

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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr KWOK Chi Yeung Peter (郭志揚醫生) (Reg. No.: M02618)

Date of hearing: 29 April 2026 (Wednesday) (Day 1)
30 April 2026 (Thursday) (Day 2)
11 July 2026 (Saturday) (Day 3)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHEUNG Chin-pang
Dr WONG Mo-lin, Maureen
Mr CHAN Wing-kai, MH
Ms TANG Hoi-lin, Helen

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by
Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Miss Julie LAM, Outside Counsel,
as instructed by Department of Justice

The Amended Charges

1. The amended charges against the Defendant, Dr KWOK Chi Yeung Peter,
are:

*“That in or about August 2011, he, being a registered medical
practitioner, disregarded his professional responsibility to his*

patient [REDACTED] (*"the Patient"*) in that he should have (i) properly advised the Patient of the risks of placenta praevia prior to performing the caesarean section; and (ii) documented the same in the medical records, but he failed to do (i) and/or (ii).

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 11 December 1975 to the present. His name has been included in the Specialist Register under the Specialty of Obstetrics & Gynaecology since 4 March 1998.
3. Briefly stated, on 4 March 2011, the Patient, a Mainland resident then 40 years old, was first seen by the Defendant at 15 weeks' gestation for antenatal care at the Outpatient Clinic of Evangel Hospital. Ultrasound examination then showed a fetus with growth parameters appropriate for gestational age and a posterior and low-lying placenta.
4. Based on the Patient's reported date of last menstruation, the expected date of confinement would be around 21 August 2011. However, the Patient requested to have the delivery for her baby by Caesarian Section at certain selected date in or around the middle of August 2011.
5. According to the Defendant, the Patient told him that her past health was good. She had one normal vaginal delivery in 1998 and one termination of pregnancy. The Patient also told him that she would not return from the Mainland for other antenatal checkups until 10 August 2011.
6. On 10 August 2011, the Patient returned to see the Defendant at the Outpatient Clinic of Evangel Hospital.
7. According to the Defendant, "[a] routine antenatal check-up was given to [the Patient], namely, a brief history on her well-being, body weight, routine urine test on sugar and protein, blood pressure and pulse checking; the uterine fundal height was estimated; fetal presentation

was determined, and the fetal heart rate was determined.” The Patient also “gave a history that she was well; previous antenatal courses in China were without abnormalities. There was no history of vaginal bleeding, no history of premature uterine contraction (premature labour). Abdominal examination [showed] that the fetus was cephalic presentation; the fetal head was engaged to the pelvis. A bed-side ultrasound estimation of the fetal size was made, which was documented to be about 2.94 kg by the ultrasound machine.”

8. There is no dispute that the Defendant did not advise the Patient during the second consultation on 10 August 2011 about the risks of placenta praevia.
9. On 13 August 2011, the Patient admitted herself to the Precious Blood Hospital for elective lower Caesarian Section by the Defendant.
10. According to the medical records obtained from Precious Blood Hospital, obstetric assessment upon admission by a midwife showed that the Patient had no antenatal complication. Abdominal examination then showed cephalic presentation. However, the ‘Engagement’ entry was left blank. The Patient also signed a pro-forma Consent Form in Chinese, in which it was mentioned, amongst others, that the nature, effects and risks of the Caesarian Section had been explained by the Defendant. Details of the explanation were however not recorded in the Consent Form.
11. There is however no dispute that the Defendant did not advise the Patient about the risks of placenta praevia before performing the Caesarean section.
12. According to the medical records obtained from Precious Blood Hospital, the Defendant started to perform lower segment Caesarian Section for the Patient under spinal anaesthesia at 19:04 hours later in the evening. A female baby of 2.75 kg with good Apgar score was delivered at 19:16 hours. Collection of cord blood for stem cells storage was performed upon the Patient’s request and completed at 19:20 hours.
13. However, large amount of bleeding from the uterine cavity was noted by the anaesthetist at 19:25 hours, accompanied by a drop in systolic blood pressure from 120-130 mmHg to 100 mmHg. Moreover, the placenta failed to separate completely from the uterine attachment. Attempt was made to deliver the placenta by cord traction but in vain.

The placenta was found to be firmly attached to the lower posterior segment of the uterus. Eventually, the placenta had to be delivered by manual removal. Two large bleeding points from the lower segment were found and plication of the bleeding points had to be done. However, a further drop of systolic blood pressure to 90mmHg was noted by the anaesthetist and blood loss was estimated to be around 2,000 ml. Assistance from a second anaesthetist was sought and preparation for blood transfusion was arranged. At 20:00 hours, transfusion of the first unit of blood was started. However, further blood loss was noted. By 20:30 hours, the total blood loss was estimated to be around 4,000 ml. The uterus was found to be floppy and atonic. Further bleeding was noticed coming from the upper uterine cavity. Further exploration of the uterine cavity however showed no residual placental tissue. Several measures including uterine massage, ligation of both of uterine arteries, B-Lynch suture over uterine fundus; and closure of uterine wound were performed. Finally, the bleeding stopped and the operation was ended at 21:25 hours.

14. Arrangement was made for the Patient to be transferred to the Princess Margaret Hospital ("PMH") for management. Eventually, escorted by the Defendant and a midwife, the Patient arrived at PMH at around 02:22 hours on 14 August 2011. Laparotomy was performed at 22:20 hours later in the day which showed 2,500 to 3,000 ml haemoperitoneum. There were also bleeding from uterine wound. Sub-total hysterectomy with removal of most of the cervix had to be performed. The Patient remained stable after the operation and her postoperative course was uneventful. However, she discharged herself from PMH against medical advice on 19 August 2011.
15. The Patient's husband subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Burden and Standard of Proof

16. 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.

17. 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 the disciplinary charge against him carefully.

Findings of the Inquiry Panel

18. After the conclusion of the Secretary's case, we ruled in favour of the defence submission of no case to answer in respect of the alternative basis that the Defendant should have documented in the medical records the advice on the risks of placenta praevia.
19. It is always the Defendant's case that he did not advise the Patient of the risks associated with placenta praevia. It follows in our view that the Defendant could not have documented in the medical records something which he never did.
20. For these reasons, taking the Secretary's case at its highest, we are unable to find the Defendant guilty of misconduct in a professional respect on the alternative basis.
21. Much time was spent during this inquiry on whether the Patient actually had placenta praevia. It is however pertinent to note that the Defendant is not being charged with failure to make the diagnosis of placenta praevia.
22. In our view, the real issue in this inquiry is whether the Defendant should have properly advised the Patient about the risks of placenta praevia prior to performing the Caesarean Section.
23. The law in this respect is clear. As the learned editors of *Jackson & Powell on Professional Liability* (8th ed.) said at 13-048:-

“General principle. A doctor is under a duty to take reasonable care to ensure that a patient is aware of any material risks involved in any

recommended treatment and of any reasonable alternative or variant treatments...”

24. In the latest edition (i.e. 9th ed.), the learned editors of *Jackson & Powell on Professional Liability* further explained at 13-023:-

“The test of materiality is whether, in the circumstances of the particular case (1) a reasonable person in the patient’s position would be likely to attach significance to the risk; or (2) the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it. The assessment whether a risk is material is fact-sensitive and sensitive to the characteristics of the patient. It cannot be reduced to percentages.”

25. When considering the materiality of the risks of placenta praevia to the Patient, we gratefully adopt as our guiding principles what the House of Lords had said in *Montgomery v Lanarkshire Health Board* [2015] AC 1430:-

“89. ... The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient.”

26. Our attention was drawn by Dr LEUNG, the Secretary’s expert witness, to the Royal College of Obstetricians & Gynaecologists’ Green-top Guideline No. 27 (January 2011) on *Placenta Praevia, Placenta Praevia Accreta and Vasa Praevia: Diagnosis and Management*; and we totally agree with the statement that “[m]aternal and fetal morbidity and mortality from placenta praevia... are considerable.”

27. Placenta praevia exists when the placenta is inserted wholly or in part into the lower segment of the uterus. As Dr LEUNG further explained, and we accept, placenta praevia will increase the risks of “*massive obstetric haemorrhage, the need for blood transfusion and the chance of hysterectomy*”. Viewed from this perspective, the risks of placenta praevia would still be of significance to a patient regardless of whether she is going to give birth by natural delivery or Caesarean Section.
28. In our view, given the dire consequences of the eventuality, any reasonable person in the position of the Patient would attach significance to the risks of placenta praevia. Accordingly, unless placenta praevia could be safely excluded, it remained in our view the Defendant’s duty to advise the Patient properly of the risks of placenta praevia.
29. When being complained, the Defendant initially explained to the Preliminary Investigation Committee (“PIC”) in his submission dated 10 December 2015 that he noticed from the bedside ultrasound taken during the first consultation with the Patient on 4 March 2011 that “*the placenta situated in the posterior aspect of the uterus, and low lying in position.*” And in his subsequent witness statement dated 22 August 2017, the Defendant further explained that “... *I recorded on my medical record (Out-patient Progress Sheet) “placenta posterior low lying”. What I meant by this note was that the placenta was not attached to the fundus of the uterus. I did not mean that the placenta was attached to the posterior lower segment of the uterus because at the gestation of 15 weeks the lower segment of the uterus was not yet formed. As I did not find the placenta covering or overlapping the cervical os, I did not record it as such on my medical record (Out-patient Progress Sheet).*”
30. When being asked in examination in chief, the Defendant told us that he wrote down “*placenta posterior low lying*” in his medical record to remind himself to exclude placenta previa. This was also why he had to look for the placenta during the ultrasound scanning when the Patient returned to see him on 10 August 2011.
31. Whilst vaginal bleeding is often seen in patients with placenta praevia, we agree with Dr LEUNG that placenta praevia may be asymptomatic.

In our view, the Defendant could not safely rely on the absence of complaint of vaginal bleeding to exclude placenta praevia. This is particularly true when the Patient did not follow up with the Defendant after the first consultation until she returned to see him on 10 August 2011.

32. We also agree with Dr LEUNG that placenta praevia could not be excluded in this case by assessing the sonographic images for the measurement of the fetal head and abdomen; and assessment should be made by a real-time ultrasound examination and, if necessary, by transvaginal scanning to ascertain the placental location and its relation to the cervical os.
33. We do not accept the Defendant's oral evidence that he found during the real-time ultrasound examination on 10 August 2011 that there was "*no placenta or trace of placenta in the area of the cervical os*".
34. When being asked by us, the Defendant accepted that he could not see the cervical os in any of the 3 pictures taken during the real-time ultrasound examination on 10 August 2011. Given one of the reasons why real-time ultrasound examination was done is to exclude placenta praevia, we naturally expect the Defendant to have taken at least one more picture, which could show that there was "*no placenta or trace of placenta in the area of the cervical os*". Indeed, there was no documentation of this important finding in the medical records for the second consultation on 10 August 2011. Nor did the Defendant mention about this in his first submission to the PIC.
35. It follows in our view that the Defendant should have properly advised the Patient of the material risks of placenta praevia in terms of "*massive obstetric haemorrhage, the need for blood transfusion and the chance of hysterectomy*" prior to performing the Caesarean Section.
36. Counsel for the Defendant submitted that the recommendation in section 6.7 of the said Guidelines of Royal College of Obstetricians & Gynaecologists that "*Any woman giving consent for caesarean section should understand the risks associated with caesarean section in general and the specific risks of placenta praevia in terms of massive obstetric haemorrhage, the need for blood transfusion and the chance*

of hysterectomy” was merely a matter of good practice. Failing to comply with the recommendation should not constitute misconduct in a professional respect.

37. In our view, this is beside the point. We are not concerned with “*any woman*”. The real point, in our view, is whether a reasonable person in the Patient’s position would be likely to attach significance to the risks of placenta praevia.
38. In failing to properly advise the Patient of the risks of placenta praevia prior to performing the caesarean section, the Defendant had in our view by his conduct in this case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as charged.

Sentencing

39. The Defendant has a clear disciplinary record.
40. 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.
41. We appreciate that the Patient’s choice of delivery by Caesarean Section might not be affected by the advice on the risks of placenta praevia. Had the Patient been properly advised of the risks of placenta praevia, she and her family could have better preparation for the eventuality.
42. Taking into consideration the nature and gravity of the disciplinary charge for which we have found the Defendant guilty and what we have heard and read in mitigation, we order that the Defendant be reprimanded.

Remark

43. The name of Defendant is included in the Specialist Register under the Specialty of Obstetrics & Gynaecology. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong