香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHUI Wing Hung (崔永雄醫生) (Reg. No.: M09288)

Date of hearing: 14 October 2026 (Wednesday)

Present at the hearing

Council Members/Assessors:	Prof. FOK Tai-fai, SBS, JP (Chairperson of the Inquiry Panel) Dr LEE Kin-wing, Vivian Prof. LAU Yu-lung, BBS, JP Mrs BIRCH LEE Suk-yee, Sandra, GBS, JP Ms YAM Hoi-yin, Cecilia
Legal Adviser:	Mr Stanley NG
Defence Solicitor representing the Defendant:	Dr David Kan of Messrs. Howse Williams
Legal Officer representing the Secretary:	Mr Louie CHAN, Senior Government Counsel

The Charges

1. The charges against the Defendant, Dr CHUI Wing Hung, are:

"That in or about June 2021, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), in that he:

(a) failed to identify the correct site of the Patient's pathological lymph node during the perioperative period of the video-assisted thoracoscopic surgery ("the Operation") on the Patient; and/or

(b) performed the Operation on the Patient improperly in a way that:
(i) damaged the Patient's left phrenic nerve during the Operation;
(ii) caused excessive blood loss during the Operation; and/or
(iii) caused the Patient to develop shortness of breath after the Operation.

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 14 January 1994 to the present. His name has been included in the Specialist Register under the Specialty of Cardio-thoracic Surgery since 4 April 2001.

3. At the time of the incident in 2021, the Patient was a 56-year-old lady who had history of left breast cancer for which she had undergone left mastectomy and axillary lymph node ("LN") dissection in April 2011. She was then given adjuvant chemotherapy and radiation therapy. Positron Emission Tomography/Computed Tomography ("PET/CT") on 12 March 2021 at Queen Elizabeth Hospital ("QEH") showed a new solitary hypermetabolic 1 cm left internal mammary LN worrisome for a metastatic node. The report did not indicate which level the LN was. The scan on 12 March 2021 showed that it was at the level of left second intercostal space (marked by an * by the radiologist).

4. On 21 March 2021, Ultrasonography ("USG") guided core biopsy of the LN confirmed carcinoma, consistent with breast origin. QEH Oncology referred the Patient to QEH Cardiothoracic Surgery ("CTS") for consideration of resection.

5. The Patient was also seen by Dr CHAU, oncologist at St. Teresa's Hospital ("STH") on 13 April 2021 who opined that with the history of radiation therapy before, further radiation could cause more harm and he advised either cardiothoracic surgery consult for excision, or palliative hormonal therapy. Dr CHAU referred the Patient to see the Defendant.

6. On 17 April 2021, the Patient consulted the Defendant. The Defendant advised surgical excision at STH.

7. The Patient was then also seen by QEH CTS on 7 May 2021 and surgery (left VATS + lymph node excision +/- thoracotomy) was offered and risks (including nerve damage) were explained. Tentative surgery date at QEH was set on 31 May 2021.

8. On 18 May 2021, before surgery, her pulmonary function test performed at St. Paul's Hospital was normal.

9. The Patient's Chest X-ray ("CXR") on 26 May 2021 before her surgery showed normal level of the left diaphragm indicating no diaphragmatic paralysis before surgery.

10. On 25 May 2021, the Patient developed left arm cellulitis and the tentative QEH surgery on 31 May 2021 was cancelled.

11. The Patient subsequently confirmed with the Defendant that she would undergo surgery at STH. On 3 June 2021, the Defendant performed left video-assisted thoracoscopic surgery and attempted resection of the LN ("the Operation"). During the Operation, the Defendant found *"An about 1.5 cm LN was located next to the LIMA (left internal mammary artery). The surface of the LN was exceptionally vascular with easy, "massive" bleeding upon dissection."*

12. The surgical procedure described *"... Dissection around the LIMA LN resulted in bleeding and this was controlled by multiple application of metal clips and direct compression. Haemostasis achieved eventually. Further dissection around the LIMA LN was deemed not feasible and risky."*

13. Anaesthetic record showed blood loss around 600ml and the surgery lasted about three and a half hours from 10:15 am to 1:45 pm.

14. According to the Defendant's progress notes, on 4 June 2021 (Day 1), the Patient was stable. On 5 June 2021 (Day 2), the chest drain was removed and a CXR was ordered. On 6 June 2021 (Day 3), the Defendant noted *"CXR yesterday clear, slightly elevated L hemidiaphragm"*, and the Patient was discharged home with a plan to follow up in clinic on 11 June 2021.

15. CXR on 5 June 2021 showed *".... reduced left lung volume and subsegmental atelectatic changes in the left lung base associated with elevated left hemidiaphragm."*

16. On 6 June 2021, the Defendant attended the Patient, who was afebrile and her condition was stable. The Defendant advised on follow up at his clinic on 11 June 2021. The Defendant wrote a referral letter to Hospital Authority Clinical Oncology in which it was stated *"... The peripheral aspect of the LN was marked with multiple metal clips to aid localization for RT."*

17. The Patient was discharged from STH on 6 June 2021. The Defendant did not see the Patient again after her discharge.

18. After the Patient returned home on 6 June 2021, she could not lay flat and needed to sit up against the head of the bed because of shortness of breath ("SOB").

19. On 9 June 2021, the Patient visited the Accident and Emergency Department ("AED") of Tseung Kwan O Hospital ("TKOH") for chest discomfort and SOB for 3 days. The Patient was admitted to TKOH until 16 June 2021. CT pulmonary angiogram ("CTPA") on 9 June 2021 showed no pulmonary embolism. CTPA confirmed significant elevation of left diaphragm, left lower lobe basal atelectasis and small amount of left pleural effusion.

20. On 6 August 2021, the Patient followed up with QEH CTS and Dr YAM there noted elevated left hemidiaphragm.

21. On 13 October 2021, the Patient visited TKOH AED again for SOB and chest pain. The Patient was admitted till 15 October 2021. Chest x-ray showed raised left hemidiaphragm and static pleural effusion. V-scan showed no right heart strain and trace left pleural effusion only.

22. The chest x-ray done at QEH on 16 May 2022 showed marked elevation of the left hemidiaphragm and markedly diminished lung volume.

23. By a statutory declaration made on 11 July 2022, the Patient lodged a complaint against the Defendant with the Medical Council ("Council").

Burden and Standard of Proof

24. 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.

25. 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 disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

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

27. The Secretary's expert, Dr SUEN, in his report dated 25 March 2023 said:

> *"On 6/6/2021, Dr Chui wrote a referral letter to HA Clinical Oncology where it was stated "... The peripheral aspect of the LN was marked with multiple metal clips to aid localization for RT."*
>
> *However, all postoperative CXR's, CT's and PET/CT showed that the clips were not at the level of left second intercostal space where the pathological LN should be. In fact, the clips (marked by circles in the CXR on 5/6/2021 at STH and CT on 14/1/2022 at QEH below) were high up behind the medial end of left clavicle and [first] rib where the phrenic nerve normally passes near the LIMA and left subclavian vein and innominate vein (marked by arrow on the CT). On the CXR on 5/6/2021, the rectangle marks the left second intercostal space where the pathological LN was but there were no clips there. There was a small speck of radio-opacity in the rectangle but it*

was not a clip but it corresponded to a radio-opacity at the hilum on the CT on 14/1/2022. The arrow in the CXR of 5/6/2021 at STH below indicated the elevated left hemidiaphragm after surgery.

…

Why did the patient develop SOB after the surgery?

It was not because of left pleural effusion because it was never documented that she had any significant left pleural effusion. On the CT scan, the amount of left pleural effusion was small, and it was judged that the amount was too small for thoracentesis. She developed significant SOB because her left diaphragm was paralyzed after the 3/6/2021 surgery. Her preop CXR and lung function were normal and she did not have SOB before surgery. However, after her surgery on 3/6/2021, CXR on 5/6/2021 and all subsequent radiological examination showed there was new significant elevation of the left diaphragm with atelectasis of the basal portion of the left lower lobe. The classical radiological sign of diaphragmatic paralysis is elevation of the diaphragm. Diaphragmatic paralysis results in significant SOB because the paradoxical motion it results is acting against the normal respiratory mechanics. The elevation of diaphragm associated with diaphragmatic paralysis results in atelectasis of the basal portion of the lower lobe resulting in shunting and hypoxia. The atelectasis was well documented in the CT scan shown above. The fact that her SOB is worse on lying down is compatible with diaphragmatic paralysis because without a functioning diaphragm, the abdominal organ will press more into the chest on lying down.

Why did the patient develop left diaphragmatic paralysis after the 3/6/2021 surgery?

There was evidence that surgery was performed over the normal course of the left phrenic nerve at the apex of the left chest. Normally, from the neck, the phrenic nerve runs behind the subclavian vein and anterior to the internal thoracic artery to enter the thoracic cavity through the superior thoracic aperture. In the postoperative CT thorax, there were clips right at

this site giving evidence that surgery was performed there and that was how the left phrenic nerve was damaged. Besides surgical trauma, there was no other explanation for the unilateral left diaphragmatic paralysis that happened right after her surgery.

Why was surgery performed over the site of the normal course of the left phrenic nerve high up in the left chest?
The surgeon's notes showed that the site of the pathological lymph node was incorrectly identified. As it was stated in the referral letter to the oncologist after the surgery ".... The peripheral aspect of the LN was marked with multiple metal clips to aid localization for RT.", the location of the clips indicates the site where the surgeon thought the pathological LN was but they were high up in the chest and not at the level of the left second intercostal space where the pathological LN should be. Surgery at the correct site (left second intercostal space around the LIMA) would not damage the left phrenic nerve because the phrenic nerve would be far away and in front of the left hilum at that level.

Why was there 600ml of blood loss for a lymph node resection?

For the same reason, because the site of the pathological lymph node was incorrectly identified, dissection was made at the apex of the left chest where the left subclavian vein, innominate vein and left internal thoracic artery were, and that resulted in significant bleeding. The multiple clips on the left subclavian vein and innominate vein give evidence of surgery there and bleeding happened there.

…

From the available evidence, the following conclusion can be drawn:

1. *The patient's lung function deteriorated after the surgery on 3/6/2021.*
2. *This was not because of pleural effusion but because of new left diaphragmatic paralysis.*
3. *The site of the pathological LN was incorrectly identified at the time of surgery.*

4. *Because dissection was performed at an incorrect location high up in the left chest, there was excessive bleeding from the left subclavian vein and/or innominate vein as marked by the clips, and*
5. *The left phrenic nerve was damaged resulting in left diaphragmatic paralysis and shortness of breath especially on lying down."*

28. We accept in full the expert opinion of Dr SUEN.

29. We are satisfied that the Defendant had failed to identify the correct site of the Patient's pathological LN during the perioperative period of the Operation on the Patient. The Defendant has by his conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find him guilty of misconduct in a professional respect as per charge (a).

30. We are also satisfied that the Defendant had improperly performed the Operation in that he performed dissection at an incorrect location high up in the left chest, resulting in damage to the Patient's left phrenic nerve, excessive blood loss during the Operation, and causing left diaphragmatic paralysis and shortness of breath. The Defendant has by his conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find him guilty of misconduct in a professional respect as per charge (b).

Sentencing

31. The Defendant has a clear disciplinary record.

32. In line with our published policy, we shall give credit to the Defendant for his admission and full cooperation.

33. 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.

34. We have considered the submitted commendation letters from the Defendant's colleagues and patients, who all praise him highly for his clinical acumen, surgical skills, and dedication to patient's care.

35. In mitigation, the Defendant told us that he was very familiar with the anatomy of the phrenic nerve and was well aware of the danger associated with operation at area of the phrenic nerve and LIMA. The Defendant honestly accepted that

the Operation on the Patient did not meet his expectation.

36. The Defendant told us that he has taken remedial measures since this incident. He has participated in a series of risk management courses to prevent recurrence of similar incidents. He has also participated in courses which would teach him how to deal with challenging surgical problems. He has also spent more time on reviewing imaging scans, and is mindful to continue to exercise due care and precautions. We accept that the Defendant has learnt his lesson, is genuinely remorseful, and the chance of re-offending should be low.

37. Taking into consideration the nature and gravity of the disciplinary charges for which the Defendant is convicted and what we have heard and read in mitigation, we shall make a global order in respect of charges (a) and (b) that the name of the Defendant be removed from the General Register for a period of 6 months. We further order that the removal order be suspended for a period of 24 months.

Remark

38. The name of the Defendant is included in the Specialist Register under the Specialty of Cardio-thoracic Surgery. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

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