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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHENG Chi Yan Frank (鄭志仁醫生) (Reg. No.: M00712)

Date of hearing: 13 January 2020 (Monday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS
(Chairperson of the Inquiry Panel)
Dr CHEUNG Chin-pang
Dr MAK Siu-king
Mr LAM Chi-yau
Ms CHUI Hoi-yee, Heidi

Legal Adviser: Mr Edward SHUM

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

Senior Government Counsel (Ag.) representing the Secretary: Ms Carmen SIU

1. The charges against the Defendant, Dr CHENG Chi Yan Frank, are:

"That between September 2010 and September 2013, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), in that he:

(a) inappropriately or without proper justification prescribed Arimidex to the Patient who was at the material times a premenopausal woman; and/or

(b) failed to refer the Patient to a specialist in oncology for management when the circumstances warranted so.

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 was at all material times and still is included in the General Register. His name has been included in the General Register from 27 August 1964 to the present. His name has been included in the Specialist Register under the specialty of General Surgery since 4 March 1998.

3. Briefly stated, the Patient was diagnosed to have breast cancer sometime in September 2010. Upon referral by another doctor, the Patient then consulted the Defendant, who subsequently performed "excision of the [left] breast mass and frozen section followed by modified radical mastectomy and dissection of the left axilla" for her on 21 September 2010.

4. According to the Defendant's submission to the Preliminary Investigation Committee ("PIC"), "[a] 3 cm tumour in the [Patient's] left breast was excised with a margin followed by modified radical mastectomy and dissection of the left axilla. Axillary lymph nodes were negative for malignant cells. Oestrogen receptor assay was positive. The Patient was prescribed Tamoxifen 10 mg twice a day and intravenous Ferrum for treatment of anaemia due to heavy menstrual bleeding".

5. It is not disputed that the Defendant never referred the Patient to see a specialist in oncology after performing the mastectomy. Instead, the Patient was seen by the Defendant for follow-up appointments on a regular basis between September 2010 and 29 November 2012. Meanwhile, the Defendant continuously prescribed Tamoxifen, an anti-oestrogenic drug, to the Patient until 16 January 2013.

6. According to the Defendant's PIC submission, he detected at the consultation with the Patient on 3 January 2013 "a small nodule in the upper third of the mastectomy wound". The Defendant then performed an excisional biopsy on the Patient on 5 January 2013, which showed recurrent ductal carcinoma. "In the light of the recurrence of the ductal carcinoma while on Tamoxifen, and being aware of studies suggesting an advantage of Arimidex over Tamoxifen in post-menopausal women, [he] advised the Patient to commence Arimidex [treatment] and at the same time he advised the Patient to undergo hysterectomy and bilateral oophorectomy immediately to induce menopause".

7. It is again not disputed that the Defendant continued to prescribe Arimidex in lieu of Tamoxifen to the Patient despite he was informed that hysterectomy and bilateral oophorectomy originally scheduled for May 2013 had to be postponed to July 2013 owing to anaemia resulting from her heavy menstrual bleeding.

8. The Patient eventually underwent hysterectomy and bilateral oophorectomy on 9 July 2013. The Patient subsequently consulted a specialist in oncology on her accord and was given multiple lines of treatment including radiotherapy to her chest wall. Unfortunately, the Patient later developed multiple carcinoma metastases over her bone, brain and liver. The Patient finally passed away on 6 January 2018.

9. Meanwhile, the Patient's husband lodged this complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

10. 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.

11. 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 charges against him separately and carefully.

Findings of the Inquiry Panel

12. It is the unchallenged evidence of Dr FOO, the Secretary's expert in oncology, which we accept, that Arimidex is not effective in pre-menopausal breast cancer patients like the Patient. This is because in pre-menopausal women, Arimidex would not be expected to lower oestrogen levels and thus offering no clinical benefit to them.

13. There is conflicting evidence whether the Defendant had advised the Patient before prescribing Arimidex to her on 25 January 2013 that she needed to undergo hysterectomy and bilateral oophorectomy to induce menopause. The Complainant was adamant that as far as he knew no such advice was given by the Defendant to the Patient.

14. Our attention was drawn on the other hand by defence solicitor to the medical report dated 5 January 2015 and given to the Patient on the following day wherein the Defendant explained that he had told the Patient "to seriously consider hysterectomy and ovarectomies to induce menopause" when treatment was switched from Tamoxifen to Arimidex.

15. Since the Defendant has elected not to attend the inquiry, we are therefore unable to question him on this. However, we need to bear in mind that it is his legal right not to do so and we must not draw any adverse inference against him.

16. But then again, we find it implausible for the Defendant not to advise the Patient to stop taking Arimidex when he was informed that hysterectomy and bilateral oophorectomy originally scheduled for May 2013 had to be postponed to July 2013 owing to anaemia resulting from her heavy menstrual bleeding. Also, we find it implausible for the Patient to continue in the meantime to take Arimidex had she been advised by the Defendant that Arimidex only worked for post-menopausal patients.

17. We therefore accept the Complainant's evidence that the Defendant had not advised the Patient before prescribing Arimidex to her on 25 January 2013 that she needed to undergo hysterectomy and bilateral oophorectomy to induce menopause.

18. However that may be, it is idle in our view to argue that the Defendant's prescription of Arimidex to the Patient was made on the understanding that she would undergo hysterectomy and bilateral oophorectomy soon to induce menopause. So long as the Patient was still having menstrual periods, the Defendant's prescription of Arimidex to her was inappropriate and without proper justification.

19. That being the case, the Defendant's conduct had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find him guilty of disciplinary charge (a).

20. Turning to disciplinary charge (b), it is not disputed that the Defendant never referred the Patient to see a specialist in oncology.

21. We recognize that there are variations in clinical practice and vigilance in deciding on the timing for referral of a patient to see a specialist. However, a doctor must always act in the best interest of his patient. It follows that where a doctor is unable to treat his patient or the choice of treatment modalities is beyond his expertise, it is his professional responsibility either to seek advice from an appropriate specialist or to refer his patient to see an appropriate specialist.

22. In this connection, there is nothing in the evidence before us to show that the Defendant had consulted a specialist in oncology at any time.

23. As Dr FOO said, "[a]djuvant therapy is always an important part in the management of breast cancer after surgery… The objective of adjuvant therapy is to reduce the risk of relapse and enhance the survival rate… One should, having scrutinized the pathology report of tumour size, grading, number of metastatic axillary nodes, tumour resection margin, estrogen receptor, progestogen receptor and HER2 status, be able to estimate the risk of relapse and then propose a plan of adjuvant therapy. Such therapy may be one or more modalities including chemotherapy, hormonal therapy, targeted therapy and radiotherapy. These options should be discussed with the patient and a treatment plan formulated…"

24. In this connection, we agree with Dr FOO that the histopathological report after the mastectomy in September 2010 showed that the Patient's breast cancer was quite aggressive. Moreover, since the Defendant did not obtain representative axillary lymph for histopathological examination, we also agree with Dr FOO that chemotherapy and radiotherapy to the Patient's chest wall had to be seriously considered.

25. It is however not disputed that apart from prescription of Tamoxifen, the Defendant never discussed with the Patient other treatment modalities to prevent possible relapse of breast cancer after the mastectomy in September 2010.

26. Dr FOO also told us and we accept that local relapse found on the Patient's chest wall in January 2013 was an ominous sign. This is because distant metastasis would be expected in around 60% to 70% of the breast cancer patients in a few years' time. Moreover, this type of breast cancer patients would become resistant to hormonal therapy.

27. It is therefore essential in our view for the Patient to be advised of other treatment modalities than Arimidex. The Defendant's failure to do so after performing the excision biopsy in March 2013 was indicative of his lack of expertise in modern oncology.

28. As Dr FOO said, "adjuvant therapy for breast cancer [had] evolved to sophisticated algorithms". Apparently, the Defendant was ignorant of how sophisticated adjuvant therapy for breast cancer had become in the ensuing 40 years from when it first started in the 1970s. Regrettably, the Defendant merely continued with what he called "the standard practice" to prescribe the Patient following mastectomy with hormonal therapy of Tamoxifen.

29. We agree with Dr FOO that "[t]he lack of oncology input would deny the [P]atient the opportunity to avert relapse and improve the final outcome…"; and "treatment options like radiation therapy, chemotherapy and ovarian ablation should have been considered" for the Patient when relapse of breast cancer was noticed in January 2013.

30. By failing to refer the Patient to see a specialist in oncology for management of her breast cancer when the circumstances warranted so whilst the Patient was still under his care, the Defendant had neglected his duty to act in her best interest.

31. For these reasons, 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 (b).

Sentencing

32. We bear in mind that the primary purpose of our disciplinary order is not to punish the Defendant. Rather, our task is 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.

33. We appreciate that the Defendant had an unblemished and distinguished career serving the medical profession for more than half a century.

34. It is however essential in our view to maintain public confidence in the medical profession by upholding its high standards and good reputation. In this connection, we are particularly concerned that the Defendant still failed to appreciate with the benefit of hindsight the failings that underlay his professional misconduct.

35. Dr Murphy, who represented the Defendant in this inquiry, urged us to give the Defendant full credit for not contesting the disciplinary charges. We cannot agree.

36. Through his solicitors' letter to the Medical Council dated 25 September 2019, while expressing his concern that "… he will be too frail to give evidence at the inquiry… [and] to explain in person… his rationale for managing the Patient as he did…", the Defendant "would hope to persuade the Medical Council that he had acted responsibly…"

37. Apparently, the Defendant still considered his management of the Patient's breast cancer to be beyond reproach. At most, it may be said that he now "acknowledges that, given the delay in the Patient undergoing hysterectomy and oophorectomy, he should have referred the Patient to an oncologist for advice regarding adjuvant treatment in or around January 2013". This reinforced, in our view, that the Defendant's lack of insight into his wrongdoings remained unchanged.

38. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we shall make a global order in respect of disciplinary charges (a) and (b) that the Defendant's name be removed from the General Register for a period of 4 months.

39. We have considered carefully whether the operation of the removal order should be suspended. We do not consider it appropriate to do so for the reasons aforesaid.

Prof. LAU Wan-yee, Joseph, SBS
Chairperson of the Inquiry Panel
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