G.N. 308

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 21 November 2016 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr. CHENG Wing-tak, Gloria (Registration No. D03786) guilty of the following charges:—

'That she, being a registered dentist, disregarded her professional responsibility to adequately treat and care for her patient Ms. LI Yee-lam ('Ms. Li'), or otherwise to have neglected her professional duties to Ms. Li in that, between March 2012 and August 2012:—

(a) [Note: Secretary offered no evidence in respect of charge (a)]

(b) she failed to carry out proper and effective Root Canal Therapy on Ms. Li for her [tooth] '14'; and/or

(c) she failed to properly or adequately advise Ms. Li of her treatment progress after the Root Canal Therapy in (b) above;

(d) [Note: Secretary offered no evidence in respect of charge (d)]

and that in relation to the facts alleged she has been guilty of unprofessional conduct.'

On 8 March 2012, Ms. Li first visited Dr. CHENG at her clinic requesting for scaling and polishing as well as restorations for her teeth due to feeling of 'hot and cold'. On intra-oral examination, Dr. CHENG found that teeth 14, 15, 24, 25, 35 and 36 were carious. Four radiographs (one for each quadrant) were taken. Dental restorations were done for teeth 24, 25, 35 and 36. For teeth 14 and 15, as caries already extended to the pulp, Root Canal Therapy ('RCT') was performed. Both teeth 14 and 15 had pulp extirpation and dressed with an intra-canal medicament.

On 17 March 2012, Ms. Li visited Dr. CHENG at her clinic and told her that the restoration in tooth 25 was dislodged. Dr. CHENG changed the restoration for tooth 25 to composite resin. Dr. CHENG also completed RCT for teeth 14 and 15. Some time later, Ms. Li discovered that tooth 14 started to have discolouration, which gradually increased in size. In early June 2012, Ms. Li also started to feel pain with tooth 14.

On 16 June 2012, Ms. Li returned to Dr. CHENG because of pain with tooth 14. A review periapical radiograph was taken. Dr. CHENG diagnosed that there was a crack running from the mesial to distal side of the tooth. Dr. CHENG suggested Ms. Li to see an endodontist for redoing RCT. Dr. CHENG also mentioned alternative treatments including extraction of tooth 14 and replacement of the missing tooth with resin bonded bridge or implant. Dr. CHENG wrote a referral letter for Ms. Li, and a list of registered specialists in endodontics was provided to Ms. Li.

The Council made the following findings:—

Charge (b)

Dr. CHENG admitted that she had failed to identify and treat the second root in tooth 14. Dr. CHENG did not contest unprofessional conduct on her part. The Council had the opportunity of looking at the x-ray taken by the dentist in Shenzhen on 14 September 2012. It was obvious from the x-ray that there were two canals in tooth 14. It was obvious that Dr. CHENG had failed to identify the second canal in March 2012 when Ms. Li consulted her.

Dr. CHENG'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 found Dr. CHENG guilty of charge (b).

Charge (c)

Dr. CHENG did not contest unprofessional conduct under charge (c).

According to Ms. Li's complaint letter to the Council dated 19 September 2012, when she went back to see Dr. CHENG on 16 June 2012, Dr. CHENG had never advised her of the possibility of there being a second root canal for tooth 14, which could have been missed out. Dr. CHENG's clinical record for 16 June 2012 had also never mentioned of such a possibility. Even in the referral letter dated 16 June 2012 given to Ms. Li, Dr. CHENG only mentioned in the referral letter her suggestion to Ms. Li that if she would wish to save tooth 14, she needed to redo RCT again by an endodontist.

Dr. CHENG had taken a review periapical radiograph on 16 June 2012. Despite that, Dr. CHENG had still failed to identify the missed second canal, and Dr. CHENG should have, but she had taken no further attempt to investigate this possibility of taking the radiograph from a different angle. Taking radiographs from different angles for a bi-rooted tooth (i.e. tooth 14) for investigation of the root canal system was a basic dental technique. Even if Dr. CHENG assumed that Ms. Li's tooth 14 was an anatomical variant of having only one canal, she still ought to advise Ms. Li the possible existence of having a second root canal. The Council considered that this was a dental advice expected of a registered dentist which must be given to the patient.

Dr. CHENG'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 found Dr. CHENG guilty of charge (c).

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 (b), a warning letter be given to Dr. CHENG.

(b) In respect of charge (c), a warning letter be given to Dr. CHENG.

(c) The orders above 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*