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

Disciplinary Inquiry under s.18 of DRO

Defendant: Dr WONG Hung-leung, Augustine 黃雄亮牙科醫生 (Reg. No. D01472)

Date of hearing: 2 July 2026

Present at the Hearing

Council Members: Dr LEE Kin-man, MH, JP (Chairperson)
Dr HSE Mei-yin, Kitty, JP
Dr YU Jerome
Dr ZHANG Chen
Ms CHOY Hok-man, Constance

Legal Adviser: Mr Stanley NG

Defendant: Represented by Mr Simon FUNG, Messrs. Howse Williams, Solicitors

Legal Officer representing the Secretary: Ms Molly WONG, Senior Government Counsel

The Charges

1. The charges against the Defendant, Dr WONG Hung-leung, Augustine, are as follows:-

"In or about July 2005 to October 2021, 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 keep proper and/or accurate treatment records of the Patient;

(ii) neglected or failed to manage the periodontal condition of the Patient;

(iii) failed to advise the Patient of the potential risks and/or complications of the implant treatment;

(iv) failed to identify or advise the Patient of the deteriorating periodontal support while providing dentures to the Patient; and/or

(v) failed to make timely referral for a second opinion on or management of the Patient's periodontal condition;

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 ("GR") since 18 May 1981. The name of the Defendant has never been included in the Specialist Register.

3. The Patient consulted the Defendant for the first time on 29 July 2005.

4. The Defendant treated the Patient over a period of time from July 2005 to October 2021, as follows:

29/7/2005	First consultation with the Defendant
4/8/2005	Treatment started with extraction of lower right first premolar (44)
29/8/2005	Placement of 2 implants at lower right posterior quadrant (44, 46)
29/12/2005	Extraction of upper right molars (16, 17)
3/1/2006 – 19/1/2006	Construction of implant-supported bridge at lower right posterior quadrant (implant bridge 44-46)
21/3/2006	Extraction of lower left premolars (34, 35)
24/4/2006	Placement of 2 implants at lower left posterior quadrant (34, 36)
1/8/2006-1/9/2006	Construction of implant-supported bridge at lower left posterior quadrant (implant bridge 34-36)
7/9/2006-12/10/2006	Root canal therapy of upper left first premolar (24) and restoration of 24
17/7/2007-26/7/2007	Extraction of upper right and upper left canines (13, 23) together with upper bridge and construction of upper temporary denture
21/8/2007 - 6/9/2007	Extraction of lower right and lower left incisors and canines (32, 33, 42, 43) together with the lower bridge and construction of lower temporary denture
13/9/2007	Placement of 4 implants at upper anterior region (12, 13, 22, 23)
1/11/2007	Placement of 4 implants at lower anterior region (31 33 41 43)
29/2/2008-18/3/2008	Construction of lower anterior implant-supported bridge (33-43)

18/4/2008-16/5/2008	Construction of upper anterior implant-supported bridge (13-23)
20/5/2008-10/6/2008	Root canal therapy of upper right first premolar (14) and restoration of 14
18/7/2008	Local scaling and medication
13/8/2009-21/8/2009	Construction of crown at upper left first premolar (24)
14/1/2011	Panoramic radiograph. Local scaling and medication
20/12/2011	Scaling and medication
22/2/2013-14/5/2013	Construction of splinted crowns at upper right premolars (14, 15)
9/7/2013	Sectioned implant-supported bridge at 44-46 and removal of 46 implant
15/10/2013	Extraction of upper left first molar (26)
22/10/2013	Scaling and polishing
28/11/2014	Scaling and polishing
13/1/2015-23/1/2015	Construction of new upper anterior implant-supported bridge 13-23
9/8/2016	Extraction of upper left premolars (24, 25)
30/8/2016	Placement of 2 implants at upper left posterior quadrant (24, 26)
13/12/2016-29/12/2016	Construction of implant-supported bridge at upper left quadrant (24-26)
6/1/2017	Scaling (bone loss at 43 implant was recorded in the record)
22/9/2017	Full mouth scaling and OHI and medication (moderate peri-implantitis was noted in the record and suggested 6 months review)
23/3/2018	Scaling and polishing and medication
22/6/2018	Extraction of upper right premolars (14, 15)
29/6/2018	Scaling and polishing
24/1/2019	Scaling and polishing
3/12/2019	Re-screw implant-supported crown at 44 and local scaling
6/12/2019-20/12/2019	Construction of new implant-supported crown at 44
3/8/2021	Loose lower anterior implant-supported bridge was recorded in the record

3/8/2021- 17/8/2021	Construction of lower acrylic denture
10/9/2021	Construction of lower implant-supported cobalt-chromium partial denture
28/10/2021	Scaling and polishing

5. On 25 June 2022, the Patient went to see a Dr IP ("Dr IP"), a registered dentist. The Patient was diagnosed to have severe peri-implant disease, and was referred to Periodontist, a Dr HO ("Dr HO"), for management of peri-implant disease.

6. According to a letter from Dr HO to Dr IP dated 10 January 2023, the Patient suffered from peri-implantitis affecting all implants in both upper and lower arches. From the radiographs taken by Dr HO, all the implants had bone loss equal to or more than 50% of implant length, while bone loss of 22 implants extended to apex. Dr HO considered that the prognosis of the implants in general was poor. The Patient was informed of the possibility of multiple loss of implants and complex oral rehabilitation might be required in future.

7. By a statutory declaration made on 12 January 2023, the Patient's daughter lodged a complaint against the Defendant with the Dental Council ("Council").

Burden and Standard of Proof

8. The Council bears in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his 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.

9. 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 him separately and carefully.

Unprofessional Conduct

10. 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

11. The Defendant admits the factual particulars of all the disciplinary charges against him but it remains for us to consider and determine on the evidence whether he has been guilty of unprofessional conduct.

Charge (i)

12. In the Defendant's clinical notes, there was no record of the Patient's chief complaint. There was no record of medical and dental history taking. There was no record showing proper clinical examination, diagnosis and treatment planning. The most basic and essential information including soft and hard tissue examination, charting, oral hygiene and periodontal status were not found. Proper treatment was not possible without such information.

13. The Defendant had only taken three panoramic radiographs. According to Dr WOO Mei-sum Becky ("Dr WOO"), the Secretary's expert, the first radiograph was undated and should be taken on or before 4 August 2005, before the extraction of the lower right first premolar. A second radiograph was taken on 14 January 2011, which should be taken after the construction of implant bridges at lower right and left posterior regions (2006), upper and lower anterior regions (2007), root canal treatment of upper right first premolar (2008) and construction of crown at upper left first premolar (2009). A third radiograph should be taken in 2021, after the loss of lower anterior implants with implant bridge.

14. There was however no radiograph showing the bone condition before placement of implants. There was also no radiograph showing the condition of the teeth before, during and after root canal treatment. There were no pre-operative radiographs before placement of implants at lower left posterior region and upper and lower anterior regions during various periods in April 2006, September 2007 and November 2007 respectively. For root canal treatment, periapical radiographs taken before, during and immediately after treatment are the standard of care. The Defendant did not take any peri-apical radiographs. Proper treatment and good treatment outcome were not possible without such information.

15. Apart from the first radiograph which was taken before any implant, there was no other record including charting and written notes concerning the Patient's pre-treatment periodontal condition. There was no record of the Patient's periodontal status during the treatment period from July 2005 to June 2018.

16. Further, according to the Defendant's record, tooth 34 was recorded to be extracted on 21 March 2006. However, tooth 34 was recorded to be extracted again on 28 August 2007. The Defendant's record was inaccurate.

17. We are satisfied that the Defendant had failed to keep proper and accurate treatment records of the Patient. 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 under charge (i).

Charge (ii)

18. The first radiograph, which was taken before any implant, showed that the Patient had lost all her upper incisors, all lower molars, lower central incisors and lower right second premolar. We agree with Dr WOO that the Patient might have severe periodontal disease that caused her multiple tooth loss.

19. From the first radiograph, according to Dr WOO, the Patient had generalized bone loss equal or greater than 50% of root length. There was also bone loss beyond apex of upper right first molar. Dr WOO opined, which we agree, that the Patient had periodontal risk.

20. From July 2005 to June 2008, the Defendant did not provide any kind of periodontal treatment including oral hygiene instruction ("OHI"), scaling or root debridement to the Patient.

21. The Defendant provided local scaling with medicament in July 2008 and January 2011, scaling with medicament in December 2011, scaling and polishing in October 2013 and November 2014, scaling in January 2017, full mouth scaling with OHI in September 2017, scaling and polishing in March 2018 and June 2018. However, there was no clinical record showing pre-operative, intra-operative and post-operative assessment of the Patient's periodontal status. Therefore, the outcomes of these treatments could not be known.

22. We are satisfied that the Defendant had neglected or failed to manage the periodontal condition of the Patient. 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 under charge (ii).

Charge (iii)

23. Before implant treatment, there was no record showing that the Defendant had assessed the oral hygiene status, periodontal condition and periodontal risk of the Patient. According to Dr WOO, smoking, diabetes mellitus, and history or presence of periodontitis are identified as risk factors of peri-implantitis.

24. There was no record about the Patient's medical and social histories, and there was no evidence showing that the Defendant had assessed the oral hygiene status, periodontal condition and periodontal risk of the Patient. The first radiograph clearly showed that the Patient had periodontal risks. However, the Defendant simply commenced implant treatment neglecting anything about the medical and periodontal condition of the Patient.

25. When the Defendant removed the loose implants at lower arch of the Patient, there was no evidence showing that he had assessed the condition of the remaining implants.

26. There is no evidence that the Defendant had identified the risks of the implant treatment. There is no evidence that the Defendant had advised the Patient about the risks and/or complications of the implants, including the biological complications i.e. peri-implantitis of implants.

27. We are satisfied that the Defendant had failed to advise the Patient of the potential risks and/or complications of the implant treatment. 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 under charge (iii).

Charge (iv)

28. At the time when the Defendant provided dentures to the Patient in 2021, the implant fixtures and the bridge were loose. There were already mobility problems.

29. We agree that the support at the time of providing dentures was deteriorating. However, since there were already no teeth left, we do not agree the wording of the charge that it can be termed as "periodontal support".

30. We will therefore acquit the Defendant of charge (iv).

Charges (v)

31. According to the first radiograph taken by the Defendant, the Patient had periodontal risk. Implant treatment should be done after the Patient's periodontal condition was stable. Therefore, the Defendant should either provide periodontal treatment to the Patient before implant treatment (if he could manage the Patient's periodontal disease) or he should refer the Patient to periodontist for management of her periodontal condition before implant treatment. However, neither was done.

32. For the whole treatment period, the Defendant failed to assess and monitor the periodontal condition of the Patient. The Defendant should have referred the Patient for the management of the periodontal condition before multiple extractions and placement of extensive implant supported prostheses, but he had failed to do so.

33. We are satisfied that the Defendant had failed to make a timely referral for a second opinion on or management of the Patient's periodontal condition. 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 (v).

Sentencing

34. We give credit to the Defendant's cooperation and admission to the facts of the charges.

35. The Defendant has one previous disciplinary record. In the previous Council's decision, the Council commented that the Defendant's dental record was "unusually scanty and inadequate", and "unacceptably inadequate". The offences in the present case covered a long period of time from July 2005 to October 2021, which involved multiple extractions, placement of extensive implant supported prostheses, and rehabilitation of the Patient's oral functions. It is expectant that the Defendant's clinical record should be proportionately adequate, covering clinical examination, diagnosis, treatment plan, treatment outcome and maintenance. However, the Defendant's clinical records over a long period of time in the case were grossly inadequate. We do not accept that the Defendant has learnt his lesson to improve his clinical record from the previous Council's decision.

36. 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.

37. We have considered the commendation letters and certificates of appreciation as submitted.

38. We have considered the Defendant's professional and volunteer contributions.

39. We have considered the remedial steps taken by the Defendant as submitted. We do not consider that the submitted remedial steps are sufficient.

40. We must stress that the offences committed by the Defendant in this case were very serious. We have to consider whether for the purpose of protecting the public, it is safe for the Defendant to continue to practise dentistry.

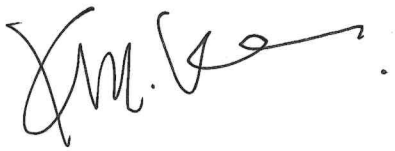
41. Having regard to the gravity of the case and the mitigation submitted by the Defendant, we make a global order in respect of charges (i), (ii), (iii) and (v) that the name of the Defendant be removed from the General Register for a period of six months.

42. We have also considered whether we should suspend our removal order. For the reasons stated in this decision above, we do not find a suspension order appropriate.

Remarks

43. While it is for the Council in future to consider the Defendant's application for restoration to the General Register, we recommend that the Council should ensure that the Defendant should satisfy the Council that (i) he has put in place a system of adequate and accurate record keeping; and (ii) he has taken steps to improve his clinical diagnostic skills.

44. We have another remark. We must stress that no part of the following remark was taken into account when considering the findings and sentencing above. Nowadays, implant treatment is a common treatment modality. Implant treatment is an option for the replacement of teeth and not the only solution for treating oral diseases. The public should not consider implant as the only and best option for treatment of dental diseases. Treating and preventing the underlying oral diseases remain the highest priority. Dentists are encouraged to place priority in maintaining the healthy status of oral environment before embarking on implant treatment. Dentists need to exercise professionalism in each individual case to make the best treatment plan(s) for patients.



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