香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr HO Chun Por (何振波醫生) (Reg. No.: M03461)

Date of hearing: 29 December 2025 (Monday)

Present at the hearing

Council Members/Assessors:	Prof. FOK Tai-fai, SBS, JP (Chairperson of the Inquiry Panel) Dr WONG Lap-gate, Michael Dr CHIU Shing-ping, James Ms LIU Lai-yun, Amanda Mr LAI Sze-wai, Alex
Legal Adviser:	Mr Stanley NG
Defence Counsel representing the Defendant:	Ms Denise Souza as instructed by Messrs. Kennedys
Legal Officer representing the Secretary:	Mr Andrew TONG, Senior Government Counsel

The Charges

1. The amended charges against the Defendant, Dr HO Chun Por, are:

"That on or about 12 November 2018, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam [redacted] *("the Patient"), in that he:*

(a) failed to admit the Patient into hospital and/or arrange further investigation and management in light of the Patient's medical history

and clinical presentation, and when the cause of her 10-day high fever had not been identified; and

(b) failed to properly and/or adequately advise the Patient for the care after discharge and/or any potential red flag signs to seek further medical assistance.

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. The name of the Defendant has been included in the General Register from 17 February 1979 to the present. His name had been included in the Specialist Register under the Specialty of Orthopaedics & Traumatology from 4 March 1998 to 9 January 2024.

3. The Patient had history of infective endocarditis in 2005 with residual moderate to severe mitral regurgitation. She was all along followed up in Princess Margaret Hospital ("PMH"). The Patient attended the Accident and Emergency ("A&E") Department of PMH on 12 November 2018 for headache with feverish feeling since 3 November 2018. On arrival, she was noticed by triage nurse to have body temperature of 39.9°C and pulse rate of 139/min.

4. The Patient was later assessed by the Defendant. After initial assessment, the Patient was arranged for electrocardiogram ("ECG"), blood test and chest X-ray. She was also prescribed with oral paracetamol 500mg. ECG showed sinus tachycardia of rate 112/min. Chest X-ray showed clear lung field. The blood test later revealed increase in white blood cell counts and raised liver enzymes.

5. On reassessment, the body temperature of the Patient dropped to 37.6°C and repeated ECG showed sinus rhythm of rate 92/min. The Defendant discharged the Patient with paracetamol and the preliminary diagnosis was "[h]igh fever".

6. The Patient was found lying in the toilet at home on 16 November 2018. She was immediately sent to A&E Department of Yan Chai Hospital ("YCH"). Her conscious level rapidly deteriorated after arrival with Glasgow Coma Scale dropped from E4V1M5 to E1V1M2. Unequal pupils were also identified. Urgent computed tomogram of brain revealed left frontal intracranial hemorrhage with midline shift and intraventricular hemorrhage. The Patient was transferred to Neurosurgical Department of PMH for further management.

7. Urgent left craniectomy with removal of blood clot and right burr-hole for insertion of external ventricular drain for intracranial pressure monitoring were performed. A second operation for revision of external ventricular drain was performed on 20 November 2018. The subsequent digital subtraction cerebral angiogram detected aneurysms at the distal branches of left anterior cerebral artery and their appearances were compatible with mycotic cerebral aneurysms. An endovascular operation was subsequently performed on 22 November 2018 to embolize the left pericallosal pseudoaneurysms and distal callosomarginal pseudoaneurysms.

8. The Patient's neurological function was gradually improving afterwards. She was later transferred to YCH for rehabilitation. The recovery was slow and incomplete. There was also one episode of post-craniectomy syndrome which presented as deteriorated neurological condition on 28 March 2019 which required to transfer her back to Neurosurgical Department for further management. Cranioplasty was subsequently performed on 1 April 2019.

9. The Patient was transferred back to YCH to continue rehabilitation on 25 April 2019. Finally, she was discharged home on 25 November 2019. There was residual right side weakness and she could only walk with frame. She was subsequently assessed by psychiatrist to suffer from severe cognitive impairments.

10. By a statutory declaration made by the Patient's sister dated 30 May 2022, a complaint was lodged against the Defendant with the Medical Council.

Burden and Standard of Proof

11. We bear in mind that the burden of proof is always on the Secretary 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.

12. There is no doubt that the allegations 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 each of the amended disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

13. The Defendant admits the factual particulars of the amended disciplinary charges against him but it remains for us to consider and determine on the evidence whether he is guilty of misconduct in a professional respect.

14. The Defendant saw the Patient at around 1404 hours on 12 November 2018. The Defendant documented the past medical history of "endocarditis and adverse reaction of neutropenia with penicillin". The Defendant also documented the Patient's symptoms, including "fever and headache since 3/11, no URTI symptoms, no chest pain, no shortness of breath, no neck rigidity and no travel history". The physical examination finding recorded in the A&E notes included satisfactory general condition, high fever, throat not congested, chest clear, no limb weakness, no skin rash but fast pulse. The Defendant arranged investigation including ECG which showed sinus tachycardia of rate 112/min, chest X-ray which showed clear lung field, and blood test which showed elevated white blood cell count (10.7), normal hemoglobin (12.2) and platelet count (327), normal high sensitive troponin. The renal function test showed sodium (135), potassium (3.8), urea (2.7) and creatinine (46). The liver function test showed elevated total bilirubin (38), elevated alkaline phosphatase (271) and elevated alanine transaminase (105).

15. The Defendant prescribed one dose of oral paracetamol (500mg) to the Patient while waiting for the investigation result. Body temperature was rechecked at 1643 hours which was 37.6°C. Second ECG was performed at 1747 hours which showed sinus rhythm of rate 92/min. The Defendant assessed the Patient

again at 1803 hours with documentation of the summary of the abnormal blood test result and recorded "decreased fever and mild headache". Finally, the Defendant discharged the Patient home with paracetamol.

16. According to the opinion of Dr SIU, the Secretary's expert, which we agree, a reasonable emergency physician should be competent to identify patients who will need further investigation or admission for subsequent care.

17. With respect to the Patient's case, there were several strong indications for further investigation and care:

(i) Fever for about ten days;
(ii) Presented with high fever in an adult;
(iii) Cause of fever was not identified; and
(iv) Liver function derangement as noted in the initial blood test.

18. However, there was no evidence that the Defendant had considered any of the above indications. There was no relevant history and physical examination conducted after the blood test showed elevated liver enzymes. The body temperature response to paracetamol was notoriously to be not a reliable indicator for mild disease. It should not be considered as the criteria to discharge the Patient home in the absence of apparent cause of fever was identified.

19. In our view, the Patient's condition at the time of the consultation was very serious. She had a history of endocarditis, 10-day high fever and the cause of which was not identified and liver function derangement. The Defendant should have immediately admitted the Patient into hospital and/or arrange further investigation and management, which in our view was very elemental, but he had failed to do so. The Defendant's conduct had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (a).

20. There was also no advice to the Patient for the care after discharge or any potential red flag signs to seek medical help again from the Defendant. The disposal plan by the Defendant was not proper and/or adequate. The Defendant's conduct had in our view fallen below the standards expected of

registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (b).

Sentencing

21. The Defendant has a clear disciplinary record.

22. In line with our published policy, we shall give credit to the Defendant for his frank admission and full cooperation throughout these disciplinary proceedings.

23. We bear in mind that the primary purpose of a disciplinary order is not to punish the Defendant but to protect the public from persons who are unfit to practise medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation.

24. We have considered the Defendant's continuing medical education ("CME") attendance, character reference letter and letters and appreciation cards from patients.

25. The offences committed by the Defendant were very serious. As we stated above, the Patient's condition at the time of consultation was very serious and the Defendant should have admitted the Patient into hospital immediately.

26. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we shall make a global order in respect of the amended charges (a) and (b) that the name of the Defendant be removed from the General Register for a period of 3 months, and that the operation of the removal order shall be suspended for a period of 24 months on condition that the Defendant shall complete during the suspension period CME courses, to be pre-approved by the Council Chairman, on management of acute medical condition to the equivalent of 20 CME points.

Prof. FOK Tai-fai, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong