

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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr KORNG Kokan Allan (關國安醫生) (Reg. No.: M09422)

Date of hearing: 14 July 2026 (Tuesday)

Present at the hearing

Council Members/Assessors: Dr CHOI Kin, Gabriel
(Chairperson of the Inquiry Panel)
Dr CHEUNG Chin-pang
Dr WONG Lok-yu
Ms LIU Lai-yun, Amanda
Mr CHOW Tat-hei

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Ms Jennifer LEE
of Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Miss Christy TSO,
Government Counsel

The Charge

1. The charge against the Defendant, Dr KORNG Kokan Allan, is:

“That on 29 May 2023, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [REDACTED] (“the Patient”), in that, he wrongly dispensed “Chloramphenicol”, an eye ointment, to the Patient instead of “Oramedy” as prescribed, when the Patient consulted him for oral ulcer.

In relation to the facts alleged, 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 since 26 April 1994 to the present.
3. On 29 May 2023, the Patient (aged 9), accompanied by his father, consulted the Defendant. The Patient presented with a 3-day history of lesion (around 1cm x 1cm in size) in his mucosa, just below his left inner lip. He was afebrile. The Defendant examined the Patient and his diagnosis was viral infection (severe). According to the Defendant’s submission, the Defendant prescribed the following medications to the Patient: (a) Oramedy paste (oral paste / gel for pain and irritation); (b) Acyclovir (antiviral medicine for infections); (c) Ibuprofen (non-steroidal anti-inflammatory drug); and (d) Polaramine (antihistamine). After the consultation, the Patient took and/or applied the prescribed medications.
4. On 30 May 2023, the Patient suddenly developed high fever. The swelling of the Patient’s oral lesion got worse. The Patient was taken to an Accident and Emergency Department of a private hospital for treatment. A doctor there noted that the drug label of “Oramedy Paste” was stuck onto the box of Chloramphenicol eye ointment, which was dispensed by the Defendant to the Patient the day before.
5. By a statutory declaration made on 28 July 2023, the Patient’s father lodged a complaint against the Defendant with the Medical Council (“Council”). Photographs of the wrongly dispensed Chloramphenicol eye ointment were enclosed therein (“Photographs”).

Burden and Standard of Proof

6. 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.

7. There is no doubt that the allegation made against the Defendant here is serious. 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 disciplinary charge against the Defendant carefully.

Findings of the Inquiry Panel

8. The Defendant admits the factual particulars of the charge.
9. We have looked at the Photographs, which show a box of ointment in its original manufacturer's box with these words printed on top "ChlorOph", "CHLORAMPHENICOL 5Gm", and "Eye Ointment STERILE". Attached to the box is the Defendant's drug label issued for the Patient, which contains the words "Oramedy Paste".
10. The manufacturer's box bears a completely different drug name, and which is for treatment of eyes, than the one printed on the Defendant's drug label. It is very clear that the Defendant had wrongly dispensed Chloramphenicol eye ointment, instead of Oramedy paste, to the Patient.
11. It is stipulated in the Code of Professional Conduct (2022 Edition) that:

"9.2 A doctor who dispenses medicine to patients has the personal responsibility to ensure that the drugs are dispensed strictly in accordance with the prescription and are properly labelled before they are handed over to the patients. The doctor should establish suitable procedures for ensuring that drugs are properly labelled and dispensed. Doctors are advised to observe the provisions of Good Dispensing Practice Manual issued by the Hong Kong Medical Association."
12. We are satisfied on the evidence before us that 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 professional misconduct as charged.

Sentencing

13. The Defendant has a clear disciplinary record.
14. We shall give credit to the Defendant for his frank admission and full cooperation throughout these disciplinary proceedings.
15. 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.
16. We have considered the character reference letters and CME records as submitted.
17. The Defendant told us that at the material times, his clinic had been in place a triple check system. At least two clinic assistants would be on duty at the clinic, and they would be in charge of preparing, checking and dispensing medications. One clinic assistant would first prepare the medications based on the Defendant's prescriptions. After preparing the medications, they would be passed to the other clinic assistant for checking. They would be further passed to the Defendant for checking before dispensing to patients. The Defendant said that for the Patient's case, he did not remember what happened and why the error occurred.
18. The Defendant said that since the incident, he has taken further or remedial steps to enhance his triple check system. At the reception area, there are now notices reminding the clinic assistants to check and cross-check medications before dispensing. Chloramphenicol eye ointment and Oramedey would no longer be placed in the same storage area. The two clinic assistants would fill in a "Medication Dispensing Checklist" ("Checklist"). A clinic assistant would (i) confirm the patient's name on the drug label(s) is correct; (ii) check the patient's allergy profile; (iii) ensure that the medication(s) match with the drug name(s) stated on the labels; (iv) ensure that the dosage and frequency of medication(s) are correct; and (v) ensure that the amount of medication(s) prescribed is correct. After confirming everything has been correct, the same clinic assistant would tick and sign on the Checklist, and pass the medications to the Defendant for checking. The Defendant would repeat the same steps and

then tick and sign on the Checklist. The remaining clinic assistant would check to ensure that both the Defendant and the first clinic assistant have signed on the Checklist; check to ensure that the medication(s) and the patient's name on the respective labels are correct; sign on the Checklist; and tick on the labels. With these remedial measures in place, we are satisfied that the risk of re-offending is low.

19. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we order that a warning letter be issued to the Defendant, to be published in the Gazette.

Remark

20. We take this opportunity to remind the Defendant that he should always familiarize himself with the Good Dispensing Practice Manual issued by the Hong Kong Medical Association.

Dr CHOI Kin, Gabriel
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong