G.N. 4500

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 15 June 2022 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr TSANG Yik-tao ('Dr TSANG') (Registration No. D04053) guilty of the following charges:—

'In or about November 2017 to September 2020, he, being a registered dentist, disregarded his professional responsibility to adequately treat and care for his patient, Dr WONG Kit-ming ('the Patient'), or otherwise neglected his professional duties to the Patient in that, he:—

(i) failed to perform appropriate preoperative assessments prior to the orthodontic treatment for the Patient using clear aligners (ad modem Invisalign);

(ii) failed to diagnose for the unerupted supernumerary tooth in the Patient's upper maxillary anterior region, before embarking on the orthodontic treatment;

(iii) failed to provide treatment options for the unerupted supernumerary tooth in the Patient's upper maxillary anterior region, before embarking on the orthodontic treatment;

(iv) failed to inform or sufficiently inform the Patient of the treatment progress of the orthodontic treatment when fixed braces were applied; and

(v) failed to keep true and/or contemporaneous treatment records of the Patient;

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

On 28 November 2017, the Patient consulted Dr TSANG, requesting for orthodontic treatment for her malaligned teeth. The problems of crowding, upper midline shift to the right, and lip protrusion were identified. The initial treatment plan suggested by Dr TSANG was orthodontic treatment with extraction of teeth 24, 34 and 44 and using clear aligners (Invisalign). The Patient accepted the treatment plan. On 20 December 2017, orthodontic records were taken and sent to Invisalign. On the same date, the consent for Invisalign treatment was signed by the Patient. On 21 December 2017, two radiographs (i.e. orthopantomogram ('OPG') and lateral cephalogram) were taken.

On 13 February 2018, Dr TSANG sent to the Patient *via* email the clincheck video with a new treatment plan. Dr TSANG called the Patient and said the new treatment plan was non-extraction with interproximal reduction. The Patient accepted the new plan. Clear aligners treatment started on 28 February 2018 with 45 sets of aligners. The first phase of 45 sets of aligners finished on 17 April 2019. Intra-oral scanning of the dentition was done, and photos were taken for refinement treatment. On 29 May 2019, refinement stage aligners were given to the Patient. A new OPG radiograph was taken. Dr TSANG told the Patient that extraction of lower right wisdom tooth was required to provide space for refinement treatment. On 22 June 2019, the lower left and right wisdom teeth were extracted. Then a refinement treatment with clear aligners continued.

The Patient attended to six review appointments from 22 June 2019 to 13 March 2020. According to the Patient, Dr TSANG told her that the progress was good. However, she noticed that the clear aligners were not fitting well, and she expressed her concern to Dr TSANG. On 13 March 2020, the Patient asked Dr TSANG whether she could switch to fixed appliances treatment (i.e. fixed braces). Dr TSANG told her that three more months were required to finish the case if she switched to fixed braces. On 15 March 2020, the Patient contacted Dr TSANG's clinic *via* Whatsapp, informing the staff that she decided to switch to fixed braces. She also asked whether updated radiograph and dental models were required. The staff replied to her that according to Dr TSANG none was needed.

On 29 March 2020, fixed braces were fitted. The Patient noticed that her tooth alignment and occlusion were getting worse progressively, and her right upper incisors, premolars were bulging outward. The Patient expressed her concerns to Dr TSANG. Dr TSANG replied to her that it was just a problem of the bite and it would get better when the bite was corrected. On subsequent appointments, Dr TSANG told the Patient that the clear aligners treatment had caused some root problems in the lower teeth, and that was why Dr TSANG suggested to switch to fixed braces. The Patient attended the last adjustment appointment on 27 September 2020.

The Patient sought a second opinion from a Dr YEUNG, an orthodontist. According to the Patient, Dr YEUNG told her that there was a supernumerary tooth located in the maxillary incisor region from the pre-treatment radiographs taken on 21 December 2017. Dr YEUNG told her that the presence of the supernumerary tooth would cause the upper teeth to bulge out and the resorption of the incisors' roots, and the supernumerary tooth should be extracted prior to the orthodontic treatment. A Cone Beam Computed Tomography was taken. Root resorption of the upper central incisor was identified, and the roots of the upper right premolars were outside the cortical bone. The prognosis of the upper central incisor was compromised.

On 16 October 2020, the Patient contacted Dr TSANG's clinic and requested for all her dental records. On 3 November 2020, the records were provided to the Patient. On 18 December 2020, the Patient lodged a complaint with the Council against Dr TSANG.

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

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

Charge (i)

Pre-operative assessments would usually include detailed history taking, clinical examination, obtaining radiographic findings, and particularly important in the context of orthodontic treatment, the taking of models to assess and determine the treatment goals.

In this case, the record showed that these assessments had been done save for periodontal charting. Two radiographs (OPG and lateral cephalogram) were taken on 21 December 2017. At the inquiry, the pre-treatment radiograph OPG taken on 21 December 2017 was shown to the Council. There was a distinct radiopaque mass located at the middle-to-apical thirds region of teeth 11 and 12. The radiographic appearance was suggestive of an unerupted supernumerary tooth. A reasonable dentist would have been expected to recognize the abnormality and arrange suitable investigation. In view that there existed a radiopaque mass suggestive of an unerupted supernumerary tooth, this case warranted further investigation by means of additional radiographs, which was the appropriate preoperative assessment for the Patient, to confirm the exact location of a possible unerupted supernumerary tooth. The presence of an unerupted supernumerary tooth would be both an obstacle as well as a risk to the orthodontic treatment. However, additional radiographs were never considered by Dr TSANG.

The Council found that Dr TSANG had failed to perform appropriate pre-operative assessment prior to the orthodontic treatment for the Patient using clear aligners. The Council was satisfied that the conduct of Dr TSANG 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 TSANG guilty of charge (i).

Charge (ii)

Despite what Dr TSANG wrote in his clinical record that he had on 2 February 2018 discussed with the Patient about the removal of the unerupted supernumerary tooth, the Patient told the Council that Dr TSANG had never throughout the whole treatment period informed her of the existence of a supernumerary tooth.

If Dr TSANG was really aware of the presence of the unerupted supernumerary tooth, it was reasonable to expect that he should have taken further radiographs. The possible management was either to extract the supernumerary tooth or to accept its presence and to continually monitor it during the orthodontic treatment. However, there was no record showing that Dr TSANG had ever monitored it. This only showed that he was not aware of the unerupted supernumerary tooth. Dr TSANG's record on 2 February 2018 contained no details as to what was discussed about the removal of the supernumerary tooth. The Council did not believe that there was any such discussion.

Further, as said above, the presence of an unerupted supernumerary tooth was both an obstacle as well as a risk to orthodontic treatment. Such an obstacle as well as risk should be clearly explained to the Patient for the purpose of seeking informed consent. However, from the written consent form signed by the Patient on 20 December 2017, there was no mentioning at all

of the presence of the unerupted supernumerary tooth, not to mention any discussion about it to the whole treatment.

The Council found that Dr TSANG had failed to diagnose the unerupted supernumerary tooth before embarking on the orthodontic treatment. The Council was satisfied that the conduct of Dr TSANG 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 TSANG guilty of charge (ii).

Charge (iii)

The Council already found under charge (ii) above that Dr TSANG had failed to diagnose the unerupted supernumerary tooth. Without such diagnosis, it followed that there could not be any treatment options for the unerupted supernumerary tooth.

The Council found that Dr TSANG had failed to provide treatment options for the unerupted supernumerary tooth before embarking on the orthodontic treatment. The Council was satisfied that the conduct of Dr TSANG 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 TSANG guilty of charge (iii).

Charge (iv)

Treatment progress in orthodontics included tooth movement (i.e. whether the teeth have moved to the desired position) and the associated changes of dental and related tissues.

When fixed braces were applied on 29 March 2020, Dr TSANG should have at least explained to the Patient about the progress of tooth movement and the control of root torque as previously planned. However, there was no such record. There was also no record that Dr TSANG had explained to the Patient about the updated risk of the presence of the unerupted supernumerary tooth. This further supported the Council's finding above that Dr TSANG had failed to diagnose the unerupted supernumerary tooth.

The Council was satisfied that Dr TSANG had failed to inform or sufficiently inform the Patient of the treatment progress when fixed braces were applied. The Council was satisfied that the conduct of Dr TSANG 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 TSANG guilty of charge (iv).

Charge (v)

Dr TSANG's record was a text record. It was not the usual kind of handwritten record or record generated from clinical software. The truthfulness of a treatment record was of paramount importance to the well-being of the patient and to the public confidence in the dental profession. Any deliberate action to insert false information in the treatment record bore serious consequences.

As stated above, the Council did not believe that there was any discussion of the removal of the supernumerary tooth on 2 February 2018. The Council did not believe the record that there was such discussion was true. Further, according to Dr TSANG's Orthodontic Treatment Report: Pretreatment dated 20 December 2017, Dr TSANG stated that the OPG and lateral cephalogram radiographs were taken on 20 December 2017 and he also stated what he saw from the radiographs. However, from the copy of the OPG and lateral cephalogram radiographs provided by the Patient, the date printed on them was clearly 21 December 2017. It was logically impossible that Dr TSANG could have viewed the radiographs on 20 December 2017 when in fact they were not even taken. In any event, Dr TSANG admitted that he had failed to keep true and/or contemporaneous records.

The Council found that Dr TSANG had failed to keep true and/or contemporaneous treatment records of the Patient. The Council was satisfied that the conduct of Dr TSANG 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 TSANG guilty of charge (v).

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

(a) In respect of charges (i) to (iv), that the name of Dr TSANG be removed from the General Register for a period of three months;

(b) In respect of charge (v), that the name of Dr TSANG be removed from the General Register for a period of three months;

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

(d) The orders in paragraphs (a) to (c) 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*