香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHIU Kong Ngai (趙剛毅醫生) (Reg. No.: ML00106)
Date of hearing: 25 November 2016 (Friday)

Present at the hearing

Council Members/Assessors:	Prof. Felice LIEH-MAK, GBS CBE JP (Temporary Chairman) Ms LAU Wai-yee, Monita Dr LEUNG Chi-chiu Dr KHOO Lai-san, Jennifer Mr POON Yiu-kin, Samuel

Legal Adviser: Mr Edward SHUM

Defendant: Dr CHIU Kong Ngai

Senior Government Counsel representing the Secretary: Mr Eric KO

1. The amended charges against the Defendant, Dr CHIU Kong Ngai, are:

"That in the period between a date on or about 9 June 2011 and a date on or about 7 July 2011, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam [redacted] ("the Patient"), deceased, in that:

(a) he inappropriately or without good medical reason prescribed systemic Dexamethasone to the Patient;

(b) he prescribed long period of high dose Diclofenac 50 mg (4 tabs/day) to the Patient without properly and/or adequately monitoring its side effect(s); and

(c) he inappropriately and/or without good medical reason prescribed Diclofenac continuously to the Patient.

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

Facts of the Case

2. Upon the recommendation of her friend, the Patient first consulted the Defendant on 9 June 2011 complaining of hip and leg pain. There is no dispute that the Defendant gave the Patient an intramuscular injection (IMI) of Dexamethasone, which is a systemic steroid, 1 ml (= 4 mg) at his clinic. The Defendant also prescribed to the Patient after the consultation, amongst others, 2 oral medicines, namely, Dexamethasone 0.5 mg 4 times a day (QID), Diclofenac, which is a nonsteroidal anti-inflammatory drug (NSAID), 50 mg QID for 2 days.

3. The Patient returned to see the Defendant again on 11 June 2011. Again, the Defendant gave the Patient the same dosage of Dexamethasone IMI at his clinic and the same 2 oral medicines were prescribed to the Patient after the consultation.

4. It is not entirely clear from the evidence altogether how many times the Patient had consulted the Defendant. However, according to the Defendant's consultation record card, he repeatedly administered and prescribed the same IMI and oral medicines to the Patient for 11 times in a span of 4 weeks from 9 June 2011 to 7 July 2011.

5. According to the medical report jointly prepared by Dr Lawrence MA, a specialist in haematology & haematological oncology, and Dr TSE Tak Sun, a specialist in cardiology, the Patient was admitted to St. Paul Hospital on 16 July 2011 with general malaise. Upon admission, her blood pressure was on low side and she was treated as a case of Addisonian crisis, precipitated by sepsis and was later transferred to the Intensive Care Unit for management. Clinical laboratory report on the same day also showed that her serum cortisol level was above normal value.

6. On 18 July 2011, the Patient had an episode of seizure for 3 minutes. Subsequent blood test then revealed markedly raised Troponin I test result which indicated that she might be suffering from acute myocardial infarction (heart attack). Bedside echocardigram also showed impaired left ventricular function. The differential diagnoses were acute myocarditis or Takotsubo cardiomyopathy secondary to acute stress with sepsis. Her condition continued to deteriorate despite dobutamine infusion. Blood test further showed renal impairment and she later developed congestive heart failure requiring bilevel positive airway pressure (BIPAP) support.

7. The Patient was transferred to the Pamela Youde Nethersole Eastern Hospital on 20 July 2011 after she developed acute pulmonary oedema with

desaturation. She was immediately admitted to the Cardic Care Unit for management. Initially, she was treated as severe sepsis with acute renal failure, convulsion and disseminated intravascular coagulopathy (DIC). However, she progressively developed respiratory distress and had to be intubated. Despite high level of inotropic support, empirical antibiotics, anti-fungals, anti-tuberculosis and other supportive treatments, she developed refractory shock and eventually died on 23 July 2011.

Burden and Standard of Proof

8. We bear in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. We also bear in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

9. There is no doubt that the allegations made against the Defendant here are serious ones. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine the above disciplinary charges against him separately.

Findings of the Council

10. We remind ourselves that we are not dealing with the causal link between the Defendant's prescription of systemic Dexamethasone and Diclofenac to the Patient and her subsequent death. In any event, it is not entirely clear from the available hospital records whether there was causal relationship between the two. In our view, the real issue is the propriety of the Defendant's prescription of systemic Dexamethasone and Diclofenac to the Patient.

11. It is clearly stated in the Code of Professional Conduct that a doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is necessary.

12. The Defendant told the Preliminary Investigation Committee (PIC) that the Patient complained to him of intermittent leg and hip pain on the first visit. No injury was noted upon physical examination albeit there was some limitation in movement. Having ascertained from the Patient that she had no history of drug allergy, the Defendant then prescribed Dexamethasone and Diclofenac to her as aforesaid.

13. It is not entirely clear from reading the consultation record card, which only recorded the names of medicine, what diagnosis the Defendant had made. The Defendant told us that the Patient presented with "腳部及髖部疼痛和風濕關節炎" (which in our view is not to be equated with rheumatoid arthritis). Apparently, the Defendant was treating the pain symptoms in her leg and hip and nothing more. However that may be, there is nothing in the evidence before us which indicates that prescription of systemic Dexamethasone was justified.

14. Even if Dexamenthasone was prescribed for off-label use, we agree with the Secretary's expert, Dr PANG, that before prescribing Dexamethasone to the Patient, the Defendant ought to weigh the expected gain carefully against the undesirable effects. This is especially true when he was dealing with a patient of the age of 64 and whose medical condition was in our view not properly assessed.

15. It was clearly stated in Harrison's Principles of Internal Medicine 15th ed. at p. 1992, systemic glucocorticoids (for which Dexamethasone is one) have no place in the treatment of osteoarthritis. Hence, even if the Defendant had actually found the Patient's pain symptoms to be of musculoskeletal origin, Dexamethasone was not indicated for the treatment of her oestoarthritic pain. Viewed from this perspective, the Defendant's prescription of Dexamethasone to Patient was without good medical reason.

16. Moreover, whilst Dexamethasone might offer the Patient some pain relief but the undesirable effects of this medicine, especially those associated with impaired or suppressed immunity, clearly outweighed the expected gain. Viewed from this perspective, the Defendant's prescription of Dexamethasone to the Patient was also inappropriate. Therefore, we find the Defendant guilty of charge (a) as amended.

17. Turning to charge (b). There is no dispute that the Defendant did not arrange for a renal function test before prescribing Diclofenac to the Patient. As with other NSAIDs, Diclofenac is contraindicated for patients with impaired renal functions. Without the benefit of a baseline renal function test, it would be difficult to gauge the renal toxic effects of Diclofenac on the Patient.

18. We agree with Dr PANG that the prescribed dosage of Diclofenac was high, bearing in mind the Patient's age and built. This was in fact 25% higher than the recommended range for an adult with normal renal functions. We also agree with Dr PANG that the adverse effect of Diclofenac on the

Patient's body might be aggravated by the continuous prescription and consumption of Dexamethasone.

19. We find the Defendant's repeated prescritions of Diclofenac for no less than 11 times to the Patient without paying proper attention to possible adverse effects on her renal functions unacceptable. In view of the lengthy period and high dosage of which Diclofenac was prescribed, the Defendant ought to have monitored the Patient's response to Diclofenac closely by arranging for appropriate laboratory tests. Therefore, we find the Defendant guilty of charge (b).

20. As to charge (c). Again, it is not entirely clear on what basis the Defendant had continuously prescribed Diclofenac to the Patient. Diclofenac can be used for the relief of signs and symptoms of osteoarthritis. But we agree with Dr PANG that without a precise diagnosis, the Defendant was achieving only a temporary relief of the pain symptoms by prescribing Diclofenac to the Patient repeatedly. Unlike the Defendant, we do not have the benefit of seeing the Patient. We cannot say for sure whether the initial prescription of Diclofenac to the Patient was proper. But then again, the real point is that the Defendant prescribed Diclofenac indiscriminately without verifying the underlying medical cause(s) for the leg and hip pain. We are firmly of the view that his continuous prescription of Diclofenac to the Patient was inappropriate and without good medical reason. Therefore, we find the Defendant guilty of charge (c).

21. By reasons of the aforesaid, the Defendant's conduct has clearly fallen below the standards reasonably expected of registered medical practitioners in Hong Kong. We therefore find him guilty of professional misconduct as charged.

Sentencing

22. The Defendant has a clear disciplinary record.

23. No doctor should prescribe medicine to his patient without proper consultation and unless drug treatment is actually indicated.

24. We are most concerned about the Defendant's indiscriminate prescription of medicines without verifying the underlying cause(s) of the Patient's medical complaints.

25. Having considered the nature and gravity of the disciplinary offences committed by the Defendant (as set forth in our findings above) and what we heard in mitigation, we order that:

(1) in respect of the amended charge (a), the Defendant's name be removed from the General Register for 3 months;

(2) in respect of charge (b), the Defendant's name be removed from the General Register for 1 month;

(3) in respect of charge (c), the Defendant's name be removed from the General Register for 3 months; and

(4) all the removal orders to run concurrently, making a total of 3 months.

26. We have considered carefully whether the operation of the removal orders should be suspended. We do not consider it appropriate to suspend the operation of the removal orders. We are particularly concerned about the Defendant's indiscriminate prescription of medicines without verifying the underlying cause(s) of the Patient's medical complaints. This also reflected on his competence to practise medicine. Regrettably, the Defendant did not seem to have sufficient insight into his wrongdoings and shortcomings.

Prof. Felice LIEH-MAK, GBS CBE JP
Temporary Chairman,
Medical Council