香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr WU Stephen Zee Kee (Reg. No.: M05558)

Date of hearing: 22 November 2022 (Tuesday)

Present at the hearing

Council Members/Assessors:	Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel) Dr HO Pak-leung, JP Dr CHUNG Wai-hung, Thomas Mr CHAN Wing-kai Mr LAI Kwan-ho, Raymond
Legal Adviser:	Mr Stanley NG
Government Counsel representing the Secretary:	Miss Sanyi SHUM
Defence Solicitor representing the Defendant:	Mr Alfred FUNG instructed by Messrs. Mayer Brown

1. As amended, the charges against the Defendant, Dr WU Stephen Zee Kee, are:

'That he, being a registered medical practitioner, disregarded his professional responsibility to his patient ("the Patient"), in that he:

(a) from about 19 June 2019 to 30 June 2019, failed to conduct proper investigations and/or clinical management in respect of the Patient's respiratory tract infection symptoms in that he failed to arrange for chest X-ray in a timely manner; and/or;

(b) on or about 22 June 2019, inappropriately or without proper justification prescribed "Ventolin inhaler" to the Patient.

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 18 January 1985 to the present. His name has never been included in the Specialist Register.

3. On 18 June 2019, the Patient attended the Urgent Care Centre of Hong Kong Adventist Hospital – Tsuen Wan ("HKAH") with two days history of fever, runny nose, cough, sputum, muscle ache and headache. He had fever of 39.5 degree Celsius with pulse rate of 105/min. He was attended by a Dr CHONG and was noted to be well in general with throat congestion. The chest examination was clear. A diagnosis of Upper Respiratory Tract Infection with fever was made and drugs for symptomatic relief was prescribed. Influenza A and B were tested negative. No chest X-ray was ordered by Dr CHONG.

4. On 19 June 2019, the Patient consulted the Defendant for the first time at the Outpatient Clinic of HKAH. The Patient presented with persistent fever and productive cough. The Patient provided to the Defendant a history that his son was admitted and discharged recently with Mycoplasma pneumonia. The Patient's temperature was 39 degree Celsius with throat, ears and chest examination unremarkable. His pulse rate was fast at 112/min. The Defendant made a diagnosis of bacterial bronchitis. The Defendant prescribed two oral antibiotics, namely Klacid (clarithromycin) 500mg twice daily and Zinnat (cefuroxime axetil) 500mg twice daily with Zantac 150mg and 5 other symptomatic relief medications.

5. On 20 June 2019, the Patient returned to consult the Defendant. The Patient presented with a persistent fever of 39.8 degree Celsius with abdominal pain and vomiting. His pulse rate was 114/min and he had nose congestion. The Defendant made a diagnosis of bronchitis with gastritis. The Defendant recommended that the Patient be admitted for further investigation and treatment.

6. On 20 June 2019, the Patient was admitted to HKAH under the Defendant's care. During the Patient's stay at HKAH, various investigations were conducted including blood tests for Mycoplasma pneumoniae IgM, nasopharyngeal swab tests for pneumonia PCR panel including Mycoplasma pneumoniae and influenza B. Medications, including IV antibiotics and oral Azithromycin 500mg daily were given. The Patient's lungs remained clear on chest auscultation.

7. The nasopharyngeal swab PCR panel tests performed based on the samples provided by the Patient to the Urgent Care Centre of HKAH on 18 June 2019 initially came back negative to influenza B and Mycoplasma pneumoniae on 21 June 2019. On 22 June 2019, a repeated pneumonia PCR tests and conventional culture was conducted based on sputum sample taken that day, and the Patient tested positive to influenza B and Mycoplasma pneumoniae. Sputum culture turned out negative. Tamiflu was started that day and antibiotics were continued. Ventolin inhaler was also given.

8. On 22 June 2019, the Patient asked the Defendant why a chest X-ray had not been taken. The Defendant said he then realized that he had at the consultation on 19 June 2019 misread the date of a chest X-ray report dated 19 June 2011 as 19 June 2019. The Defendant said that he was under the mistaken impression that it was reporting on a chest X-ray that the Patient had recently taken (when no chest X-ray was in fact taken) at the Urgent Care Centre of HKAH. According to the chest X-ray report, the Patient's cardiac and mediastinal shadows were normal and there was no radiological evidence of pulmonary mass or active inflammatory lesion. The Defendant said he immediately apologized to the Patient, but explained that a chest X-ray was not clinically indicated at that moment as the Patient's chest was clinically clear, there was no abnormality with the Patient's SaO2 level, and the Patient's fever was subsiding.

9. On 24 June 2019, the Patient's fever subsided and he was discharged by the Defendant with Zithromax, Zinnat, Tamiflu, Ventolin inhaler, Zantac and three other symptomatic relief medications. The Defendant's primary diagnosis was bronchitis and gastroenteritis, and his secondary diagnosis was influenza B and Mycoplasma pneumonia. The Patient was scheduled to return to the Outpatient Clinic for follow-up on 26 June 2019.

10. On 26 June 2019, the Patient returned to the Outpatient Clinic for follow-up and was seen by the Defendant. On physical examination, the Patient's vital signs were stable. A chest auscultation showed that his lungs were clear. His abdomen was soft and non-tender with active bowel sounds. The Defendant made the diagnosis of "resolving bronchitis/gastroenteritis (antibiotic-induced)". Symptomatic relief medications were prescribed.

11. On 30 June 2019, the Patient returned for follow-up and was seen by the Defendant. On physical examination, the Patient's condition was afebrile. His vital signs were stable. His throat was unremarkable. Chest auscultation showed that his lungs were clear. The Defendant changed the diagnosis to "follow up of resolving mycoplasma pneumonia bronchitis". The Patient was prescribed with symptomatic relief medications, and was asked to return for follow-up if his condition did not improve upon completion of the medication. This was the last time the Patient consulted the Defendant. The Patient did not return to see the Defendant or return to HKAH for follow-up.

12. On 1 July 2019, the Patient said he went to consult his own family physician as he had cough overnight affecting his sleep. Chest X-ray was advised by the Patient's family physician. The use of Ventolin inhaler was also questioned as the Patient had no past history of asthma.

13. On 13 August 2019, the Patient lodged a complaint with the Medical Council against the Defendant.

Burden and Standard of Proof

14. We bear in mind that the burden of proof is always on the Secretary 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 against the Defendant here is a serious one. 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 charge against him carefully.

Findings of the Inquiry Panel

16. The Defendant admits the factual particulars of charge (a) against him but it remains for us to consider and determine on the evidence whether he has been guilty of misconduct in a professional respect.

17. During the entire period from 19 June 2019 to 30 June 2019, the Defendant had seen the Patient for a number of times and had plenty of opportunities to take a chest X-ray of the Patient. However, the Defendant had failed to do so.

18. We agree with the Secretary's expert that a chest X-ray should have been ordered to exclude any community acquired pneumonia and to detect any underlying causes not identified clinically.

19. We are satisfied that the Defendant had failed to conduct proper investigations and/or clinical management in respect of the Patient's respiratory tract infection symptoms in that he failed to arrange for chest X-ray in a timely manner. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find him guilty of misconduct in a professional respect under charge (a).

20. The Secretary offers no evidence in respect of charge (b). We therefore acquit the Defendant of charge (b).

Sentencing

21. The Defendant has a clear disciplinary record.

22. 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.

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

24. The Defendant told us that he had taken steps to amend by being more prudent to order necessary investigations in future. We accept that this was a one-off incident and the risk of re-offending is low.

25. The Defendant is honest to his mistake as he admitted to the Patient of his mistake when he was questioned. We accept that the Defendant is remorseful and has learnt his lesson.

26. Having considered the nature and gravity of charge (a) for which the Defendant was found guilty and what we have heard and read in mitigation, we order that the Defendant be reprimanded.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong