G.N. 3669

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 12 May 2022 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr NG Wai-sang ('Dr NG') (Registration No. D02435) guilty of the following charges:—

'In or about May to October 2020, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient, Ms OR Wai-lin ('the Patient') or otherwise neglected your professional duties to the Patient in that, you:—

(i) failed to obtain proper informed consent of the Patient before carrying out the dental treatment involving the upper right posterior teeth ('Tooth 14 to Tooth 16');

(ii) failed to make appropriate diagnosis for the postoperative sensitivity or discomfort after the bridge was cemented for Tooth 14 to Tooth 16; and

(iii) failed to devise a proper plan of action for the postoperative sensitivity or discomfort after the bridge was cemented for Tooth 14 to Tooth 16;

and that in relation to the facts alleged, either individually or cumulatively, you have been guilty of unprofessional conduct.'

On 26 May 2020, the Patient consulted Dr NG regarding pain in the right maxillary region. Root Canal Treatment ('RCT') on tooth 14 was performed and was completed over three consultations on 28 May, 2 and 9 June 2020.

On 9 July 2020, the Patient returned to see Dr NG regarding prosthesis on the root-treated tooth 14. On 15 July 2020, Dr NG removed the Patient's existing cantilever bridge on teeth 15 to 16 and fitted a three-unit temporary bridge over teeth 14 to 16. The Patient reported postoperative sensitivity. On 16 July 2020, tender to percussion was noted. On 27 July 2020, Dr NG removed the Patient's temporary bridge and he cemented the permanent bridge. Dr NG arranged the Patient to attend a follow-up consultation two days later. However, the Patient could not return until later, as there were suspected COVID-19 cases at the building where the Patient lived.

The Patient attended to a multiple of review appointments with Dr NG since 15 September 2020. On 22 September 2020, post-operative sensitivity was recorded and Dr NG adjusted the occlusion of the bridge 14 to 16. On 29 September 2020, tender to percussion on terminal molar 17 and sensitivity was noted. On 30 September 2020, occlusion of tooth 16 was further adjusted and night guard suggested.

The Patient consulted a Dr CHAN on 6 October 2020 and a Dr WONG on 26 October 2020 for second opinions on her post-operative pain and hypersensitivity. The Patient's last appointment with Dr NG was on 28 October 2020. The Patient was referred by Dr WONG to consult a Dr MAK, Endodontist on 27 November 2020.

On 6 November 2020, the Patient lodged a complaint against Dr NG to the Council.

The Council made the following findings in respect of the charges:—

Dr NG admitted the factual particulars of the disciplinary charges against him but it remained for the Council to consider and determine on the evidence whether he had been guilty of unprofessional conduct.

Charge (i)

The Council gratefully adopted as its guiding principles the statements of the law on informed consent as expounded in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 at paragraphs 87 and 90 thereof and paragraph 5 of the Council's Code of Professional Discipline (revised in December 2019) which dealt with consent.

There was no clinical note or charting which recorded the Patient's dental condition including chief complaint, clinical examination, findings, diagnosis and treatment plan, but only a very brief mentioning of the treatment procedure regarding RCT of tooth 14, which commenced on 26 May 2020. There was no record whatsoever, whether in the form of signed written consent or record of verbal consent given by the Patient, that Dr NG had told the Patient about the

anticipated benefits and risks involved in the recommended treatment, namely the RCT of tooth 14, the removal of the existing cantilever bridge on teeth 15 to 16 and the fitting of a three-unit temporary bridge over teeth 14 to 16, and any reasonable alternatives. Most importantly, Dr NG accepted that he had failed to obtain proper informed consent from the Patient.

The Council found that Dr NG had failed to obtain proper informed consent from the Patient before carrying out the dental treatment involving the upper right posterior teeth 14 to 16. The Council was satisfied that the conduct of Dr NG had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr NG guilty of charge (i).

Charge (ii)

According to the clinical record, on 22 September 2020, there was record of sensitivity of teeth 14 and 16. On 29 September 2020, there was record of tender to percussion of tooth 17 and mild sensitivity. On 7 October 2020, there was record that teeth 16 and 17 were sensitive. On 30 September 2020, there was record that night guard was suggested. Dr NG had therefore recorded the symptoms. However, the Council could not see from the clinical record at all of the record of diagnosis of what caused these symptoms.

Dr NG said that the Patient had been taking anti-depressant medications and therefore difficult to adapt to the prostheses. The Patient said Dr NG told her that the post-operative sensitivity and discomfort might possibly be caused by bruxism or trigeminal neuralgia. Despite informing the Patient these possibilities, Dr NG had not performed any diagnostic procedure at all to confirm his provisional diagnosis. There was no record of any x-ray done, no detailed history taking, no operative procedure, and no prescribed treatment to confirm his provisional diagnosis. What Dr NG did on a number of occasions was simply mainly to adjust the occlusion of the bridge. This suggested that Dr NG believed that adjustment to occlusion would solve the problem of postoperative sensitivity despite the sensitivity or discomfort persisted.

The Council was satisfied that Dr NG had failed to make appropriate diagnosis for the postoperative sensitivity or discomfort. The conduct of Dr NG had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr NG guilty of charge (ii).

Charge (iii)

As stated above, which was confirmed by the clinical record, Dr NG had only made adjustment to the occlusion of the bridge despite the Patient's repeated complaint of post-operative sensitivity or discomfort. Dr NG had also suggested the use of night guard on 30 September 2020. These were all the Council could see from his clinical record as long as what actions were taken by Dr NG. Adjustment to occlusion and the suggestion of using night guard were therefore Dr NG's plan of actions, but despite the adjustment of occlusion, seemingly the sensitivity and discomfort were not relieved.

The Council already found under Charge (ii) above that Dr NG had failed to make appropriate diagnosis for the post-operative sensitivity or discomfort. Without an appropriate diagnosis, it must follow that no proper action plan could be formulated. The Council was satisfied that Dr NG had failed to devise a proper plan of action for the postoperative sensitivity or discomfort. The conduct of Dr NG had seriously fallen below the standard expected amongst registered dentists. It would be reasonably regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr NG guilty of charge (iii).

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

(a) In respect of charge (i), that a warning letter be given to Dr NG.

(b) In respect of charges (ii) and (iii), that Dr NG be reprimanded.

(c) The orders in paragraphs (a) and (b) 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*