香港牙醫管理委員會
The Dental Council of Hong Kong

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr NG Alice 吳芷茵牙科醫生 (Reg. No. D03912)

Date of hearing: 16 November 2023

Present at the hearing

Council Members: Dr CHEUNG Tat-leung (Temporary Chairman)
Dr KO Hay-ching, Brian
Dr LEUNG Kwok-ling, Ares
Dr WAI Tak-shun, Dustin

Legal Adviser: Mr Stanley NG

Legal representative for the Defendant: Mr Chris HOWSE, Messrs Howse Williams, Solicitors

Legal Officer representing the Secretary: Miss Sanyi SHUM, Senior Government Counsel

The Charges

1. The charges against the Defendant, Dr NG Alice, are as follows:-

"In or about August 2019, you, being a registered dentist, disregarded your professional responsibility to adequately treat and care for your patient, [redacted] ("the Patient") or otherwise neglected your professional duties to the Patient in that, you –

(i) failed to exercise proper and/or adequate care to avoid causing injuries to the Patient's lower lip and/or its vicinity during the removal of the Patient's wisdom tooth;

(ii) failed to sufficiently and/or duly inform the Patient of the severity of the injuries to her lower lip and/or its vicinity; and/or

(iii) failed to provide prompt and/or adequate wound care to the Patient's lower lip and/or its vicinity;

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

Burden and Standard of Proof

2. The Council bears in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove her innocence. The Council also bears in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

3. There is no doubt that the allegations against the Defendant here are serious. Indeed, it is always a serious matter to accuse a registered dentist of unprofessional conduct. Therefore, we need to look at all the evidence and to consider and determine each of the disciplinary charges against her separately and carefully.

Unprofessional Conduct

4. According to section 18(2) of the Dentists Registration Ordinance, Cap. 156 ("DRO"), "unprofessional conduct" means an act or omission of a registered dentist which would be reasonably regarded as disgraceful or dishonourable by registered dentists of good repute and competency.

Facts of the Case

5. The name of the Defendant has been included in the General Register ("GR") since 13 July 2011. Her name has never been included in the Specialist Register.

6. On 9 August 2019, the Patient attended the Defendant's clinic ("the Clinic") with her parents. An orthopantogram ("OPG") was taken. The Defendant reviewed the OPG with the Patient and her parents. The Defendant noted that teeth 38 and 48 were horizontally impacted. The Defendant suggested the extraction of teeth 38 and 48.

7. Later that day at around 5 p.m., the Patient attended the Clinic for extraction of tooth 38. Local anaesthesia was injected on the lower left side of the Patient's gum. The Patient said that throughout the procedure, she had her eye mask on and was not aware what tool(s) or equipment were used by the Defendant. She said she was able to feel equipment being placed on and touching her left lower lip area and the lower left of her face. The Patient felt mild pain at her left lower lip area and the lower left of her face, but did not feel any heat from the equipment. The Patient said she had informed the Defendant that she had felt mild pain. The Defendant asked her if it was very painful. The Patient told her that the pain was still tolerable and the Defendant continued with the extraction.

8. Upon conclusion of the extraction, the Defendant informed the Patient that the extraction was successful. The Patient was given a mirror to check her appearance. The Patient then noticed that her lower left lip and adjacent skin surface exhibited a burnt wound. The Defendant applied certain ointment on the wound, and placed a gauze to cover the wound. The Patient said the Defendant had not prescribed medication to her to apply to the wound.

9. On the night of 9 August 2019, after the anaesthetic effect wore off, the Patient suffered painful and swollen lip and face. Her parents removed the gauze and the wound was bleeding and had yellowish discharge.

10. On 10 August 2019, the Patient's father contacted the Defendant and was informed by the Defendant that the wound was caused by a hot instrument. The Patient then consulted Accident and Emergency Department of Union Hospital, and was referred to see Plastic Surgeon.

11. On 12 August 2019, the Patient consulted Dr OR, a Plastic Surgeon, who provided wound care and scar treatment with silicone gel. There were several follow-up appointments until 10 February 2020.

12. Between 18 April 2020 to 29 August 2020, the Patient consulted Dr YING, another Plastic Surgeon, and was given four sessions of steroid injection treatment.

13. According to the medical report of Dr YING dated 15 September 2020, regarding prognosis, (i) the scar was permanent; (ii) although treatment with steroid injection could improve it to certain degree, complete resolution of scar was unlikely; and (iii) even if the Patient chose to have scar revision, a permanent surgical scar would be visible.

14. On 6 May 2021, the Patient lodged a complaint against the Defendant with the Dental Council.

Findings of Council

15. The Defendant admitted the factual particulars of the charges against her. However, it remains for us to consider and determine whether in respect of each of the charges the Defendant was guilty of unprofessional conduct.

16. According to the Defendant's Supplemental Dental Report dated 23 May 2022 ("Supplemental Dental Report") attached to her Solicitors' submission to the Preliminary Investigation Committee ("PIC") dated 24 June 2022, she was using an implant motor called Nobel Biocare Osseoset 100 ("Osseoset 100") during the wisdom tooth extraction. The Defendant said there was no overheating in the parts of the Osseoset 100 that was in contact with her hands nor strange noise which would have prompted her to consider whether there was any problem with Osseoset 100. There did not appear any error message indicating that the motor temperature of Osseset 100 was too high. In other words, the Osseoset 100 the Defendant was using was not faulty and there was no signs of overheat of the handpiece during the procedure.

17. We agree with the Secretary's expert that burn injuries to the lip and its vicinity are rare during surgical removal of lower impacted wisdom teeth. There can be several possibilities, which led to burn injuries in the present case. First, the surgical drill could be defective, but this possibility was already ruled out for reason stated in paragraph 16 above. Second, the Defendant might not have prepared the drill well as, for example, the chuck holding the bur was not tightened. When the bur was put into full speed rotation, even slightly loose connection would lead to friction and the bur shaft would be overheated. The situation would become worse if there was not enough water irrigation as coolant. Third, faulty technique during the surgery as, for example, the failure to ensure proper and adequate retraction of soft tissue might lead to lip and cheek tissue entrapment and the rotating bur shaft could cause abrasion/burnt injuries to the lip, cheek or even angle of mouth. Certain

instruments could be used to facilitate retraction of lip and its vicinity. Fourth, there was the possibility of slip of hand by the operator while the bur was still running, when passing the lip and angle of mouth.

18. According to Dr OR, who had examined the Patient's injury on 12 August 2019, the wound was found to be at the left side of the Patient's lower lip, which was extended from skin to the oral mucosa. The wound was measured to have 20 mm x 5 mm at the skin side and 20 mm x 10 mm at the mucosal side and deemed to be compatible with one after burn injury.

19. According to the Secretary's expert, from the photo of the wound taken on Day 1 (9 August 2019), the size of the wound inflicted was akin to the size that Dr OR described or even bigger. The skin wound looked like at least 20 mm in length and wider in width. With respect to wound size and severity, it was serious as the depth of vermillion border and the skin wound were likely down the dermis and healing might result in scarring. We agree with the Secretary's expert that, judging from the shape of the wound, it was likely caused by the revolving shaft of a running bur, which trapped the vermillion border tissue during the course of the surgical procedure. It was likely because retraction of the soft tissue of the corner of the mouth was inadequate or improper, and lip tissue might somehow be sucked in and trapped while the revolving shaft of the bur caused abrasion and burnt injury to the vermillion border and the adjacent skin. A proper retraction could have prevented injuries to the skin and oral tissues even if it was the case of instrument malfunction.

20. We are satisfied that the Defendant had failed to exercise proper and/or adequate care to avoid causing injuries to the Patient's lower lip and/or its vicinity during the removal of the Patient's wisdom tooth 38. The Defendant's conduct 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. We therefore find the Defendant guilty of charge (i).

21. According to the Defendant's Dental Report dated 27 October 2020 and her Supplemental Dental Report, the Defendant said she did notice a pale, oval-shaped wound in the left corner of the Patient's mouth during the extraction procedure. The Defendant said she used Vaseline to dress the wound and proceeded to continue the surgery which took about 30 minutes to finish. The Defendant said that she did not think the injury was too serious because the wound measured approximately 10 mm in length and 2 mm in width, i.e. it was relatively small and there was no bleeding. Upon conclusion of the procedure, the Defendant said she reviewed the wound again and found no deterioration in size and appearance and remained of the view that the wound was not serious. Despite what the Defendant alleged, there was no contemporaneous handwritten dental record of the size of wound, dressing of Vaseline or the issuing of dressing medication. As stated in paragraph 19 above, we agree with the Secretary's expert on his opinion regarding the size and severity of the wound on Day 1 (9 August 2019). The wound was much bigger in size and much serious than what the Defendant described. Even if we accept what the Defendant wrote in her computer-generated day sheet that she recognized the wound as a burn wound, in our view, the assessment of a burn wound cannot be based on its initial appearance or size. We therefore cannot accept what the Defendant said that the wound was not serious on 9 August 2019.

22. The Patient said that upon completion of the surgery the Defendant did not give explanation of the reason and cause of the injury. The Patient also said the Defendant did not mention to her about severity of the wound or the risk of wound infection, nor did the Defendant mention to her how long it would take the wound to heal. The Patient also said the Defendant did not refer to the wound as a wound or an injury, but simply called it as "redness and swelling" ("紅

腫"). Clearly, in our view, the Defendant underestimated or downplayed the severity of the wound.

23. We are satisfied that the Defendant had failed to sufficiently and/or duly inform the Patient of the severity of the injuries to her lower lip and/or its vicinity. The Defendant's conduct 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. We therefore find the Defendant guilty of charge (ii).

24. According to the Patient, the Defendant did not give her any proper instructions with respect to wound care about the lip and its vicinity, and did not even inform the Patient's mother about the wound in the waiting area in the Clinic. The Patient said the Defendant did not prescribe her medication to apply to the wound. The Patient also said apart from mentioning that she could apply Vaseline herself later, the Defendant did not say how she could take care of the wound. The Defendant did not mention she could keep the wound moist and undisturbed. The Defendant did not suggest she should follow up on the wound with other doctors. We are satisfied that the Defendant had failed to provide prompt and/or adequate wound care to the Patient's lower lip and/or its vicinity. The Defendant's conduct 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. We therefore find the Defendant guilty of charge (iii).

Sentencing

25. The Defendant has no previous disciplinary record.

26. We bear in mind that the purpose of a disciplinary order is not to punish the Defendant, but to protect the public and maintain public confidence in the dental profession.

27. The Defendant does not contest the charges at today's inquiry. We will give the Defendant credit for her admission and not contesting unprofessional conduct.

28. We give credit to the community work and voluntary dental work undertaken by the Defendant.

29. We give credit to the course undertaken by the Defendant on burn injury management.

30. We also give credit to the reference letters as submitted.

31. We accept that the Defendant is remorseful and the risk of re-offending is low.

32. Having regard to the gravity of the case and the mitigation submitted by the Defendant, the Council makes a global order in respect of charges (i), (ii) and (iii) that the Defendant be reprimanded. Our order shall be published in the gazette.

Dr CHEUNG Tat-leung
Temporary Chairman
The Dental Council of Hong Kong