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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr. CHEUNG Sheung-kin 張尚堅牙科醫生 (Reg. No. D01398)

Date of hearing: 3 December 2015

1. The charges against the Defendant, Dr. CHEUNG Sheung-kin, as amended, are that:

> "He, being a registered dentist, in the period from about April 2007 to June 2013, disregarded his professional responsibility to adequately treat and care for his patient [redacted] ("the Patient"), or otherwise neglected his professional duties to her in that –
>
> (a) he failed to carry out adequate examination and assessment on the Patient's dental condition before commencement of orthodontic treatment ("the treatment");
>
> (b) he failed to adequately advise the Patient of the risks and complications associated with the treatment before he commenced the treatment;

(c) he failed to offer the Patient any alternative options for managing the Patient's dental condition before he commenced the treatment;

(d) he failed to perform the treatment properly by increasing the Patient's overjet and overbite, failing to upright the tooth 38 and causing the shifting of lower dental midline; and/or

(e) he failed to provide the Patient with a copy of the full set of clinical records despite her repeated requests for such records;

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

Facts of the case

2. On 20 April 2007, the Patient went to the Defendant's clinic to enquire about having a tooth implant for her lost molar tooth. After checking her teeth, the Defendant recommended the Patient to have brace treatment in the lower jaw. The Defendant claimed that the moving of a buck tooth and the pulling up of a wisdom tooth would obviate the need of a tooth implant. The Defendant claimed that the brace treatment would only take 18 months. The Defendant referred the Patient to Germany Medical X-Ray & Laboratory Center ("Germany Medical") for X-ray images of the teeth.

3. On 21 or 22 April 2007, the Patient went to Germany Medical for taking X-ray image. On 23 April 2007, the Patient took the X-ray image along with her to the Defendant for another consultation. The Defendant took a dental cast from the Patient.

4. Around the end of April or early May 2007, the Defendant began orthodontic treatment of the Patient.

5. Between May and December 2007, the Patient went to the Defendant for regular follow-up consultations. Sometime after the completion of the brace placement in the lower jaw, the Patient found the teeth in her upper jaw starting to displace, which caused distorted lips, slurring, difficulty in eating, etc. The Patient told the Defendant about these, but the Defendant denied tooth displacement in the upper jaw.

6. On 13 December 2007, during the middle of the treatment, the Defendant extracted tooth 34 from the Patient without the Patient's prior consent. The Defendant had never mentioned to the Patient beforehand that any tooth extraction was required.

7. Between December 2007 and November 2010, the Patient continued to have follow-up consultations with the Defendant. The Patient found the progress of the brace treatment not satisfactory. The Defendant also started brace treatment on the Patient's upper jaw, which was not something in the Defendant's suggested treatment plan. When the Patient mentioned to the Defendant about the tooth displacement problem, the Defendant took another set of dental casts from the Patient.

8. On 17 November 2010, the Patient sought a second opinion from Dr. Winston T. TONG ("Dr. TONG"), Specialist in Orthodontics. Dr. TONG gave the Patient some suggestions, which were (a) pulling up of a wisdom tooth; (b) alignment of upper and lower jaws; and (c) restoration of the ability to move the upper and lower jaws and to eat. The Patient told the Defendant of Dr. TONG's suggestions. In the next follow-up consultation with the

Defendant, the Defendant only used a rubber band to pull the pin on the Patient's wisdom tooth, without other follow-ups.

9. At another consultation on 28 December 2010, the Patient expressed her discontent and told the Defendant that she was going to seek another dentist for treatment and asked the Defendant to reimburse her. The Defendant agreed to bear the expenses on condition that the Patient only went to see Dr. LAU Yun-wah ("Dr. LAU"). This was the last follow-up consultation the Patient had with the Defendant.

10. The whole treatment the Patient had with the Defendant lasted for 44 months. The Patient said the Defendant had never explained to her the risks involved in the treatment, nor had he told her about the need for tooth extraction, or whether there was other alternative treatment plans.

11. On 5 January 2011, the Patient went to see Dr. LAU. Dr. LAU told the Patient that he was not confident of aligning her upper and lower jaws, and pulling up her wisdom tooth.

12. On 17 January 2011, the Patient went to Dr. TONG for treatment. Between 17 January and 8 March 2011, the Patient tried to get in touch with the Defendant, but failed. On 8 March 2011, the Patient finally got in touch with the Defendant. The Patient told the Defendant about Dr. TONG's treatment, and asked the Defendant to reimburse her for the expenses. The Defendant said he disagreed with Dr. TONG's opinion, and said he would write to Dr. TONG directly. Subsequently, the Patient tried to contact the Defendant many times, but failed.

13. On 24 May 2011, the Patient complained to this Council against the Defendant.

14. On 21 September 2011, the Chairman of the Preliminary Investigation Committee ("PIC") of this Council requested the Patient to provide medical records and X-ray images retained by the Defendant.

15. On 23 September 2011, the Patient called the Defendant and asked him to provide the medical records, but the Defendant refused.

16. On 27 September 2011, the Patient sent a letter to the Defendant by registered post, requesting for her medical records.

17. On 28 September 2011, the Patient made data access request with the Defendant through the Office of the Privacy Commissioner for Personal Data ("OPCPD"). The Patient requested for "X-ray images of teeth, photos before dental brace treatment, medical records".

18. On 1 November 2011, the Defendant replied to the Patient that he would charge HK$10,000 for the provision of the medical records.

19. On 16 November 2011, the Patient filed a complaint with OPCPD as the fees was excessive.

20. The OPCPD then investigated into the matter. From the end of 2011 to the beginning of 2013, the OPCPD had repeatedly asked the Defendant on how he came up with the sum of HK$10,000, and on the items and quantity of the X-ray images, teeth photos and medical records. However, for more than one year, the Defendant had failed to make clear to

OPCPD on how he calculated the fees of HK$10,000, and on the actual quantity and number of pages of the Patient's teeth photos and medical records being held by him. The OPCPD found it hardly acceptable for the Defendant, during his meeting with OPCPD's investigators in December 2012, which was some fifteen months after the Patient's putting forward her Data Access Request, to claim that the number of photos should range from three to five, the number of pages of the medical records should range from six to ten, and the time for requesting the requested data should range from three to seven hours. The OPCPD took the view that what the Defendant did was to avoid to let them have the actual data so as to delay or prevent the Patient's access to the data she had requested. On 2 May 2013, the OPCPD concluded that the fee of HK$10,000 imposed by the Defendant was excessive and in violation of section 28(3) of the Personal Data (Privacy) Ordinance ("PD(P)O"). The OPCPD served an enforcement notice under section 50(1) of the PD(P)O on the Defendant, instructing him to take steps specified in the notice in order to remedy the violations.

21. On 13 June 2013 at 15:45 hours, the Defendant sent to the Patient an e-mail attaching ten photos of dental casts and four photos of the Patient (three of which showing the Patient's teeth).

22. On 13 June 2013 at 18:00 hours, the Defendant sent to the Patient another e-mail attaching a photo of an X-ray image.

23. At a later stage, the Defendant sent to the Patient another seven pages of her medical records ("the Patient's Record").

24. At today's hearing, the Legal Officer and the Defendant's Solicitors had filed with the Council a signed Statement of Agreed Facts dated 3 December 2015.

25. According to the signed Statement of Agreed Facts, the Defendant in effect pleaded guilty to all the charges, as amended.

Burden and Standard of Proof

26. This 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.

27. There are five charges against the Defendant. This Council needs to look at all the evidence and to consider and determine each of the charges separately.

Findings of the Council

28. The Defendant does not challenge the expert report of Dr. YUEN Kwok-wah dated 28 July 2014, which was relied upon by the Legal officer as part of the prosecution case.

29. The Council accepts the expert opinion, as set out in the expert report of Dr. YUEN.

Charge (a)

30. Charge (a) is about the failure to carry out adequate examination and assessment on the Patient's dental condition before commencement of orthodontic treatment.

31. The registration of chief complaint is often the first thing to do in history taking. It tells what the patient's chief concern is. It should be registered in patient's own words to avoid subjective interpretation of patient's complaint. The Patient's chief complaint on 20 April 2007 was to enquire about a tooth implant of her lost molar tooth. In the Patient's Record, it mentioned that "This is a case of a [redacted], an adult female patient who seek consult in my dental office for proper orthodontic evaluation and management", and "The treatment was carried on the request of the patient for simple alignment of her teeth." There was no mentioning of which teeth or in which region the Patient wanted the teeth to align. Further, these statements were obviously different from the Patient's chief complaint.

32. Before treatment, intra-oral and extra-oral photographs should be taken as a matter of routine. They provide important information such as symmetry of the face, lip position with respect to the teeth, alignment of the facial midline with the dental midlines, and lateral facial contour. This information is essential for initial assessment and subsequent monitoring of treatment changes. However, the Defendant had not taken any pre-treatment photographs of the Patient.

33. Taking lateral cephalometric radiograph and conducting proper cephalometric analysis are often indispensible for most orthodontic treatments. They allow evaluation of the relationships, both horizontally and vertically, of the major functional components of the face, which will affect the treatment options, execution, and outcomes. The Defendant first informed the Patient that the treatment would last for 18 months. The expected treatment time was average or longer than average. Lateral cephalometric radiograph should have been taken and cephalometric analysis should have been conducted before

treatment. However, from the record, there was no lateral cephalometric radiograph and cephalometric analysis.

34. The findings of examination and assessment must be recorded in indelible form, as entries on day-sheet or on a separate assessment form. However, the Patient's Record provided by the Defendant was not such a document as it was not prepared before the treatment commenced. The Defendant could only provide to the Council a one-page dental record of the Patient.

35. The Defendant's conduct, as above, is seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by any registered dentist of good repute and competency. We find him guilty of unprofessional conduct as in Charge (a).

Charge (b)

36. Charge (b) is about the failure to adequately advise the Patient of the risks and complications associated with the treatment before he commenced the treatment.

37. Risks and complications associated with orthodontic treatment should be explained clearly to the patient before treatment. This is part of the consent process. It allows the patient to weigh the risks and costs against the benefits of the various treatment options before making treatment decision. Risks and complications can be general or specific.

38. In the present case, it is not apparent that other general risks such as root resorption, tooth non-vitality, enhanced periodontal breakdown when periodontal diseases strike during tooth movement, decalcification patches on tooth surfaces caused by inadequate oral hygiene,

dark triangles, and the relapse tendency that requires the use of retainers have been explained to the Patient before treatment. Further, according to the treatment plan taken by the Defendant, the following specific risks and complications which were readily identifiable should have been explained to the Patient: possible shifting of lower dental midline, possible increase in overjet, uprighting 38 will take long time and may cause premature contact with 27 and openbite anteriorly that may require occlusal adjustment. However, the Defendant never mentioned any of these specific risks and complications to the Patient.

39. General risks and specific risks must be explained to the Patient before the treatment, and this was not done. The Patient was therefore not able to weigh the risks against the benefits so as to make an informed decision regarding the treatment.

40. The Defendant's conduct in this respect is seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by any registered dentist of good repute and competency. We find him guilty of unprofessional conduct as in Charge (b).

Charge (c)

41. Charge (c) is in relation to failure to offer the Patient any alternative options for managing the Patient's dental condition before the commencement of the treatment.

42. When diagnosis is reached and treatment objectives are devised, ways to address patient's complaints and other diagnosed problems are then formulated. Different treatment options are then designed which may be able to address all, most, or only some of the problems the patient faces. The limitations and differences in outcomes of the various

options are then highlighted and explained to the patient. This is part of the informed consent process.

43. In the present case, there are other possible treatment options, such as (but not limited to) the following:-

(i) No orthodontic treatment with or without prosthetic assessment for prosthesis at 36

(ii) Upper and lower fixed appliance treatment with extraction of 38

(iii) Upper and lower fixed appliance treatment non extraction

44. Other possible treatment options should be made available to the Patient. The Defendant had failed to do so.

45. The Defendant's conduct in this respect is seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by any registered dentist of good repute and competency. We find him guilty of unprofessional conduct as in Charge (c).

Charge (d)

46. Charge (d) is about the failure to perform the treatment properly by increasing the Patient's overjet and overbite, failing to upright the tooth 38 and causing the shifting of lower dental midline.

47. The desirable anterior dental aesthetics of the patient (straight teeth, normal overjet, overbite, alignment of midlines) that exists before treatment should not be sacrificed unnecessarily. According to the Defendant's plan, it was his treatment objectives and plan

to "maintain acceptable overjet to 1-2 mm only" and "maintain overbite to 1-2mm only". These two objectives/plan were never achieved.

48. After the prolonged period of 44 months, there was no significant upright of tooth 38. The Defendant had failed to maintain the 1-2 mm overjet and overbite as planned. In addition, the lower dental midline was shifted to left significantly.

49. The Defendant's conduct in this respect is seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by any registered dentist of good repute and competency. We find him guilty of unprofessional conduct as in Charge (d).

Charge (e)

50. Charge (e) is about the failure to provide the Patient with a copy of the full set of clinical records despite her repeated requests for such records.

51. Since 23 September 2011, the Patient had made repeated requests to the Defendant for her clinical records. The Patient had even made a Data Access Request through the OPCPD. All along the Defendant failed to provide the same to the Patient.

52. The OPCPD had investigated into this matter. We accept the views of the OPCPD that what the Defendant did was to avoid to let OPCPD to have the requested clinical records so as to delay or prevent the Patient's access to them.

53. The Defendant's conduct in this respect is seriously below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by any

registered dentist of good repute and competency. We find him guilty of unprofessional conduct as in Charge (e).

Sentencing

54. The Defendant has a clear record.

55. 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 unfit to practice dentistry and to maintain public confidence in the dental profession.

56. The Defendant pleaded guilty to all the charges at the beginning of the inquiry.

57. Having regard to the gravity of the case, and bearing in mind our duty of protecting the public, we make the following orders:-

(i) In respect of each of charges (a) to (d), the Defendant's name be removed from the General Register for a period of 2 months, and the removal orders shall run concurrently;

(ii) In respect of charge (e), the Defendant be reprimanded and

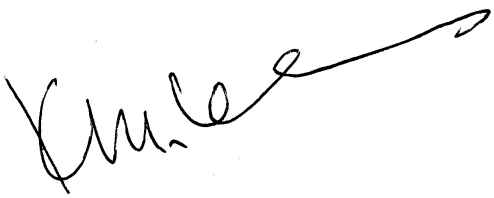
(iii) The orders in (i) and (ii) above shall be published in the Gazette.

58. We have considered whether the removal orders can be suspended. We see no reason for suspension.

Other Remarks

59. While it is for the Council in future to consider the Defendant's application for restoration to the General Register, we recommend that the Council should ensure that the following condition be satisfied:-

(i) The Defendant is required to produce evidence of having completed satisfactorily 30 hours of continuing dental education in courses of orthodontics organized by established dental institutions, which shall be pre-approved by the Chairman of the Council, before the application for restoration is approved.



Dr. LEE Kin Man

Chairman

The Dental Council of Hong Kong