香港牙醫管理委員會
The Dental Council of Hong Kong
Disciplinary Inquiry under s.21 of DRO

Defendant: Dr. KAN Chun-sing 靳鎮城牙醫 (Reg. No. D01863)

Date of hearing: 22 August 2012 and 13 September 2012

1. The Defendant, Dr. KAN Chun-sing, is charged that:

"That he, being a registered dentist, disregarded his professional responsibility to adequately treat and care for his patient [redacted], or otherwise neglected his professional duties to her in that, in or about May and June 2011 -

(i) he failed to devise a proper treatment plan for [redacted];

(ii) he failed to advise [redacted] of the risks and possible complications involved in the dental procedures in relation to the impacted upper left canine (23);

(iii) he failed to implement a proper and effective surgical treatment on [redacted]'s impacted upper left canine (23); and/or

(iv) he failed to refer [redacted] to another dental practitioner or specialist for remedial treatment when the circumstances so required;

and that in relation to the facts alleged he has been guilty of unprofessional conduct."

Facts of the case

2. At the relevant time the patient was 12 years old. On 20 May 2011, the patient, accompanied by her mother, consulted the Defendant for orthodontic treatment to correct her dental occlusion. Upon being told by the mother that there was an impacted tooth in the upper jaw, the Defendant took a periapical radiograph. He then told the patient and the mother that there was an impacted maxillary canine which was in a "*very, very, high position*", and he would surgically expose the impacted canine for traction into position for orthodontic treatment. After the impacted canine had been moved into position, further orthodontic treatment would follow. The whole treatment process would take about 2 years. A panoramic radiograph and a lateral cephalometric radiograph would be taken before the operation.

3. Subsequently the patient made appointment for the operation to be performed on 11 June 2011. On 10 June 2011, a panoramic radiograph and a cephalometric radiograph were taken by a laboratory and sent to the Defendant's clinic. On 11 June 2011, the Defendant said that traction of the impacted canine could not be done, because it would involve moving the tooth for too long a distance along an L-shape route. Therefore, he changed the treatment plan to surgical extraction of the impacted canine. He then proceeded with the surgical extraction. For about 30 to 40 minutes, he made repeated and unsuccessful attempts to extract the tooth. Throughout the process, the patient was in pain and in tears, despite the fact that anaesthetic injections were repeated for 3 times. The patient eventually cried.

4. The Defendant then decided to abandon the plan of extraction and change back to the original plan of exposure for traction. The mother queried how that could be done, given his earlier conclusion that it could not be done. The Defendant said that the X-ray might not be accurate, but was unable to answer how the traction could be achieved. He then bonded a bracket onto the tooth,

and put a dressing on the surgical wound. He prescribed antibiotic and painkiller to the patient and sent her home, telling her to return in the next week for further orthodontic treatment.

5. About 45 minutes after leaving the clinic, the patient started to have nose bleeding. Upon being informed of the bleeding over the telephone, the Defendant simply reassured the mother that it was not a problem, with no instruction for the patient to return or to attend the Accident and Emergency Department of a hospital to treat the bleeding. According to the mother, the bleeding continued for about an hour.

6. On 12 June 2011, the patient's upper lip, face and nose were swollen.

7. On 13 June 2011, the pain persisted. The upper lip, face, nose and bottom of her eye were severely swollen, causing distortion of the face. She consulted another dentist, who found inflammation of the wound with pus. That dentist drained the pus, and prescribed antibiotics and painkiller. He asked them to obtain the radiographs for his analysis.

8. On the same day, the patient accompanied by her mother and aunt went back to the Defendant's clinic to complain about the situation and to retrieve the radiographs. When the Defendant examined the wound and saw the inflammation, he apologized saying that he was wrong and he failed.

9. On 14 June 2011, the other dentist upon seeing the radiographs told the patient that it would be a difficult procedure for extracting the impacted canine because of its high position and proximity to the maxillary antrum. It would also be very difficult to move the tooth to orthodontic position because of the long distance involved. He referred the patient to a Specialist in Oral and Maxillofaxcial Surgery.

10. The Specialist in Oral and Maxillofaxcial Surgery examined the patient on 17 June 2011 and subsequently extracted the impacted canine under sedation and

local anaesthetic on 6 July 2011.

Council's findings

11. The Defendant initially admitted the allegation in Charge (ii) but not the allegations in Charges (i), (iii) and (iv). However, after giving evidence in the inquiry, he admitted that he had committed errors in his conduct as alleged in Charges (i), (iii) and (iv). Nevertheless, it remains our duty to make determinations in respect of the various allegations of the charges and decide whether the Defendant's conduct constitutes unprofessional conduct.

12. An important starting point for all dental treatment, in particular surgical treatment, is that there must be a proper treatment plan based on a proper diagnosis. Surgical treatment should not commence until proper investigation had been performed and a proper plan has been formulated, because different treatment plans will involve different approaches to the surgery. The treatment plan should include the treatment objectives to be achieved by the treatment, and what to do in case of complications. It is unprofessional to commence a surgical operation without a clear picture of the situation and a concrete plan.

13. Impacted maxillary canine may be moved into an erupted position by orthodontic traction, or surgically removed. It is essential to properly localize the impacted canine and its relationship to the neighbouring structures, in order to formulate a proper treatment plan. This is important for ascertaining the feasibility of orthodontic traction. In the case of surgical removal, because of its proximity to the neighbouring structures and thus the possible complications, accurate localization of its position is important for safe surgical access to the tooth.

14. The closer the impacted maxillary canine to the neighbouring structures, the more precision is required for the surgical procedure, and the more important it is to accurately establish its position relative to the neighbouring structures.

With the current imaging technology, cone-beam CT scan which is readily available, is the standard investigation in respect of impacted maxillary canines in a high position. Such investigation was clearly required in the present case.

15. The patient's impacted canine, as the Defendant noted in the first consultation, was in a high position. Based only on a single periapical radiograph, it was impossible for the Defendant to formulate in that consultation the treatment plan of surgical exposure for orthodontic traction. He realized that this was not feasible upon seeing the panoramic radiograph at the 2nd consultation. At that juncture, he should cause further investigation to be made by a cone-beam CT scan, before reformulating his treatment plan. To switch to surgical extraction immediately without further investigation and assessment was entirely inappropriate.

16. When the Defendant changed his treatment plan to surgical extraction, he should have given the patient proper explanation of the proposed procedure, its risks and complications. Fresh informed consent for the changed surgical procedure based on proper explanation should have been obtained, before embarking on the changed surgical procedure. In the absence of such explanation, the validity of the patient's consent to the changed surgery is questionable at best, and probably invalid.

17. The way the Defendant performed the surgical extraction was fraught with difficulties. Obviously this was the result of lack of a clear pre-operative picture of the surgical field, the absence of a proper operative plan, and insufficient training in the relevant surgery. Given the Defendant's admission that he has had no formal training in such surgery and that this was the first time he performed such surgery, we are not surprised that he failed to extract the impacted canine in such a difficult case. He obviously was not even aware of the difficulty involved in this case.

18. When the Defendant had made a few unsuccessful attempts, he should have realized that the procedure was beyond his competence and referred the patient to a specialist for remedial treatment, instead of persisting with the procedure for a prolonged period even in the face of the patient's suffering. He did not stop until the patient could not bear the pain and started to cry. Nevertheless, instead of admitting that the procedure was beyond his competence, he blamed his inability to extract the tooth on the patient's being not cooperative. We simply cannot accept this attitude.

19. After a patient has undergone a surgical procedure, the dentist must ensure that there was haemostasis of the surgical wound before sending the patient away. He should advise the patient to return for treatment in case of bleeding after leaving the clinic, or to attend the Accident and Emergency Department of a hospital. The Defendant had done neither, nor did he take appropriate action when being informed of the patient's nose bleeding. It is not acceptable to simply reassure the patient that it was not a big problem.

20. Having considered all the evidence, we make the following findings:-

    (a) There was no record whatsoever of the patient's dental and medical history. There was not even a dental charting, which was a basic requirement for dental treatment. The Defendant had not taken the dental and medical history of the patient which was necessary for formulating a proper treatment plan.

    (b) The Defendant had not conducted proper investigation to establish the impacted canine's relative position to the neighbouring structure. Nor had he made the necessary analysis and measurements from the radiographs which were required for both orthodontic treatment and surgical procedure.

    (c) The Defendant's original treatment plan was surgical exposure and

orthodontic traction of the impacted canine. When he decided to abandon that plan and change to surgical extraction, he had not formulated any treatment plan for the surgical extraction at all. He just went ahead with the surgical extraction and improvised as he went along, without advance planning.

(d) The Defendant had not explained the proposed surgical extraction, the risks and complications to the patient or her parents. In respect of surgical removal of an impacted maxillary canine in a high position, the risks of perforation of the maxillary antrum and the nasal floor and nose bleeding are particularly pertinent.

(e) Given the lack of proper pre-operative investigation, measurements and assessment, the lack of a proper treatment plan, and the lack of training in the relevant surgical procedure, the Defendant's surgical treatment on the patient was neither proper nor effective.

(f) When the Defendant realized that the impacted canine was in a very high position, he should have realized that the case was beyond his competence and referred the patient to a specialist. Nevertheless, this is not the subject-matter of the charges, and we shall disregard this for the purpose of determining on the charges.

(g) When the Defendant had made a few unsuccessful attempts at the surgical removal, and in the face of the patient's suffering, he should have stopped the procedure and referred the patient to a specialist for remedial treatment. Nevertheless, he persisted in the procedure for an extended period.

21. We are satisfied that the allegations set out in each of the 4 charges have been proven. We are satisfied that such conduct would be reasonably regarded by registered dentists of good repute and competency to be dishonourable and disgraceful. We find him guilty of unprofessional conduct in respect of each

charge.

Sentencing

22. The Defendant has a clear record.

23. We give him some credit for admitting some of the allegations, and that he has not disputed most of the factual issues of the case.

24. We bear in mind that the purpose of a disciplinary order is not to punish the Defendant, but to protect the public from persons who are not fit to practise dentistry for reason of competence or otherwise, and to maintain public confidence in the dental profession by upholding the reputation of the profession.

25. His mitigation focused on his record keeping practice, his not committing the errors intentionally, and humiliation by the press reports on the inquiry. Although he also addressed the issues of recklessness, pre-operative explanation, and specialist referral, we are concerned that he is still not fully aware of his problem of not realizing the limits of his competence.

26. In law a registered dentist is entitled to perform all levels of dental work, as long as he has the necessary training and competence. It is important that the dentist is able to recognize where his limit lies, and to recognize the cases which he should refer to other dentists and specialists.

27. An incompetent dentist poses a danger to the public. However, a dentist who is not aware of the limits of his competence is even more of a threat, as he may perform complicated and difficult treatments beyond his competence, in the belief that he has the necessary competence. The injury thus caused may be even more serious.

28. Having considered the gravity of the case and the mitigating factors, we make a

global order in respect of all the charges that the Defendant's name be removed from the General Register for a period of 3 months.

29. We have considered whether the removal order can be suspended. We are of the view that this is not a suitable case for suspension.

Other remarks

30. While it is a matter for the Council to consider the Defendant's application (if any) for restoration to the General Register at the time when it is made, we recommend that before allowing the restoration the Council should consider the following:-

(a) Cogent evidence that the Defendant has improved his dental competence to the required standard, in particular in respect of surgical dentistry and the ability to recognize what cases are within his competence.

(b) A peer audit and monitoring condition be imposed on his practice, upon his restoration to the General Register, in the following terms:-

(i) The Defendant's practice be subject to peer audit and monitoring by a Practice Monitor to be appointed by the Council, for a period of 2 years.

(ii) The Practice Monitor shall conduct at least one audit and monitoring visit to the Defendant's clinic in every 3 months.

(iii) The audit and monitoring visits should be conducted without prior notice to the Defendant.

(iv) The Practice Monitor should be granted unrestricted access to the dental records and such parts of the Defendant's clinic which

the Practice Monitor considers to be necessary for proper discharge of his duty.

(v) The Practice Monitor shall submit reports to the Council at 6-month intervals. If any irregularity is detected, such irregularity should be reported as soon as practicable.

31. We wish to advise the Defendant that during the removal period he should take the opportunity to improve his competence, if he wishes to apply for restoration to the General Register.

Dr. Homer TSO, SBS, JP
Chairman, Dental Council