SINGAPORE DENTAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY FOR DR WANG KIT MAN
ON 3 SEPTEMBER 2019, 17 SEPTEMBER 2019 & 10 OCTOBER 2019

Disciplinary Committee:
Dr Kaan Sheung Kin (Chairman)
Dr Seah Tian Ee
Dr Lee Chi Hong Bruce
Dr Rachael Pereira (Layperson)

Legal Assessor:
Mr Edmund Kronenburg (Braddell Brothers LLP)

Counsel for the SDC:
Mr Burton Chen
Ms Junie Loh
(M/s Tan Rajah & Cheah)

Counsel for the Respondent:
Mr S Selvaraj
Mr Edward Leong
(M/s MyintSoe & Selvaraj)

DECISION OF THE DISCIPLINARY COMMITTEE
IN RELATION TO THE RESPONDENT'S PLEA OF GUILT

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

Introduction

1. The Respondent – Dr Wang Kit Man – is a registered dentist practising at a clinic known as "Q&M Dental Surgery (Simei MRT)" located at 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888 **("Clinic")**.

2. These proceedings arose out of a Complaint made on 9 January 2017

(“Complaint”) by one Mr P **(“Complainant”)** in respect of the Respondent's care and management of one Ms T **(“Patient”)**, who was the wife of the Complainant.

3. A notice dated 20 January 2017 was sent by the SDC to the Respondent, enclosing a copy of the Complaint and inviting the Respondent to offer his written explanation.

4. The Respondent provided his written explanation in a letter dated 17 February 2017 to the SDC.

5. By a letter dated 22 February 2017 to the Respondent, the SDC requested for:

   (a) the original treatment notes/records for the Patient;

   (b) the original x-rays, clinical photographs and a CD/thumb drive containing the same; and

   (c) copies of any relevant documents, correspondence, consent forms, referrals and receipts.

6. The requested documents were provided by the Respondent on or about 3 May 2017.

7. The SDC appointed a Complaints Committee to investigate the matter. On 31

August 2017, the Complaints Committee informed the Respondent of its recommendation that the matter be reviewed by a Disciplinary Committee.

The Original Charges

8. The SDC issued the Respondent a Notice of Inquiry **("NOI")** dated 8 May 2019 setting forth five charges **("Original Charges")** against him in respect of his care and management of the Patient. They were as follows :-

1st Charge

*1. That you, **Dr Wang Kit Man,** are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to exercise due care in the management of your patient, namely one **T ("the Patient"),** in that you arrived at a diagnosis of irreversible pulpitis without conducting a comprehensive clinical evaluation of the Patient's tooth #15.*

Particulars

(a) You failed to take the Patient's history on the nature and duration of the pain experienced by the Patient on exposure of tooth #15 to hot and cold stimuli.

(b) You failed to conduct hot and cold testing to determine and/or confirm the nature and duration of the pain complained of by the Patient.

(c) The dental panoramic radiographs of the Patient did not show significant loss of crestal or apical bone of tooth #15.

(d) Your clinical note of "tooth #15 tender to percussion" did not justify your diagnosis of "irreversible pulpitis".

*And that in relation to the facts alleged, you have breached Clauses 4.1.1.1 and/or 4.1.1.5 of the Singapore Dental Council Ethical Code & Guidelines **("ECG")** and accordingly you are guilty of professional*

misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

2nd Charge

2. *That you,* ***Dr Wang Kit Man,*** *are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to obtain the informed consent of the Patient for the extraction of her tooth #15 and the immediate placement of an implant fixture thereafter.*

Particulars

(a) You inaccurately advised the Patient that the option of a root canal treatment would only last for 5 years, when dental literature supported a longer survival period.

(b) You failed to advise the Patient as to the risks and benefits of immediate implant fixture placement over that of delayed implant fixture placement.

(c) You failed to advise the Patient on the option of replacing the extracted tooth with a denture or a fixed-fixed bridge instead of an implant.

And that in relation to the facts alleged, you have breached Clause 4.2.2 of the ECG and accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

3rd Charge

3. *That you,* ***Dr Wang Kit Man,*** *are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient.*

Particulars

(a) You did not maintain sufficient documentation of the history and condition of the Patient's tooth #15, that is, the severity

of the mobility of tooth #15 and the nature, duration and severity of the pain at tooth #15.

(b) You did not maintain sufficient documentation of what investigations you conducted in respect of the Patient's tooth #15.

(c) You did not maintain sufficient documentation of your advice to the Patient on alternative treatment options (i.e. details of treatment options other than the extraction of tooth #15 followed by implant surgery) and their risks and benefits.

(d) You did not maintain sufficient documentation of your advice to the Patient as to the risks and benefits of an immediate implant fixture placement over that of a delayed implant fixture placement.

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

4th Charge

4. *That you, **Dr Wang Kit Man,** are charged that on 11 June 2016 and 22 June 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888, you failed to exercise due care in the management of the Patient's post-operative condition, in that you failed to adequately manage the Patient's pain in/around the surgical area.*

Particulars

(a) On both 11 June 2016 and 22 June 2016, you failed to carry out appropriate investigation(s) to determine the severity, nature and characteristics of the Patient's pain.

(b) On 22 June 2016, you attributed the Patient's pain to sinusitis resulting from her recent cold/flu, without carrying out adequate investigation(s) to determine that the pain could properly be so attributed.

(c) On 22 June 2016, you failed to consider and investigate the

possibility of sinus perforation.

And that in relation to the facts alleged, you have breached Clause 4.1.1.5 of the ECG and accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

5th Charge

5. *That you,* ***Dr Wang Kit Man,*** *are charged that on 11 June 2016 and 22 June 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient's post-operative condition.*

Particulars

(a) On 11 June 2016, you did not record sufficient detail of the nature and severity of the Patient's pain.

(b) On 22 June 2016, you did not sufficiently record how the decision to remove the implant fixture was arrived at.

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

The Amended Charges

9. The hearing on 3 September 2019 was adjourned to 17 September 2019 for SDC Counsel (Mr Chen) to consider whether to proceed on the Original Charges *inter alia* in view of recent decision of the Court of Three Judges in *Singapore Medical Council v Lim Lian Arn* [2019] SGHC 172 ***("Lim Lian Arn")***, a copy of which was tendered to the Disciplinary Committee by SDC Counsel at the same hearing.

10. In addition, SDC Counsel also clarified that the Original Charges, even though they did not expressly state so, were based on the "second limb" of professional misconduct in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ***("Low Cze Hong")*** i.e. where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a dental practitioner. Respondent's Counsel (Mr Selvaraj) took note of this but was content to proceed on the basis of SDC Counsel's clarification, without any formal amendment to the Original Charges being made.

11. Notwithstanding the above, at the hearing on 17 September 2019, SDC Counsel as a matter of good order sought to amend three of the Original Charges (namely, the 1st, 3rd and 5th Charges) to reflect that the SDC was proceeding on the second limb of *Low Cze Hong*. He tendered a document setting out the three amended charges **("Amended Charges")** to the Disciplinary Committee, which the Disciplinary Committee marked "P2". The Amended Charges were as follows (amendments in **bold, underlined** words):-

Amended 1st Charge

*1. That you, **Dr Wang Kit Man,** are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to exercise due care in the management of your patient, namely one **T ("the Patient"),** in that you arrived at a diagnosis of irreversible pulpitis without conducting a comprehensive clinical evaluation of the Patient's tooth #15.*

Particulars

(c) You failed to take the Patient's history on the nature and duration of the pain experienced by the Patient on exposure of tooth #15 to hot and cold stimuli.

(d) You failed to conduct hot and cold testing to determine and/or confirm the nature and duration of the pain complained of by the Patient.

(e) The dental panoramic radiographs of the Patient did not show significant loss of crestal or apical bone of tooth #15.

(f) Your clinical note of "tooth #15 tender to percussion" did not justify your diagnosis of "irreversible pulpitis".

And that in relation to the facts alleged, you have breached Clauses 4.1.1.1 and/or 4.1.1.5 of the Singapore Dental Council Ethical Code & Guidelines ***("ECG")*** *and* ***your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a dentist,*** *accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.*

Amended 3rd Charge

3. *That you,* ***Dr Wang Kit Man,*** *are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient.*

Particulars

(a) You did not maintain sufficient documentation of the history and condition of the Patient's tooth #15, that is, the severity of the mobility of tooth #15 and the nature, duration and severity of the pain at tooth #15.

(b) You did not maintain sufficient documentation of what investigations you conducted in respect of the Patient's tooth #15.

(c) *You did not maintain sufficient documentation of your advice to the Patient on alternative treatment options (i.e. details of treatment options other than the extraction of tooth #15 followed by implant surgery) and their risks and benefits.*

(d) *You did not maintain sufficient documentation of your advice to the Patient as to the risks and benefits of an immediate implant fixture placement over that of a delayed implant fixture placement.*

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and ***your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a dentist,*** *accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.*

Amended 5th Charge

5. *That you,* ***Dr Wang Kit Man,*** *are charged that on 11 June 2016 and 22 June 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient's post-operative condition.*

Particulars

(a) *On 11 June 2016, you did not record sufficient detail of the nature and severity of the Patient's pain.*

(b) *On 22 June 2016, you did not sufficiently record how the decision to remove the implant fixture was arrived at.*

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and ***your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a dentist,*** *accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.*

12. Respondent's Counsel confirmed that he had no objections to the above amendments being made, and the Disciplinary Committee accordingly allowed the said amendments.

13. SDC Counsel further stated that with the agreement of the Respondent :-

(a) the SDC would not proceed on the 2nd Charge and 4th Charge;

(b) the SDC would proceed with the Amended 1st Charge and Amended 3rd Charge; and

(c) the SDC would not proceed with the Amended 5th Charge but this would be taken into account for purposes of sentencing in relation to the Amended 3rd Charge.

14. SDC Counsel then tendered the following documents to the Disciplinary Committee, which the Disciplinary Committee marked with the abbreviations in **[bold square brackets]** below :

(a) Agreed Bundle of Notice of Inquiry and Agreed Statement of Facts **[ABN]**;

(b) Agreed Bundle of Documents **[ABD]**;

(c) Prosecution's Bundle of Documents **[PBD]**; and

(d) Prosecution's Bundle of Authorities **[PBA]**.

15. Upon clarification being sought by the Disciplinary Committee, both SDC Counsel and Respondent's Counsel confirmed that the documents within ABN, ABD and PBD were agreed not only as to authenticity, *but also as to the truth of their contents.*

The Respondent's Plea of Guilt

16. The Amended 1st Charge and Amended 3rd Charge were read to the Respondent, and he pleaded guilty in respect of each of these charges. The Respondent also expressly agreed that the Amended 5th Charge would be taken into account for purposes of sentencing in relation to the Amended 3rd Charge.

17. Mindful of the principles stated in *Lim Lian Arn,* the Disciplinary Committee considered it appropriate not simply to accept the Respondent's plea of guilt without more, but to determine for itself (1) whether the Amended 1st Charge and Amended 3rd Charge, respectively, had been made out on the totality of the undisputed evidence before the Disciplinary Committee (including the Agreed Statement of Facts), and accordingly (2) whether to accept the Respondent's plea of guilt in relation to those two charges. In particular, the Disciplinary Committee bore in the mind the following extract from *Lim Lian Arn* (emphasis added), not wishing to occasion a repeat any of the 'mis-steps' in that case :-

> *"… 20 Before we turn to the substantive analysis of the issues, it is appropriate to make some brief observations about this case. It seems to us that the case took the course that it did largely because of a series of missteps that were, in a sense, preventable. As we have already noted and will elaborate in due course, the DT found that Dr Lim's conduct was an honest one-off mistake. On the basis of the facts that he admitted,* ***Dr Lim might have fallen short of the standards set out in the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition) (hereinafter referred to the "ECEG (2002)"; the 2016 edition will be referred to as the "ECEG (2016)", and both editions collectively as the "ECEG"). But it seems to have escaped all the parties that such a breach does not necessarily or inevitably lead to the conclusion that Dr Lim was guilty of professional misconduct under s 53(1)(d) of the MRA.*** *… [W]hen the matter came before the DT, it appears that once Dr Lim made the decision to plead guilty, neither the respective parties' counsel nor the DT further considered the question of liability. Moreover, having made findings on the nature and extent of Dr Lim's infraction, the DT did not then re-assess the logic of its conclusions and consider whether the charge was made out; specifically, whether Dr Lim's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. Before us, it became evident that neither Mr Chia nor Mr Tin were alive to this critical point. In the circumstances, it is apposite to first reiterate what constitutes professional misconduct under the MRA …"*

18. To that end, the Disciplinary Committee sought clarification from both counsel as to what evidence it ought to consider. Both SDC Counsel and Respondent's Counsel confirmed that the Disciplinary Committee ought to take into account the totality of the evidence in ABN (which included the Agreed Statement of Facts), ABD and PBD.

19. There being a mass of evidence to review, the Disciplinary Committee took time to consider its decision and adjourned the hearing to 10 October 2019 to

deliver its decision, as set forth herein.

The Disciplinary Committee's Decision On Whether To Accept the Respondent's Plea Of Guilt In Relation To Amended 1st Charge and Amended 3rd Charge

20. In summary, having duly considered the totality of the evidence before it in ABN, ABD and PBD, the Disciplinary Committee :-

    (a) accepts the Respondent's plea of guilt on the Amended 3rd Charge; but

    (b) is unable to accept the Respondent's plea of guilt on the Amended 1st Charge.

21. The Disciplinary Committee's brief reasons for its decision are set out below.

Amended 1st Charge

22. In relation to the Amended 1st Charge, the Disciplinary Committee is not satisfied on the evidence before it that the Respondent's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a dental practitioner.

23. The crux of the Amended 1st Charge is the Respondent's alleged arrival at a diagnosis of irreversible pulpitis without conducting a comprehensive clinical

evaluation of the Patient's tooth #15 as set out in the Particulars to that charge.

24. The Disciplinary Committee notes that the Respondent has himself agreed – in the Agreed Statement of Facts in ABN **("Agreed Facts")** - that he arrived at a diagnosis of irreversible pulpitis of the Patient's tooth #15 without conducting a comprehensive clinical evaluation of the tooth, in that :-

(a) he failed to take the Patient's history on the nature and duration of the pain experienced by the Patient on exposure of tooth #15 to hot and cold stimuli;

(b) he failed to conduct hot and cold testing to determine and/or confirm the nature and duration of the pain complained of by the Patient;

(c) though the Respondent did a radiographic examination of the Patient tooth #15, the dental panoramic radiographs did not show significant loss of crestal or apical bone of tooth #15; and

(d) though the Respondent in his clinical examination noted that tooth #15 was "tender to percussion", this symptom did not justify his diagnosis of "irreversible pulpitis".

25. That said, the Disciplinary Committee is unable to conclude from the Agreed Facts, or on the totality of the evidence presently before it, that the Respondent's conduct rises to the level of *"such serious negligence that it*

objectively portrayed an abuse of the privileges which accompany registration as a dental practitioner". At best, the current evidence indicates that the Respondent's conduct – as admitted by him above - may have fallen short of what would be expected of a responsible and competent dentist in the shoes of the Respondent, but this is certainly not tantamount to "serious negligence" within the meaning of the second limb of *Low Cze Hong*. This was made amply clear by the Court of Three Judges in *Lim Lian Arn*.

26. Applying the principles in *Lim Lian Arn*, the evidence presently before the Disciplinary Committee does not disclose that the Respondent was, in relation to matters which are the subject matter of the Amended 1st Charge, simply indifferent to the Patient's welfare, or indifferent to his own professional duties, or that he abused the trust and confidence reposed in him by the Patient.

27. In fact, the evidence presently before the Disciplinary Committee indicates that the Respondent did not rush into his diagnosis, and that tooth #15 was obviously the cause of the Patient's pain, giving some grounds for the Respondent's diagnosis of irreversible pulpitis. Indeed, on the face of the evidence presently before the Disciplinary Committee, one is unable to say that the Respondent made an incorrect diagnosis, and/or rendered inappropriate treatment to the Patient (which are in any event, not matters that the Respondent is charged with).

28. For the reasons stated above, the Disciplinary Committee is unable to accept the Respondent's plea of guilt in relation to the Amended 1st Charge.

Amended 3rd Charge

29. In relation to the Amended 3rd Charge however, the Disciplinary Committee is satisfied on the evidence before it that the Respondent's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a dental practitioner.

30. The crux of the Amended 3rd Charge is the Respondent's alleged failure to keep sufficient records of his care and management of the Patient as set out in the Particulars to that charge.

31. The Disciplinary Committee notes that the Respondent has himself agreed – in the Agreed Facts - that he failed to keep sufficient clinical records of his care and management of the Patient, in that:

(a) he did not maintain sufficient documentation of the history and condition of the Patient's tooth #15, that is, the severity of the mobility of tooth #15 and the nature, duration and severity of the pain at tooth #15;

(b) he did not maintain sufficient documentation of what investigations he conducted in respect of the Patient's tooth #15;

(c) he did not maintain sufficient documentation of his advice to the Patient on alternative treatment options (i.e. details of treatment options other than the extraction of tooth #15 followed by implant

surgery) and their risks and benefits; and

(d) he did not maintain sufficient documentation of his advice to the Patient as to the risks and benefits of an immediate implant fixture placement over that of a delayed implant fixture placement.

32. The Disciplinary Committee finds that based on the Agreed Facts, as well as the evidence presently before it in relation to the Amended 3rd Charge, the Respondent's record keeping fell very far below the standards required by Clause 4.1.2 of the ECG, the relevant parts of which are reproduced below, for ease of reference (emphasis added) :-

> *4.1.2. Dental Records*
>
> *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 …***

33. The Disciplinary Committee agreed with what the Respondent himself admitted in the Agreed Facts as regards his own conduct (see [31] above) and also noted *inter alia* that :-

(a) the Respondent's handwritten records were in many places, wholly illegible;

(b) the consent-taking process in relation to the Patient was shoddily documented;

(c) on 12 February 2016, upon the Patient's first consultation with the Respondent, the only recorded observation by the Respondent was "tenderness" on tooth #15, after which he then performed adjustments of an "occlusal high spot" on tooth #15; and

(c) on 27 May 2016, when the Patient returned and complained of pain in the upper right quadrant and tooth #15 was "tender to percussion" and "mobile", the Respondent failed adequately to record the severity of this pain and mobility, or other clinical findings regarding tooth #15 sufficient to support his "guarded prognosis".

34. By reason of the matters stated above, and the totality of the evidence before the Disciplinary Committee, the Respondent's records came nowhere close to being "sufficiently detailed" so that any other dentist reading them would be able to rely on them to take over the management of the Patient's case from the Respondent. The Respondent's conduct fell far short of the mark; it placed the Patient unjustifiably at risk – what would have happened if she needed to see another dentist? The Respondent's record keeping was so poor that the Disciplinary Committee concluded that he was either simply indifferent to the Patient's welfare or indifferent to his own professional duties.

35. As such, the Disciplinary Committee finds that the Respondent's conduct in relation to the Amended 3rd Charge amounts to *"such serious negligence that*

it objectively portrayed an abuse of the privileges which accompany registration as a dental practitioner". The Disciplinary Committee accepts the Respondent's plea of guilt on the Amended 3rd Charge.

36. That said, the Disciplinary Committee wishes to state its view that on the evidence before it, the intractable pain that the Patient experienced following the implant placement and its subsequent failure was atypical and was not contributed-to by the Respondent's substandard record-keeping.

37. The Disciplinary Committee reserves its right to expand on its aforesaid analysis of the Respondent's conduct vis-à-vis the Amended 3rd Charge in rendering its decision on sentencing.

Directions

38. In view of the Disciplinary Committee's decision above, the hearing will continue on 18 and 19 November 2019 (as fixed previously) *but only in relation to the Amended 1st Charge*, after which the Disciplinary Committee will consider and render its decision thereon.

39. The Disciplinary Committee will hear the parties' submissions on sentencing in relation to the Amended 3rd Charge, and any plea in mitigation from the Respondent, after it renders its decision on the Amended 1st Charge.

Dated this 10th day of October, 2019.

Dr Kaan Sheung Kin
(Chairman)

Dr Seah Tian Ee	Dr Lee Chi Hong Bruce	Dr Rachael Pereira (Layperson)