G.N. 719

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 2 December 2021 in accordance with section 18 of the Dentists Registration Ordinance, Chapter 156 of the Laws of Hong Kong, found Dr HUI Tak-leung ('Dr HUI') (Registration No. D03080) guilty of the following charge:—

'In and about March 2020, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient, Mr MOU Man-chi ('the Patient') or otherwise neglected your professional duties to the Patient in that, you failed to carry out appropriate and/or sufficient examination(s) and/or assessment(s) before performing the extraction of the lower left last molar (tooth situated at around 37–38 position) on the Patient; and that in relation to the facts alleged you have been guilty of unprofessional conduct.'

On 16 March 2020 at around 1800 hours, the Patient attended Dr HUI's clinic for consultation and presented with pain at lower left last molar. Dr HUI said he extracted the left third molar (38) on the same day under local anaesthesia due to gross caries. Dr HUI prescribed a 3-day course of Ponstan, a non steroidal anti-inflammatory drug as post-operative analgesics. That night since 1930 to until 2130 hours, the Patient developed chill and trembling. Post-operatively, the Patient developed gradual increase of facial swelling and persistent pain despite taking the analgesics prescribed by Dr HUI.

On 20 March 2020, the Patient attended Dr HUI's clinic with a chief complaint of pain at 38 tooth extraction wound. Dr HUI applied dry socket paste to 38 socket for the pain and prescribed a 5-day course of analgesic (Ponstan) as well as antibiotics (amoxicillin 250mg three times a day). The symptoms did not improve and the Patient returned to Dr HUI's clinic on 21 March 2020. Dr HUI informed the Patient that the symptoms might be due to the buccal caries of the upper left first premolar (tooth 24). Dr HUI applied socket paste to 38 wound and warned the Patient of the possibility of extraction of tooth 24. The Patient presented with further pain and facial swelling on 22 March 2020 and visited the Accident and Emergency Department at Kwong Wah Hospital in the evening. He was advised to seek treatment at dental clinic the next day.

On 23 March 2020, the Patient saw another general dental practitioner, a Dr SAM, with the chief complaint of intense pain and swelling on his lower left face. On physical examination, the lower left face was swollen, firm and tender. The swelling extended to the lower border of the mandible. There were pus and exudates from the tooth 38 socket. A panoramic radiograph was taken and a retained root at the left mandible was found. The Patient was prescribed with antibiotics. The Patient was referred to see a Dr TSUI, specialist in Oral and Maxillofacial Surgery, on the same day. The Patient attended Dr TSUI's clinic on 23 March 2020. The Patient reported to Dr TSUI that a lower left molar was extracted on 16 March 2020 after a few months of pain. The Patient presented with facial swelling on the left mandibular angle and chin region with no fluctuation. There were severe trismus and slight purulent exudate found in the 38 socket. Dr TSUI prescribed antibiotics, which included a 7-day course of Augmentin 625mg three times a day and a 5-day course of Metronidazole 400mg three times a day.

On 24 March 2020 morning, the Patient's condition further deteriorated and was admitted to the Department of General Surgery *via* the Accident and Emergency Department of Queen Elizabeth Hospital for facial swelling and fever. The Patient had past medical history of diabetes, hypertension, hyperlipidemia and acid reflux. Emergency operation was performed subsequently for incision and drainage. Intraoperatively, left facial abscess overlying parotid gland which extended to zygomatic arch superiorly, pre-auricular space posteriorly and the inferior border of the mandible inferiorly.

On 10 April 2020, the Patient's son lodged a complaint against Dr HUI to the Council.

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

Dr HUI did not contest the charge but it remained for the Council to consider and determine on the evidence whether he had been guilty of unprofessional conduct. Examination and assessment of the patient's conditions were the hallmarks of the diagnosis and treatment planning process. Failure to carry out examination and assessment in an appropriate and sufficient manner

would not be in the best interest of the patient as other factors might not have been considered. According to Dr HUI's clinical record, there was no written entry at all about the medical history of the Patient. This was an essential part of the assessment before any clinical examination was carried out. In this case, the Patient had a medical history of diabetes, which made him more susceptible to post-operative infection.

A panoramic radiograph was subsequently taken by Dr SAM on 23 March 2020 ('the Radiograph') from which a retained root was found in the 37–38 region. The Council however agreed with Dr CHOI, the Secretary's expert, that given (i) the tooth being extracted by Dr HUI was the last tooth present at the lower left quadrant; and (ii) although the extraction site was labeled by Dr HUI as tooth 38, there was no record indicating if tooth 38 was mesially tilted or not, whether the retained root belonged to the tooth being extracted by Dr HUI would become questionable. The Council could not therefore establish if the retained root found from the Radiograph at 37–38 region was a result of the extraction of tooth 38 which was a fractured part or it was a retained root already left in that area before the extraction. Having said that, the Council however took the view that the subsequent infection caused to the Patient arose from the extraction of the last molar in the lower left quadrant, which was mentioned as tooth 38 by Dr HUI. In this particular case, given that there were so many uncertainties, a pre-operative radiograph was therefore essential. In the Council's view, the omission in this case to take a pre-operative x-ray was an elemental and grievous failure.

In view of the above, the Council was satisfied that the conduct of Dr HUI had seriously fallen below the standard expected amongst registered dentists. It would be regarded as disgraceful and dishonourable by registered dentists of good repute and competency.

The Council therefore found Dr HUI guilty of the charge.

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

(a) Dr HUI be reprimanded; and

(b) The order 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*