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)

Dates of hearing: 28 February 2018

Present at the hearing

Council Members: Prof CHEUNG Shun-pan, Gary (Temporary Chairman)
Dr CHAN Chi-chun
Dr TONG Chi-kit, Antonio
Dr TUNG Sau-ying, MH

Legal Adviser: Mr Stanley NG

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

Legal Officer representing the Secretary: Mr William LIU, Senior Government Counsel

The Charge

1. The charge against the Defendant, Dr TONG Yat-him, Clement, is as follows:-

> "In about September 2014, 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 her in that, you –
>
> (i) failed to carry out proper and adequate examination and/or assessment on the Patient's dental condition including the level of bone impaction before removing her lower left third molar; and/or
> (ii) failed to adequately advise the Patient of the risks and complication

associated with the removal before removing her lower left third molar;

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

Facts of the case

2. On 17 September 2014, Miss [redacted] ("Miss [redacted]") consulted Dr TONG Yat-him, Clement, the Defendant. Miss [redacted] told the Defendant that her gum was swollen and felt pain. After examination, the Defendant told Miss [redacted] that the gum would ooze pus with a gentle push around the lower wisdom tooth. The Defendant said the gum had been inflamed for some time, and the lower wisdom tooth could not erupt and had to be extracted after the gum recovered from inflammation. The Defendant said the extraction of the lower wisdom tooth would also necessitate the extraction of the upper wisdom tooth. The Defendant said the extractions of both the lower and upper wisdom teeth could be performed in the following week when the swelling of the lower wisdom tooth subsided. The Defendant made an appointment with Miss [redacted] on 28 September 2014 for the extraction of both the lower and upper wisdom teeth at his Tseung Kwan O clinic. There is no dispute that the lower wisdom tooth in question at all material time was to refer to the lower left third molar.

3. A full mouth dental orthopantogram X-ray of Miss [redacted] was taken on 21 October 2013 ("the 21.10.2013 X-ray").

4. On 28 September 2014, Miss [redacted] visited the Defendant at his Tseung Kwan O clinic. According to Miss [redacted], the Defendant had looked at his email, which purportedly contained the record of her 21.10.2013 X-ray, and said there was no risk for the extraction of the lower left third molar. The Defendant had not explained to Miss [redacted] the risks and complication associated with the removal of the lower left third molar despite Miss [redacted]'s repeated enquiries. The Defendant then performed extraction of the lower left third molar under local anaesthesia.

5. After extraction of the lower left third molar, Miss [redacted] started to have numbness at her lower left lip and chin, which persisted beyond the normal expected duration of local anaesthesia.

6. On 29 September 2014, Miss [redacted] visited the Defendant at his clinic for her persistent left lower lip and chin numbness. Another orthopantogram X-ray was taken at that appointment ("the 29.9.2014 X-ray").

7. Miss [redacted] then consulted other specialists for her left lower lip and chin numbness, including a Dr John LO, a Professor CHEUNG Lim-kwong, and a Dr CHEUNG Loi-ming ("Dr CHEUNG").

8. According to the Medical Report dated 31 October 2014 provided by Dr CHEUNG in respect of Miss [redacted], it was stated that the lower left third molar was mesial angularly impacted. The 21.10.2013 X-ray had demonstrated clearly a deviation of the course of bony canal of the left inferior alveolar nerve (also known as mandibular canal) when it came into proximity with the left lower third molar. The 21.10.2013 X-ray was highly indicative that there was above-average risk of damaging the nerve upon extraction. Dr CHEUNG also stated in his Medical Report that from the 29.9.2014 X-ray, there was a breach in continuity of the superior aspect bony inferior dental nerve canal when it crossed with the lower left third molar socket, which was compatible with trauma and injury to the left inferior dental nerve from the

extraction of the lower left third molar. Dr CHEUNG certified in his Medical Report that Miss [redacted] had left inferior dental nerve injury after extraction of the lower left third molar on 28 September 2014.

9. The Defendant had made submission to the Preliminary Investigation Committee of this Council by a letter from Messrs. Howse Williams Bowers, his Solicitors, dated 13 February 2017 ("the PIC Submission").

10. According to the Defendant's PIC Submission, the Defendant accepts the facts of the complaint against him, namely that he had failed to carry out proper and adequate examination or assessment on Miss [redacted]'s dental condition before removing her lower left third molar; and he had failed to adequately advise Miss [redacted] of the risks and complications associated with the removal before removing her lower left third molar. The Defendant would wish to apologise for his mistakes. The Defendant also said in the PIC Submission that at inquiry he would not wish to make submissions on whether the facts of the complaint constitute unprofessional conduct. He would leave this issue to be determined by the Council.

11. At today's inquiry, the parties produce a Statement of Agreed Facts. The Defendant admits *inter alia* that before extracting the lower left third molar of Miss [redacted] on 28 September 2014, the Defendant had failed to (a) carry out proper and adequate examination and/or assessment on Miss [redacted]'s dental condition including the level of bone impaction; and (b) adequately advise Miss [redacted] of the risks and complication associated with the extraction.

Burden and Standard of Proof

12. 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

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

On Charge (i)

14. Charge (i) is that the Defendant had failed to carry out proper and adequate examination and/or assessment of Miss [redacted]'s dental condition including the level of bone impaction before removing her lower left third molar.

15. Examination and assessment of the patient's conditions are the hallmarks of the diagnosis and treatment planning process. Failure to carrying out examination and assessment in a proper and adequate manner would not be in the best interest of the patient as other factors might not have been considered.

16. In this case, the impaction of Miss [redacted]'s lower left third molar was situated at such a level that a diversion of the mandibular canal was clearly indicated in the 21.10.2013 X-ray. Diversion or deviation of the mandibular canal would indicate a close relationship with the inferior alveolar nerve, thus an above-average risk for nerve damage.

17. In view of the above-average risk of nerve damage involved, the Defendant should have taken other means to verify the relationship of the mandibular canal and the tooth root in order to minimize such risk. However, from the clinical record of the Defendant, there is no indication that the Defendant had carried out any further investigation.

18. 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.

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

Charge (ii)

20. Charge (ii) is in relation to the Defendant's failure to adequately advise Miss [redacted] of the risks and complication associated with the removal before removing her lower left third molar.

21. In this case, the risk of nerve damage was clearly above average. The Defendant must advise Miss [redacted] accordingly. However, the Defendant had not advised Miss [redacted] of the risks and complications of extracting this tooth. Indeed, the Defendant indicated to Miss [redacted] that there was no risk at all despite Miss [redacted]'s repeated enquiries.

22. 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.

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

Sentencing

24. The Defendant has one previous disciplinary record, but that previous record is in relation to canvassing and is not similar to the present charges, which are in relation to treatment.

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

26. The Defendant submitted to the Council a number of letters of mitigation, which the Council has considered.

27. This Council gives weight to the Defendant's effort in taking subsequent steps to address the omission of information and advice on the risks and complications provided to patients, and to enhance competence in diagnosis and treatment planning.

28. 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.

29. The Council takes into account the "totality principle" when sentencing charges (i) and (ii).

30. 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 three months;
    (b) In respect of charge (ii), that the name of the Defendant be removed from the General Register for a period of three months;
    (c) The orders in paragraphs (a) and (b) above be concurrent;
    (d) The operation of the orders as set out in paragraphs (a) to (c) above be suspended and shall not take effect for a period of 12 months;
    (e) The orders in paragraphs (a) to (d) above shall be published in the Gazette.

Other Observations

31. The Council has other observations. The Council stresses that no part of the following observations was taken into account when considering the findings and sentencing above.

32. In this case, there is no indication of any record of diagnostic test apart from the one 21.10.2013 X-ray. Indeed, the patient record was so brief that one cannot find the medical history and the dental chart of Miss [redacted].

33. The Council strongly advises the Defendant to reflect on this matter.

Prof CHEUNG Shun-pan, Gary
Temporary Chairman
The Dental Council of Hong Kong