香 港 醫 務 委 員 會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr WONG Cheuk Yi (黃卓義醫生)(Reg. No.: M14666)

Dates of hearing: 8 May 2018 (Day 1) and 9 May 2018 (Day 2)

Present at the hearing

Inquiry Panel Members: Prof. Felice LIEH-MAK, GBS CBE JP (Chairperson)
Dr HO Pak-leung, JP
Dr HUNG Se-fong, BBS
Ms HUI Mei-sheung, Tennessy, MH JP
Mr WONG Hin-wing

Legal Adviser: Mr Edward SHUM

Defence Solicitor representing the Defendant: Mr Alfred FUNG as instructed by Messrs. Kennedys

Senior Government Counsels representing the Secretary: Mr Mark CHAN and Miss Carmen POON

1. The charges against the Defendant, Dr WONG Cheuk Yi, are :

> "That during hospitalization of [redacted] ("the Patient") at the Kowloon Hospital from October to November 2011, he, being a registered medical practitioner, failed to discharge his professional responsibility in managing the Patient, who was under his charge of care, in that :
>
> (a) he failed to take proper steps to prevent the permanent tracheostoma of the Patient being treated or managed as a temporary tracheostomy wound;
>
> (b) he failed to take proper steps to ensure no dangerously or improperly putting of layer(s) of gauze and/or medical adhesive tapes over the Patient's tracheostoma;

(c) he failed to alert or instruct the nursing, medical and/or allied health care staff that :

(i) the wound was a permanent tracheostoma and not a temporary tracheostomy; and/or

(ii) the term "tracheostomy" in the medical record was improper or misleading in the circumstances where the Patient had been with a tracheostomy tube in the wound.

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 Defendant was at all material times a registered medical practitioner. His name has been included in the General Register from 2 July 2005 to present. His name has been included in the Specialist Register under the specialty of General Surgery since 5 March 2014.

3. Briefly stated, the Patient, who suffered from cancer in the hypopharynx, underwent pharnygolaryngectomy at Queen Elizabeth Hospital ("QEH") on 9 June 2011. Since that surgery involved the removal of both his larynx and pharynx, the Patient could no longer breathe through the upper airway. Therefore, an opening called "tracheostoma", which would be permanent, was created in the trachea at the centre of the lower neck; and the Patient became wholly dependent on it to breathe after the surgery.

4. The pharnygolaryngectomy was uneventful but the Patient developed post-operative complications with chronic obstructive pulmonary disease exacerbation. Furthermore, the Patient suffered a massive stroke 4 days after the surgery leaving him with significant cognitive impairment and right hemiplegia. Unfortunately, the Patient never recovered from these incapacities.

5. From 24 June 2011 to 14 November 2011, the Patient had several inter-hospital transfers between QEH and Kowloon Hospital ("KH") for various clinical reasons.

6. During the initial post-operative period, a tracheostomy tube was inserted at the tracheostoma to maintain a patent airway. In this connection, the Defendant admitted in his submission to the Preliminary Investigation Committee ("PIC") that when he first saw the Patient at KH on 25 June 2011, he already knew that the reason for the tracheostomy tube was for splinting purpose and would be kept for a few months so as to maintain the diameter of the permanent tracheostoma. There

is also no dispute that the Defendant was one of the case doctors responsible for the care of the Patient during his stay at KH.

7. The tracheostomy tube was later removed on 28 October 2011 at QEH when the Patient's condition became stable and the permanent tracheostoma was well formed.

8. On 1 November 2011, the Patient was transferred to KH for rehabilitation.

9. On 7 November 2011, the Patient was transferred back to QEH for treatment due to blockage of the feeding tube.

10. On 8 November 2011, the Patient was transferred back to KH for rehabilitation.

11. On 14 November 2011, at around 00:50 hours, the Patient was found to have cardiac arrest. Active cardio-pulmonary resuscitation was performed but in vain. Eventually, the Patient was certified dead at 01:31 hours on the same day.

12. Subsequently, an autopsy was performed on the Patient. According to the autopsy report dated 8 December 2011, a piece of gauze was found in tracheal lumen at 4.2 cm below the permanent tracheostoma, extending from the mid-trachea to the left main bronchus. The gauze was soaked with sputum and had partially occluded the tracheal lumen. The direct cause of death as shown by the autopsy was said to appear to be upper airway obstruction by foreign body.

13. It was revealed in the investigation carried out by the Hospital Authority after the incident that the nursing staff, who took care of the Patient at the material times during his stay at KH, had mistaken the permanent tracheostoma of the Patient to be a temporary tracheostomy. In their interviews with the investigation panel (the "HA Panel"), a majority of the nursing staff mentioned that they had covered the tracheostoma of the Patient with a piece of 4-ply gauze and they also applied adhesive tape to the edges of the gauze, varying from 2 to 4 edges. Two nurses mentioned to the HA Panel that they had covered the tracheostoma of the Patient with the gauze folded, which would effectively be 8-ply and they applied adhesive tape to 2 edges of the gauze. One nurse also mentioned to the HA Panel that she had noticed 2 pieces of gauze being applied to the tracheostoma of the Patient on some occasions.

14. On 30 May 2016, 3 of the nursing staff, who took care of the Patient at the material times during his stay at KH, were found guilty after due inquiry by the Nursing Council of unprofessional conduct in that they "failed to provide safe and competent nursing care to the Patient by treating the permanent tracheostoma of the Patient as a temporary tracheostomy wound, and failing to take steps to prevent putting layers of gauze and medical adhesive tape over the permanent

tracheostoma in an inappropriate way, thus causing the blocking of the permanent tracheostoma".

15. There is no dispute that the Defendant was the case doctor of the Patient at the material times during his stay at KH. Although the Defendant denied having seen the permanent tracheostoma of the Patient being covered with gauze at any time during the ward rounds, the Defendant admitted that such wrong management by the nursing staff at KH revealed itself in the medical records of nurses and physiotherapist. However, the Defendant failed to notice such wrong management from those medical records.

Burden and Standard of Proof

16. We bear in mind that the burden of proof is always on the Legal Officer 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 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 Inquiry Panel

18. Between 2 to 11 November 2011, the Defendant saw the Patient at KH on 8 different occasions. The Defendant did not challenge the finding of the HA Panel that the nursing staff, who took care of the Patient at the material times during his stay at KH, had mistaken the permanent tracheostoma of the Patient to be a temporary tracheostomy and improperly covered it with gauze strapped on either 2 or 4 sides with medical adhesive tapes.

19. We also find as a fact from reading the medical records kept by KH on the Patient, in particular, the Observation Chart from 2 to 7 November 2011 and Treatment Sheet from 8 to 14 November 2011, that the permanent tracheostoma of the Patient was frequently, if not continually, dressed or covered by gauze. The remark made by the physiotherapist, who had the care of the Patient on 9 November 2011, in the Physiotherapy Ward Sheet also confirmed our finding that the Patient's "tracheostomy hole [was] covered by gauze".

20. In our view, the Defendant's failure to notice from reading those medical records the repeated wrong management by the nursing staff of the permanent tracheostoma of the Patient was inexcusable. This demonstrated either the Defendant had not read those medical records or he did not read them carefully enough.

21. However that might be, the real point is that as the case doctor of the Patient, the Defendant had the primary responsibility to provide proper medical care to the Patient during the ward rounds. Given the repeated wrong management by the nursing staff of the permanent tracheostoma of the Patient, the Defendant ought to have taken proper steps to prevent it from being treated or managed as a temporary tracheostomy wound again. And yet, nothing was done by the Defendant to prevent this from happening.

22. For these reasons, we are satisfied on the evidence before us that the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find him guilty of disciplinary charge (a).

23. Turning to disciplinary charge (b), the Defendant denied having seen the permanent tracheostoma of the Patient being covered with layer(s) of gauze and/or medical adhesive tapes during any of the ward rounds at the material times.

24. The Defendant further explained that it was the usual practice of the nursing staff at KH to remove dressing(s) of wound(s) from patients before he came for ward rounds. We have doubts about this explanation. The nursing staff would not know beforehand when the Defendant actually arrived. We find it hard to imagine that the nursing staff would expose the patients' wound(s) for an unknown duration.

25. However, we need to remind ourselves that the burden of proof is always on the Legal Officer. None of the nursing staff, who took care of the Patient at the material times during his stay at KH, had been called by the Secretary to give evidence. Nor was there any direct evidence to contradict the Defendant's denial of knowledge about the layer(s) of gauze and/or medical adhesive tapes over the permanent tracheostoma of the Patient.

26. We are not satisfied on the evidence before us that the Defendant knew or ought to have known about the dangerous or improper way in which layer(s) of gauze and/or medical adhesive tapes were put over the permanent tracheostoma of the Patient. Accordingly, we find the Defendant not guilty of disciplinary charge (b).

27. Turning to disciplinary charge (c), Counsel for the Defendant submitted and we accepted that there was no case to answer in respect of disciplinary charge (c)(ii).

In our view, the term "tracheostomy" connoted an opening into the trachea; and that opening might be either temporary or permanent. That being the case, there was nothing improper or misleading about its use in the medical records kept on the Patient.

28. However, we ruled that there was a case to answer in respect of disciplinary charge (c)(i).

29. The Defendant ought to have known from reading the medical records kept on the Patient that the nursing staff had repeatedly managed the permanent tracheostoma of the Patient as though it were a temporary tracheostomy. Therefore, it was incumbent on the Defendant, as the case doctor of the Patient, to alert them of the mistake.

30. Regardless of whether the nursing staff actually knew the difference between a permanent tracheostoma and a temporary tracheostomy, their management of the permanent tracheostoma of the Patient as though it were a temporary tracheostomy was patently wrong.

31. We disagreed with the Defendant that he was entitled to leave it for the nursing staff to exercise their own professional judgment in the circumstances of this case. Given the repeated wrong management by the nursing staff of the permanent tracheostoma of the Patient, the Defendant ought to realize that there was something wrong with their professional judgment. As mentioned above, the Defendant, being the case doctor of the Patient, had the primary responsibility to provide proper medical care to the Patient. Accordingly, it was incumbent on the Defendant, as the case doctor of the Patient, to alert them that the wound was a permanent tracheostoma and not a temporary tracheostomy. And yet, nothing was done by the Defendant.

32. For these reasons, we are satisfied on the evidence before us that the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we also find him guilty of disciplinary charge (c)(i).

Sentencing

33. The Defendant has a clear disciplinary record.

34. 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.

35. Until Day 1 of this inquiry, the Defendant never admitted his failure to notice from the medical records the repeated wrong management by the nursing staff of the permanent tracheostoma of the Patient. It was only at the closing submission by his Counsel that we were told that the Defendant would admit to the disciplinary charge (a). However that may be, we shall give him credit for his admission to the disciplinary charge (a) before us today.

36. The Defendant never told us through his Counsel how he could fail to notice from the medical records the repeated wrong management by the nursing staff of the permanent tracheostoma of the Patient. We appreciate that the Defendant had a heavy workload at the material times but we are particularly concerned about the Defendant's inexcusable failure to notice from the medical records such wrong management over a period of 10 days during which he had seen the Patient on 8 different occasions.

37. We have grave concerns about the Defendant's lack of insight into his wrongdoings. The Defendant still maintained that he was entitled to rely on the professional judgment of the nursing staff when it was his primary responsibility, as case doctor, to provide proper medical care to the Patient. In our view, the Defendant also failed to reflect on his wrongdoings and this indicated the lack of remorse on his part.

38. Having considered the nature and gravity of the disciplinary charges for which the Defendant was convicted and what we have read and heard in mitigation, we shall make a global order in respect of disciplinary charges (a) and (c)(i) that the Defendant's name be removed from the General Register for a period of 6 months.

39. We have considered whether to suspend the operation of the said removal order. For the protection of the public, we need to be satisfied that the Defendant will fully address our concerns. And yet, we do not find anything throughout the inquiry and in the mitigation plea that warrants a suspension. We therefore consider it inappropriate to suspend the said removal order.

Prof. Felice LIEH-MAK, GBS CBE JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong