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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr LAM Kam-yui, Joseph 林錦銳牙科醫生 (Reg. No. D03868)

Date of Hearing: 26 May 2025

Present at the Hearing

Council Members: Dr HSE Mei-yin, Kitty, JP (Temporary Chairperson)
Dr LIU Wai-ming, Haston
Dr WAI Tak-shun, Dustin
Prof CHAN Hon-wai, Felix, JP
Ms CHOY Hok-man, Constance

Legal Adviser: Mr Stanley NG

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

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

The Charges

1. The Defendant, Dr LAM Kam-yui, Joseph is charged that:-

"On or about 2 August 2022, 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 take basic or adequate precautions to prevent injury to the Patient's lip and face during surgical removal of the lower right third molar; and/or

(ii) failed to make necessary or appropriate referral for the management of the burn to the Patient's lip and corner of mouth;

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

Facts of the Case

2. The name of the Defendant has been included in the General Register since 28 July 2010. His name has never been included in the Specialist Register.

3. At around 3 p.m. on 2 August 2022, the Patient attended the Defendant's clinic for surgical extraction of his partially erupted impacted lower right wisdom tooth (48) and simple extraction of the fully erupted upper right wisdom tooth (18).

4. After injection of local anesthetics, the Patient felt numbness on right side of his face. The Defendant then started the surgical extraction of tooth 48 ("the Procedure"). The Patient said that during the Procedure, he felt strong pulling on the right corner of his mouth, which lasted for at least five minutes.

5. When the Procedure was almost completed, the Defendant said he noted that there was some peeling of skin in the right corner of the Patient's mouth.

6. After completion of the Procedure, the Defendant applied Vaseline to the injury site.

7. The Defendant then proceeded to extraction of tooth 18. When completed, the Defendant told the Patient to sit up and was given a mirror. The Patient was shocked to see that the right corner of his mouth and lip had an indentation. The Defendant explained to the Patient that the injury was a burn injury and it could have been caused by the surgical handpiece, which overheated during the Procedure. The Defendant also said that according to his experience, the wound would completely heal in about two to three weeks.

8. The Defendant then told the Patient to leave the consultation room and said he would offer him a discount for the extractions and five days of sick leave. The Patient said that apart from applying Vaseline on the wound, the Defendant and his nurse did not give him any immediate wound care. There was no external dressing to cover the wound, and the Patient only used his face mask to cover it. The Defendant later prescribed the Patient with Acroxia, Paracetamol, Amoxicillin and Chlorhexidine mouthwash.

9. The Patient said he had asked the Defendant for a referral letter to a specialist in Dermatology or in some other relevant areas, but was not given any.

10. At around 5 p.m., the Patient left the Defendant's clinic. There was a specialist in Dermatology, a Dr YU, nearby. The Patient went directly to consult Dr YU.

11. After examination, Dr YU arrived at the diagnosis of second degree burn with blister and erosion on the Patient's right lower lip and right angle of jaw.

12. At around 11:30 p.m. on the same day, the Patient attended the Accident and Emergency ("A&E") Department of Ruttonjee & Tang Shiu Kin Hospitals. A doctor in A&E Department recorded as follows: "...right corner of mouth, face and buccal mucosa second degree burn injury...", "... Reason of Referral: right lower lip and facial burn ...", "...attended dentist for teeth extraction; R corner of mouth burn injury by pressure of hot handle of equipment (?drill); no pain due to LA, only told by dentist after procedure; mucosal injury + blister + lip wound + swelling + ..."; "...P/E see clinical photos in patient album; right lower lip 1cm x 1cm defect at corner of mouth, depth down to vermillion border; skin burn & erythaema +; right buccal mucosal ruptured blisters...". The Patient was then referred to see the Plastic and Reconstructive Surgery in Queen Mary Hospital ("QMH").

13. On 3 August 2022, the Patient was followed up by the Defendant through the clinic manager, who called the Patient in the morning with the intention to arrange the Patient to consult a specialist in Dermatology promptly. On the same day, the Patient was also followed up by Dr YU and further dressing was performed. It was found that there was a grey necrotic area, which was painless and suggestive of third degree burn. Dr YU furnished a referral letter for the Patient to seek consultation from a Dr CHAN, a Specialist in Plastic Surgery. Dr CHAN gave the opinion that it would take some time to monitor progress of the injury site to see whether any surgery should be performed.

14. On 4 and 5 August, 2022, the Defendant continued to follow up with the Patient through telephone. The Patient did not attend the Defendant for suture removal appointment on 8 August 2022.

15. On 13 August 2022, Dr CHAN suggested surgery to facilitate wound healing. On 16 August 2022, the Patient consulted a Dr LAU, a Plastic Surgeon, who then performed wound debridement and wound closure with sutures under general anesthesia at Matilda International Hospital on 23 August 2022. The Patient was discharged from hospital on 25 August 2022.

16. By a statutory declaration made on 17 January 2023, the Patient lodged a complaint against the Defendant with the Dental Council of Hong Kong ("the Council"). A number of photos showing the Patient's facial injury were enclosed in the statutory declaration.

Burden and Standard of Proof

17. We bear in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. We also bear 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.

18. 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 the disciplinary charges against him separately and carefully.

Unprofessional Conduct

19. According to section 2 of the Dentists Registration Ordinance, Cap. 156, "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.

Findings of Council

20. The Defendant admits to the facts of the charges. However, it remains for us to consider and determine whether he is guilty of unprofessional conduct.

21. From the photo dated 2 August 2022 of the Defendant's dental record, the injury site was an oval shaped wound at the right corner of the mouth near the end of the lower right vermillion

border extending to the adjacent skin of the face. The vermillion/mesial end of the wound was quite deep, presented as a notch/indentation with loss of nearly the whole thickness of normal vermillion tissue involving at least the epidermis and dermis, while the distal end of the wound was much shallower and likely just involving the epidermis.

22. The photo dated 3 August 2022 showed an area of tissue necrosis with black colour and Dr YU classified the wound to be one of third degree burn. We agree with the Secretary's expert that a third degree burn will leave scar and may cause loss of function and/or sensation. It does not heal by primary intention and needs surgical treatment like scar excision or skin graft.

23. From the photo taken on 5 August 2022, it showed that the necrosis area seemed to get enlarged. The photo taken on 23 August 2022 showed no healing after the superficial necrotic area had been sloughed off. The photo taken on 24 August 2022 showed suturing of the wound, which had become a linear scar, with further healing shown by another photo taken on 5 September 2022.

24. According to the Secretary's expert, there could be several possibilities which could lead to the burn incident. First, the surgical drill system could be defective and thus overheated. Second, the chuck holding the bur might not be fully tightened. When the bur was put into full 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. As wisdom teeth are located at the back of the upper and lower jaw, lip and vicinity must be properly retracted to gain access to the wisdom teeth area to complete the procedure of extraction. Failure to ensure proper and adequate retraction of soft tissue might lead to lip and cheek entrapment and the rotating bur shaft could cause abrasion or burn injuries to the lip, cheek or even angle of mouth. Very often, the Bowdler Henry retractor is used to retract mucoperiosteal flap in the lower wisdom tooth area to expose the tooth and adjacent bone and it also helps to retract the lip. During surgical procedure of removal of lower impacted wisdom tooth, the dentist will hold the handpiece with one hand while the other hand will hold the Bowdler Henry retractor. The Bowdler Henry retractor has serrated edge at tip for promoting flap retraction while resting on sound bone stability and slender shaft for deep surgical access. However, the narrow shaft end outside the mouth will only protect a small area of the corner of the mouth and the adjacent skin. Additional retraction of the lip and its vicinity by a dental mirror or other retractors should be used to facilitate portal of access and prevent soft tissue entrapment during the surgical procedure. Therefore, if the bur shank or the handpiece is overheated or the buccal soft tissue of the cheek is not retracted properly by other instruments like a mouth mirror or other cheek retractors, burn/abrasion injury to the cheek or angle of mouth by overheated handpiece or rotating bur head or shank will be inflicted upon intraoral buccal cheek mucosa or even the extraoral tissues near the angle of the mouth.

25. In the present case, there is no dispute that the wound was a result of burn injury by an overheated handpiece. The Defendant's dental record on 2 August 2022 recorded the following: "R lip corner and skin nearby were injured during surgery (likely due to heat generated from handpiece)."

26. We agree with the Secretary expert that the Defendant had the responsibility to avoid overheating of surgical instruments or to ensure adequate soft tissue retraction to prevent injury to intraoral or extraoral structures during the Procedure. During the Procedure, the Defendant should be vigilant to any overheating of the handpiece or any abnormal vibration or noise from the bur shank after the bur had been running for some time. Should any abnormal situations arise, he should immediately stop the Procedure. However, the Defendant seemed to be unaware of overheating of the handpiece not until injuries had been inflicted upon the Patient.

If the Defendant had been vigilant to overheating of the handpiece or had he performed adequate soft tissue retraction, such mishap of burn injury on the Patient could be prevented.

27. We are satisfied that the conduct of the Defendant 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).

28. We take the view that it would be preferable to give specific advice to the Patient (e.g. attending 24-hour outpatient clinic) in case there was deterioration of the injured site on the same day of the incident. The Defendant had however given post-operative instructions to the Patient on wound care. The Defendant's dental record of 4 August 2022 also shows that the Defendant intended to make referral for the Patient to consult a Specialist in Dermatology the day after the incident. In fact, the Defendant's clinic nurse had called the Patient the next day, intending to refer him to consult Dr YU. We do not think the Defendant had failed to make necessary or appropriate referral for the management of the burn to the Patient's lip and corner of mouth. We will therefore acquit the Defendant of charge (ii).

Sentencing

29. The Defendant has no previous disciplinary record.

30. The Defendant does not contest the charges at today's inquiry. We will give the Defendant credit for his admission.

31. 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.

32. We have considered the character reference letters as submitted and the charitable health talks given by the Defendant.

33. The Defendant told us that since the incident he has taken a number of remedial steps to prevent accidental injury during minor oral surgery. To prevent handpiece related complications, the Defendant had promptly motivated the management team of his clinic to raise staff's awareness about the issue of overheated handpieces and implement guidelines for proper handpiece maintenance. The Defendant had also attended a series of courses on handpieces maintenance, safe practice in minor oral surgery to prevent/manage accidental injury, burns management courses, etc. With these remedial steps in place, we are satisfied that the Defendant had insight into his wrongdoing, and the risk of re-offending is low.

34. The Defendant had forthwith apologized to the Patient and he had sent to the Patient an apology letter. The Defendant also submitted to us that he had fully compensated the Patient's expenses. We accept that the Defendant is remorseful.

35. Having regard to the nature and gravity of the case and the mitigation submitted by the Defendant, we order that in respect of charge(i), a warning letter to be served on the Defendant. We further order that our order shall be published in the Gazette.

Dr HSE Mei-yin, Kitty, JP
Temporary Chairperson
The Dental Council of Hong Kong