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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr YUNG Ching-wah（容清華牙科醫生）(Reg. No. D01148)

Dates of hearing: 19 February 2019, 7 March 2019, 13 March 2019, 28 March 2019 and 28 April 2019

Present at the hearing

Council Members: Dr LAM Tak-chiu Wiley, JP (Temporary Chairman)
Dr CHAN Chi-chun
Dr TUNG Sau-ying, MH
Dr WAI Tak-shun, Dustin

Legal Adviser: Mr Stanley NG

Legal representative for the Defendant: Mr Robin McLeish, Barrister-at-law, instructed by Messrs. Howse Williams, Solicitors

Legal Officer representing the Secretary: Mr Mark CHAN, Assistant Principal Government Counsel (Ag)
Miss Vienne LUK, Senior Government Counsel

The Charges

1. The charges, as amended, against the Defendant, Dr YUNG Ching-wah, are as follows:-

> "In the period from February 2014 to November 2014, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient [redacted] ("the Patient"), or otherwise to have neglected your professional duties to the Patient in that –
>
> (a) you failed to adequately and timely explain to the Patient about the horizontal crown fracture of his upper right lateral incisor ("tooth 12");

(b) you failed to timely offer proper alternative options to the Patient for managing the fracture; and/or

(c) you failed to timely, properly and/or adequately advise the Patient of the treatment options when the original implant treatment failed;

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

Facts of the case

2. At all material times, the Defendant was a specialist in prosthodontics. During the period between February and November 2014, both the Defendant and Dr Morgan Olsson ("Dr. Olsson"), a registered general dental practitioner in Hong Kong and a specialist in oral surgery in Europe and working part-time at the Defendant's clinic, were involved in the management of [redacted] ("the Patient").

3. On 6 October 2010, the Patient consulted the Defendant presenting with a vertical root fracture at tooth 11. The Defendant advised the Patient to undergo an extraction of tooth 11. The Patient said he would consider.

4. On 5 February 2014, the Patient returned to see the Defendant presenting with gum boil with mild inflammation at the region of the tooth 11. The Patient agreed to have tooth 11 extracted, followed by bone grafting and implant placement.

5. On 26 February 2014, the Defendant performed extraction of tooth 11. Dr Olsson then performed bone grafting at the extraction socket. Then, the Defendant placed a temporary acrylic denture to replace tooth 11 temporarily.

6. On 28 February 2014, the Patient returned to consult the Defendant. The Patient indicated that he did not wish to continue wearing the temporary denture. The Defendant then advised the Patient to wear a Maryland bridge with teeth 12 and 21 as abutments. The Patient agreed.

7. On 5 March 2014, the Maryland bridge was fitted with its metal wings cemented to the back of teeth 12 and 21.

8. On 29 July 2014, the Defendant removed the Maryland bridge and Dr Olsson inserted the implant fixture. A removable denture was delivered by the Defendant.

9. On 5 August 2014, the Patient returned to the Defendant's clinic for removal of sutures. The Maryland bridge was fitted again.

10. On 21 November 2014, the Patient returned to the Defendant's clinic. This was a scheduled appointment for the Defendant and Dr Olsson to assess the implant and perform Stage II implant surgery. When the Defendant removed the Maryland bridge, tooth 12 was fractured. The Defendant then performed acid etching of the enamel of tooth 12, placed tooth coloured composite resin on its surface. After the Defendant repaired tooth 12, Dr Olsson then exposed the surgical site and found that the implant fixture was mobile indicating that

osseointegration had failed. Dr Olsson removed the failed implant fixture and then performed bone grafting as a second attempt. The Defendant then invited the Patient to have a discussion on the same day.

11. A few days later, the crown of tooth 12 came off. The Patient immediately called Dr Leung Siu Fai ("Dr Leung") for an urgent consultation.

12. On 29 November 2014, the Patient consulted Dr Leung. Dr Leung noticed that tooth 12 suffered complicated horizontal crown fracture, with most of the anatomical crown severed. The fragment was bonded with composite resin to the tooth. The periapical radiograph confirmed the fracture but there was no periapical lesion. Dr Leung advised that Root Canal Treatment ("RCT") of tooth 12 should be performed. On the same day, the Patient consulted the Defendant. The Defendant performed RCT and placed a temporary crown at tooth 12. The Patient did not go back to consult the Defendant after this visit.

13. On 18 December 2014, the Patient consulted another dentist, Dr Robert Lau ("Dr Lau"), for implant replacement of missing tooth 11. Dr Lau took a periapical radiograph which revealed the extraction site of tooth 11 had a radiopaque area resembling root fragment of a tooth, and he advised that the fragment should be removed before any implant surgery.

14. On 31 December 2014, the Patient consulted another dentist, Dr James Chow Kwok Fai ("Dr Chow") for implant consultation. Dr Chow took Cone Beam CT and suspected a root remnant was at extraction site 11. On 3 January 2015, Dr Chow removed the remnant from site 11, which was in one piece of about 1 cm long. The Patient had since kept the remnant in a medicine bag in the refrigerator. The remnant had already been broken into five small pieces by the time of this inquiry. The broken pieces of remnants were produced by the Patient as Secretary's Exhibit N.

Burden and Standard of Proof

15. 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

16. 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 (a)

17. Charge (a) is that the Defendant had failed to adequately and timely explain to the Patient about the horizontal crown fracture of tooth 12.

18. The Council considers that an adequate and timely explanation should include the true nature, cause, extent and seriousness of the fracture, and be given at the first reasonable opportunity.

19. The Patient told the Council that on 21 November 2014 the Defendant had never told him at all, whether during the dental procedure or afterwards at the conference, about the fracture of tooth 12. All that the Defendant had said to him was that tooth 12 was weak.

20. The Defendant's case was that he had told the Patient that he noticed a "fractured line" after detaching the Maryland bridge, and that he had repaired the "fractured line" by bonding composite resin over it. The Defendant also said he had told the Patient that tooth 12 could still develop into complete fracture, in which case RCT would be needed.

21. In the Defendant's medical notes dated 21 November 2014, the Defendant wrote "tooth #" which he said meant "tooth fracture". He also wrote "Patient conference: inform of failure of implant & Re. bone graft and waiting period for another 6 months before placement of another implant." In his conference notes dated 21 November 2014, he wrote "Fix Maryland Br = no good Abutments" and "Diagnosis. #line #RCT". Nowhere in the Defendant's medical notes or conference notes showed that he had informed the Patient of the cause of the fracture. The Defendant explained to the Council that the words "Fix Maryland Br = no good Abutments" in his conference notes meant that he had informed the Patient that when he detached the Maryland bridge he had caused the fracture. The Council finds this explanation illogical and unconvincing. The Defendant also told the Council that throughout his so many years of practice, he had never caused any fracture of patient's teeth, and this was the first time ever in his practice of causing fracture. If so, there should be more the reason of recording that he had informed the Patient of the cause of the fracture. However, there is no such record.

22. Further, Ms Ivy Cheung, the Defendant's witness, said that she had attended the conference on 21 November 2014. However, Ms Cheung had never mentioned, whether in her witness statement or at the inquiry, that the Defendant had told the Patient the cause of the fracture.

23. The Council does not believe that the Defendant had informed the Patient the cause of the fracture of tooth 12 on 21 November 2014. This was grossly inadequate and unacceptable to the profession.

24. In the Defendant's Medical Report dated 27 June 2017, at paragraph 22 thereof, the Defendant wrote that on 21 November 2014, before Dr Olsson performed the Stage II surgery he had to detach the Maryland bridge, and "upon examination [he] found a low to mid horizontal unstable fracture line on the facial side through the entire tooth 12…" In the Defendant's witness statement dated 8 February 2019, at paragraph 5 thereof, he wrote that when he examined tooth 12 on 21 November 2014, he noted an "unstable mobile fracture" across the lower one third of the crown of tooth 12. The Defendant said the unstable mobile fracture was an incomplete fracture because it was not a complete detachment.

25. At the inquiry, the Council asked the Defendant what he meant by the word "unstable" in his witness statement. The Defendant said by "unstable" he meant the upper part of the crown above the fracture was mobile, and he confirmed only the upper part was mobile. The Defendant agreed that if there was a rigid structure, and if there was a crack line only, then the part would not be mobile because it was a rigid structure; however, if there was a mobile part, that part would have been separated from the main bulk of the rigid structure. The Council takes the view that the upper part of tooth 12, which had already been separated from the main body of the tooth, even if it was still not completely detached in the Defendant's wordings, was no doubt a complete fracture. Dr Olsson also agreed with this view of the Council.

26. Therefore, the fracture caused by the Defendant to tooth 12 on 21 November 2014 was not simply a "fractured line", which according to the Defendant's case, could develop into a complete fracture. Furthermore, the location of the fracture involved the cervical third of the crown of tooth 12. The pulp must have been exposed. This warranted early RCT.

27. The Council considers that even the Defendant had on 21 November 2014 told the Patient that there was a "fracture line" at tooth 12, he was no doubt playing down or embellishing the level of seriousness of the fracture. It was not reflecting the true nature of the fracture and was grossly inadequate and unacceptable to the profession.

28. 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.

29. The Council therefore finds the Defendant guilty of charge (a).

Charge (b)

30. Charge (b) is that the Defendant had failed to timely offer proper alternative options to the Patient for managing the fracture at tooth 12.

31. The Prosecution was of the view that immediate "endodontics and post" was necessary for the complete horizontal fracture of tooth 12 on 21 November 2014.

32. In view of the seriousness and the location of the fracture of tooth 12, the pulp must have been exposed. The pulp would be infected and the proper option to the Patient was RCT. The Council considers that the Defendant should explain to the Patient the risk of infection and the need of RCT, and make arrangement for RCT at the earliest possible timing, rather than waiting for the detachment of the fractured fragment or any sign and symptom.

33. However, the Defendant merely told the Patient on 21 November 2014 that tooth 12 was weak and might require RCT in the future. The Defendant failed to inform the Patient of the seriousness of the fracture. In any event, no arrangement was made on 21 November 2014 with the Patient for RCT.

34. 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.

35. The Council therefore finds the Defendant guilty of charge (b).

Charge (c)

36. Charge (c) is that the Defendant had failed to timely, properly and/or adequately advise the Patient of the treatment options when the original implant treatment of tooth 11 failed.

37. The Council had examined the five broken pieces of remnants (Secretary's Exhibit N), the periapical radiograph taken by Dr Leung dated 29 November 2014, the periapical radiograph taken by Dr Lau on 18 December 2014, and the Cone Beam CT taken by Dr Chow on 31 December 2014. The Council agrees with Dr Cheung Lim Kwong, the Defendant's expert, that the remnants are not tooth fragments but bone fragments due to displaced cortical bone. In fact, the Defendant had produced a photograph taken on 21 November 2014 which showed the extracted tooth 11 with a seemingly intact root, and which the Patient agreed that that was his tooth.

38. The Council takes the view that implant procedure does not guarantee a 100% success rate. It is not unusual for implant to fail. Having failed osseointegration of the implant in the first attempt, a re-attempt is acceptable to the profession. Further, the Defendant did offer the options of cantilever resin-bonded bridge and "triple crown" (conventional bridge) as alternatives to the implant treatment to the Patient.

39. The Council therefore acquits the Defendant of charge (c).

Sentencing

40. Charges (a) and (b) committed by the Defendant are serious.

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

42. This Council gives credit to the Defendant's over 40 years of contributions to the profession and the community.

43. 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.

44. 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 (a), that the name of the Defendant be removed from the General Register for a period of 1 month;

    (b) In respect of charge (b), that the name of the Defendant be removed from the General Register for a period of 1 month;

    (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 Observation

45. The Council has the following observation.

46. The Council observes that the Defendant's medical records were very brief. Medical records are very important documentation and should record accurate and relevant details of the case. For iatrogenic injury, it is even more important to record the explanation and discussion with the patient about the details of the incident.

Dr LAM Tak-chiu Wiley, JP
Temporary Chairman
The Dental Council of Hong Kong