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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr CHIU Hon-ching 趙汗青牙科醫生 (Reg. No. D03791)

Date of hearing: 4 August 2016

1. The Defendant, Dr CHIU Hon-ching, is charged of the following:

> "That you, being a registered dentist, from about June 2013 to September 2013, disregarded your professional responsibility to adequately treat and care for your patient [redacted] ('the Patient'), or otherwise have neglected your professional duties to her in that –
>
> (i) you failed to properly maintain the Patient's records of dental treatment; and/or
>
> (ii) you failed:
>
> (a) to note and/or to inform the Patient that an endodontic file was fractured during the treatment with its fragment left in the Patient's tooth; and/or
>
> (b) to refer the Patient to another dental practitioner or a specialist when the circumstances so required;
>
> and that in relation to the facts alleged you have been guilty of unprofessional conduct."

Facts of the Case

2. The Defendant's name has been included in the General Register of this Council from 27 July 2009 to present.

3. The Complainant told the Council that since around June 2013, she consulted the Defendant at his clinic on a number of occasions for root canal therapy of a tooth. The Complainant

produced to the Council a total of three receipts issued by the Defendant's clinic on 29 June 2013, 6 July 2013 and 22 July 2013 for payments of "Root Canal Therapy 根管治療, Ceramo-Metal Crown 合金-陶瓷牙套".

4. The Complainant said that the root canal therapy was completed sometime in July 2013. She said she felt pain after the therapy and she had told the Defendant. The Defendant told the Complainant that feeling pain after the therapy was normal.

5. The Complainant's pain did not subside. She then consulted another dentist, Dr TSANG Leung Hei (曾良熹醫生) ("Dr TSANG"), for a second opinion. Dr TSANG's opinion to her was that the pain could be due to a crack of the tooth or due to a fourth nerve of the tooth. Dr TSANG then referred the Complainant to consult Dr CHAN Tak Kam (陳德錦醫生) ("Dr CHAN"), a specialist in Endodontics.

6. The Complainant then related Dr TSANG's opinion about a fourth nerve of the tooth to the Defendant. The Defendant told her that the possibility of the 4th nerve of the tooth was not high. The Defendant suggested to her the solution of tooth extraction followed by dental implant, and would offer her a discounted fee, offsetting the fees previously charged for the root canal therapy. The Complainant did not proceed with the suggestion.

7. The Complainant then went to consult Dr CHAN. Dr CHAN took a Cone Beam CT scan of her tooth. Dr CHAN told her that the scan shows that an endodontic file had been left inside her tooth.

8. The Complainant then telephoned the Defendant, and told the Defendant about the discovery of an endodontic file being left in her tooth. The Complainant delivered to the Defendant a copy of the scan.

9. In around October 2014, the Complainant made a data access request using the form prescribed by the Office of the Privacy Commissioner of Personal Data for all her records of dental treatment from the Defendant. About a week after the making of the request for such records, a nurse of the Defendant's clinic telephoned the Complainant and asked if she was complaining. The nurse also told the Complainant that the Defendant's then clinic had ceased business, and all her dental records were lost.

10. At today's inquiry, the prosecution and the defence have submitted to the Council a signed Statement of Agreed Facts. According to the Statement of Agreed Facts, both parties agreed as the truth of facts that in the period from about June 2013 to September 2013 the Defendant disregarded his professional responsibility to adequately treat and care for his patient (i.e. the Complainant), or otherwise neglected his professional duties to her in that (a) he failed to properly maintain the Complainant's records of dental treatment; and (b) he failed to inform the Complainant that an endodontic file was fractured during the treatment with its fragment left in the Complainant's tooth and to refer the Complainant to another dental practitioner or a specialist when the circumstances so required.

11. The prosecution and the defence also admitted to the Council the meaning of the wordings "when the circumstances so required" as referred to in paragraph 2(b) of the Statement of Agreed Facts. The parties agreed that the wordings mean the root canal treatment itself and the persistent pain subsequent to the treatment of her tooth.

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. This 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.

13. There are two charges against the Defendant. The Council needs to look at all the evidence and to consider and determine each of the charges separately.

Unprofessional Conduct

14. 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 (i)

15. Charge (i) is in relation to the Defendant's failure to properly maintain the patient's records of dental treatment.

16. According to paragraph 4 of the Council's Code of Professional Discipline ("Code"), dental practitioners should keep accurate and contemporaneous records of dental treatment and should keep them for a minimum of three years since the patient's last treatment. It is the responsibility of the dental practitioner to safely maintain these records against loss and to safeguard their confidentiality.

17. The last treatment of the Complainant by the Defendant was sometime in July 2013. According to the Code, the Defendant should have safely maintained the Complainant's dental records for a minimum of three years. However, the Defendant's nurse told the Complainant sometime before end of 2014 that the Defendant had lost the dental record in respect of the Complainant.

18. A properly and accurately maintained patient record ensures the continuity of patient care which is to the best interest of the patient. It is also important should the patient need to seek care from another practitioner.

19. The Council is satisfied that the Defendant's conduct was seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

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

Charge (ii)

21. Charge (ii) is in relation to the Defendant's failure to note and/or to inform the Complainant that an endodontic file was fractured during the treatment with its fragment left in the Complainant's tooth; and/or to refer the Complainant to another dental practitioner or a specialist when the circumstances so required.

22. The Defendant admitted that he knew an endodontic file was fractured during the treatment of the Complainant with its fragment left in the Complainant's tooth.

23. The Council considers that it is the professional responsibility of the Defendant to inform the Complainant of the fact that an endodontic file was fractured with its fragment left in her tooth. Failure to do so is a serious disregard of his professional duty.

24. Further, despite the complaints made by the Complainant to the Defendant about her persistent pain on her tooth and the fact that the endodontic file had been fractured and left in her tooth, the Defendant should have clearly explained and referred the Complainant to another dental practitioner or a specialist.

25. The Defendant's conduct was seriously 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 (ii).

Sentencing

27. The Defendant has a clear record.

28. The Defendant pleads guilty to the two charges at today's inquiry and is remorseful.

29. The Council accepts these as mitigating factors.

30. 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.

31. Having regard to the gravity of the case, the Council makes the following orders:-
    (a) In respect of charge (i), the Defendant be reprimanded.
    (b) In respect of charge (ii), the Defendant be reprimanded.
    (c) The orders above shall be published in the Gazette.

Dr LEE Kin Man
Chairman
The Dental Council of Hong Kong