinical record of date "5 May 2015" wrote "perio, remove wire, treat perio…" This shows the Defendant was already aware, as at this date, that there had been periodontal problem with the Patient's teeth. Periodontal problem was clearly another complication. The Defendant had done no investigation on this complication.

21. The entry of his clinical record of date "26 November 2015" reads "…OPG, bone level ok". This was the only OPG that the Defendant had in his record. The prosecution expert told the Council that the OPG shows that there was angular bone loss in the Patient's lower teeth. The Council has looked at the copy of the OPG. The Council agrees entirely with the prosecution expert's observation. Bone level as shown was clearly not alright. The OPG shows as at 26 November 2015 there was a complication of angular bone loss. The Defendant had however done no investigation in relation to this complication.

22. The entries of his clinical record of dates "15 April 2016", "12 May 2016" and "30 June 2016" show that the Defendant had considered on all these three occasions if periapical radiographs should be taken. The Council considers that periapical radiographs were essential to investigate into the complications which had by that time arisen. However, no periapical radiographs had been taken.

23. According to the prosecution expert, the Defendant should also have done periodontal charting to monitor the amount of attachment loss at the periodontally involved molars, and evaluation of effectiveness of the local measures (scaling and polishing) performed on those teeth. The Defendant should also have made progress study models to evaluate the occlusal interference and eccentric loading of those involved teeth. However there was no such charting or model.

24. The Defendant admits that he had failed to carry out proper and adequate investigation when complications arose from his orthodontic treatment.

25. The Council agrees that the Defendant had failed to carry out proper and adequate investigation when complications arose.

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

27. The Council therefore finds the Defendant guilty of charge (ii).

Charge (iii)

28. As said above, from his clinical record, as at 5 November 2014, the Defendant had already changed his treatment plan from using braces/metal wirings. As at 5 May 2015, the Defendant had already identified there was periodontal problem with the Patient's teeth. The Defendant should have at least as from this date discussed or considered the possibility of referring the Patient to a specialist. However, the Patient told the Council that there had been no such discussion with her. There was no record of referral to take care of the orthodontic complication and/or periodontal problems.

29. The Defendant admits that he had failed to provide timely referral when complications arose.

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

31. The Council therefore finds the Defendant guilty of charge (iii).

Sentencing

32. The Defendant has two previous disciplinary records. The first previous record is in relation to canvassing and is not similar to the present charges. The second previous record is however similar; it was also a treatment case. In that second case, there were two unprofessional conduct charges. On 28 February 2018, the Council (differently constituted) ordered that for the said two charges the name of the Defendant be removed from the General Register for a period of three months, and be suspended for a period of 12 months ("the Suspension Order").

33. In the present case, the three charges were committed prior to, and therefore not during the operational period of the Suspension Order. This Council will therefore not activate the Suspension Order.

34. In sentencing for the present case, this Council gives credit to the Defendant's cooperation and admission to the facts of the charges.

35. 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.

36. The Council takes into account the "totality principle" when sentencing charges (i) to (iii).

37. Having regard to the gravity of the case and the mitigation submitted by the Defendant, the Council makes the following orders:-

    (a) In respect of charge (i), that the name of the Defendant be removed from the General Register for a period of 3 months;
    (b) In respect of charge (ii), that the name of the Defendant be removed from the General Register for a period of 3 months;

(c) In respect of charge (iii), that the name of the Defendant be removed from the General Register for a period of 3 months;

(d) The orders in paragraphs (a) to (c) above be concurrent;

(e) The orders in paragraphs (a) to (d) above shall be published in the Gazette.

38. The Council has considered whether we should suspend the sentence. The Council does not find a suspension order appropriate. Failure to diagnose and assess is elemental and grievous. Not only that, the Defendant had failed to diagnose and assess over an extended period of time. He had ample opportunity to diagnose and manage the complications arisen from the orthodontic treatment, but he failed to do so. Being busy is not an excuse.

Other Remarks

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

40. Orthodontics, like other dental treatment modalities, requires clear understanding of the science and the possession of the necessary skills involved in delivering safe and useful treatment outcomes.

41. Advances in technology and development in concepts in biomechanics cannot free the practitioner from the responsibility in accurate diagnosis, treatment plan prescriptions and the subsequent treatment delivery, continuous assessment, monitoring and maintenance care. Clear plastic sequential orthodontic aligner could be an effective treatment tool only if used by trained, competent and responsible dentists. The Council takes strong position against any form of neglect of duties to patients.

42. In this case, the Council notes that the Defendant had not even seen the Patient when she consulted his clinic for long periods of time i.e. from 21 January 2013 to 25 January 2014, a period of about 1 year; from 27 January 2014 to 5 August 2014, a period of about 6 months. In other words, the Defendant only saw the Patient once in around 18 months. During these 18 months, it was only the Defendant's dental assistant who saw the Patient to provide her with clear aligners. The Council also notes that when the Patient subsequently visited the Defendant's clinic in around February 2017 about protrusion of wire end, the Defendant did not treat her problem. The protruded wire end was only cut by a dental assistant in one of his clinics. These are not acceptable.

43. Further, the Council agrees with the prosecution expert that the Defendant's pre-treatment clinical assessment was grossly inadequate, incomplete, and fell short of the required standards of a complete record. There was a complete lack of assessment of the dentofacial morphology and occlusal features evaluation; no diagnostic model; missing pretreatment OPG and lateral cephalogram. It is not acceptable.

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