香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TIO Man Kwun Peter (張民冠醫生) (Reg. No.: M10362)

Date of hearing: 24 August 2018 (Friday)

Present at the hearing

Council Members/Assessors: Prof. Felice LIEH-MAK, GBS, CBE, JP
(Chairperson of the Inquiry Panel)
Dr LAM Tzit-yuen, David
Ms HUI Mei-sheung, Tennessy, MH, JP
Mr WOO King-hang
Dr LAI Sik-to, Thomas

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Ashok SAKHRANI instructed by Messrs Kennedys

Senior Government Counsel representing the Secretary: Ms Vienne LUK

1. The charge against the Defendant, Dr TIO Man Kwun Peter, is:

> "That on or about 30 October 2014, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam [redacted] ("the Patient") in that he wrongly performed sural nerve biopsy on the Patient when he was supposed to perform muscle biopsy according to the referral letter.
>
> In relation to the facts alleged, 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 25 October 1995 to present and his name has been included in the Specialist Register under the specialty of Orthopaedics & Traumatology since 15 October 2003.

3. The Defendant admits the factual particulars of the disciplinary charge against him.

4. Briefly stated, the Patient consulted one Dr WONG, a specialist in neurology, some time in or around September 2014, for her complaint of progressive leg weakness, bilateral foot drop, hip adduction weakness and left hand weakness. During the consultation, Dr WONG advised the Patient to undergo a muscle biopsy at her right tibialis anterior by an orthopaedic surgeon, who would send out the samples taken for pathological investigation. The Patient agreed.

5. Dr WONG then prepared and gave to the Patient a referral letter for the attention of the Defendant. In this letter, Dr WONG specifically informed the Defendant that the Patient had a history of "bilateral foot drop, hip adduction weakness and… left hand weakness" and requested the Defendant to "perform muscle biopsy at her RIGHT tibialis anterior (to avoid artifact from recent EMG of her LEFT side), preferably at Baptist Hospital so the pathology service can send to QMH for sub-specialist histological assessment."

6. On 14 October 2014, the Patient attended the Defendant's clinic. After examination, the Defendant explained to the Patient and confirmed that the surgical procedure to be performed on her was "right side tibialis anterior muscle biopsy" (the "Biopsy"). Arrangement was also made with the Baptist Hospital for the Biopsy to be performed on 30 October 2014.

7. On 30 October 2014, the Patient was admitted to the Baptist Hospital. Before the Biopsy began, the Patient was asked to sign on a written consent form (the "Consent Form") in acknowledgement of her consent to undergo the surgical procedure of "[e]xcision muscle biopsy of right calf". The Defendant also declared and countersigned on the Consent Form that he had already explained to the Patient the nature, risks, benefits and costs of the said surgical procedure.

8. There is no dispute that the Defendant performed a sural nerve biopsy instead of muscle biopsy on the Patient's right calf.

9. During the first post-operative follow up on 5 November 2014, the Defendant also confirmed with the Patient that sural nerve biopsy was performed on her right calf and the extracted nerves were sent for laboratory examination.

10. The Patient's husband subsequently checked the referral letter and confirmed from Dr WONG that a muscle biopsy should have been performed on the Patient's right calf.

11. On 12 November 2014, the Patient attended the Defendant's clinic to remove the dressing. The Defendant then admitted that he mistakenly performed a nerve biopsy instead of a muscle biopsy on the Patient's right calf. The Defendant apologized but the Patient's husband considered this was professional misconduct and would pursue further.

12. According to his submission to the Preliminary Investigation Committee ("PIC"), which is not challenged by the Secretary, the Defendant offered to perform a muscle biopsy on the Patient at his own cost but the Patient refused. The Defendant also offered to refer the Patient to one Professor LEUNG, a specialist in neurology at the Chinese University of Hong Kong, for assessment of her condition and to provide an independent advice on appropriate treatment. However, the Patient did not take up the offer and she never returned to see the Defendant again.

13. The Patient's husband later lodged this 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 allegation made against the Defendant here is a serious one. 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 charge against him carefully.

Findings of the Inquiry Panel

16. The Defendant admits the factual particulars of the disciplinary charge against him but it remains for us to consider and decide on the evidence whether he is guilty of misconduct in a professional respect.

17. In our view, the Defendant's mistake in performing a nerve biopsy instead of a muscle biopsy on the Patient's calf was inexcusable.

18. In giving her consent to undergo the Biopsy, the Patient had placed full confidence and complete trust on the Defendant that he would exercise reasonable care and due diligence in carrying out each step of the surgical procedure.

19. Regrettably, the Defendant did not pay adequate attention to the nature of the Biopsy to be performed on the Patient. Although the various pre-operation forms and documents signed by the Defendant before the surgical procedure began would have indicated to him the true nature of the Biopsy to be performed, the Defendant still committed the mistake.

20. In our view, the Defendant's conduct has fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find him guilty of the disciplinary charge as charged.

Sentencing

21. The Defendant has one previous disciplinary record back in 2011 relating to failure to insert date(s) of issue and/or consultation on sick leave certificates that he issued. We accept that the nature of the disciplinary charge in this case is different.

22. In line with published policy, we shall give the Defendant credit in sentencing for admitting the factual particulars of the disciplinary charge against him and his cooperation throughout the present disciplinary proceedings.

23. 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 the public confidence in the medical profession by upholding its high standards and good reputation.

24. We accept that there was nothing in the evidence to indicate a lack of surgical skill or necessary competence on the part of the Defendant to distinguish between muscle biopsy and nerve biopsy. However, the gravamen of the mistake lies in that by removing a portion of the sural nerve, the Defendant had inflicted a permanent sensory loss on the Patient albeit a small area of her right foot.

25. When being confronted by the Patient and her husband, the Defendant immediately apologized and offered to rectify the mistake and to refer the Patient for assessment by a specialist in neurology at the Chinese University of Hong Kong for assessment of her condition and to provide an independent advice on appropriate treatment.

26. The Defendant admitted that he initially tried to put up various excuses to explain the mistake. However, he felt ashamed of what he did. So, by a letter dated 17 November 2014, he apologized to the Patient and her husband for not admitting the mistake immediately and for putting up various excuses when being confronted with the mistake. This indicated in our view that the Defendant was remorseful and prepared to accept full responsibility of the mistake.

27. We are told in mitigation that the Defendant has since taken remedial measures to verify and make sure that the surgical procedure that he performed would be the appropriate one. Apart from devising and implementing an operative checklist to strengthen his pre-operative checks and to minimize/avoid surgical mistakes, the Defendant also attended a workshop called "Achieving a safe and reliable clinical practice" held by the Medical Protection Society on 18 May 2016 to enrich his knowledge on patients' safety.

28. In our view, the Defendant has learnt a hard lesson but we need to be assured that the chance of his committing the same or similar mistake in the future is low.

29. Having considered 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, and the operation of the removal order be suspended for a period of 24 months, subject to the condition that the

Defendant shall complete during the suspension period satisfactory peer audit by a Practice Monitor to be appointed by the Council with the following terms:

(a) the Practice Monitor shall conduct random audit of the Defendant's practice with particular regard to surgical procedures that he performed for patients;

(b) the peer audit should be conducted without prior notice to the Defendant;

(c) the peer audit should be conducted at least once every 6 months during the suspension period;

(d) during the peer audit, the Practice Monitor should be given unrestricted access to all parts of the Defendant's clinic and the relevant records which in the Practice Monitor's opinion is necessary for proper discharge of his duty;

(e) the Practice Monitor shall report directly to the Chairman of the Council the finding of his peer audit at 6-monthly intervals. Where any defects are detected, such defects should be reported to the Chairman of the Council as soon as practicable;

(f) in the event that the Defendant does not engage in active practice at any time during the suspension period, unless otherwise ordered by the Council, the peer audit shall automatically extend until the completion of 24-month suspension period; and

(g) in case of change of Practice Monitor at any time before the end of the 24-month suspension period, unless otherwise ordered by the Council, the peer audit shall automatically extend until another Practice Monitor is appointed to complete the remaining period of peer audit.

Remarks

30. The Defendant's name is included in the Specialist Register under the Specialty of Orthopaedics and Traumatology. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

Prof. Felice LIEH-MAK, GBS, CBE, JP
Chairperson of the Inquiry Panel