香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr LEUNG Yin Ching (梁燕菁醫生)(Reg. No.: M14617)

Date of hearing: 11 April 2018 (Wednesday)

Present at the hearing

Council Members/Assessors: Prof. Felice LIEH-MAK, GBS CBE JP
(Temporary Chairman)
Dr CHENG Chi-man
Dr HUNG Se-fong, BBS
Mr HUNG Hin-ching, Joseph
Dr KONG Wing Ming, Henry
Mr POON Yiu-kin, Samuel

Legal Adviser: Mr Edward SHUM

Defence Solicitor representing the Defendant: Dr Bernard Murphy of Messrs. Howse Williams Bowers

Assistant Law Officer (Acting) representing the Secretary: Mr William LIU

1. The charges against the Defendant, Dr LEUNG Yin Ching, are :

"That on or around 17 January 2012, she, being a registered medical practitioner, disregarded her professional responsibility to her patient [redacted] ("the Patient"), deceased, in that:

(a) she failed to carry out active investigation for hypoxia and hypotension of the Patient;

(b) she failed to have sufficient regard to the physical signs of the Patient when examining the Patient; and

(c) she failed to admit the Patient to the hospital for proper care and treatment when the circumstances so warranted.

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

Facts of the case

2. The Defendant was at all material times a registered medical practitioner. Her name has been included in the General Register from 2 July 2005 to present. Her name has never been included in the Specialist Register.

3. According to the Complainant, the Patient, who was then 14 years old, started to complain of front shoulder pain and chest bone pain in the morning of 17 January 2012 and rash was noted over her face.

4. The Patient subsequently attended the Outpatient Department of Hong Kong Sanatorium and Hospitals ("HKS&H") with her mother (the "Complainant") at about 22:13 hours in the evening of 17 January 2012.

5. According to the report prepared by the Deputy Medical Superintendent of HKS&H, the Patient was called to the Triage area for measurement of vital signs at about 22:24 hours.

6. Vital signs measured temperature of 36.6 degree Celsius, blood pressure of 90/60 mmHg, pulse rate of 130/minute, oxygen saturation of 92% and respiratory rate of 20/minute were noted. Re-measurement of oxygen saturation was done and it showed a SpO2 of 95%.

7. The Patient was later seen by the Defendant, one of doctors on duty at the Outpatient Department of HKS&H, at about 22:27 hours.

8. According to her submission to the Preliminary Investigation Committee ("PIC"), the Defendant learnt from the Patient that she had been unwell for a few days with runny nose and a cough with low grade fever. The Patient had seen other private doctors during the past few days, who told her that she had upper respiratory tract infection or influenza for which they prescribed her with medication for symptomatic treatment. One doctor also prescribed her with antibiotic but there had been no improvement in her condition.

9. According to the Defendant, the Patient did not have a fever when she saw her. The Defendant did not note any respiratory distress or skin rash on the Patient. The Defendant noted that the Patient's throat was congested and the tonsils were inflamed. There was however no ulceration or enlargement of tonsils and there was no evidence of strawberry tongue. The Defendant noted that the Patient had slight decrease in skin tone and she considered the Patient to be mildly dehydrated.

10. Upon chest examination of the Patient, the Defendant noted during auscultation the presence of mild crepitation and wheezes in her chest. However, her airway was noted to be good.

11. Following chest examination, the Patient's vital signs were rechecked at about 22:38 hours, which showed blood pressure of 81/44 mmHg, pulse rate of 70 bpm and oxygen saturation on room air of 90%.

12. In light of her aforesaid examination findings, the Defendant made the working diagnosis of acute bronchitis/bronchiolitis and decided to prescribe the Patient with a different antibiotic. The Defendant also advised the Patient that she could continue treatment at home with plenty of rest and to increase her fluid intake. The Defendant further advised the Patient to return to see her or other doctors of the Outpatient Department of HKS&H for follow up in 3 days, or sooner if symptoms worsened or did not improve.

13. According to the Complainant, the Patient's condition deteriorated after returning home and she developed shortness of breath. The Complainant therefore decided to take the Patient to the Accident & Emergency ("A&E") Department of Pamela Youde Nethersole Eastern Hospital ("PYNEH") for treatment.

14. According to the medical records obtained from PYNEH, the Patient attended its A&E Department at about 02:28 hours on 18 January 2012. Triage assessment of the Patient showed a blood pressure of 87/50 mmHg, pulse rate of 125/min and oxygen saturation on room air of 87%. Physical examination by the A&E doctor revealed that the Patient had dehydration with dry lips, cool and clammy peripheries. Skin rash was noted over her face and body and the Patient also had strawberry tongue. Re-measurement of vital signs then showed a blood pressure of 81/51 mmHg, pulse rate of 162/min and oxygen saturation on 100% O2 of 96%.

15. The Patient was later admitted to the Paediatric Intensive Care Unit ("PICU") of PYNEH. Physical examination upon admission to PICU revealed weak

peripheral pulses, hypotension (blood pressure of 60/35), desaturation and reduced breathing sound over her left chest. The Patient was diagnosed with septic shock, severe pneumonia and left pleural effusion.

16. Unfortunately, the Patient's condition continued to deteriorate during the day and eventually she was certified dead at 20:33 hours.

17. The Complainant subsequently lodged this complaint through a legislative Councillor with the Medical Council.

Burden and Standard of Proof

18. We bear in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove her 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.

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

Findings of the Medical Council

20. The Defendant admits the factual particulars of the disciplinary charges against her and she does not intend to challenge the expert evidence adduced by the Secretary. However, it remains for us to decide on the evidence whether she is guilty of misconduct in a professional respect.

21. Vital sign abnormalities have long been the cornerstone of shock recognition. We agree with the Secretary's expert, Dr CHAN, that at the time of her presentation to the Defendant, the Patient had already demonstrated clinical features suggestive of hypoxia and septic shock.

22. We agree with Dr CHAN that the low oxygen saturation of the Patient should be a

matter of concern for the Defendant. Oxygen saturation of less than 90% is a clinical emergency requiring treatment urgently. Since oxygen saturation of less than 94% is presumed to be due to hypoxia until proven otherwise, the Defendant ought to have carried out in our view further investigation to ensure that true hypoxia did not exist.

23. We also agree with Dr CHAN that the Patient's sustained hypotension should be a matter of concern for the Defendant. Decreased blood pressure of 90 mmHg or less is generally considered to be hypotension. Although hypotension in itself may not necessarily indicate shock, we agree with Dr CHAN that the Defendant ought to have recognized the need to further evaluate for shock, given the history of poor oral intake, impression of mild dehydration, presence of infection and abnormal vital signs.

24. In our view, the Defendant did not pay sufficient regard to the physical signs when examining the Patient. The Defendant failed to recognize the physical signs indicative of hypoxia and hypotension. Despite the presence of signs of "mild creps and wheeze" which indicated that the Patient might be suffering from pneumonia, the Defendant failed to order chest radiographs for the Patient.

25. And yet, the Defendant discharged the Patient home with antibiotic when her medical condition clearly warranted in our view her admission to hospital for further investigation and proper care and treatment.

26. For these reasons, we are satisfied that the Defendant's conduct had fallen below the standards expected amongst registered medical practitioners in Hong Kong. Accordingly, we also find her guilty of professional misconduct as charged.

Sentencing

27. The Defendant has a clear disciplinary record.

28. In line with published policy, we shall give her credit for her frank admission and full cooperation throughout this inquiry.

29. We bear in mind that the 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.

30. We are particularly concerned about the Defendant's management of the Patient in this case. Notwithstanding the presence of a host of abnormal vital signs that should have raised a warning of something being seriously wrong, the Defendant merely discharged the Patient home with antibiotic. This reflected her lack of competence at the material time.

31. However, we accept that the Defendant had since the incident taken prompt remedial actions to brush up her professional knowledge. Following the incident, the Defendant met with senior colleagues, including Professor Cocks, to discuss her management of the Patient with a view to ascertaining whether she should have managed the Patient differently. Following their meeting, the Defendant had written a reflective article on the management of sepsis and septic shock. Having reviewed this reflective article, we share with Professor Cocks' view that the Defendant has demonstrated an understanding of the subject. More importantly, the Defendant has shown her ability to apply this knowledge to the work of a general practitioner, for whom reliance on clinical acumen is essential in being able to identify cases needing further investigation and/or referral or admission to hospital.

32. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we order that the Defendant's name be removed from the General Register for a period of 3 months. We further order that the operation of the removal order be suspended for 24 months.

Prof. Felice LIEH-MAK, GBS CBE JP
Temporary Chairman,
The Medical Council of Hong Kong