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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr PU Yucheng 蒲宇成牙科醫生 (Reg. No. D03913)

Date of Hearing: 18 September 2025

Present at the Hearing

Council Members: Dr LEE Kin-man, Raymond, MH, JP (Chairperson)
Dr HSE Mei-yin, Kitty, JP
Dr WAI Tak-shun, Dustin
Dr KO Hay-ching, Brian
Prof. CHAN Hon-wai, Felix, JP

Legal Adviser: Mr Stanley NG

Legal Representative for the Defendant: Ms Maureen LIU, Messrs. Howse Williams, Solicitors

Legal Officer representing the Secretary: Mr Edward CHIK, Senior Government Counsel

The Charge

1. The Defendant, Dr PU Yucheng, is charged that:-

"In or about 2021, you, being a registered dentist, disregarded your professional responsibilities to adequately treat and care for your patient, [redacted] ("the Patient") in that in respect of the implant treatment at tooth site 37 of the Patient, when performing the treatment, you failed to competently perform the treatment, which caused nerve injury to the Patient. In relation to the facts alleged, 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 13 July 2011. His name has never been included in the Specialist Register.

3. On 18 March 2021, the Patient attended the Defendant's clinic for consultation of replacement of her missing teeth 17, 16, 13-22, 36-38, 46 and 47. The Defendant performed intra-oral

examination, took clinical photos and pre-operative Cone Beam Computed Tomography (CBCT) scan and prepared study casts.

4. On 25 March 2021, the Defendant explained and discussed various treatment options with the Patient. The Patient agreed to have implant treatment at teeth 26, 36, 37 and 46 with/without simultaneous guided bone regeneration and implant-supported prosthesis.

5. On 7 August 2021, the Defendant performed the implant surgery under local anaesthesia ("LA") on 26 with insertion of a dental implant fixture with raising a mucoperiosteal flap. He then raised a mucoperiosteal flap at lower left quadrant (Q3) and prepared the implant insertion beds at 36, 37 sites under LA. After raising a full thickness flap, the Defendant performed osteotomies guided by the prosthetic guide (the suck-down splint) he had prepared before. For 36, he used a gauge to measure the preparation depth of 7 mm with reference to the buccal margin. For 37, he also measured the preparation depth of 7 mm with reference to the buccal margin. After enlarging the sites with three to four twist drills with different diameters, he used a screw tap drill to finally prepare the implant sites at 36 and 37. He then inserted a dental implant fixture measuring 4.3 mm in diameter x 7 mm in length to 36 and another one measuring 5 mm in diameter x 7 mm in length to 37. Healing abutments were then connected.

6. The Defendant then took a post-operative CBCT. He then discharged the Patient with antibiotics, analgesics and mouthrinse. On the same evening, the Patient contacted the Defendant and complained of numbness at the surgical area and at the corner of her mouth. A follow-up appointment on the next day was arranged.

7. On 8 August 2021, the Patient complained persistent numbness on the teeth and gingivae in Q3 as well as on the lower left lip and chin. The Defendant marked the affected area and took clinical photos for the Patient. The Defendant studied the post-operative CBCT and thought that the numbness could be due to bleeding from the implant osteotomy site, which created pressure on the nerve, thus suggested that the numbness probably was transient. The Defendant prescribed a non-steroidal anti-inflammatory drug, Arcoxia 120mg, to the Patient, and advised her to return for review on the next day.

8. On 9 August 2021, the Patient informed the Defendant that there was no improvement of the numbness. The Defendant reviewed the post-operative CBCT again and noticed that the osteotomy might have been too deep. The Defendant then removed the implant fixture at 37 and referred the Patient to a Dr E HUI ("Dr E HUI"), a specialist in Oral & Maxillofacial Surgery for further evaluation and management of the numbness.

9. On 14 August 2021, Dr E HUI saw the Patient, and once every month from September 2021 to April 2022. Dr E HUI reported that there was initial rapid improvement of the numbness in the first 2 months during this 8-month follow up period. However, there was no significant further improvement since then.

10. On 25 August 2021, the Patient sought a second opinion from another specialist in Oral & Maxillofacial Surgery, a Dr A HUI ("Dr A HUI"). In his medical report dated 17 December 2021, Dr A HUI stated the following: " ... *On examination, there nerve sensitivity test shown almost anesthesia left lower lip, chin and mucosa of left mandible. On CT Scan examination, there was a radioluence drill hole (previous implant site 37) and was closed to Inferior alveolar nerve (ID Nerve)...* " The Patient was reviewed again by Dr A HUI on 6 November 2021.

11. The Patient also went for acupuncture treatment. From 12 October 2021 to 28 December 2021, the Patient had received 22 sessions of acupuncture treatment. Her numbness did not improve. She complained of abnormal sensation i.e. hyperesthesia to hot and cold water.

12. On 8 February 2022, the Patient lodged a complaint against the Defendant with the Dental Council of Hong Kong.

Burden and Standard of Proof

13. 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.

14. There is no doubt that the allegation against the Defendant here is 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 charge against him carefully.

Unprofessional Conduct

15. According to section 2 of the Dentists Registration Ordinance, Cap. 156, "unprofessional conduct", in relation to a person, means an act or omission of the person that would reasonably be regarded as disgraceful or dishonourable by registrants of good repute and competency.

Findings of Council

16. The Defendant admits to the facts alleged in the charge. However, it remains for us to consider and determine whether the Defendant is guilty of unprofessional conduct under the charge.

17. Dr CHOW Lop-keung Raymond ("Dr CHOW"), the Defendant's expert, in his expert report dated 16 June 2023, opined that *"[f]rom the immediate post-operative CBCT (dated 7 August 2021...) taken by Dr. PU, the implant was placed in the proper position, but the depth of preparation was too deep (exceeding the intended preparatory depth) and reached the ID canal ... It seems like the implant was not intruded into the ID canal but there was injury to the IDN as a result of Dr. PU's implant bed preparation."* Dr CHOW was of the view that the Defendant had failed to competently perform the implant treatment at tooth site 37, which caused nerve injury to the Patient.

18. Dr WONG Yiu-kai ("Dr WONG"), the Secretary's expert, agreed with the view of Dr CHOW. In his expert report dated 8 April 2025, Dr WONG opined that that the Defendant had over-prepared the implant site at 37 beyond the pre-planned length of 7 mm. The twist drill had intruded into the mandibular canal and the said intrusion had inflicted trauma to the Inferior Dental Nerve ("IDN"). The IDN could be crushed, entangled or even severed by the twist drill during the implant bed preparation, leading to the resultant numbness of the Patient's left lip, chin and gingivae.

19. We have carefully examined the image of the CBCT taken by the Defendant immediately following insertion of the implant fixtures at 36 and 37 sites on 7 August 2021. We agree with the views of both experts. It is obvious from the post-operative CBCT image that the apical part of the depth of the preparation bed of the fixture at 37 site had penetrated beyond the roof

of the mandibular canal in which the IDN is running. The preparation depth was around 3mm longer than the planned depth (7mm). A similar appearance of the preparation bed can be seen in the images of the CBCT taken by Dr A HUI on 25 August 2021. It is evident that the Defendant had over-prepared the implant site at 37 beyond the pre-planned length of 7mm, and the twist drill had intruded into the mandibular canal, inflicting trauma to the IDN, leading to the numbness caused to the Patient.

20. We agree with Dr WONG that there could be various reasons for the cause of such over-preparation. Whatever the reasons, it is the responsibility of the operator to ensure that the implant fixtures are properly placed to the planned site at the planned depth. In our view, the Defendant could have taken measures to ensure that the twist drill would not go beyond the planned depth, but he had not done so.

21. Further, routinely, after implant surgery, the operator should assess the result of the surgery from post-operative x-rays. In this case, the Defendant had taken post-operative CBCT. There is however no record on 7 August 2021 which shows that the Defendant took the view that he noticed on that day from the CBCT that the osteotomy might have been too deep. The Defendant only realized that the osteotomy might have been too deep on 9 August 2021. Had the Defendant competently reviewed the post-operative CBCT on 7 August 2021, he would have noticed that the osteotomy was drilled too deep, and he would have taken immediate measures to minimize the damage caused to the Patient, including considering to remove the fixture on the same day, informing the Patient, giving appropriate and proper advice to the Patient, and referring the Patient to a specialist as soon as possible. The Defendant's failure to find out on 7 August 2021 from the post-operative CBCT of such deficiencies again show his incompetency in performing the implant treatment to the Patient.

22. 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 as charged.

Sentencing

23. The Defendant has no previous disciplinary record.

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

25. 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.

26. We consider that the offence committed by the Defendant was serious. The Defendant's incompetence in this case had caused permanent nerve damage to the Patient.

27. We have considered the character reference letters as submitted and the CPD courses undertaken by the Defendant.

28. The Defendant told us that he believed the reason for the incident was likely because he was pressing too hard on the drill while drilling. The Defendant has since the incident taken remedial actions. The Defendant has purchased an implant surgery kit with drills with safety stopper. The Defendant also plans to invest on an implant navigation system in the future. We are

satisfied that the Defendant has insight into his wrongdoing and the likelihood of re-offending is low.

29. The Defendant told us that he had also reimbursed the Patient of some of the medical fees caused to the Patient arising out of the incident. We are satisfied that the Defendant is remorseful.

30. Having regard to the gravity of the case and the mitigation submitted by the Defendant, in respect of the charge, we make the order that the Defendant be reprimanded. Our order shall be published in the Gazette.

Remarks

31. We stress that the following remarks form no part of the decision on findings and sentencing above.

32. Implant treatment nowadays is a well-proven modality for missing tooth replacement and has to be well justified. It is technique-demanding and requires high level of precision. Its efficacy very much depends on carefulness in pre-operative assessment, carrying through the surgery, and post-operative maintenance. We are particularly concerned because any deficiency in performing the treatment might result in permanent damage to vital structures, including nerves, sinuses and blood vessels. We wish to take this opportunity to impress upon dental practitioners and the public that implant surgery is not a simple treatment. It must be carefully planned and performed. Patients should be sufficiently and appropriately informed and advised at all stages by the practitioners.

Dr LEE Kin-man, MH, JP
Chairperson
The Dental Council of Hong Kong