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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr TAM Kai-tai, Carl 譚啟泰牙科醫生 (Reg. No. D02744)

Dates of hearing: 21 February 2019

Present at the hearing

Council Members: Dr LEE Kin-man (Chairman)
Dr CHAN Chi-chun
Prof. CHEUNG Shun-pan, Gary
Dr LAU Kin-kwan, Kenny
Dr TONG Chi-kit, Antonio

Legal Adviser: Mr Stanley NG

Legal representative for the Defendant: Mr Alfred FUNG, Barrister-at-law
Ms Phyllis CHIU, Mayer • Brown, Solicitors

Legal Officer representing the Secretary: Mr Mark CHAN, APGC (Ag)

The Charge

1. The charge against the Defendant, Dr TAM Kai-tai, Carl, is as follows:-

> "In about December 2015 to September 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 her in that, you –
>
> (i) failed to perform adequate pre-operative assessments and investigations before the implant treatment;
> (ii) failed to devise a proper and effective treatment plan for the Patient's upper jaw; and/or

(iii) failed to carry out proper and effective implant treatment for the Patient's upper jaw;

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

Facts of the case

2. On 15 December 2015, [redacted] ("the Patient") attended the clinic of Dr TAM Kai-tai, Carl ("the Defendant") for the construction of an implant supported bridgefor her upper anterior edentulous ridge from 12 to 21.

3. Oral examination was performed by the Defendant and OPG was taken and showed the following finding:-

(a) Q1 for the upper teeth region: Multiple missing teeth were found at 11, 12, 15, 16, 21, 25, 26. Three implants were placed at positions 13, 14 and 15. A cantilever bridge was constructed from 13 to 16. A removable denture was found at her upper teeth from 12 to 21. 22 was crowned. 27 and 28 had drifted forward to occupy the position of 26. Bone resorption was observed from the upper right premolar (i.e. 14) to molar region.

(b) For the lower region: A bilateral metallic based removable denture was constructed previously.

4. The initial treatment plan as suggested by the Defendant was to place implants at 21 and 12 for the construction of a 3-unit implant supported conventional bridge. The Defendant then performed an anterior edentulous ridge measurement for the labial-palatal thickness with a caliper, which showed thickness of 6.5mm, 7mm and 8.5mm for positions 21, 11 and 12 respectively. In view of the said measurement, the Defendant considered that 21 might not be suitable for an implant fixture of 3.5mm in diameter. The Defendant informed the Patient of his findings and proposed an alternative plan of placing the implant fixtures at 11 and 12 instead.

5. Implant surgery was performed under local anaethesia using the flapless technique. Implant fixtures of 3.5mm in diameter and 10mm in length were then placed at positions 11 and 12. According to the Defendant, the position of each implant was measured with a caliper and a ruler in relation to the adjacent teeth. According to the Defendant, the result was found to be satisfactory and primary stability was obtained for both fixtures with the shoulders of the fixtures at about 2mm below gum surface (or at bone level). The covering screw were placed subgingivally (with surface slightly below gum level), which avoid interruption of the placement of the existing upper denture.

6. The Patient was asked to return for follow up in one week's time so that the condition of her wound could be monitored.

7. On 22 December 2015, the Patient returned to the Defendant's clinic. She was asked to return again in about a month from the implant surgery.

8. On 19 January 2016, the Patient returned for follow-up for checking the stability of the implant fixtures. The Defendant used a torque wrench to test the condition of the two implant fixtures by applying force to them. The Patient felt pain on 11 implant area and the Defendant told her that the said implant fixture had not yet fully integrated. The Defendant claimed 12 to be satisfactory. The Defendant asked the Patient to come back in one month's time.

9. On 16 February 2016, the Patient attended the Defendant's clinic for follow-up. The Patient complained of pain at 11. The Defendant asked the Patient to come back in one month's time.

10. On 16 March 2016, the Patient attended the Defendant's clinic. 11 was checked and still could not pass the torque-wrench test. One month review was again arranged.

11. On 11 April 2016, the Patient attended the Defendant's clinic. Again, 11 could not pass the torque-wrench test.

12. Between 9 May 2016 to 7 November 2016, the Patient made numerous visits to the Defendant's clinic. On all these consultations, 11 could not pass the torque-wrench test. In around May 2016, the Patient became impatient and the Defendant advised her that if she did not want to wait, she could consider removing the implant fixture at position 11 and reinserting the implant at that position after the socket had healed, which would take a few months. The Defendant told the Patient to seek a second opinion if she wanted.

13. On 14 November 2016,the Patient returned to the Defendant's clinic to request for copies of her clinical records.

14. On 9 January 2017, the Patient returned to the Defendant's clinic to check the stability of the implant fixture at 11. 11 did not pass the torque-wrench test but the test revealed less pain. The Defendant advised her that she could continue to wait for the implant fixture at 11 to fully integrate, which might take another few months. The Defendant also advised her of removing the implant fixture and reinserting. The Patient did not agree to remove and reinsert the implant fixture at position 11. The Patient did not return to the Defendant after this visit.

15. At the beginning of today's inquiry, the Defendant did not contest all three charges.

16. Further, the Secretary applied to remove the expert report of Dr Anthony S.K. TSE ("Dr TSE"), the Defendant's expert, from the Secretary's bundle on the ground that Dr TSE was previously convicted by this Council of a disciplinary offence relating to implant treatment, and therefore Dr TSE was not qualified, according to the Secretary, to serve as an expert witness. The Defendant confirmed to this Council that he had no knowledge of Dr. TSE's previous conviction until yesterday. The Defendant also confirmed that he would not rely on Dr TSE's expert report in these proceedings at all. The Defendant also had no objection to the Secretary's application. The Council allowed the Secretary's application and removed Dr TSE's expert report from the Secretary's bundle.

17. Still further, whilst the Council retired for deliberation, the Secretary suddenly disclosed to the Council that their own expert, Dr YEUNG Wai-kit, Richie ("Dr YEUNG"), was also subject to a disciplinary conviction by this Council relating to the issuance of medical certificates.

The Secretary informed the Council that they were just made known of this fact. On the Council's enquiry, the Secretary also confirmed that there was no record of criminal conviction apart from the disciplinary order. The Defendant took time to consider the matter. After consideration, the Defendant asked the Council to remove Dr YEUNG's report from the Secretary's bundle. The Secretary did not oppose to the removal of Dr YEUNG's report. The Council made an order removing Dr YEUNG's report from the Secretary's bundle. The Defendant further confirmed that notwithstanding the removal of Dr YEUNG's report from the Secretary's bundle, he would continue to maintain his previous position of not contesting all three charges. The Defendant confirmed to the Council that the Council could proceed to determine the case based on the remaining evidence of the Secretary's bundle, even without Dr YEUNG's report.

Burden and Standard of Proof

18. 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

19. 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)

20. Charge (i) is that the Defendant had failed to perform adequate pre-operative assessments and investigations before the implant procedure.

21. The implant treatment performed by the Defendant on the Patient refers to 12 to 21.

22. The Council stresses that implant treatment is a form of precision dental procedure. By precision, we refer to a clear understanding of the physical condition of the potential implant site and its relationship to the final prosthesis. It is elemental to perform adequate pre-operative assessments and investigations so that the clinician can gather clinical information to make a decision to restore the function and aesthetics after tooth loss. Clinicians have to consider, so far as implant is concerned, both surgical and prosthetic aspects of the fixtures and the definitive prosthesis.

23. Therefore, adequate assessments usually include, but not limited to, registering the chief complaint, history of the present complaint, past medical and dental history, social and family history, intra-oral assessment including detailed dental hard and soft tissue status, occlusion, and extra-oral examination.

24. Regarding adequate investigations, they usually include, but not limited to, study models, plain and/or 3-dimensional radiographic imaging and photographs to inform the quality and quantity of bone, aesthetics and optimum placement of the prosthesis when implant is concerned.

25. The Council is of the view that assessments and investigations should commensurate with the complexity of the presenting condition, dental and patient factors included.

26. Despite the Defendant had described in his statement that the Patient had an unmarkable medical history, this is in variance with the Patient's witness statement that she suffered from low platelet count. Indeed, there is no evidence in the Defendant's record that there was any entry for the medical and dental history of the Patient.

27. According to the Defendant's statement, the Patient had a recent extraction of teeth but the extraction history of 12 and 21 was not taken; therefore the status of the ridge was unknown.

28. Before the implant procedure, the Defendant did take an OPG and took a clinical examination of the Patient. According to the Defendant's statement, he performed an anterior edentulous ridge measurement for the labial-palatal thickness with a caliper, which showed thickness of 6.5mm, 7mm and 8.5 mm for position 21, 11 and 12 respectively.

29. OPG is a plain tomographic radiograph. It does not reflect the true architecture of the implant site in three dimensions. In particular, interpretation of OPG in the anterior region may be compromised by the limitation of the tomographic cut and the overlapping of the spine. Sole reliance of OPG for assessment is grossly inadequate for the anterior region.

30. The Defendant attempted to measure the labial-palatal thickness of the anterior edentulous ridge with a caliper. Details of performing those measurements were not provided. Only three readings at unknown bone level were given. These specific measurements however could not be found in the Patient's record. It did not provide any information of the three-dimensional status of the implant site. The Council considers that this measurement by caliper in his manner was grossly inadequate.

31. 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.

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

<u>Charge (ii)</u>

33. Charge (ii) is in relation to the Defendant's failure to devise a proper and effective treatment plan for the Patient's upper jaw.

34. A proper and effective treatment plan should be based on the clinical information obtained from adequate pre-operative assessments and investigations in order to optimize the treatment outcome.

35. In this case, the Council notices that there was no entry for the treatment plan in the Patient's record.

36. In the Defendant's statement, he described the treatment plan for the Patient was a three-unit bridge supported by two implants with the placement of the implant fixtures to be performed using the flapless approach on the same day of the consultation. The edentulous space would be provisionalized by the patient's existing removable partial denture. The Defendant expected the entire treatment to be completed within 2 to 3 months.

37. The Council had already ruled above that the Defendant failed to perform adequate pre-operative assessments and investigations. There was no mention of the exact location of the fixtures and their connection to the prosthesis, the choice and the design of implant and prosthesis, their relationship with the soft tissues and the occlusion.

38. The flapless approach suffers from a number of limitations, one of which is limited visibility of drilling and of implant placement with the risk of causing wrong implant directions. Based on the lack of details as described in the preceding paragraph and the inability to visualize the surgical site using a flapless approach, the Council considers the Defendant failed to devise a proper and effective treatment plan. Such a failure is elemental and grievous.

39. 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.

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

Charge (iii)

41. Charge (iii) is in relation to the Defendant's failure to carry out proper and effective implant treatment for the Patient's upper jaw.

42. A failure to perform adequate pre-operative assessments and investigations before implant treatment would necessarily lead to a failure to devise a proper and effective treatment plan, and in turn will necessarily lead to the failure to carry out proper and effective implant treatment.

43. The Defendant used the flapless approach on 15 December 2015 for the placement of implant on 11 and 12. The outcome of the Defendant's treatment to the Patient deviated from the Defendant's original treatment plan in that the treatment was not completed within 2 to 3 months as the Defendant promised, and there were two implants, one of which was not ready for implant supported bridge as designed.

44. Flapless surgeries should be restricted to well selected cases in which proper assessments and investigations had been performed. It is a blind technique that hinders a clear view of the bony ridge including the quantity and quality of the bone. The Defendant did not take any post-operative radiograph. Indeed, one cannot ascertain the final position of the implant and its relationship with the bone including, but not limited to, the possibility of fenestration, perforation, improper depth and directions.

45. A proper and effective implant treatment must include post-operative care and checking the status of osseointegration. In this case, the Defendant performed torque wrench tests and solely relied on them over a period of time to determine the readiness to proceed to the prosthetic stage. Under no circumstances did the Defendant indicate that he would perform other tests such as radiographs and periodontal examination. Such a failure is elemental and grievous.

46. 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.

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

Sentencing

48. The Defendant has a clear record.

49. This Council gives credit to the Defendant's cooperation and the fact that he does not contest all three charges despite the Secretary's disclosure at the eleventh hour of the previous disciplinary conviction of the Secretary's own expert.

50. The Council considers the Defendant remorseful.

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

52. The Defendant informed the Council, which the Council is surprised, that after this incident he had not voluntarily participated in any continuing professional development courses relating to assessments and radiographic investigations of dental implant treatment.

53. 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.

54. The Council takes into account the "totality principle" when sentencing charges (i) to (iii).

55. 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 one month;
    (b) In respect of charge (ii), that the name of the Defendant be removed from the General Register for a period of one month;
    (c) In respect of charge (iii), that the name of the Defendant be removed from the General Register for a period of one month;
    (d) The orders in paragraphs (a), (b) and (c) above be concurrent;
    (e) The operation of the orders as set out in the paragraphs above be suspended and shall not take effect for a period of 12 months;
    (f) During the suspension period of 12 months, the Defendant shall satisfactorily complete a total of 15 hours of continuing dental education in courses relating to

assessments and radiographic investigations of dental implant treatment organized by established dental institutions and to be approved by the Chairman of the Council, and every such approval of intended courses which the Defendant wishes to take has to be sought from the Chairman one month in advance;

(g) The order of suspension in paragraph (e) above shall be uplifted if the Defendant is found by the Council to be in breach of the order as set out in paragraph (f) above, or if a finding is made against the Defendant during the said suspension period under section 18(1)(a) to (e) of the Dentists Registration Ordinance, Cap.156.

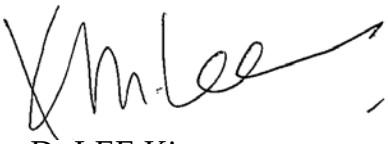
(h) The orders in paragraphs (a) to (g) above shall be published in the Gazette.

Other Observations

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

57. In proceedings before this Council, the Council must stress that an expert witness has an overriding duty to help the Council impartially and independently on matters relevant to the expert's area of expertise. An expert's paramount duty is to the Council and not to the person from whom the expert has received instructions or by whom he is paid. An expert witness is not an advocate for a party. For an expert who himself has a previous disciplinary conviction, such information may go to the admissibility or to weight of his expert evidence. Parties are therefore encouraged to make prompt enquiry with their experts as to whether they were subject to any previous disciplinary conviction before deciding on whether or not to proceed with engagement.

58. Implant treatment like other advanced dental modalities is in a stage of constant development. It is the duty of every practicing dentist to update his skills and knowledge.



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