Inquiry of the Dental Council
Re: Dr. LEE Chung-lick, Kerry

Date of hearing : 3 March 2011

1. The Defendant, Dr. Lee Chung-lick, Kerry, is charged as follows:

   "That he, being a registered dentist, disregarded his professional responsibility to adequately treat and care for his patient ("n"), or otherwise neglected his professional duties to her in that, during the period from about 15 November 2008 to 22 January 2009:-

   (i) he devised and implemented an improper and ineffective dental implant treatment plan and treatment for n; and/or

   (ii) he failed to provide proper post-operative management to n after her complaint to him about the infection at Tooth 42.

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

Facts of the case

2. On 15 November 2008, the patient consulted the Defendant for a dental implant to replace the missing tooth 42. According to the Defendant's submission to the Preliminary Investigation Committee, he diagnosed gingivitis, a lesion apical to 41 and 43, and tooth 41 was mobile. He recommended scaling and polishing to address the gingivitis, and root canal treatment to address the infected root canals in 41 and 43, to be followed by apical surgery if the lesion did not resolve. These matters were not reflected in his patient record.

3. Despite the advice to address the gingivitis and the infection before proceeding to implant surgery, the Defendant proceeded to insert the implant at 42 on 15 November 2008 without dealing with the gingivitis and the infection. A mini-implant with a ball retentive anchor was inserted. The Defendant took one periapical radiograph but did not make any study model before performing the implant surgery. The surgery took 15 to 20 minutes.

4. The patient returned to the Defendant on 4 subsequent occasions for follow-up consultation: 15 December 2008, 11 January 2009, 22 January 2009 and 14 February 2009. On those consultations, the Defendant did not perform any radiographic examination to monitor the development after the insertion of the implant.

5. On 21 January 2009, the patient had a severe toothache. A dentist at Project Concern Hong Kong found that there was inflammation of all the teeth around the dental implant and advised the patient to return to the Defendant for management. The patient returned to see the Defendant on 22 January 2009 and informed him of the inflammation and the toothache. The Defendant prescribed antibiotics and painkillers, and advised the patient to stop biting edge-to-edge.

6. On 14 February 2009, the patient again complained of pain in the area of 41 to 43. The Defendant again advised the patient to stop biting edge-to-edge.

7. On 28 February 2009, the patient consulted another dentist because of the episodic pain over the body of the mandible for over a month. The other dentist on radiographic examination found that there was infection extending from the apical region of 31 to 43, and both 41 and 43 tested negative for vitality. The patient was then referred to the Prince Philip Dental Hospital for treatment. The referring dentist then completed root canal treatment on 43, removed the mini-implant. Subsequently, the cyst was enucleated at the dental hospital. Follow-up radiographs showed complete recovery of the surgical site.

Council's findings

8. The Defendant admitted the allegations of the charge and did not dispute the facts of the case. Nevertheless, we have to determine whether the Defendant's conduct constituted unprofessional conduct according to the definition in section 18(2) of the Dentists Registration Ordinance.

9. It is a fundamental principle that an implant should not be installed in an infected area. To insert the implant in an infected area will increase the risk of exacerbating the infection and compromise the process of osseo-integration. If the infection is not eliminated, the infection can easily spread to the implant and the implant is unlikely to succeed. Every dentist performing implant surgery must know and comply with the principle. To insert an implant in an infected area reflects that the dentist is either unaware of this fundamental principle or that he is recklessly disregarding the principle.

10. According to the Defendant's submission to the Preliminary Investigation Committee and the patient record, the Defendant clearly recognized that there was infection in the area of the dental implant and that the infection needed to be eliminated before proceeding to the implant surgery. Nevertheless, he immediately proceeded to insert the implant without addressing the infection. This is a blatant and deliberate violation of the principle that implants are not to be installed in infected areas.

11. The proper implant for an esthetically demanding reconstruction of an incisor should be a diameter-reduced bone level implant. The mini-implant with a ball retentive anchor inserted by the Defendant was inappropriate for the patent's condition.

12. After inserting an implant, the patient's dental condition must be closely monitored to determine the degree of osseo-integration and to detect any infection around the insertion site. Radiological examination is essential for such monitoring.

13. When the patient complained of pain, the Defendant should have immediately performed radiological examination to investigate the problem. There was even more reason to perform immediate radiological examination when he was informed that another dentist had diagnosed infection. He did not do so. Instead, he repeatedly advised the patient to stop her edge-to-edge biting as he believed that it was the cause of the problem. There is convincing scientific evidence that occlusal factors do not have a major role in etiology of infectious diseases. The unfounded belief of a causal relationship between occlusal factors and infection has been abandoned for many years. This shows that the Defendant is not up to date in his dental knowledge.

14. When the patient returned on 14 February 2009 and the pain had persisted for more than 3 weeks, there was no reason for a competent dentist exercising reasonable care not to take immediate action to address the problem. However, the Defendant still ignored the problem and simply advised the patient to stop the edge-to-edge biting. This shows that the Defendant was unaware of the cause and seriousness of the problem, and that he was not aware of the proper management of infection after implant surgery.

15. We are satisfied that the Defendant devised and implemented an improper and ineffective dental implant treatment plan for the patient. Such conduct would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency. This clearly constitutes unprofessional conduct. We find the Defendant guilty of charge (i).

16. We are also satisfied that the Defendant failed to provide proper post-operative management to the patient, particularly after the patient's complaint of pain. Registered dentists of good repute and competency would reasonably regard the Defendant's conduct as disgraceful and dishonourable. We find him guilty of unprofessional conduct under charge (ii).

Other observation

17. We have to make an observation. In the morning we asked for the original patient record. We were informed that the Defendant had to go back to his clinic to retrieve the original. The original was provided to us in the afternoon, after we had typed up our decision as set out above. Therefore, our observation below regarding the original patient record has not affected our decision above.

18. We have examined the original patient record, and noted some very unusual features. At many places the entries have been covered by correction fluid and then amended. While we have no evidence as to when and why the amendments were made, the entries on 22 January 2009 and 14 February 2009 are different from those shown in the photocopy provided by the Defendant's solicitors in the submission to the Preliminary Investigation Committee dated 30 June 2010. This can only be explained that the record has been amended after 30 June 2010.

19. Patient records should be made contemporaneously, and amendments should be made only for proper reasons. We fail to see the reason and the basis for amending the record more than 5 months afterwards. We are pointing this out on expectation that a reason will be given during mitigation.

Sentencing

20. The Defendant has a previous conviction in 2004. He was found guilty of 6 charges of disregarding his professional responsibility to his patient, in relation to treatment on 10 teeth of a patient. The Council then ordered that his name be removed from the Register of Dentists (now the General Register) for a period of 2 months.

21. The charges in the last conviction were of similar nature to the present charges. In that case, the Council was "*of the view that the conduct of the defendant is deplorable*" and

was "*particularly concerned that a major treatment was rushed through in a short period of time, without either informing the patient the true nature of the treatment or obtaining the consent of the patient before commencing such treatment*". Similar to the present case, he immediately commenced treatment in that case on the first consultation. The previous conviction is directly relevant to sentencing in the present case. It reflects that he has not learned from the previous case. It also reflects on the likelihood of re-offending

22. In accordance with our policy stated in the 'Practice Directions on Disciplinary Inquiries', we give the Defendant credit for admitting the allegations of the charge and not disputing the facts of the case. Other than this, we see no mitigation of weight. We note that he has attended continuing dental education in April to June 2010 and in January 2011, more than a year after the incident and after the case has been referred for inquiry.

23. This is a case of reckless disregard of the Defendant's professional responsibility to his patient. He rushed into the implant treatment knowing that the implant should not have been inserted. Upon deterioration of the patient's condition and despite repeated opportunities to remedy the situation, he failed to take any meaningful and effective remedy at all. This is dangerous to the patient. It was only fortunate for both the patient and the Defendant that the patient had decided to consult another dentist before serious deterioration of her dental condition.

24. We bear in mind our duty to protect the public from substandard and unsafe dental practice of dentists who are unfit to practise dentistry. The purpose of a disciplinary order is not to punish the Defendant, but to protect the public by ensuring that only competent dentists who are fit to practise are given the right to practise dentistry.

25. Having regard to the gravity of the case and the mitigation, we order that the Defendant's name be removed from the General Register for a period of 1 year. Suspension of the order is clearly unsuitable.

26. While it is for the future Council to consider his application for restoration to the General Register as and when it is made, we recommend that the Council should require the Defendant to produce cogent evidence that he has clearly improved his competence in dentistry to the standard required for registration. In this respect, reference should be made to the benchmark document 'Competences for the Hong Kong Dentist' which sets out the standard of competences for registration. The Council should also consider imposing a condition that upon restoration the Defendant be subject to satisfactory peer audit and supervision for a period of 2 years.

Other remarks

27. Upon our invitation above for explanation as to amendments to the original patient record, and in the belief that no difference can be detected between the original and the photocopy provided to the Preliminary Investigation Committee, the Defendant explained that all amendments were made contemporaneously. Given the differences between the photocopy in June 2009 and the original now produced, and the fact that he changed his words immediately when confronted with the differences, that must be a deliberate lie.

28. After the specific differences have been pointed out, he immediately said that the amendments were made because the grammar was wrong. That is a completely unacceptable reason, as the amendments relating to the prescribed drugs recorded in point

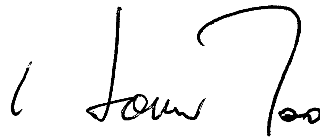
form involved no grammar at all. The patient record consisted of only 14 short lines, but there were substantial amendments in 10 lines. No explanation can be given for the amendment. That is a situation suspicious in the extreme.

29. Although we are not dealing with charges of dishonesty or tampering with evidence, we must point out that it is a serious criminal offence to tamper with crucial evidence to pervert the course of public justice. Dishonesty is a much more serious misconduct than lack of competence.

30. For the avoidance of doubt, we have not taken this matter into consideration in sentencing.

31. This case illustrates the importance of adhering to the 'Practice Directions on Disciplinary Investigation', in particular Direction No. 13 that "*Originals of documentary evidence should be produced at the inquiry. Explanation is required for not producing the originals.*"

32. We understand that patient records are in the hands of the dentists concerned, and the Preliminary Investigation Committee or the Legal Officer has no power to compel a dentist to provide the patient records. However, if the dentist refuses to provide the patient record upon the request of the Preliminary Investigation Committee or the Legal Officer, it is a matter which can be taken into consideration in determining the good faith of the dentist and the credibility of any positive defence both during preliminary investigation and the inquiry. In this respect, Direction Nos. 6, 7 and 8 of the 'Practice Direction on Preliminary Investigation of Complaints' are relevant.



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