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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr CHAN Ting-hon, Kevin 陳亭翰牙科醫生 (Reg. No. D03783)

Date of hearing: 29 March 2018

Present at the hearing

Council Members: Dr LEE Kin-man (Chairman)
Dr FOO Tai-chuen
Dr LAM Tak-chiu Wiley, JP
Dr YOUNG Wan-yin, Betty
Ms WONG Yu-pok, Marina, JP
Dr LAU Kin-kwan, Kenny

Legal Adviser: Mr Stanley NG

Legal representative for the Defendant: Mr David KAN, Messrs. Howse Williams Bowers, Solicitors; Defendant absent at inquiry

Legal Officer representing the Secretary: Ms. Carmen SIU, Government Counsel

The Charge

1. The charge against the Defendant, Dr CHAN Ting-hon, Kevin is as follows:-

"In the period from about July 2015 to March 2016, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient Ms [redacted] ("the Patient"), or otherwise neglected your professional duties to the Patient in that, you –

(i) failed to carry out adequate pre-operative assessment to investigate the potential risks before embarking on the removal of 4 wisdom teeth in one single visit under local anaesthesia;

(ii) failed to have properly advised the Patient on the possible risks and complications arising from the treatment; and/or

(iii) failed to properly execute the removal of the lower left third molar resulting in inferior dental nerve damage;

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

Facts of the case

2. Ms ("Ms ") first consulted Dr CHAN Ting-hon, Kevin on 6 July 2015 for possible orthodontic treatment. Four impacted wisdom teeth, namely teeth 18, 28, 38 and 48 ("the Four Wisdom Teeth") were diagnosed. The Defendant suggested extraction of the Four Wisdom Teeth. Ms refused. Ms started orthodontic aligner treatment by the Defendant from September 2015.

3. During the follow-up appointment on 23 February 2016, the Defendant again advised extraction of the Four Wisdom Teeth.

4. On 14 March 2016, extractions were done. Under local anaesthesia, all the Four Wisdom Teeth were removed by the Defendant non-surgically.

5. In the first two days after extractions, Ms experienced acute pain post-operatively. On 19 March 2016, she started to feel numbness in her lower lip and chin area of the left side. The numbness persisted and Ms went back to see the Defendant for a follow-up appointment on 21 March 2016. A cone beam CT scan was done and the Defendant explored the 38 socket and sutured the socket while Ms was under local anaesthesia.

6. In the evening on 21 March 2016, the Defendant asked Dr John LO, a specialist in Oral and Maxillofacial Surgery, to see Ms in a follow-up appointment. Dr LO told Ms that the numbness could be due to an infection or the orthodontic aligner that she started to use after the extraction. A course of steroid and antibiotic for seven days was prescribed.

7. On 23 March 2016, Ms consulted another specialist in Oral and Maxillofacial Surgery, Dr YEUNG Wai-kit, Richie, for a second opinion. Dr YEUNG suggested that the condition was not due to an infection and asked her to stop the steroid treatment.

8. The Defendant had made submission to the Preliminary Investigation Committee of this Council by a letter from Messrs. Howse Williams Bowers, his Solicitors ("HWB"), dated 15 February 2017 ("the PIC Submission").

9. In the Defendant's PIC Submission, the Defendant accepted that he failed to carry out an adequate pre-operative assessment to investigate the potential risks before embarking on the removal of the Four Wisdom Teeth on 14 March 2016. This is in relation to Charge (i). The Defendant further accepted that he failed to properly execute the removal of the lower left third molar resulting in inferior dental nerve damage. This is in relation to Charge (iii). The Defendant further said that if the case was to be referred to inquiry, he would accept the

facts of both these charges (viz. Charge (i) and Charge (iii)) and would leave the issue of whether the facts under both these charges constitute unprofessional conduct to be determined by the Council.

10. By a letter from HWB to the Council dated 18 January 2018, the Defendant informed the Council that in relation to Charge (i) and (iii), he maintained the same position as he made in his PIC Submission. The Defendant would admit the facts of Charges (i) and (iii) and would not contest whether the facts of Charges (i) and (iii) amount to unprofessional conduct. Further, the Defendant said he wished to admit the facts of Charge (ii) and would not contest whether the facts of Charge (ii) amount to unprofessional conduct.

11. At today's inquiry, the parties produce a Statement of Agreed Facts. The Defendant admits the facts as set out in Charges (i), (ii) and (iii).

12. The Defendant's legal representative confirms to the Council that the Defendant will not challenge: (a) the facts as set out in Charges (i), (ii) and (iii); (b) the facts as set out in the complainant's letter; (c) the facts and opinion as set out in the prosecution's expert report of Dr Philip Kin Man LEE ("the Expert") dated 15 December 2017; and (d) that the facts as alleged in Charges (i), (ii) and (iii) all amount to unprofessional conduct.

Burden and Standard of Proof

13. 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

14. 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

On Charge (i)

15. Charge (i) is that the Defendant had failed to carry out adequate pre-operative assessment to investigate the potential risks before embarking on the removal of the Four Wisdom Teeth in one single visit under local anaesthesia.

16. For extraction of impacted wisdom teeth, pre-operative assessment includes clinical examination and radiographic investigation.

17. The Council agrees with the Expert that there are local factors that will affect the surgical difficulties, which include angulation of the impaction (mesial, horizontal, vertical, distal);

depth of impaction; type of tissue overlying the impacted tooth (bone or soft tissue); root morphology; and proximity to vital anatomy and inferior dental nerve.

18. In the present case, the Defendant had taken an OPG on 6 July 2015 ("the OPG"). The Council has looked at the OPG as contained in the CD produced by the prosecution (Prosecution Exhibit C-3).

19. An adequate pre-operative assessment should aim at determining an appropriate treatment plan commensurate with the treatment difficulties, risks and operator competency. The Council considers that the assessment by the OPG for teeth 18 and 28 was adequate. However, from the OPG, teeth 38 and 48 were in close proximity to the inferior dental canal. This was highly suspicious of the true relationship between the inferior dental bundle and the apices of teeth 38 and 48 with the potential risks of nerve and bone damage. This should have alarmed the Defendant to consider further investigative measures to determine the definitive treatment plan such as referral or extraction approach.

20. However, the Defendant had not taken any further investigative measures. Instead, the Defendant went straight into removal of teeth 38 and 48. This was clearly inadequate.

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

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

<u>Charge (ii)</u>

23. Charge (ii) is in relation to the Defendant's failure to properly advise Ms ██████ on the possible risks and complications arising from the treatment.

24. According to the complaint letter of Ms ██████, she arrived at the clinic of the Defendant on 14 March 2016 at around 1 p.m. About 15 minutes later, a nurse of the Defendant asked her to make payment for the extractions, and subsequently asked her to sign on a consent form which she duly signed in the absence of the Defendant.

25. The Defendant was absent throughout the consent process. There is no clinical record that shows the Defendant had informed Ms ██████ of the possible risks and complications of extraction of the Four Wisdom Teeth, in particular tooth 38.

26. The Council agrees with the Expert that consent must be given voluntarily by the patient after the dentist informs the patient of the relevant aspects of the treatment, including the effects and risks involved. The explanation should be given in clear, simple and consistent language and in terms that the patient can understand.

27. In the present case, there was no documentation in the dental records about the Defendant's assessment of the difficulty of the extractions and any discussion of the risks involved in the removal of tooth 38 with Ms ██████. There was also no documentation about the Defendant's providing any option to Ms ██████ to refer the case to a specialist.

28. The Council is satisfied that the Defendant had not sought informed consent from Ms [redacted] before performing the extractions.

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

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

Charge (iii)

31. Charge (iii) is in relation to the Defendant's failure to execute the removal of the lower left third molar resulting in inferior dental nerve damage.

32. The Defendant extracted tooth 38 by non-surgical approach under local anaesthesia. From the OPG, the Council can see that there are obstacles to extraction of tooth 38. The obstacles of tooth 38 were that (a) it was distal angularly impacted with bulbous crown and bony impaction; (b) it was multi-rooted with mesial curve of the distal root; and (c) it was in close proximity with the inferior dental canal.

33. The Council agrees with the Expert that tooth 38 should be removed surgically, instead of non-surgically, to avoid unnecessary trauma to the left inferior dental nerve close to the roots.

34. In Ms [redacted]'s case, after the extraction of 38 by the Defendant, she began to feel numbness on 19 March 2016, five days after extraction. The Council agrees with the Expert that the initial discomfort and pain of the extraction had masked the numbness, which started to become more obvious when the initial symptoms subsided. She also had complication of lingual plate fracture confirmed by the cone beam CT taken on 21 March 2016. It indicated the traumatic nature of the extraction. The Council agrees with the Expert that the cause of the numbness was not due to bacterial infection or trauma from an orthodontic aligner, but the direct trauma of the left inferior dental nerve from the dental extraction of tooth 38. The damage was confirmed by the cone beam CT taken on 21 March 2016 (Prosecution Exhibit C-3).

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

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

Sentencing

37. Charges (i) and (iii) committed by the Defendant are very serious in that the level of failure was elemental and grievous.

38. The Council takes note that the Defendant has no previous disciplinary record.

39. This Council gives credit to the Defendant's cooperation and early admission to the facts of the charges.

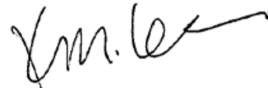
40. This case is a treatment case which heavily relied on the clinical competency of the operating dentist. By competency, this Council expects adequate knowledge and skill. Meticulous attention to pre-operative assessment and effective delivery of treatment by necessary skill is essential for the safety of the patient. The Council is not satisfied with the competency of the Defendant.

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. 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 Defendant be reprimanded;
    (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) and (c) above be concurrent;
    (e) The orders in paragraphs (a) to (d) above shall be published in the Gazette.

43. The Council has considered whether the removal orders under paragraph 42(a), (c) and (d) above can be suspended. In view of the reasons set out in paragraphs 37 and 40 above, the Council sees no reason for suspension.



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

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Footnote to the judgment of the disciplinary inquiry against
Dr CHAN Ting-hon, Kevin 陳亭翰牙科醫生 (Reg. No. D03783)

Dr CHAN Ting-hon, Kevin subsequently appealed against the orders of the Dental Council of Hng Kong to the Court of Appeal with Case No. CACV 113/2018.

Upon the Request for Dismissal of Appeal filed by Dr CHAN on 24 July 2018, the appeal was ordered to be dismissed by the Court on 8 August 2018.