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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr LO Kwok Cheung (盧國章醫生) (Reg. No.: M13652)

Dates of hearing: 23 August 2021 (Monday) and 24 August 2021 (Tuesday)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr LAU Chor-chiu, GMSM, MH, JP
Dr CHAN Nim-tak, Douglas
Mrs BIRCH LEE Suk-yee, Sandra, GBS, JP
Mr LUI Wing-cheung, Kenneth

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by Messrs. Mayer Brown

Legal Officer representing the Secretary: Mr Edward CHIK, Senior Government Counsel (Ag.)

1. The charges against the Defendant, Dr LO Kwok Cheung, are:

"That in or about April to May 2015, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), a three year old child, in that, he:

(a) failed to timely diagnose the Patient with pneumococcal pneumonia;
(b) failed to refer the Patient to a specialist for further treatment as and when the circumstances so warranted;
(c) prescribed medication to the Patient without any medical examination and/or consultation of the patient beforehand; and
(d) prescribed Augmentin syrup 6 ml to the Patient on 4 May 2015 without proper justification and clinical indication.

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 2 July 2002 and to the present. His name has never been included in the Specialist Register.

3. The Defendant was the family doctor of the Patient, a 3-year old boy at the material time, his mother and his sister.

4. On 30 April 2015, the Patient was brought to the Defendant's clinic for fever. The Defendant was not in the clinic. There was no consultation by the Defendant. However, the Patient was given Panadol, antihistamines and cough expectorant.

5. On 4 May 2015, the Patient was brought by his grandmother to consult the Defendant at his clinic. The Defendant diagnosed the Patient to have upper respiratory tract infection ("URTI") and gastroenteritis ("GE"). Symptomatic treatment for fever, cough, running nose, abdominal pain, vomiting as well as antibiotic Augmentin 6ml BD were given.

6. In the morning on 5 May 2015, the Patient was taken to the Accident and Emergency Department of Alice Ho Miu Ling Nethersole Hospital ("AED of AHNH"). The doctor in AED noticed that the Patient had fair general condition with shortness of breath. Temperature measured was 37.8°C. Physical examination showed respiratory rate 28/min with decreased air entry on chest examination. Oxygen saturation (SpO2) 98% on 2 L/min oxygen. Chest x-ray showed pneumonia with pleural effusion (parapneumonic effusion).

7. The Patient was later admitted and assessed by a paediatric doctor at 0950 hours on the same day. Physical examination showed the Patient was alert but tired looking with SpO2 98% on 2L/min O2. Respiratory rate was 50/min with insucking of chest. Decreased air entry, bronchial breathing and dull percussion note were found on right side of chest. Capillary refill was less than 2 seconds.

8. The diagnosis was pneumonia with right pleural effusion. The Patient was put on cefotaxime, pencillin, Zithromax and Tamiflu. Later the Patient was transferred to PICU of Prince of Wales Hospital ("PWH") on the same day.

9. On admission to PICU PWH, it was recorded on the admission note that the Patient had oxygen saturation 95% on 3L/min oxygen via nasal cannula. Respiratory rate was 70/min with nasal flaring and insucking of chest wall.

10. On 6 May 2015, the hospital notes recorded that Chest x-ray showed increased right pleural effusion with mediastinal shift and urgent ultrasound (USG) guided pigtail insertion to right thorax yielded purulent turbid pleural fluid. Intrapleural urokinase was given.

11. During the stay in PICU PWH, USG guided bilateral chest pigtail insertions, revision of chest drains were done. Repeated adjustments of antimicrobial treatment were done. Oxygen supplement and pigtail were taken off from the Patient on 5 June 2015.

12. Urine and pleural fluid from the Patient were positive for pneumococcal antigen while nasopharyngeal swab PCR was positive for rhinovirus/enterovirus.

13. On 9 March 2016, the Patient's mother lodged a complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

14. 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.

15. There is no doubt that the allegations against the Defendant here are 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 each of the disciplinary charges against him carefully.

Findings of the Inquiry Panel

Charge (a)

16. Under Charge (a), one important element which the Secretary is required to prove is the presence of pneumococcal pneumonia at the consultation with the Defendant on 4 May 2015.

17. The Secretary had however adduced no evidence in this respect.

18. In our view, pneumococcal pneumonia is a pathological diagnosis. It is not expected that a general practitioner can make this diagnosis on a first consultation without any laboratory test done.

19. At the inquiry, we ruled that there was no case to answer for Charge (a).

20. The Defendant is therefore acquitted of Charge (a).

Charge (b)

21. According to Dr MIU Ting Yat ("Dr MIU"), the Defendant's expert, fever and cough are nonspecific features for pneumonia. Tachypnea, chest pain, increased work of breathing are the signs which medical practitioners in clinical practice should look for as the usual signs for diagnosing pneumonia. Dr NG Daniel Kwok Keung ("Dr NG"), the Secretary's expert, agreed that these are the signs to look for to diagnose pneumonia.

22. The Patient's mother gave evidence. She told us that the Patient was very weak on 1, 2 and 3 May 2015. The Patient's grandmother also gave evidence. She told us that on 4 May 2015, the Patient was very weak and she had to carry the Patient on her back into the Defendant's consultation room, and inside the consultation room, the Patient was sitting on her lap. What she described to us was that the Patient was very weak on that day and could hardly move or address her by name. The Defendant however told us that on that day the Patient's grandmother was holding the Patient's hand and they walked into his consultation room together, and they sat on two separate chairs. The Defendant also said that he had asked the Patient to go to the scale to measure his weight and the Patient walked to the scale himself, without assistance.

23. The Defendant said that the Patient did not appear weak on 4 May 2015. What he said was corroborated by his clinical note for that day which showed that there was no reporting of malaise from the Patient's grandmother. There was also the record of weight being taken from the Patient which was 16kg. In any case, the Secretary never challenged the authenticity of the Defendant's record. When cross-examined, the Patient's grandmother said she had no recollection if the Defendant had weighed the Patient.

24. On whether the Patient had shortness of breath on 4 May 2015, both the Patient's mother and grandmother said that the Patient occasionally took deep breaths. At the inquiry, both had demonstrated to us how the Patient took deep breaths, which were the making of sighing sounds. In our view, these sighing sounds could not be equated with shortness of breath. In the Defendant's clinical record on 4 May 2015, there was no record of signs of respiratory distress.

25. At the inquiry, Dr NG agreed that according to the Defendant's clinical note on 4 May 2015, there were no signs of pneumonia. Dr NG said that since it took 5 to 10 days for uncomplicated parapneumonic effusion to evolve to purulent stage, it was most likely that the effusion was there when the Defendant saw the Patient on 4 May 2015. According to Dr MIU, pneumococcal pneumonia, a virulent serotype 3, is known for rapid progression, and in some cases it could progress from parapneumonic effusion to purulent stage in just a number of hours. Dr NG concurred with Dr MIU in this regard. Therefore, if the progression was rapid, it was possible that on 4 May 2015, the Patient might not be in the purulent stage.

26. Both experts remarked that not all cases of pneumonia required specialist attention, and pneumonia patients in stable condition could be managed by general practitioners. We agree with the experts.

27. On the basis of the above, we acquit the Defendant of Charge (b).

Charge (c)

28. The Defendant admits the factual particulars of Charge (c) against him. However, it remains for us to consider and determine on the evidence whether he is guilty of misconduct in a professional respect.

29. In the Defendant's letter to the Preliminary Investigation Committee ("PIC") of the Medical Council dated 26 March 2018, medication was prescribed to the Patient on 30 April 2015 without consultation beforehand. The Defendant said the medication prescribed was a repeated prescription from the Patient's most recent consultation, which included Panadol, antihistamines and cough expectorant. The Defendant accepted that this was not a valid excuse and it was inappropriate for him to prescribe medication without a consultation, and he was willing to accept responsibility for his actions in this regard.

30. It is stated in section 9.1 of the Code of Professional Conduct (Revised in January 2009) ("the Code") that:

> *"A doctor may prescribe medicine to a patient only after proper consultation ... "*

31. By prescribing medication to the Patient on 30 April 2015 without a consultation, the Defendant had clearly breached section 9.1 of the Code.

32. In our view, if a doctor had already seen a patient with chronic illness in stable condition, and had decided to give him repeated prescriptions at intervals, that would be acceptable. However, in the present case, on 30 April 2015, the Patient presented with an acute condition, it would be necessary for the Defendant to personally assess the Patient before any medication was given.

33. We are satisfied that the Defendant's conduct as such had fallen below the standard expected of registered medical practitioners in Hong Kong. We find the Defendant guilty of Charge (c).

Charge (d)

34. At the beginning of the inquiry, the Secretary indicated that Charge (d) would not be pursued. The Secretary offered no evidence for Charge (d).

35. We therefore acquit the Defendant of Charge (d).

Sentencing

36. The Defendant has a clear disciplinary record.

37. In line with published policy, we shall give credit to the Defendant in sentencing for his frank admission and full cooperation throughout these disciplinary proceedings.

38. 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.

39. We take a very serious view that medications are prescribed for an acute condition without prior assessment by doctors. This is spelt out clearly in section 9.1 of the Code.

40. Taking into consideration the nature and gravity of the disciplinary charge for which we find him guilty of and what we have heard and read in mitigation, in respect of Charge (c), we order that:

    (1) the Defendant's name be removed from the General Register for a period of 1 month; and

    (2) the operation of the removal order be suspended for a period of 6 months.

Remarks

41. The Defendant's clinical notes consisted of a number of abbreviated terms and drawings. These are not standard abbreviations. No one will know what these abbreviations mean, except himself. The medical record was illegible, and short of details. The Defendant said he suspected pneumonia in this case. However, he did not record as such nor communicate with the Patient's grandmother about this suspicion. It is incumbent on doctors to communicate clearly with patients about their conditions, including diagnosis, treatment and follow-up. Good record keeping and adequate communication are essential to good medical practice.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
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