G.N. 5693

DENTISTS REGISTRATION ORDINANCE (Chapter 156)

ORDER MADE BY THE DENTAL COUNCIL OF HONG KONG

It is hereby notified that the Dental Council of Hong Kong ('the Council'), after due inquiry held on 4 August 2016 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr CHIU Hon-ching (Registration No. D03791) guilty of the following charges:—

'He, being a registered dentist, from about June 2013 to September 2013, disregarded his professional responsibility to adequately treat and care for his patient Miss CHAN Ka-sin ('the Patient'), or otherwise have neglected his professional duties to her in that:—

(i) he failed to properly maintain the Patient's records of dental treatment; and/or

(ii) he 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 he has been guilty of unprofessional conduct.'

Since around June 2013, the Patient consulted Dr CHIU at his clinic on a number of occasions for root canal therapy of a tooth. The Patient said that the root canal therapy was completed sometime in July 2013. She said she felt pain after the therapy and she had told Dr CHIU. Dr CHIU told her that feeling pain after the therapy was normal.

The Patient's pain did not subside. She then consulted another dentist, a Dr TSANG ('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 Patient to consult a Dr CHAN ('Dr CHAN'), a specialist in Endodontics.

The Patient then related Dr TSANG's opinion about a fourth nerve of the tooth to Dr CHIU. Dr CHIU told her that the possibility of the fourth nerve of the tooth was not high. Dr CHIU 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 Patient did not proceed with the suggestion.

The Patient 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. She then telephoned Dr CHIU, and told Dr CHIU about the discovery of an endodontic file being left in her tooth. The Patient delivered to Dr CHIU a copy of the scan.

In around October 2014, the Patient 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 Dr CHIU. About a week after the making of the request for such records, a nurse of Dr CHIU's clinic telephoned the Patient and asked if she was complaining. The nurse also told the Patient that Dr CHIU's then clinic had ceased business, and all her dental records were lost.

The Council made the following findings:—

Charge (i)

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.

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

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.

Dr CHIU's conduct was seriously below the standard expected amongst registered dentists, and would be regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council finds Dr CHIU guilty of charge (i).

Charge (ii)

Dr CHIU admitted to the Council that he knew an endodontic file was fractured during the treatment of the Patient with its fragment left in the Patient's tooth.

The Council considers that it is the professional responsibility of Dr CHIU to inform the Patient 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 Dr CHIU's professional duty.

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

Dr CHIU's conduct was seriously below the standard expected amongst registered dentists, and would be regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council finds Dr CHIU guilty of charge (ii).

Having regard to the gravity of the case, and bearing in mind the duty of protecting the public and maintaining public confidence in the dental profession, the Council made the following orders:—

(a) In respect of charge (i), Dr CHIU be reprimanded.

(b) In respect of charge (ii), Dr CHIU be reprimanded.

(c) The orders above shall be published in the *Gazette*.

In accordance with section 18(5) of the Dentists Registration Ordinance, the orders of the Council shall be published in the Government of Hong Kong Special Administrative Region Gazette. The full judgment of the Council is published in the official website of the Dental Council (http://www.dchk.org.hk).

LEE Kin-man *Chairman, Dental Council of Hong Kong*