G.N. 4323

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 19 February, 7, 13 and 28 March and 28 April 2019 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr YUNG Ching-wah ('Dr Yung') (Registration No. D01148) guilty of the following charges:—

'In the period from February 2014 to November 2014, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient Mr Vincent WUN ('Mr Wun'), or otherwise to have neglected your professional duties to Mr Wun in that:—

(a) you failed to adequately and timely explain to Mr Wun about the horizontal crown fracture of his upper right lateral incisor ('tooth 12');

(b) you failed to timely offer proper alternative options to Mr Wun for managing the fracture; and/or

(c) you failed to timely, properly and/or adequately advise Mr Wun of the treatment options when the original implant treatment failed;

and that in relation to the facts alleged you have been guilty of unprofessional conduct.'

At all material times, Dr Yung was a specialist in prosthodontics. During the period between February and November 2014, both Dr Yung and Dr Morgan Olsson ('Dr Olsson'), a registered general dental practitioner in Hong Kong and a specialist in oral surgery in Europe and working part-time at Dr Yung's clinic, were involved in the management of Mr Wun. On 6 October 2010, Mr Wun consulted Dr Yung presenting with a vertical root fracture at tooth 11. Dr Yung advised Mr Wun to undergo an extraction of tooth 11. Mr Wun said he would consider.

On 5 February 2014, Mr Wun returned to see Dr Yung presenting with a gum boil with mild inflammation at the region of the tooth 11. Mr Wun agreed to have tooth 11 extracted, followed by bone grafting and implant placement. On 26 February 2014, Dr Yung performed extraction of tooth 11. Dr Olsson then performed bone grafting at the extraction socket. Then, Dr Yung placed a temporary acrylic denture to replace tooth 11 temporarily. On 28 February 2014, Mr Wun returned to consult Dr Yung. Mr Wun indicated that he did not wish to continue wearing the temporary denture. Dr Yung then advised Mr Wun to wear a Maryland bridge with teeth 12 and 21 as abutments. Mr Wun agreed. On 5 March 2014, the Maryland bridge was fitted with its metal wings cemented to the back of teeth 12 and 21. On 29 July 2014, Dr Yung removed the Maryland bridge and Dr Olsson inserted the implant fixture. A removable denture was delivered by Dr Yung. On 5 August 2014, Mr Wun returned to Dr Yung's clinic for removal of sutures. The Maryland bridge was fitted again.

On 21 November 2014, Mr Wun returned to Dr Yung's clinic. This was a scheduled appointment for Dr Yung and Dr Olsson to assess the implant and perform Stage II implant surgery. When Dr Yung removed the Maryland bridge, tooth 12 was fractured. Dr Yung then performed acid etching of the enamel of tooth 12, placed tooth coloured composite resin on its surface. After Dr Yung repaired tooth 12, Dr Olsson then exposed the surgical site and found that the implant fixture was mobile indicating that osseointegration had failed. Dr Olsson removed the failed implant fixture and then performed bone grafting as a second attempt. Dr Yung then invited Mr Wun to have a discussion on the same day.

A few days later, the crown of tooth 12 came off. Mr Wun immediately called Dr Leung Siu Fai ('Dr Leung') for an urgent consultation. On 29 November 2014, Mr Wun consulted Dr Leung. Dr Leung noticed that tooth 12 suffered complicated horizontal crown fracture, with most of the anatomical crown severed. The fragment was bonded with composite resin to the tooth. The periapical radiograph confirmed the fracture but there was no periapical lesion. Dr Leung advised that Root Canal Treatment ('RCT') of tooth 12 should be performed. On the same day, Mr Wun consulted Dr Yung. Dr Yung performed RCT and placed a temporary crown at tooth 12. Mr Wun did not go back to consult Dr Yung after this visit.

On 18 December 2014, Mr Wun consulted another dentist, Dr Robert Lau ('Dr Lau'), for implant replacement of missing tooth 11. Dr Lau took a periapical radiograph which revealed the

extraction site of tooth 11 had a radiopaque area resembling root fragment of a tooth, and he advised that the fragment should be removed before any implant surgery. On 31 December 2014, Mr Wun consulted another dentist, Dr James Chow Kwok Fai ('Dr Chow') for implant consultation. Dr Chow took Cone Beam CT and suspected a root remnant was at extraction site 11. On 3 January 2015, Dr Chow removed the remnant from site 11, which was in one piece of about 1 cm long. Mr Wun had since kept the remnant in a medicine bag in the refrigerator. The remnant had already been broken into five small pieces by the time of this inquiry. The broken pieces of remnants were produced by Mr Wun at the inquiry.

The Council made the following findings:—

Charge (a)

Charge (a) was that Dr Yung had failed to adequately and timely explain to Mr Wun about the horizontal crown fracture of tooth 12. The Council considered that an adequate and timely explanation should include the true nature, cause, extent and seriousness of the fracture, and be given at the first reasonable opportunity. Mr Wun told the Council that on 21 November 2014 Dr Yung had never told him at all, whether during the dental procedure or afterwards at the conference, about the fracture of tooth 12. All that Dr Yung had said to him was that tooth 12 was weak. Dr Yung's case was that he had told Mr Wun that he noticed a 'fractured line' after detaching the Maryland bridge, and that he had repaired the 'fractured line' by bonding composite resin over it. Dr Yung also said he had told Mr Wun that tooth 12 could still develop into complete fracture, in which case RCT would be needed.

In Dr Yung's medical notes dated 21 November 2014, Dr Yung wrote 'tooth #' which he said meant 'tooth fracture'. He also wrote 'Patient conference: inform of failure of implant & Re. bone graft and waiting period for another 6 months before placement of another implant.' In his conference notes dated 21 November 2014, he wrote 'Fix Maryland Br = no good Abutments' and 'Diagnosis. #line #RCT'. Nowhere in Dr Yung's medical notes or conference notes showed that he had informed Mr Wun of the cause of the fracture. Dr Yung explained to the Council that the words 'Fix Maryland Br = no good Abutments' in his conference notes meant that he had informed Mr Wun that when he detached the Maryland bridge he had caused the fracture. The Council found this explanation illogical and unconvincing. Dr Yung also told the Council that throughout his so many years of practice, he had never caused any fracture of patient's teeth, and this was the first time ever in his practice of causing fracture. If so, there should be more the reason of recording that he had informed Mr Wun of the cause of the fracture. However, there was no such record. Further, Ms Ivy Cheung, Dr Yung's witness, said that she had attended the conference on 21 November 2014. However, Ms Cheung had never mentioned, whether in her witness statement or at the inquiry, that Dr Yung had told Mr Wun the cause of the fracture. The Council did not believe that Dr Yung had informed Mr Wun the cause of the fracture of tooth 12 on 21 November 2014. This was grossly inadequate and unacceptable to the profession.

In Dr Yung's Medical Report dated 27 June 2017, Dr Yung wrote that on 21 November 2014, before Dr Olsson performed the Stage II surgery he had to detach the Maryland bridge, and 'upon examination [he] found a low to mid horizontal unstable fracture line on the facial side through the entire tooth 12…'. In Dr Yung's witness statement dated 8 February 2019, he wrote that when he examined tooth 12 on 21 November 2014, he noted an 'unstable mobile fracture' across the lower one third of the crown of tooth 12. Dr Yung said the unstable mobile fracture was an incomplete fracture because it was not a complete detachment.

At the inquiry, the Council asked Dr Yung what he meant by the word 'unstable' in his witness statement. Dr Yung said by 'unstable' he meant the upper part of the crown above the fracture was mobile, and he confirmed only the upper part was mobile. Dr Yung agreed that if there was a rigid structure, and if there was a crack line only, then the part would not be mobile because it was a rigid structure; however, if there was a mobile part, that part would have been separated from the main bulk of the rigid structure. The Council took the view that the upper part of tooth 12, which had already been separated from the main body of the tooth, even if it was still not completely detached in Dr Yung's wordings, was no doubt a complete fracture. Dr Olsson also agreed with this view of the Council.

Therefore, the fracture caused by Dr Yung to tooth 12 on 21 November 2014 was not simply a 'fractured line', which according to Dr Yung's case, could develop into a complete fracture. Furthermore, the location of the fracture involved the cervical third of the crown of tooth 12. The pulp must have been exposed. This warranted early RCT. The Council considered that even Dr Yung had on 21 November 2014 told Mr Wun that there was a 'fracture line' at tooth 12, he

was no doubt playing down or embellishing the level of seriousness of the fracture. It was not reflecting the true nature of the fracture and was grossly inadequate and unacceptable to the profession.

The Council was satisfied that the conduct of Dr Yung had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful or dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr YUNG guilty of charge (a).

Charge (b)

Charge (b) was that Dr Yung had failed to timely offer proper alternative options to Mr Wun for managing the fracture at tooth 12. The Prosecution was of the view that immediate 'endodontics and post' was necessary for the complete horizontal fracture of tooth 12 on 21 November 2014. In view of the seriousness and the location of the fracture of tooth 12, the pulp must have been exposed. The pulp would be infected and the proper option to Mr Wun was RCT. The Council considered that Dr Yung should explain to Mr Wun the risk of infection and the need of RCT, and make arrangement for RCT at the earliest possible timing, rather than waiting for the detachment of the fractured fragment or any sign and symptom. However, Dr Yung merely told Mr Wun on 21 November 2014 that tooth 12 was weak and might require RCT in the future. Dr Yung failed to inform Mr Wun of the seriousness of the fracture. In any event, no arrangement was made on 21 November 2014 with Mr Wun for RCT.

The Council was satisfied that the conduct of Dr Yung had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful or dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr YUNG guilty of charge (b).

Charge (c)

Charge (c) was that Dr Yung had failed to timely, properly and/or adequately advise Mr Wun of the treatment options when the original implant treatment of tooth 11 failed.

The Council had examined the five broken pieces of remnants, the periapical radiograph taken by Dr Leung dated 29 November 2014, the periapical radiograph taken by Dr Lau on 18 December 2014, and the Cone Beam CT taken by Dr Chow on 31 December 2014. The Council agreed with Dr Cheung Lim Kwong, Dr Yung's expert, that the remnants were not tooth fragments but bone fragments due to displaced cortical bone. In fact, Dr Yung had produced a photograph taken on 21 November 2014 which showed the extracted tooth 11 with a seemingly intact root, and which Mr Wun agreed that that was his tooth.

The Council took the view that implant procedure does not guarantee a 100% success rate. It was not unusual for implant to fail. Having failed osseointegration of the implant in the first attempt, a re-attempt is acceptable to the profession. Further, Dr Yung did offer the options of cantilever resin-bonded bridge and 'triple crown' (conventional bridge) as alternatives to the implant treatment to Mr Wun.

The Council therefore acquitted Dr YUNG of charge (c).

Having regard to the gravity of the case and the mitigation submitted by Dr YUNG, the Council made the following orders:—

(a) In respect of charge (a), that the name of Dr Yung be removed from the General Register for a period of 1 month;

(b) In respect of charge (b), that the name of Dr Yung be removed from the General Register for a period of 1 month;

(c) The orders in paragraphs (a) and (b) above be concurrent;

(d) The operation of the orders as set out in paragraphs (a) to (c) above be suspended and shall not take effect for a period of 12 months;

(e) The orders in paragraphs (a) to (d) 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 the 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*