SINGAPORE DENTAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY AGAINST DR KENJI CHIN CHOON TSZE ON 6 FEBRUARY 2023, 15 AND 16 MAY 2023, 3 AUGUST 2023, AND 4 OCTOBER 2023

4 October 2023

Disciplinary Committee:
Dr Chan Siew Luen (Chairman)
Dr Tan Tien Wang
Dr Lui Jeen Nee
Dr Tyrone Goh (Observer)

Legal Assessor:
Mr Kenny Chooi
(Adsan Law LLC)

Counsel for the SDC:
Ms Chang Man Phing
Ms Dorcas Ong
(WongPartnership LLP)

Counsel for the Respondent:
Mr Charles Lin
Ms Tracia Lim
(Charles Lin LLC)

DECISION OF THE DISCIPLINARY COMMITTEE

INTRODUCTION

1. The Respondent, Dr Kenji Chin Choon Tsze, is a fully registered dentist under the Dental Registration Act 1999 ("***DRA***").

2. At all material times, the Respondent was practising as a dentist at 1728 Dental Practice (Ang Mo Kio) at 704 Ang Mo Kio Ave 8, #01-2559, Singapore 560704 ("***Clinic***").

3. These proceedings arose out of a complaint dated 21 June 2019 from one patient, Mr DT (“***Patient***”) against the Respondent.

4. Pursuant to the said complaint, the Singapore Dental Council (“***SDC***”) preferred 3 main charges (and 3 alternative charges) against the Respondent, as set out in the Notice of Inquiry dated 21 November 2022.

5. During the course of proceedings, the SDC proceeded with the First and Second main Charges, and withdrew the First and Second alternative Charges as well as the Third main and alternative Charges.

CHARGES

6. The First main Charge (“***First Charge***”) against the Respondent is as follows:

FIRST CHARGE

That you, **DR KENJI CHIN CHOON TSZE**, a registered dental practitioner under the Dental Registration Act 1999, are charged that whilst practising as a dentist at 1728 Dental Practice (Ang Mo Kio) Pte Ltd (the “**Clinic**”) between 22 May 2018 and 4 August 2018, you failed to carry out appropriate planning and assessment for pre-treatment diagnosis and placement of implants at tooth position #46 and #47 (collectively, the “**Implants**”) on your patient, Mr DT (the “**Patient**”).

Particulars

(a) On 22 May 2018, the Patient attended a consultation with you for a painful and mobile tooth at tooth position #47 (“**Tooth #47**”). An Orthopantomogram (“**OPG**”) was carried out on the Patient.

(b) Based on your clinical examination and review of the OPG image on 22 May 2018, you recommended that Tooth #47 be extracted and that implants be placed at Tooth #47 and tooth position #46 (“**Tooth #46**”).

(c) You proceeded to extract Tooth #47 on the same day.

(d) Based on the OPG image, you informed the Patient that there was insufficient bone height in the area at Tooth #46 and Tooth #47 for placement of the Implants, and scheduled for the Patient to return in three (3) months to ensure that there was sufficient bone height for placement of the Implants.

(e) On 4 August 2018, the Patient returned to the Clinic. An OPG was carried out on the Patient.

(f) Based on the OPG images on 4 August 2018, you estimated the location of the Inferior Alveolar Nerve ("**IAN**") and did not take any appropriate pre-surgery measurement of the alveolar bone height before confirming there was sufficient alveolar bone height and recommending for implants to be inserted at Tooth #46 and Tooth #47 on that day.

(g) You ought to have carried out appropriate planning and assessment to ascertain the measurements of the alveolar bone height at Tooth #46 and Tooth #47, by using the software accompanying the OPG to take the appropriate measurements.

(h) You failed to do so and thereafter proceeded with the placement of an implant of 5 mm in diameter and 10 mm in height at Tooth #46 and an implant of 5mm in diameter and 8.5mm in height at Tooth #47, which were significantly longer than the alveolar bone height of Tooth #46 and Tooth #47.

(i) While carrying out the osteotomy drilling for placement of the Implants, the Patient gave feedback that he felt slight sensitivity to pain. You relied on the Patient's feedback of pain and stopped drilling further.

(j) During the insertion of the implant at Tooth #47, the Patient also gave feedback of sensitivity to pain. You then unscrewed the implant slightly until there was no sensitivity.

(k) After placement of the Implants, an OPG was carried out (the "**4th August 2018 Second OPG**"). The 4th August 2018 Second OPG image showed the implant at Tooth #47 superimposed on the IAN canal and almost touching the inferior border of the IAN canal and the implant at Tooth #46 just above the IAN canal.

(l) The Patient suffered numbness at his lower right lip which had developed shortly after the placement of the Implants.

(m) The numbness at the Patient's lower right lip was caused by injury to the IAN during the drilling and/or placement of the Implants of inappropriate lengths as a result of your failure to carry out appropriate planning and assessment for pre-treatment diagnosis and placement of implants at tooth position #46 and #47.

and your aforesaid conduct amounts to an intentional or deliberate departure from standards observed or approved by members of the profession of good repute or competency, and that in relation to the facts alleged you have been guilty of professional misconduct under section 50(1)(d) of the Dental Registration Act 1999.

7. The Second main Charge ("***Second Charge***") against the Respondent is as follows:

<u>SECOND CHARGE</u>

That you, **DR KENJI CHIN CHOON TSZE**, a registered dental practitioner under the Dental Registration Act 1999 are charged that whilst practising as a dentist at 1728 Dental Practice (Ang Mo Kio) Pte Ltd (the "**Clinic**") between 4 August 2018 and 20 August 2018, you failed to monitor and review the Patient timeously when you knew or

ought to have known that the Patient's Inferior Alveolar Nerve may have been injured after the placement of the implants on 4 August 2018 and that the Patient was at a higher risk of developing paresthesia:

PARTICULARS

(a) On 4 August 2018, the Patient attended a consultation with you at the Clinic. An OPG was carried out on the Patient.

(b) You recommended that the Implants be placed at tooth position #46 and #47 that day.

(c) You proceeded with the placement of an implant of 5 mm in diameter and 10 mm in height at Tooth #46 and an implant of 5mm in diameter and 8.5mm in height at Tooth #47.

(d) While carrying out the osteotomy drilling for placement of the Implants, the Patient gave feedback that he felt slight sensitivity to pain. You then stopped drilling further. During the insertion of the implant at Tooth #47, the Patient again gave feedback of sensitivity to pain. You then unscrewed the implant slightly until there was no sensitivity. Based on the Patient's feedback of sensitivity to pain, you ought to have known that the IAN was very close to the implant osteotomy site and that nerve injury may have occurred.

(e) After placement of the Implants, an OPG was carried out (the "**4th August 2018 Second OPG**"). The 4th August 2018 Second OPG image showed the implant at Tooth #47 superimposed on the IAN canal and almost touching the inferior border of the IAN canal and the implant at Tooth #46 just above the IAN canal.

(f) From the 4 August 2018 OPG and the Procedure itself, you knew or ought to have known that the Patient's IAN may have been injured after the placement of the Implants on 4 August 2018 and he was at a higher risk of developing paresthesia.

(g) You knew or ought to have known that you had to monitor and review the Patient timeously within 24 to 48 hours to ascertain if he had developed paresthesia so that the appropriate action could be taken promptly. However, you failed to do so.

(h) The Patient only returned to the Clinic on 20 August 2018 to remove the stiches (*sic*) for the Implants. At the same visit, the Patient also complained of numbness at his lower right lip, which had developed shortly after the placement of the Implants. You assessed the Patient to have a 30% sensory deficit.

(i) The numbness at the Patient's lower right lip was caused by injury to the IAN during the drilling and/or placement of the Implants of inappropriate lengths.

and your aforesaid conduct amounts to an intentional or deliberate departure from standards observed or approved by members of the profession of good repute or competency, and that in relation to the facts alleged you have been guilty of professional misconduct under section 50(1)(d) of the Dental Registration Act 1999.

8. During the hearing, the Respondent pleaded guilty to the aforesaid First Charge and Second Charge.

THE AGREED FACTS

9. The Respondent agreed to the facts stated in the Agreed Statement of Facts (“***ASOF***”) without qualification.

10. The salient agreed facts in the ASOF are set out in the paragraphs below.

Consultation with the Respondent on 22 May 2018

11. The Patient was 61 years old at the material time. On 22 May 2018, the Patient attended a consultation with the Respondent for a painful and mobile tooth at Tooth #47. An OPG was carried out on the Patient.

12. Based on the Respondent's clinical examination and review of the OPG image on 22 May 2018, he recommended that Tooth #47 be extracted and that implants be placed at Tooth #47 and Tooth #46.

13. The Respondent proceeded to extract Tooth #47 on the same day.

14. Based on the OPG image, the Respondent informed the Patient that there was insufficient bone height in the area at Tooth #46 and Tooth #47 for placement of the Implants, and scheduled for the Patient to return in three (3) months to ensure that there was sufficient bone height for placement of the Implants.

Consultation with the Respondent on 4 August 2018

15. On 4 August 2018, the Patient returned to the Clinic. An OPG was carried out on the Patient.

16. Based on the OPG images on 4 August 2018, the Respondent confirmed that there was sufficient alveolar bone height and estimated the location of the IAN.

The Respondent recommended for implants to be inserted at Tooth #46 and Tooth #47 on that day.

17. The Respondent should have carried out appropriate planning and assessment to ascertain the measurements of the alveolar bone height at Tooth #46 and Tooth #47, by using the software accompanying the OPG to take the appropriate measurements.

18. The Respondent failed to do so and thereafter proceeded with the placement of an implant of 5 mm in diameter and 10 mm in height at Tooth #46 and an implant of 5mm in diameter and 8.5mm in height at Tooth #47, which were significantly longer than the alveolar bone height of Tooth #46 and Tooth #47.

19. Based on the OPG images of 4 August 2018, Tooth #46 has an alveolar bone height of between 10.1mm to 10.84mm, and Tooth #47 has an alveolar bone height of between 6.58mm to 6.6mm.

20. The Respondent gave the Patient local anaesthesia. 4% articaine was administered by way of both IDN block and buccal and lingual infiltration.

21. While carrying out the osteotomy drilling for placement of the Implants, the Patient gave feedback that he felt slight sensitivity to pain. Accordingly, the Respondent stopped drilling further.

22. During the insertion of the Implants, the Patient also gave feedback of sensitivity to pain. The Respondent then unscrewed the implant slightly until there was no sensitivity.

23. After placement of the Implants, an OPG was carried out (the "***4 August 2018 Second OPG***"). The 4 August 2018 Second OPG image showed the implant at Tooth #47 appearing superimposed on the IAN canal and the #47 implant tip appeared to encroach mandibular canal about 50% of canal diameter. The 4 August 2018 Second OPG also showed that the implant at Tooth #46 was just above the IAN canal.

24. The superimposition of the implant at Tooth #47 on the IAN canal exposed the Patient to direct trauma to the IAN as well as a higher risk of developing paraesthesia either from nerve compression or direct trauma to the IAN.

25. The Patient suffered numbness at his lower right lip which had developed shortly after the placement of the Implants.

26. The numbness at the Patient's lower right lip was caused by injury to the IAN during the drilling and/or placement of the Implants of inappropriate lengths as a result of the Respondent's failure to carry out appropriate planning and assessment for pre-treatment diagnosis and placement of implants at Tooth Position #46 and #47.

27. The Respondent's conduct at paragraphs 11 to 26 above amounts to an intentional or deliberate departure from standards observed or approved by members of the profession of good repute or competency, and that in relation to the facts alleged, the Respondent is guilty of professional misconduct under section 50(1)(d) of the Dental Registration Act 1999.

<u>Consultation with the Respondent on 20 August 2018</u>

28. The Patient returned to the Clinic on 20 August 2018 to remove the stitches for the Implants. At the same visit, the Patient complained of numbness at his lower right lip, which had developed shortly after the placement of the Implants. The Patient further stated that the numb area was originally larger but had become smaller. This was the first time the Respondent was told that the Patient suffered numbness.

29. From the 4 August 2018 OPG and the implant procedure, the Respondent knew, or at the very least, ought to have known that the Patient's IAN may have been injured after the placement of the implants on 4 August 2018 and that he was at a higher risk of developing paraesthesia.

30. The Respondent should have monitored and reviewed the Patient timeously within 24 to 48 hours to ascertain if the Patient had developed paraesthesia so that the appropriate action could be taken promptly. The Respondent next reviewed the Patient on 20 August 2018 (i.e. 16 days after the implant procedure).

31. The Respondent assessed the Patient to have a 30% sensory deficit. The Respondent made markings on the Patient's face to identify the area of numbness and a photograph was taken.

32. The Respondent's conduct at paragraphs 28 to 31 above amounts to an intentional or deliberate departure from standards observed or approved by members of the profession of good repute or competency, and that in relation to the facts alleged, the Respondent is guilty of professional misconduct under section 50(1)(d) of the Dental Registration Act 1999.

Consultation with the Respondent on 10 September 2018

33. On 10 September 2018, the Patient informed the Respondent that he was still experiencing numbness. The Respondent made markings on the Patient's face to identify the area of numbness and a photograph was taken. The photograph showed that between 20 August 2018 to 10 September 2018, the area of numbness had become smaller.

34. On the same day, the Respondent removed the implant at Tooth #47.

Consultation with the Respondent on 8 October 2018

35. On 8 October 2018, the Patient informed the Respondent that he was still experiencing numbness on his lower right lip. The Respondent prepared a referral letter dated 8 October 2018, referring the Patient to Dr AT ("***Dr AT***"). The Patient was scheduled to consult Dr AT on 3 January 2019.

36. The Patient did not see Dr AT at that time.

Conversation with Dr TM ("***Dr TM***") on 11 December 2018

37. The Respondent contacted Dr TM over WhatsApp regarding the Patient's reported paraesthesia. The Respondent said, "*Patient was referred to NDC Dr AT, but as the appointment given was too distant, patient has requested for an OS in private practice.*" The Respondent enclosed copies of the radiographs and the referral letter dated 8 October 2018 to Dr AT. The Respondent informed Dr TM that the Patient would call Dr TM's clinic to arrange an appointment.

38. Dr TM informed the Respondent that the nerve repair prognosis was very poor.

Consultation with Dr TM on 13 December 2018

39. On 13 December 2018, the Patient attended a consultation with Dr TM. The Patient informed Dr Tan that the numbness persisted.

Conversation with Dr Tan on 14 December 2018

40. The Respondent contacted Dr TM over WhatsApp requesting an update on the Patient regarding whether the Patient wanted a refund. The Respondent also asked Dr TM to advise the Patient on obtaining recourse via SDA.

Consultation with Dr Tan on 26 December 2018

41. On 26 December 2018, the Patient attended a consultation with Dr TM. The Patient informed Dr TM that the numbness had decreased.

Patient defaulted on appointment with Dr AT on 3 January 2019

42. The Patient did not attend his appointment with Dr AT on 3 January 2019 as he had consulted Dr TM.

Consultation with Dr TM on 4 January 2019

43. On 4 January 2019, the Patient attended a consultation with Dr TM. The Patient informed Dr TM that the numbness persisted. An X-Ray and Cone Beam CT ("***CBCT***") scan were done.

44. The CBCT scan showed that the implant at Tooth #46 was almost touching but not impinging the IAN. The CBCT scan showed the implant osteotomy site at Tooth #47; it was clear that the implant had intruded into the IAN canal and would have impinged on the IAN.

45. On the same day, Dr TM removed the implant at Tooth Position #46.

Consultation with Dr TM on 10 January 2019

46. On 10 January 2019, the Patient attended a consultation with Dr TM. The Patient reported that he was still experiencing numbness.

Consultation with the Respondent on 26 January 2019

47. On 26 January 2019, the Patient attended a consultation with the Respondent. The Patient informed the Respondent that he was still experiencing numbness and informed the Respondent that he did not see Dr AT but saw Dr TM instead. The Respondent refunded the treatment fee of $2,200 to the Patient's Medisave account.

Consultation with Dr TM on 7 March 2019

48. On 7 March 2019, the Patient attended a consultation with Dr TM and informed him that the intensity of the numbness remained the same.

Consultation with Dr TM on 20 June 2019

49. On 20 June 2019, the Patient attended a consultation with Dr TM. Dr TM carried out stage 1 of the implant surgery at, inter alia, Tooth #46 and Tooth #47, using shorter implants of 6mm length.

Complaint on 21 June 2019

50. The Patient filed a complaint against the Respondent on 21 June 2019.

Consultation with Dr TM on 10 October 2019

51. On 10 October 2019, the Patient attended a consultation with Dr TM. Dr TM carried out stage 2 of the implant surgery at, inter alia, Tooth #46, and Tooth #47.

Consultation with the Respondent on 29 January 2020

52. On 29 January 2020, the Patient attended a consultation with the Respondent. The Patient informed the Respondent that the numbness persisted. The Respondent agreed to accompany the Patient to the appointment with Dr AT on 26 March 2020.

Email exchange between the Respondent and Dr AT on 16 March 2020

53. On 16 March 2020, the Respondent emailed Dr AT regarding the appointment on 26 March 2020 and explained the Patient's condition. The Respondent enclosed a referral letter, radiographs, and electronic treatment notes.

Consultation with Dr AT on 26 March 2020

54. On 26 March 2020, the Patient attended a consultation with Dr AT at the National Dental Centre Singapore (NDCS). The Patient was accompanied by the Respondent. The Respondent paid for the Patient's consultation with Dr AT.

55. Based on the 4 August 2018 Second OPG, Dr AT observed that "*the #46 implant tip was just above the right mandibular canal superior border, and the #47 implant tip appeared to encroach mandibular canal about 50% of canal diameter*".

56. On examination, Dr AT found that "*the area of numbness involved the right lower lip (vermilion, skin, mucosa) sparing a lateral 1 cm wide vertical band, right chin*

sparing a lateral 1 cm vertical band, and involving the labial and lingual alveolar mucosa of teeth #41 to #47".

57. On the same day, neurosensory testing using the Zuniga-Essick (1992) protocol was performed (1 year 8 months after the implant surgery at #47). Dr AT noted that "*the neurosensory testing indicated no sensory impairment of the right inferior alveolar nerve. This was suggestive of a Sunderland III degree nerve injury. ... A Sunderland III degree nerve injury may improve but may not completely recover….*"

58. Dr AT's prognosis for recovery was guarded and he noted that "*the Patient's right lower lip and chin numbness may not resolve to normal sensation*".

59. Dr AT advised observation and sensory retraining but did not recommend exploration and repair of the right IAN.

60. The Patient still experiences numbness at his right lower lip and chin.

PROSECUTION'S SUBMISSIONS ON SENTENCING

61. Counsel for the SDC submitted that a sentence of at least 14 months' suspension ought to be imposed, and that the usual orders of a censure, undertaking, and for the Respondent to pay the costs of the proceedings, ought to be given.

62. Given that the misconduct alleged in the 2 Charges arise out of the same Procedure (being the pre-op and post-op aspects of the Procedure), the SDC submitted that they are part and parcel of the same chain of events. As such, the SDC evaluated the culpability of the Respondent and the harm caused to the Patient as a whole.

63. Applying the sentencing matrix in ***Wong Meng Hang v Singapore Medical Council*** [2019] 3 SLR 526 ("***Wong Meng Hang***"), the SDC submitted that:

(1) The Respondent's misconduct in the present case demonstrated a low degree of culpability (but at the high end of the range). The Respondent's misconduct was an intentional and deliberate departure from standards/guidelines. The Respondent was the dental practitioner who carried out the procedure and was solely involved in causing the harm, and he failed to take prompt action to remedy the situation.

(2) There is severe harm to his patients. The Respondent caused serious personal injury that was permanent and irreversible; and the Respondent's misconduct led the Patient to expend significant time and effort to rectify the harm caused.

(3) As the Respondent's misconduct falls under the high end of low culpability and severe harm, he would fall within the sentencing range of a suspension of 1 to 2 years, and the appropriate starting point would be a suspension period of 23 months.

(4) In *Disciplinary Committee Inquiry for Dr Oliver Hennedige* ("***Dr Oliver***"), the respondent faced 2 charges. Under the 1st charge, he had recommended and carried out on the patient, the treatment with placement of 15 mini-implants to support a 14-unit bridge in the patient's lower jaw when he knew or ought to have known was not an appropriate treatment, in light of the patient's limited bone width. Under the 2nd charge, the respondent had failed to exercise due care in the design and execution of the treatment of the patient, with placement of 15 mini-implants to support a 14-unit bridge in the patient's lower jaw to ensure that the treatment was carried out in an appropriate manner.

(5) The DC in *Dr Oliver's case* had evaluated both charges together and found that the charges fell into the category of serious/severe harm and moderate culpability. The DC there thus found that the appropriate starting point would be a suspension period of 2.5 years (30 months). The SDC accepted that the Respondent's culpability in the present case is lower than Dr

Oliver's (ie. it should be at the high end of the low culpability range), and should therefore warrant a shorter suspension period of 23 months.

(6) The Respondent is a senior dental practitioner with 20 years' experience, who has "*focused his area of practice on dental implants*" and would be accorded a higher level of trust and confidence by his patients. Thus, the Respondent's failures to carry out appropriate planning and assessment, and review and monitor the Patient's condition timeously, are particularly egregious.

(7) There is little mitigating effect in the Respondent's plea of guilt as Dr WT's expert report has effectively eroded a key plank of his defence to the 1st Charge, which is that there was sufficient bone height for the implants he had inserted.

(8) There should be an uplift of 1 month to take into account the offender-specific aggravating factors, and SDC submitted that the suspension should be for a period of 24 months.

(9) The SDC accepted that the 3 years 2 months taken in the present case could be considered an inordinate delay based on the precedents. A discount of no more than 40% ought to be applied which will reduce the suspension to 14.4 months, which SDC is prepared to round down to 14 months.

RESPONDENT'S MITIGATION AND SENTENCING SUBMISSIONS

64. Counsel for the Respondent submitted that his wrongdoing in the present case can be addressed by a moderate period of suspension of not more than 8 months.

65. The Respondent submitted that there were mitigating factors in the overall circumstances of the Respondent's inquiry as follows:

(1) Dr Chin is a first-time offender, with no prior antecedents and has elected to plead guilty at the earliest opportunity. This shows that Dr Chin's actions were out of character and what happened to the patient was an unfortunate confluence of patient presenting symptoms, physical condition and subsequent events. As a result of the incident, he has taken steps to limit his implant practice. It is clear that he is unlikely to re-offend.

(2) In support of his good character, the Respondent enclosed testimonials from Dr DG, Dr JG, Dr SY, and Dr CL, who are the Respondent's colleagues. The testimonials show that the Respondent is professional, compassionate, and is appreciated by his patients. These are testaments to the high standards of care provided by Dr Chin and the trust placed in him by his employers, colleagues, and patients. In addition, the Respondent volunteers at a charity, Willing Hearts. Willing Hearts operates a soup kitchen which prepares, cooks, and distributes meals to its beneficiaries.

(3) It is unfortunate that there was a 16-day gap between the dental implant surgery on 4 August 2018 and the Patient's review appointment with the Respondent on 20 August 2018. By way of explanation, it is standard practice at the Clinic for the clinic nurse on duty to call patients one day after a surgery.

(4) The Disciplinary Tribunal in *Singapore Medical Council v Dr Ganesh Ramalingam* [2018] SMCDT 6 had regard to the manner in which Dr Ganesh actively and voluntarily took steps to improve his clinical care and medical practice and found it to be a strong mitigating factor. In this regard, the Respondent is committed to improving his clinical care and medical (*sic*) practice so that future patients will not suffer nerve injuries. At his present practice, patients are called the day after surgery to check for complications. In addition to the abovementioned measures, Dr Chin has also taken proactive steps to prevent recurrences.

(5) The Respondent has shown remorse and insight by personally arranging remedial follow-up treatment for the Patient. The Respondent's actions are

noteworthy as they were done despite the Notice of Complaint dated 25 September 2019.

(6) The Respondent has not made financial gain from the Patient. The Patient received a full refund of his treatment fees on 29 January 2019. Furthermore, Dr Chin also paid for the Patient's consultations with Dr AT on 26 March 2020.

(7) Since the length of the delay in Dr Chin's prosecution (3 years and 2 months from the Notice of Complaint to the Notice of Inquiry) is similar to that in *Dr Oliver's case* (3 years and 5 months), a discount of 40% should also be applied.

66. The Respondent set out the sentencing framework in *Wong Meng Hang*, and submitted as follows:

<u>The First Charge</u>

(1) The level of harm is moderate. The harm suffered by the Patient was damage to the IAN. The Respondent distinguished the bodily harm suffered by the Patient from the severe harm suffered in *Dr Oliver's case*, which was an example of severe harm "*given the unsustainability of the Patient's current state and the likelihood of some intervention and surgery being necessary in the years to come*."

(2) The Respondent's culpability is on the high end of low. The Respondent was negligent in his conduct of the dental implant surgery, and he failed to take precise measurements to avert the risk of nerve injury. The Respondent distinguished his culpability from the DC's findings in *Dr Oliver's case*, where Dr Oliver failed to take proper precautions in light of the patient's limited bone width and poor oral hygiene, including 3D X-ray and CBCT scans, prior to dental implant surgery.

(3) The Respondent has submitted that the harm and culpability for the First Charge are moderate and high end of low respectively. Using the matrix in *Wong Meng Hang*, the applicable indicative sentencing range would therefore be a suspension of three months to one year. In the circumstances, the appropriate starting point is a suspension of 10 months.

The Second Charge

(4) The level of harm is on the lower end of the moderate range. The Respondent analogised the present case to *In the Matter of Dr Fong Wai Yin* [2016] SMCDT 7 ("***Fong Wai Yin***"). The Court of Three Judges in *Wong Meng Hang* had stated that the harm that was actually caused in *Fong Wai Yin's case* seemed to have been the patient's loss of chance to recuperate from the patient's existing medical condition.

(5) In the present case, the IAN injury, the eventual harm caused to the Patient, was not a direct result of Dr Chin's failure to monitor and review the Patient timeously. Instead, the harm occasioned to the Patient was his loss of a chance to receive appropriate and timely treatment for his IAN injury, therefore worsening his prognosis.

(6) The Respondent's culpability is on the high end of low. With regard to the circumstances surrounding the Second Charge, Dr Chin was of the mistaken view that the Patient did not suffer IAN injury because the Patient did not report any pain or sensitivity after the dental implant surgery. The Respondent was unfortunately relying on the clinic's protocol to check on patients post-surgery. In the circumstances, the Respondent failed to take prompt action to address a potential injury because he was relying on his clinic's protocol instead of personally checking.

(7) The Respondent submitted that the harm and culpability for the Second Charge are on the low end of moderate and high end of low respectively. Using the matrix in *Wong Meng Hang*, the applicable indicative sentencing

range would therefore be a suspension of three months to one year. In the circumstances, the appropriate starting point is a suspension of 6 months.

(8) The aggregate sentence of the two charges should be 16 months. However, there are mitigating factors which should reduce the aggregate sentence. Firstly, the Respondent has made a timely plea of guilt and has shown genuine remorse. Secondly, there have been inordinate delays in the prosecution of the Respondent. Thirdly, the Respondent made attempts to follow up with the Patient and arranged the Patient's consultations with Dr AT and Dr TM from 2018 to 2020. The Respondent has also made no financial gain from the Patient as he had refunded the Patient's treatment fees.

(9) The starting point of 16 months' suspension should be reduced downwards to a duration of no more than 8 months' suspension. In view of the inordinate delay in prosecution, a sentencing discount of 40% should be applied. The sentence is now 10 months' suspension. Furthermore, in view of Dr Chin's mitigating factors and strong show of remorse, the sentence should be further revised downwards by 2 months. The final sentence is 8 months' suspension.

DECISION OF THE DISCIPLINARY COMMITTEE

67. The Respondent had pleaded guilty to the First and Second Charges, and had admitted that he failed to carry out appropriate planning and assessment for pre-treatment and diagnosis and placement of the Implants on the Patient, and that he also failed to monitor and review the Patient timeously when he knew or ought to have known that the Patient's IAN may have been injured after the placement of the Implants on 4 August 2018 and that the Patient was at a higher risk of developing paraesthesia.

68. The undisputed evidence shows that the Respondent's conduct, in relation to the Patient, had amounted to an intentional or deliberate departure from the

applicable standards observed or approved by members of the profession of good repute or competency.

69. As such, having regard to the Respondent's plea of guilt, his admission to the ASOF without qualification and the evidence before us, we find the Respondent guilty of the Charge and convict him accordingly.

70. We now move on to consider the issue of the appropriate sentence to be imposed in the present case.

The level of harm and culpability will be assessed separately by this DC

71. As a preliminary point, the parties have adopted a different approach as to whether to apply the harm-culpability matrix as a whole or separately in respect of the 2 charges, in assessing the seriousness of the offence.

72. During the oral hearing of the sentencing submissions, counsel for the SDC had relied on *Dr Oliver's case* and evaluated the level of harm and culpability in respect of the 2 charges in the present case *as a whole*, on the basis that the misconduct alleged in the 2 charges arose out of the same procedure.

73. On the other hand, the Respondent had submitted that the level of harm and the level of culpability should be considered *separately* for each of the 2 charges.

74. In *Dr Oliver's case*, the DC (at [89]) was of the view that it was appropriate, on the facts of its case, to assess both charges together, and had stated as follows:

> "…*we are of the view that it would be apposite for both charges to be assessed together... While the First Charge relates to the Respondent's decision to carry out the mini implant procedure and the Second Charge relates to the design and execution of the same, the actions under both charges ultimately form part of a singular process. Thus, the harm caused by each charge cannot be segregated disjunctively from said process and should be evaluated as a whole.*"

75. We find that the charges and facts in *Dr Oliver's case* can be distinguished from those in the present case. In *Dr Oliver's case*, the first charge was in relation to the respondent's inappropriate carrying out of the procedure (including placing 15 mini-implants in the patient's lower jaw and a temporary bridge over the 15 mini-implants on 19 March 2015, and cementing a 14-unit bridge over the 15 mini-implants on 5 May 2015). The second charge was in relation to the respondent's inappropriate design and execution of the *same procedure* on the *same dates* (ie. 19 March 2015 and 5 May 2015 respectively).

76. As the same or similar acts/actions which fell on the same dates had formed the main basis of the first and second charges in *Dr Oliver's case*, the 2 charges were very closely intertwined. It was therefore perhaps understandable that the DC in Dr Oliver's case was of the view that the actions under both charges ultimately formed part of a singular process and that both charges could be assessed together.

77. In contrast, the First and Second Charges in the present case are for *different types of misconducts* and for *different periods of time*. In this regard, the First Charge was for ***pre***-treatment misconduct (for failing to carry out appropriate pre-treatment planning and assessment) between 22 May 2018 and 4 August 2018, whereas the Second Charge was for ***post***-treatment misconduct (for failing to monitor and review the patient timeously after the treatment) between 4 August 2018 and 20 August 2018. As such, the acts and periods constituting the basis of the First and Second Charges respectively in the present case are different or dissimilar.

78. In the premises, this DC is of the view that it would be appropriate to assess the levels of harm and culpability for the First and Second Charges separately. We will proceed to do so accordingly.

Level of Harm and Culpability in respect of the First Charge

<u>Level of Harm</u>

79. With regard to the level of harm, this DC is of the view that the harm caused by the Respondent in respect of the First Charge is moderate.

80. In this regard, the Respondent has agreed in the ASOF that the Patient suffered numbness at his lower right lip which had developed shortly after the placement of the Implants, and that the said numbness was caused by injury to the IAN during the drilling and/or placement of the Implants of inappropriate lengths by the Respondent.

81. As for the permanence / reversibility of harm, Dr AT in his Specialist Medical Report suggested that the nerve injury may improve but may not completely recover:

> "*4. …Sensation in the right lower lip and chin was reported as 6/10 [0 = totally numb, 10 = normal] …*
>
> *6. …The neurosensory testing indicated no sensory impairment of the right inferior alveolar nerve. This was suggestive of a Sunderland III degree nerve injury (Sunderland I-II degree nerve injury is temporary and recovers fully; <u>Sunderland III degree nerve injury may improve but may not completely recover</u>; Sunderland IV-V degree nerve injury is usually permanent.)*"

82. On 11 December 2018, the Respondent informed Dr TM via WhatsApp that "*Quadrant 4 was numb but area getting smaller, now maybe 2cmx3cm on lower right lip*". Further, the Patient had informed Dr TM during a consultation on 26 December 2018 that the numbness had decreased.

83. However, at the time of the ASOF (ie. 31 July 2023), the Patient still experienced numbness at his right lower lip and chin.

84. Accordingly, there appears to be some improvement, but not full recovery, of the nerve injury.

85. In the circumstances, we find the harm caused by the Respondent to be ***moderate***.

Level of culpability

86. In relation to the Respondent's culpability, both parties have submitted that the Respondent's level of culpability is on the high end of low.

87. The Respondent has accepted that his conduct was an intentional and deliberate departure from the applicable standards. He should have carried out appropriate planning and assessment to ascertain the measurements of the alveolar bone height at Tooth #46 and Tooth #47 on 4 August 2023, by using the software accompanying the OPG to take the appropriate measurements.

88. However, the Respondent admitted that he had failed to do so and had thereafter proceeded with the placement of an implant of 5mm in diameter and 10 mm in height at Tooth #46 and an implant of 5mm in diameter and 8.5mm in height at Tooth #47, which were longer than the alveolar bone height of Tooth #46 and Tooth #47.

89. Nevertheless, the Respondent's conduct appears to be a one-off incident in respect of a single patient. This would be less culpable than an offence that had been perpetrated over a prolonged period of time.

90. In addition, there is no evidence that the Respondent's breach was motivated by financial gains. We find that the Respondent's treatment fee of $2,200 (including GST) was reasonable, which he had in any event refunded in full to the patient's Medisave account subsequently. The Respondent had also paid for the Patient's consultation with Dr AT on 26 March 2020. As such, the Respondent did not simply put his own interests over the welfare of his patient.

91. Accordingly, this DC is prepared to accept the parties' submission that the Respondent's level of culpability is on the ***high end of low***.

Level of Harm and Culpability in respect of the Second Charge

Level of Harm

92. With regard to the level of harm in respect of the Second Charge, the Respondent has submitted that the harm caused by the Respondent is moderate.

93. The parties have agreed that the Respondent should have monitored and reviewed the Patient timeously within 24 to 48 hours to ascertain if the Patient had developed paraesthesia so that the appropriate action could be taken promptly.

94. Instead, the Respondent only next reviewed the Patient on 20 August 2018, which was 16 days after the implant procedure.

95. However, there is insufficient evidence before the DC to show that the Respondent's failure to monitor and review the Patient timeously had directly caused the IAN injury (which was the eventual harm occasioned to the Patient).

96. Rather, the DC finds that Respondent's failure to monitor and review the Patient timeously, to ascertain if the Patient had developed paraesthesia, may have caused the Patient a loss of chance to receive timely treatment and potentially recuperate from such a condition.

97. Even if the Respondent had monitored and reviewed the Patient timeously, there is insufficient evidence before the DC that the prompt removal of the implant would result in an improvement of sensation.

98. In the circumstances, we find that the harm caused by the Respondent was ***moderate*** (tending towards the lower end).

Level of Culpability

99. In relation to the Respondent's culpability, both parties have submitted that the Respondent's level of culpability is on the high end of low.

100. In this regard, the Respondent has stated that he was of the mistaken view that the Patient did not suffer the IAN injury as the Patient did not report any pain or sensitivity after the dental implant surgery, even though the Patient had experienced pain and sensitivity during the osteotomy drilling and implant insertion.

101. The Respondent stated that he had unfortunately relied on the clinic's protocol to alert him to any complications the Patient might have suffered. The Respondent claimed to have given the Patient post-operation instructions to call the clinic if he had issues.

102. We find that the Respondent should not have simply relied on the clinic's protocol to alert him to any complications the Patient might have suffered. This was not a valid excuse for the Respondent's failure to monitor and review the Patient timeously.

103. Nevertheless, having regard to the circumstances of the case, we are prepared to accept the parties' submission that the Respondent's culpability was on the ***high end of low***.

Applicable indicative sentencing range and appropriate starting point of the First Charge and Second Charge

104. According to the sentencing matrix set out in *Wong Meng Hang*, the applicable indicative sentencing range in respect of each charge would be a suspension of 3 months to 1 year for cases involving moderate harm and low culpability.

105. In relation to the **First Charge**, we have found that the harm caused was *moderate* and that the culpability of the Respondent is at the *high end of low*. We are of the view that the appropriate starting point within the indicative sentencing range for the First Charge would be a suspension of **10 months**.

106. With regard to the **Second Charge**, we have found that the harm caused was *moderate* (tending towards the lower end) and that the culpability of the

Respondent is at the *high end of low*. We are of the view that the appropriate starting point within the indicative sentencing range for the Second Charge would be a suspension of **8 months**.

107. In sum, the applicable starting point for both the First Charge and Second Charge would be a suspension for a cumulative period of **18 months** (ie. 10 months for the 1st Charge and 8 months for the 2nd Charge).

108. In this regard, we are of the view that the Respondent's misconduct in the present case was *less egregious* than the misconduct in *Dr Oliver's case*.

109. Unlike *Dr Oliver's case*, where there was a finding of *severe* harm (at the lower end) and *moderate* culpability, we have found that there was *moderate* harm and *low* culpability in respect of the Respondent. Therefore, the applicable starting point of a suspension period of 18 months would necessarily be lower than that of the 30 months that was applied in *Dr Oliver's case*.

Offender-specific aggravating and mitigating factors

110. We agree with the SDC that the Respondent's seniority of 20 years in the dental profession would have reposed a higher degree of trust and confidence in the Respondent, thereby making his misconduct more egregious.

111. The Respondent's seniority in the dental profession would ordinarily have resulted in an uplift of 2 months to the starting point of 18 months suspension (see also *Dr Oliver's case* where the DC there stated that the dentist's seniority is an aggravating factor which would, without more, result in an uplift to one's sentence of 2 months).

112. However, the aforesaid uplift would be offset by the following mitigating factors in the present case:

    (1) The Respondent's plea of guilt.

(2) The Respondent’s absence of prior convictions for professional misconduct.

(3) The Respondent’s taking of steps to improve his clinical care and dental practice to prevent recurrences.

113. Apart from the above offender-specific factors, both parties have submitted that there had been an inordinate delay in the prosecution of the proceedings. In this regard, the SDC accepted that a period of 3 years and 2 months between the issuance of the Notice of Complaint and the Notice of Inquiry could be considered an inordinate delay based on the precedents.

114. Both parties referred to and relied on *Dr Oliver’s case*, where the DC there had applied a discount of 40% to the starting point due to the delay of 3 years and 5 months in that case.

115. Based on *Dr Oliver’s case*, both parties agreed that since the period of delay in the present case was similar to that in *Dr Oliver’s case*, a sentencing discount of 40% should be applied in the present case.

116. As a preliminary point, this DC notes that the Court of Three Judges have stressed in the recent decision of ***Singapore Medical Council v Wee Teong Boo*** [2023] SGHC 180 that “*a discount in sentence for any delay in prosecution is not automatic or routine. In every case in which there has been a delay, all the circumstances have to be scrutinised to determine whether the application of a discount is appropriate and will not trivialise or undermine the sanction being meted out.*”

117. As such, this DC is of the view that although there had been a delay in prosecution of 3 years and 2 months in the present case, a discount in sentence of the delay is not automatic or routine.

118. Accordingly, it would not be appropriate for the parties to simply refer to the period of delay in a precedent case and without more, apply the sentencing discount applied in that precedent case to the case at hand, without first

scrutinising all the circumstances of the case at hand to determine whether the application of a discount is appropriate to the case at hand and would not trivialise or undermine the sanction being meted out.

119. In the present case, the parties did not set out or explain all the circumstances giving rise to the delay of 3 years and 2 months. Instead, the SDC had basically conceded that the period of 3 years and 2 months could be considered an inordinate delay based on the precedents and had thereby submitted for a sentencing discount of 40%.

120. In the absence of an explanation of all the circumstances giving rise to the delay of 3 years and 2 months in the present case and given the parties' common agreement for a sentencing discount of 40% to be applied in the present case, this DC will exercise its discretion to reduce the appropriate starting point of a suspension of 18 months to that of **11 months**.

CONCLUSION

121. Having carefully considered the submissions and documents before us, and having also taken into account all the circumstances of the case, the Disciplinary Committee orders as follows:

(1) The Respondent's registration in the Register of Dentists be suspended for a period of 11 months.

(2) The Respondent be censured.

(3) The Respondent is to give a written undertaking to the SDC that he will not engage in the conduct complained of or any similar conduct in the future.

(4) The Respondent is to pay the costs and expenses of and incidental to these proceedings, including the costs of counsel to the SDC and the Legal Assessor to the Disciplinary Committee, and such reasonable expenses as are necessary for the conduct of these proceedings.

122. We further order that the grounds of our decision be published.

123. The hearing is hereby concluded.

Dated this 4th day of October 2023

Dr Chan Siew Luen
Chairman, Disciplinary Committee

Dr Tan Tien Wang
Member, Disciplinary Committee

Dr Lui Jeen Nee
Member, Disciplinary Committee

Dr Tyrone Goh
Observer, Disciplinary Committee