SINGAPORE DENTAL COUNCIL

DISCIPLINARY INQUIRY AGAINST DR SNG WEE HOCK

ON 13, 17, AND 18 SEPTEMBER 2018, 17, 21, AND 23 JANUARY, AND 29 MARCH 2019

Disciplinary Committee:
Dr Long Benjamin Charles (Chairperson)
Dr Chan Siew Luen
Dr Rajendram Sivagnanam
Mr Philip Leong (Layperson)

Legal Assessor:
Mr Woo Tchi Chu

Prosecution Counsel (M/s. Goh JP & Wong LLC):
Mr Goh Teck Wee
Mr Soon Wei Song

Respondent Counsel (M/s Dentons Rodyk & Davidson LLP):
Mr Christopher Chong
Ms Zoe Pittas

DECISION OF THE DISCIPLINARY COMMITTEE

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

1 Dr Sng Wee Hock (**"the Respondent"**) is a general dental practitioner and was at all material times the founder and principal dentist of the practice known as WH Dental Surgeons located at No 1 Hougang Street 91, #01-16/17 Hougang 1, Singapore 538692.

2 On or about 27 June 2015, one Mr C (**"the Complainant"**) took his 13 year old son P (**"the Patient"**) to consult the Respondent for braces for the Patient and eventually settled for metal braces for him.

3 The present Inquiry arose out of a complaint made by the Complainant.

4 On 12 March 2018, the Singapore Dental Council ("**SDC**") served notice on the Respondent that an Inquiry would be held to look into the following three charges against him:

(a) <u>1st Charge</u>

That you, **DR SNG WEE HOCK**, a registered dentist under the Dental Registration Act (Cap. 76) are charged that you, between 27 June 2015 and 2 August 2016, whilst practicing as a dentist at WH Dental Surgeons Pte Ltd, failed to keep clear and accurate dental records in respect of the specific treatment performed by each dental professional on one patient, P ("**the Patient**"), in breach of Guideline 4.1.2. of the Singapore Dental Council's Ethical Code & Guidelines ("**SDCECG**"), to wit:-

<u>Particulars</u>

a) You had by way of your letter to the Singapore Dental Council ("**SDC**") dated 20 April 2017 informed the SDC that you have had many male associate dentists assist you in your clinic, and they may have attended to the Patient between 27 June 2015 and 2 August 2016.

b) That notwithstanding, you failed to keep clear and accurate records of:-

(i) what specific treatments you and/or your Associate Dentists and/or your Oral Health Therapists ("**Dental Professionals**") had performed on the Patient;

(ii) which Dental Professional attended to the Patient at any one time

and that in relation to the facts alleged you have been guilty of professional misconduct pursuant to Section 40(1)(d) of the Dental Registration Act (Cap. 76)."

(b) 2nd Charge

That you, **DR SNG WEE HOCK**, a registered dentist under the Dental Registration Act (Cap. 76) are charged that you, between 27 June 2015 and 2 August 2016, in the treatment of the Patient, did permit one Mr O, a registered Oral Health Therapist to practice dentistry beyond the scope of work allowed by Section 22(1A) of the Dental Registration Act (Cap. 76) read with Regulation 40A of the Dental Registration Regulations (Cap. 76, Reg 1), to wit, by placing separators on the Patient's first permanent molars, and placing and removing elastic modules under your supervision, and that in relation to the facts alleged you are guilty of professional misconduct pursuant to Section 24(1) of the Dental Registration Act (Cap. 76) read with Section 22(1A) of the Dental Registration Act (Cap. 76)."

(c) Amended 3rd Charge

That you, **DR SNG WEE HOCK**, a registered dentist under the Dental Registration Act (Cap. 76) are charged that you, on or about 7 November 2015 and 22 November 2015, recommended and performed an unnecessary and unacceptable treatment to resolve the Patient's teeth crowding problem in breach of Guideline 4.1.1.1. of the SDCECG, to wit, you recommended and performed the prophylactic removal of the four wisdom teeth of the Patient, a 13 year old boy, when you knew or ought to have known that it was not proper or

clinically indicated for the Patient's four wisdom teeth to have been removed prior to the removal of his four premolars when the removal of the four premolars would have been sufficient to resolve the Patient's teeth crowding problem, and that in relation to the facts alleged you have been guilty of professional misconduct pursuant to Section 40(1)(d) of the Dental Registration Act (Cap. 76)."

5 At the opening of the Inquiry on 13 September 2018, the Respondent pleaded not guilty to all three charges. The hearing then took place over a period of seven days and concluded on 29 March 2019 after the witnesses had given their testimonies, all oral and written submissions were made, and the Decision of the Disciplinary Committee (DC) rendered on that day.

The 1st Charge

6 The Respondent was charged with failure to keep clear and accurate dental records of the specific treatments he and each of his dental professionals had performed on the Patient in breach of Guideline 4.1.2. of the 2006 Edition of the SDC's Ethical Code and Guideline ("SDCECG"). The relevant part of the Guideline reads as follows:

> *"Proper documentation is a hallmark of quality dentistry and a standard of care that patients have come to expect from the profession. All treatment records maintained by dentists shall therefore be clear, accurate, legible and contemporary. All records shall be of sufficient detail so that any other dentist reading them would be able to take over the management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drug or procedures should be documented."*

7 It is therefore obligatory that dental records should be clear, accurate, legible and contemporary and contain clinical details, investigation results, discussion of treatment options, informed consents and treatment. Furthermore, all records should be of sufficient detail so that any other dentist reading them would be able to take over the management of the case.

8 The DC then examined the Respondent's treatment notes and what other dental records were kept and available in regard to the treatment performed on the Patient. It had to agree with the Prosecution's submission that the treatment notes were "regrettably bare and scant" and that based on a reading of these notes, it would be difficult for another dentist to take over the management of the patient. The notes did not specify which clinician administered what treatment to the Patient although the Respondent was not the only dentist treating him.

9 The Prosecution also pointed out areas where the notes were grossly inadequate and they are as follows:

(a) the clinical findings set out by the Respondent only set out the conclusion and did not explain the basis or rationale for the findings;

(b) they failed to record the details of wires used for the Patient's orthodontic treatments;

(c) details pertaining to how the brackets were used were absent;

(d) notes on the surgery, the amount of anaesthetics given to the Patient, a 13 year old boy, was also not recorded;

(e) The Patient had a deep bite which according to the Prosecution's expert witness, Dr A, Senior Consultant and Head, Department of Orthodontics at X, would inhibit orthodontic treatment if left unaddressed. However, the notes kept by the Respondent made no mention of any form of treatment of the Patient's deep bite;

(f) many abbreviations were made in the treatment notes which the DC agreed would inhibit another dental professional's understanding or cause him to second-guess if he should take over the management of the Patient;

(g) the Respondent's diagnosis of teeth impaction nor did he indicate the degree of overcrowding of the Patient's teeth;

(h) The Respondent's handwriting lacked clarity causing Dr A to comment at one stage: "then the other thing of course is the handwriting. Of course we look at the typewritten notes, it looks very straight. But when you look at the written notes, it's there are different styles of handwriting. So I don't know who is the scribe, who is the clinician. Who is doing the writing and who is treating the patient".

10 After considering the above evidence, the DC accepted the submission of the Prosecution that the Respondent has failed to comply with the minimum standards prescribed in Section 4.1.2. of the SDCECG. While he did keep some record of his treatment notes in regard to the Patient, what he recorded fell far short of what is required and was also done in a haphazard manner. In the circumstances, he had deliberately departed from the profession's applicable standard of conduct among its members of good standing and repute.

11 The DC also accepted the Prosecution's submission that the Respondent's failure to keep clear and sufficiently detailed treatment notes amounted to serious negligence

on his part. Such negligence constituted an abuse of the privileges of being a registered practitioner and could well result in serious consequences especially if the Respondent failed to recall his diagnosis of the Patient, the basis for the diagnosis, and his treatment plan.

12 Consequently, the DC found the Respondent guilty of professional misconduct pursuant to section 40(1)(d) of the Dental Registration Act (Cap. 76) ("**DRA**").

The 2nd Charge

13 This charge against the Respondent for professional misconduct is that between the period 27 June 2015 to 2 August 2016, he permitted his Oral Health Therapist ("**OHT**"), Mr O, to practise dentistry beyond the scope allowed by inserting separators as well as replacing and placing plastic modules in the Patient's mouth. This charge stems from an allegation from the Complainant that the Respondent allowed Mr O to perform orthodontic procedures on the Patient under his supervision.

14 Under Section 22(1)(a) of the DRA, OHTs are required to practise dentistry only within the ambit set out in the Fourth Schedule. If a dentist allows an OHT to practise dentistry in contravention of the Section then he would be guilty of an offence under Section 24(2) of the Act.

15 It was decided by another DC (*Singapore Dental Council v Dr Yap Eng Huat Jimmy*) that he would not be liable if he could establish that the offence was committed by the OHT without his knowledge and that as employer he had taken all reasonable precautions and exercised due diligence to prevent the commission of the offence.

16 In the present case, the complaint was made after the Patient informed his father, the Complainant, that apart from the Respondent, two other persons had carried out orthodontic treatment on him, one a Chinese and the other a non-Chinese. Mr O was the only non-Chinese working in WH Dental Surgeons at the material time.

17 In his evidence, Mr O candidly admitted to giving orthodontic treatment to the Patient by placing separators on the Patient's first permanent molars, and placing and removing the modules in his mouth. He not only did so once but admitted that apart from one instance of placing separators, there were about three instances where he had placed or removed modules for the Patient. In making these admissions, he exposed himself to a possible charge of practising dentistry beyond the scope allowed.

18 The Respondent's defence is quite simply he did not permit the Patient to carry out the procedures as alleged after all "Firstly there was no financial benefit to him (Mr O) and secondly, he knew that he would be breaching the Regulations." The procedures were quite quick and easy for the Respondent to do himself, i.e. to reinsert the modules and fix the wire. It is the Respondent's case that it would have been very easy to come back (from treating another patient) to the Patient, do it (the procedures), check and then discharge the Patient, rather than permit or ask Mr O to do the same, a procedure which even Mr O admitted would have taken two minutes or less. Besides, there was a qualified dentist, Dr B, who was assisting him with his patients at the time and "could have removed the modules for the Patient, if I was of the view that the modules had to be removed."

19 The DC carefully considered the different versions in the evidence and is unanimously of the view that Mr O's testimony was the more credible. He was asked by both Prosecution and Defence counsel no less than five or six times on the treatment he performed on the Patient, and while he might have been somewhat tentative on some

of the dates this took place, he stood his ground that he did perform orthodontic procedures on the Patient and that in fact, he was "tasked" to do so by the Respondent. There was no doubt in the DC's mind that he was speaking the truth.

20 The DC notes that the Respondent had not taken any reasonable precaution or put in place any form of due diligence to prevent the commission of the offence described in this charge.

21 The DC therefore found the Respondent guilty of the 2nd charge.

The Amended 3rd Charge

22 This charge relates to the Respondent recommending to the Complainant and performing on the Patient the prophylactic removal of all four of his wisdom teeth prior to the removal of the premolars when it was not proper or clinically indicated for him to do so to resolve the Patient's overcrowding problems.

23 It is the Prosecution's case that the subsequent removal of the four premolars would have created sufficient space to resolve the overcrowding of the Patient's teeth and that there was therefore no need for the prophylactic removal of his wisdom teeth.

24 The Respondent's defence is that overcrowding was not the only reason for the treatment; there were other reasons as well. These reasons were set out in his letter of explanation as follows:

(a) The wisdom teeth's eruption path where there is quite a bit of crowding in the Patient's case will usually be blocked especially for the lower wisdom teeth. This will result in the wisdom tooth being impacted or slanted and either erupt partially

or will not erupt at all and stay buried in the gum. Such a case will result in gum infection/pericoronitis, food impaction and decay. This decay can affect both the wisdom teeth and the adjacent second molar.

(b) The second molar positions are not good and are not aligned.

(c) Removal of the wisdom teeth at the Patient's age will result in less complications and faster recovery and also be less traumatic.

(d) Absence of wisdom teeth will make it easier to retract the second molars should the need arise to distalise the second molars to create more space.

25 The Prosecution's two expert witnesses, Dr A and Dr B were referred to the charge which alleged that the treatment the Respondent recommended for the Patient was both "unnecessary and unacceptable". While both experts appeared to agree that the treatment recommended and performed was unnecessary, Dr A declined to say that it was "unacceptable". He preferred to say that he would have offered a "different approach" in treating a patient like the Patient, and left open the question as to whether the Respondent's treatment was in the Patient's "best interest" or "best practice". In his letter to Prosecution counsel on 17 September 2018, he referred to "conflicting opinions about early excision of third molars" but did not offer any damning opinion on the treatment referred to in the charge.

26 Dr B is the Director of Service and Senior Consultant, Oral and Maxillofacial Surgery, Department of Dentistry at Y. He was asked by Dr Chan (a member of the DC) if he thought the treatment on the 13-year-old Patient was both "unnecessary and unacceptable". While he had no hesitation agreeing that it was unnecessary, he only conceded that it was "unacceptable" when the question was put to him a second time

by Dr Chan. The DC also looked at his report of 10 September 2018. All he would say is that the surgical removal of wisdom teeth at such a young age as the Patient is “not routinely practiced” by oral maxillofacial surgeons in Singapore unless absolutely indicated. After looking at the clinical records and radiographs, he concluded that “there was no strong indication, at that point of time, for the prophylactic surgical removal of the upper and lower wisdom teeth.”

27 In spite of the ordeal that the Patient had to go through, he did not suffer any harm.

28 It is the Prosecution’s duty to show professional misconduct. For the charge to stick as framed, it is not sufficient to show that the treatment was unnecessary. It had to show based on the evidence and testimony of the expert witnesses that it was also unacceptable, which is a much more serious ingredient of the charge. This the Prosecution was not able to do.

29 In the circumstances, the DC found the Respondent not guilty of the 3rd charge.

Mitigation

30 The Respondent’s counsel was invited to mitigate the two offences that the Respondent was found guilty of.

31 In his written submissions, he pointed out that:

(a) no harm was caused to the Patient by the Respondent’s conduct relating to both charges;

(b) the level of culpability of the Respondent's conduct was low in that he did not deliberately depart from the standards expected of him, and;

(c) the Respondent's antecedents that the Prosecution referred to did not bear similarities to the present charges and therefore recalcitrance and unwillingness to adhere to the values and those of the profession were not demonstrated.

32 There were also other testimonials from his patients and colleagues which the DC looked at.

Antecedents

33 The Prosecution pointed out that the Respondent had been previously been convicted of three sets of offences, namely:

(a) In *Singapore Dental Council v Dr Sng Wee Hock* held on 11 April, 7 June, 18 July, 4 and 5 September, and 20 November 2013, he was charged and found guilty of one charge of representing to the complainant that the cost of the entire dental implant procedure was fully claimable from her Medisave Account with the CPF Board, when the said representation was untrue. He was fined $15,000, censured, ordered to give an undertaking that he would not further engage in such conduct complained of, and asked to pay 80% of the costs of the inquiry.

(b) In *Singapore Dental Council v Dr Sng Wee Hock* held on 25 July 2016, Dr Sng was charged with abdicating his professional responsibilities to his dental assistants. The SDC preferred 14 charges against him and proceeded on four while taking the other 10 into consideration. Dr Sng pleaded guilty, and was suspended for 15 months, fined $40,000, censured, ordered to give an

undertaking that he would not engage in the conduct complained of and had costs ordered against him.

(c) In *Singapore Dental Council v Dr Sng Wee Hock* held on 28 June 2017, he was found guilty of two charges of failing to supervise one Dr June Soo Lee for seven months on 100 sessions and one Dr Park Seunghyun for three weeks on nine sessions. He was suspended for a total of 15 months, fined $50,000, censured and ordered to give the usual undertaking and pay costs.

34 Based on the above, and the current Inquiry in which the Respondent is found guilty on two charges, the Prosecution invited the DC to have the Respondent struck off the register of approved dental practitioners. In the Prosecution's submission, the Respondent had demonstrated "clear recalcitrance and disregard for the interests of the patients under his care as well as the ethical duties and obligations incumbent on him as a registered practitioner".

<u>DC's views</u>

35 Taking into consideration the nature of the two charges that the Respondent was found guilty of, the DC is of the opinion that this is not an appropriate case to remove the Respondent from the Register of approved dental practitioners. The DC has noted his antecedents and his propensity through his own fault of getting into trouble with the SDC. However as conceded by the Prosecution, there was no antecedent in respect of his failure to keep clear and accurate records. The records show he did keep some treatment notes although they were scanty, haphazard and grossly inadequate.

36 The DC agrees with the view expressed in *Singapore Medical Council v Dr Lim Chong Hee* held on 4 May 2012 that the normal tariff for failure to keep proper records should be about $10,000. In the present case however, as some records were kept by the Respondent, the DC was prepared to consider a slight discount of the penalty in his favour.

37 As for the second charge, the DC took the view that the placing of separators and modules into the Patient's mouth, though part of orthodontic work and clearly forbidden and beyond the scope of work permitted to Mr O, was not a particularly difficult or complicated part of the whole procedure. Nevertheless, it should not have been allowed by the Respondent.

38 The DC agreed that in this case, no harm appeared to have been caused to the Patient.

<u>The Sentence</u>

39 Taking into consideration the submissions by the Prosecution and the Respondent, this DC hereby orders as follows:

(a) In respect of the First Charge: the Respondent pay a fine of $8,000;

(b) In respect of the Second Charge: the Respondent be suspended for a period of 4 months, the suspension to run immediately after the Respondent's current suspension ordered in DC 2015/03, and pay a fine of $10,000;

(c) The Respondent be censured;

(d) The Respondent give a written undertaking to Singapore Dental Council that he would not engage in the conduct complained of in the First and Second Charges;

(e) The Respondent pay the costs and expenses of, and incidental to these proceedings including costs of counsel to the SOC and the Legal Assessor.

40 It is also ordered that the Grounds of this Decision be published for the benefit of the public.

41 The hearing is hereby concluded.

Dated 9th day of May, 2019.

Dr Benjamin Long

Chairperson, Disciplinary Committee

Dr Chan Siew Luen

Member, Disciplinary Committee

Dr Rajendram Sivagnanam

Member, Disciplinary Committee