G.N. 8173

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF THE MEDICAL COUNCIL OF HONG KONG

DR LEUNG NGAN CHIU (REGISTRATION NO.: M09261)

It is hereby notified that after due inquiry held on 9 November 2021 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong found Dr LEUNG Ngan Chiu (Registration No.: M09261) guilty of the following charges:—

'That on or about 16 June 2016, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ('the Patient'), in that:—

(a) he failed to initiate appropriate follow-up actions in light of the abnormal chest X-ray finding; and/or

(b) he failed to properly identify appropriate follow-up actions in the A&E notes for the Patient.

In relation to the facts alleged, either singularly or cumulatively, he has been guilty of misconduct in a professional respect.'

Dr LEUNG's name has been included in the General Register from 8 November 1993 to the present. His name has never been included in the Specialist Register.

Briefly stated, the Secretary of the Medical Council received on 29 November 2017 a complaint against a doctor at the Accident & Emergency Department ('AED') of Pok Oi Hospital ('POH') for alleged misconduct in respect of treatment of the Patient on 16 June 2016. Subsequent enquiry by the Secretary with POH revealed that the Patient visited AED of POH on 16 June 2016 and was attended by Dr LEUNG, who was then a medical officer of AED of POH.

According to the medical records obtained from the Hospital Authority, the Patient attended Yuen Long Jockey Club Health Centre ('YLJCHC') on 16 June 2016 because of chest wall pain for one week. He was then referred to AED for assessment.

According to the AED attendance record obtained from POH, the Patient attended AED of POH at 19:31 hours on 16 June 2016 and noted to be '*Ref (referred) by GOPC (General Outpatient Clinic)*'. At triage station, the Patient was ambulatory with blood pressure of 124/87mmHg and pulse of 109/min. His body temperature was 37.8°C. His respiratory rate was 13/min and oxygen saturation was 100% on room air. Electrocardiogram was done at 19:50 hours and showed sinus rhythm with rate of 98/min with no ST elevation.

There was no dispute that the Patient was later seen by Dr LEUNG. According to the AED attendance record obtained from POH, the Patient was noticed to have cough with running nose and pain over sternal region. Dr LEUNG then ordered blood test and chest X-ray for the Patient. Chest X-ray was done at 20:18 hours and Dr LEUNG put down '*? Rt (right) hilar mass*' in the AED attendance record. The Patient was then arranged to be observed at the Observation Room of AED. After reviewing his blood test results, Dr LEUNG prescribed the Patient with one dose of 30 mg intramuscular ketorolac before discharging him home with a provisional diagnosis of costochondritis.

There was also no dispute that despite the abnormal chest X-ray finding, Dr LEUNG did not initiate any follow-up actions before discharging the Patient home; nor had Dr LEUNG properly identified appropriate follow-up actions in the AED notes for the Patient.

On 28 September 2016, the Patient attended AED of POH again because of left shoulder pain for one week following his fall from bed. X-ray of left shoulder was taken and revealed multiple opacities at left lung. The Patient was admitted to the Medical Ward of POH with a provisional diagnosis of abnormal lung shadows.

Subsequent investigations then revealed that the Patient was suffering from malignant germ cell tumour with metastasis. Despite series of chemotherapy, there was no significant improvement and the Patient presented with right hemiparesis on 8 February 2017. Computed tomogram of brain then confirmed left parietal brain metastasis with haemorrhage. Eventually, the Patient succumbed to his illness on 16 February 2017.

Dr LEUNG admitted the factual particulars of the disciplinary charges against him and indicated through his solicitor that he would not be contesting the disciplinary proceedings.

It was the unchallenged evidence of the Secretary's expert witness that it was evident from viewing the chest X-ray taken on 16 June 2016 that there was a mass in the hilum of Patient's right lung. In putting down '*? Rt (right) hilar mass*' in the AED attendance record, Dr LEUNG was no doubt mindful of the abnormality shown in the Patient's chest X-ray. And yet, nothing further was done by Dr LEUNG to confirm the presence of the right hilar mass and let alone to determine its nature.

The Inquiry Panel agreed with the Secretary's expert witness in emergency medicine, that:—

> *'…Even the finding was not confirmed and was just suspected, appropriate follow up action should be arranged. A second opinion could be obtained from senior staff in the department, or the film could be sent to Department of Radiology for formal reporting. [The Patient] could also be referred to Specialist out-patient clinic for further assessment. However, none of these actions were identified in the A&E note and it unavoidably led to the delay in the diagnosis…*
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> *As Chest X-ray could not reveal the full picture of the extent of the tumour, I could not make any comment on whether the outcome of [the Patient] would be altered if the diagnosis could be made on 16/6/201(6)…'*

The Inquiry Panel was of the view that any registered medical practitioner standing in the position of Dr LEUNG at the material time and exercising reasonable skill and care ought to have initiated appropriate follow-up actions in the light of the abnormal chest X-ray finding. In failing to initiate appropriate follow-up actions in light of the abnormal chest X-ray finding, Dr LEUNG had in view of the Inquiry Panel by his conduct during the incident fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, Dr LEUNG was found guilty of professional misconduct as per disciplinary charge (a).

There was no dispute that Dr LEUNG had failed to properly identify appropriate follow-up actions in the AED notes for the Patient before discharging him home. Indeed, nothing was mentioned in the AED notes about follow-up actions at all. In failing to properly identify appropriate follow-up actions in the A&E notes for the Patient, Dr LEUNG had in view of the Inquiry panel by his conduct during the incident fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, Dr LEUNG was found guilty of professional misconduct as per disciplinary charge (b).

Taking into consideration the nature and gravity of Dr LEUNG's case and what the Inquiry Panel had heard and read in mitigation, the Inquiry Panel ordered that Dr LEUNG's name be removed from the General Register for a period of 1 month and that the operation of the removal order be suspended for a period of 12 months..

The order is published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Inquiry Panel of the Medical Council is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*