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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr NG Wai-sang 伍偉生牙科醫生 (Reg. No. D02435)

Date of hearing: 12 May 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: Miss Sanyi SHUM, SGC

The Charges

1. As set out in the Notice of Inquiry dated 15 October 2021, the charges against the Defendant, Dr NG Wai-sang, are as follows:-

"In about May to October 2020, 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 obtain proper informed consent of the Patient before carrying out the dental treatment involving the upper right posterior teeth ("Tooth 14 to Tooth 16");

(ii) failed to provide an effective root canal treatment for Tooth 14;

(iii) failed to make appropriate diagnosis for the postoperative sensitivity or discomfort after the bridge was cemented for Tooth 14 to Tooth 16;

(iv) failed to devise a proper plan of action for the postoperative sensitivity or discomfort after the bridge was cemented for Tooth 14 to Tooth 16; and/or

(v) failed to make referral to other dentist(s) and/or specialist(s) in a timely manner in order to manage the Patient's condition;

and that in relation to the facts alleged, either individually or cumulatively, 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 30 January 1989. The name of the Defendant has never been included in the Specialist Register.

3. On 26 May 2020, the Patient consulted the Defendant regarding pain in the right maxillary region. Root Canal Treatment ("RCT") on tooth 14 was performed and was completed over three consultations on 28 May, 2 and 9 June 2020.

4. On 9 July 2020, the Patient returned to see the Defendant regarding prosthesis on the root-treated tooth 14.

5. On 15 July 2020, the Defendant removed the Patient's existing cantilever bridge on teeth 15 to 16 and fitted a three-unit temporary bridge over teeth 14 to 16.

6. The Patient reported postoperative sensitivity. On 16 July 2020, tender to percussion was noted.

7. On 27 July 2020, the Defendant removed the Patient's temporary bridge and he cemented the permanent bridge. The Defendant arranged the Patient to attend a follow-up consultation two days later. However, the Patient could not return until later, as there were suspected COVID-19 cases at the building where the Patient lived.

8. The Patient attended to a multiple of review appointments with the Defendant since 15 September 2020. On 22 September 2020, post-operative sensitivity was recorded and the Defendant adjusted the occlusion of the bridge 14 to 16. On 29 September 2020, tender to percussion on terminal molar 17 and sensitivity was noted. On 30 September 2020, occlusion of tooth 16 was further adjusted and night guard suggested.

9. The Patient consulted a Dr CHAN on 6 October 2020 and a Dr WONG on 26 October 2020 for second opinions on her post-operative pain and hypersensitivity.

10. The Patient's last appointment with the Defendant was on 28 October 2020.

11. The Patient was referred by Dr WONG to consult a Dr MAK, Endodontist on 27 November 2020.

12. On 6 November 2020, the Patient lodged a complaint against the Defendant to the Council.

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.

14. There is no doubt that each of the allegations against the Defendant here is a serious one. 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

15. 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

16. The Defendant admits the factual particulars of all 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)

17. 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 ..."

18. Paragraph 5 of the Council's Code of Professional Discipline (revised in December 2019) ("Code") deals with consent. Particularly, paragraph 5.7(b) reads:

    "Consent is valid only if ... (b) the dentist has provided proper explanation of the nature, effect and risks of the proposed treatment and other treatment options (including the option of no treatment)..."

19. There was no clinical note or charting which recorded the Patient's dental condition including chief complaint, clinical examination, findings, diagnosis and treatment plan, but only a very brief mentioning of the treatment procedure regarding RCT of tooth 14, which commenced on 26 May 2020.

20. There was no record whatsoever, whether in the form of signed written consent or record of verbal consent given by the Patient, that the Defendant had told the Patient about the anticipated benefits and risks involved in the recommended treatment, namely the RCT of tooth 14, the removal of the existing cantilever bridge on teeth 15 to 16 and the fitting of a three-unit temporary bridge over teeth 14 to 16, and any reasonable alternatives.

21. Most importantly, the Defendant accepted that he had failed to obtain proper informed consent from the Patient.

22. We find that the Defendant had failed to obtain proper informed consent from the Patient before carrying out the dental treatment involving the upper right posterior teeth 14 to 16.

23. 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.

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

<u>Charge (ii)</u>

25. Charge (ii) is on whether the Defendant had failed to provide an effective RCT on tooth 14. The key issue is on whether the RCT on tooth 14 was effective.

26. When the Patient first consulted the Defendant, she complained of pain in the region of teeth 14 to 16. The clinical record of the Defendant does not reveal anything at all as to the

diagnosis of the source of pain, whether or not the pain came from tooth 14. In any event, the Defendant decided to perform RCT on tooth 14 in an attempt to relieve pain in that area.

27. Immediately after the completion of RCT of tooth 14 on 9 June 2020, the Patient no longer complained of pain in the region of teeth 14 to 16.

28. It was only until the dismantling of the cantilever bridge of teeth 15 to 16 on 9 July 2020 that the Patient started to complain of pain again at the region of 14 to 16. There was no complaint of pain for a month.

29. As to whether the RCT of tooth 14 was effective, from the Patient's perspective, since her complaint was pain and the pain was relieved, we take the view that the RCT could not be said to be ineffective at the time.

30. We will therefore acquit the Defendant of Charge (ii).

Charge (iii)

31. According to the clinical record, on 22 September 2020, there was record of sensitivity of teeth 14 and 16. On 29 September 2020, there was record of tender to percussion of tooth 17 and mild sensitivity. On 7 October 2020, there was record that teeth 16 and 17 were sensitive. On 30 September 2020, there was record that night guard was suggested. The Defendant had therefore recorded the symptoms.

32. However, we cannot see from the clinical record at all of the record of diagnosis of what caused these symptoms.

33. The Defendant said that the Patient had been taking anti-depressant medications and therefore difficult to adapt to the prostheses. The Patient said the Defendant told her that the post-operative sensitivity and discomfort might possibly be caused by bruxism or trigeminal neuralgia.

34. Despite informing the Patient these possibilities, the Defendant had not performed any diagnostic procedure at all to confirm his provisional diagnosis. There was no record of any x-ray done, no detailed history taking, no operative procedure, and no prescribed treatment to confirm his provisional diagnosis. What the Defendant did on a number of occasions was simply mainly to adjust the occlusion of the bridge. This suggests that the Defendant believed that adjustment to occlusion would solve the problem of postoperative sensitivity despite the sensitivity or discomfort persisted.

35. We are satisfied that the Defendant had failed to make appropriate diagnosis for the postoperative sensitivity or discomfort. 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.

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

Charge (iv)

37. As stated above, which is confirmed by the clinical record, the Defendant had only made adjustment to the occlusion of the bridge despite the Patient's repeated complaint of post-operative sensitivity or discomfort. The Defendant had also suggested the use of night guard on 30 September 2020. These are all we can see from his clinical record as long as what actions were taken by the Defendant.

38. Adjustment to occlusion and the suggestion of using night guard are therefore the Defendant's plan of actions, but despite the adjustment of occlusion, seemingly the sensitivity and discomfort were not relieved.

39. We already find under Charge (iii) above that the Defendant had failed to make appropriate diagnosis for the post-operative sensitivity or discomfort. Without an appropriate diagnosis, it must follow that no proper action plan could be formulated.

40. We are satisfied that the Defendant had failed to devise a proper plan of action for the postoperative sensitivity or discomfort. 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.

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

Charge (v)

42. From the clinical record, after the Defendant cemented the bridge on 27 July 2020, the next visit of the Patient was 15 September 2020, which was almost two months later. The Patient could not attend earlier due to the pandemic.

43. We see from the record that there had been a total of seven visits from 15 September 2020 to 12 October 2020. It was recorded on 12 October 2020 that the Defendant referred the Patient to see endodontist.

44. It was less than a month's time between 15 September 2020 and 12 October 2020 and all along during this period the Defendant had been attempting to manage the Patient's condition. The Defendant did offer the Patient the option of referral to an endodontist at the end. We do not see how the referral in less than a month's time in this case, whilst there was continuing attempt of management of the Patient, can be said to be not timely.

45. We therefore acquit the Defendant of charge (v).

Sentencing

46. The Defendant has no previous disciplinary records.

47. The Council gives credit to the Defendant's apologies, his cooperation and admission to the facts of the charges.

48. 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.

49. The Defendant was convicted of three charges. In respect of charges (iii) and (iv), we take the view that the failure to make appropriate diagnosis and to devise a proper action plan was a very elemental failure.

50. Although the Defendant alleged that he has enrolled in courses including crown and bridge, RCT and implant dentistry, he has nonetheless still not taken the courses, for whatever reasons that might be. We will therefore not give any weight of his mere enrolment in these courses. We also take note that he had taken up a number of case studies on many areas and particularly on consent.

51. 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 a warning letter be given to the Defendant.
(b) In respect of charges (iii) and (iv), that the Defendant be reprimanded.
(c) The orders in paragraphs (a) and (b) above shall be published in the Gazette.

Other Remarks

52. The Council wishes to make the following remarks, which have nothing to do with our decision of conviction and sentencing above.

53. Continuing professional development is very important to maintain competence and knowledge and to ensure trust of patients on the profession and on individual dentist. We will therefore urge the Defendant to actively participate in continuing professional development programs to update his skills and knowledge.

54. Time and again, the Council stresses that record keeping is very important. In this case, the Defendant's clinical record was too brief. Such kind of record is totally unsatisfactory, and he was only fortunate that no charge was laid against him. We would advise the Defendant to ensure that his record keeping be up to standard.

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