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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr FONG Tak-san (Reg. No. D03797)

Date of hearing: 6 August 2020

Present at the hearing

Council Members: Dr LEE Kin-man (Chairman)
Dr CHAN Chi-chun
Prof. CHEUNG Shun-pan, Gary
Dr FOO Tai-chuen
Dr LEUNG Kwok-ling, Ares
Dr TONG Chi-kit, Antonio

Legal Adviser: Mr Stanley NG

Defendant: Represented by Mr William CHAN of Messrs Mayor Brown, Solicitors

Legal Officer representing the Secretary: Miss Sanyi SHUM, SGC (Ag.)

The Charges

1. As set out in the Notice of Inquiry dated 24 September 2019, the amended charges against the Defendant, Dr FONG Tak-san, are as follows:-

> "On or about 12 October 2016, 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 –
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> (a) you failed to carry out adequate pre-operative assessment to investigate the potential risks, including nerve damage, before embarking on the removal

of the lower third molar under local anaesthesia; and/or

(b) you failed to have properly advised the Patient of the possible risks and complications arising from the treatment;

and that in relation to the facts alleged 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 27 July 2009. The name of the Defendant has never been included in the Specialist Register.

3. On 12 October 2016, the Patient consulted the Defendant and complained of pain at the upper left and lower left wisdom teeth (i.e. teeth 28 and 38) area. Intra-oral examination showed that there was pericoronitis at tooth 38 with gum redness and swelling, and there was no clear sign of pericoronitis at tooth 28. The Defendant advised the Patient that tooth 38 was the likely cause of the pain. A periapical x-ray was taken and a removal surgery of tooth 38 was performed on the same day under local anaesthesia. During the surgery, the Defendant fractured the mesial root of tooth 38. He attempted to remove it but was not successful. He then stopped the surgery and retained the mesial root of tooth 38. Medications were given and the Patient was scheduled to come back one week later.

4. On 13 October 2016, the Patient called the Defendant's clinic and complained of numbness over the lower left face and lip region after the extraction. An appointment was arranged for the next day.

5. On 14 October 2016, the Patient consulted the Defendant. An orthopantomogram x-ray ("OPG") was taken. The fractured mesial root of tooth 38 was found deeply impacted and close to the inferior dental ("ID") nerve. The Defendant told the Patient that her condition would be monitored closely. The Defendant suggested the Patient to take some vitamin B and return for follow-up one week later.

6. There were a number of phone conversations between the Defendant's dental surgery assistant and the Patient between 17 October 2016 and 9 August 2017, and two consultations with the Defendant on 24 October 2016 and 9 November 2016, mainly concerning the Patient's numbness.

7. On 4 November 2016, the Patient visited another general dental practitioner, a Dr CHIU. An OPG x-ray was taken. Dr CHIU suggested the Patient to see a Dr TSUI, a specialist in Oral and Maxillofacial Surgery.

8. On 19 November 2016, the Patient consulted Dr TSUI about her numbness. The numbness score was 3 out of 10. Dr TSUI advised the Patient to wait for potential spontaneous healing and recovery of sensation, and suggested removal of the retained mesial root of tooth 38 if the wound would not heal up after another one to two months.

9. On 13 May 2017, the Patient consulted Dr TSUI again. An OPG x-ray was taken. The severity of numbness had improved. The numbness score was 1 out of 10.

10. In 2018, the Patient consulted a Dr LEUNG of Prince Philip Dental Hospital. The mesial root of tooth 38 was removed subsequently.

11. On 9 April 2018, the Patient lodged a complaint against the Defendant to the Council.

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

Charge (a)

14. An adequate pre-operative assessment before embarking on extraction includes the patient's chief complaint, medical history taking, and conducting clinical examination, which includes intra-oral and extra-oral examination, and special investigation if the circumstances require. For an adequate pre-operative assessment of third molar removal, the special investigation would require radiographic examination for the purposes of diagnosis and assessment of the possible risk and potential damage to the vital structure, treatment planning and the execution of removal.

15. In this case, the Defendant had taken a periapical x-ray on 12 October 2016. The Council had looked at the original periapical x-ray. This periapical x-ray did not reveal the relationship of the whole distal root of tooth 38 and the ID canal. It showed an incomplete view of the adjacent vital structure, ID canal, bony obstacles and root morphology. This periapical x-ray was therefore grossly inadequate. The Defendant had taken no step at all to take additional radiograph(s) in order to better evaluate the planning of the surgery. The periapical x-ray was the only x-ray taken by the Defendant for his pre-operative assessment. The failure to take further radiograph(s) before embarking on surgical extraction of tooth 38 was an elemental failure.

16. The Defendant admits to the facts as alleged in charge (a).

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 (a).

Charge (b)

19. 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.*
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> …
>
> *89. Three further points should be made. First, it follows from this approach that the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have on the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics to the patient.*
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> *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 …"*

20. A proper identification of possible risks and complications is essential for the dentist to manage any clinical case and to avoid the risks and complications from happening. It also allows the dentist to consider the options of taking a better view of the tooth by taking necessary radiograph(s), seeking for a second opinion, referring to a specialist, or modifying the treatment process to ensure the level of risks and complications be contained or lowered.

21. From the OPG x-rays respectively taken by the Defendant on 14 October 2016 and by Dr CHIU on 4 November 2016, the outline of the extraction socket of tooth 38 clearly showed that both

the mesial and distal roots of tooth 38 were overlapping with the ID canal. This case should have been considered a high-risk case. The high risk would have been damage to ID nerve. The complications would have been root fracture and/or paraesthesia.

22. In the Council's view, a reasonable person in the position of the Patient would no doubt attach significance to such high risks and complications. It was therefore incumbent upon the Defendant to advise the Patient of the high risks and complications associated with the treatment so that the latter could make an informed decision.

23. There was no evidence from the Defendant's clinical record to show that he had properly advised the Patient of such high risks and complications. The alleged advice of risks and complications given by the Defendant to the Patient was irrelevant and not adequate. The Defendant's failure to advise the Patient of the possible risks and complications arising from the treatment was grossly improper.

24. The Defendant admitted to the facts as alleged in charge (b).

25. 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.

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

Sentencing

27. 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.

28. The Defendant has no previous disciplinary records.

29. The Council gives credit to the Defendant's cooperation and admission to the facts of both charges.

30. The Council notes that the Defendant had maintained contact with the Patient after having known that the Patient had developed numbness after the extraction, and he also had subsequently referred the Patient to see a specialist, namely Dr LEUNG of Prince Philip Dental Hospital.

31. The Defendant has shown remorse for having committed the offences.

32. The Council considers that the offences committed by the Defendant should be one-off. The risk of re-offending is low.

33. The Council takes into account the "totality principle" when sentencing charges (a) to (b).

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

    (i) In respect of both charges (a) and (b), a warning letter be served on the Defendant.

(ii) The order in paragraph (i) above shall be published in the Gazette.

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