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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHUNG Ronald Siu Hong (Reg. No.: M12488)

Date of hearing: 2 June 2023 (Friday)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHUNG Kin-lai
Prof. TAN Choon-beng, Kathryn
Mrs BIRCH LEE Suk-yee, Sandra, GBS, JP
Ms SHARMA Asha Rani

Legal Adviser: Mr Edward SHUM

Senior Government Counsel representing the Secretary: Mr Edward CHIK

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

1. The amended charge against the Defendant, Dr CHUNG Ronald Siu Hong, is:

> "That on 20 September 2018, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ("the Patient"), in that he failed to keep proper and adequate medical records in respect of the Patient.
>
> In relation to the facts alleged, 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 8 September 1999 to the present. His name has been included in the Specialist Register under the Specialty of Ophthalmology since 6 February 2013.

3. Briefly stated, the Patient first consulted the Defendant at the Tseung Kwan O Polyclinic (the "Clinic") of the Union Hospital ("UH") on 20 September 2018 for her left eye problem.

4. There is conflicting evidence as to the Patient's medical complaint. According to the Patient, she had told the Defendant during the consultation that there was a shadow at the lower part of her left eye which disturbed her vision. But according to the Defendant, the Patient merely complained of grittiness, discomfort and increase in watery discharge of her left eye.

5. Be that as it may, there is no dispute that having conducted an eye examination on the Patient, the Defendant told her that she was suffering from left eye conjunctivitis and mild cataract in both eyes. The Defendant then prescribed the Patient with Tobradex eye drop, which contained antibiotic and steroid, and asked her to return for follow-up if the symptoms persisted or worsened.

6. And according to the Internal Communication Record of the Clinic kept by UH, the Patient made a telephone call to the Clinic on 21 September 2018 and mentioned to a clinic nurse, amongst others, that she started to see shadow in her eye and wanted to know if that was due to the side effect of the eye drop prescribed to her and whether she needed to come back to have an earlier follow up visit.

7. According to the Defendant, the Patient's enquiry as recorded in the Internal Communication Record of the Clinic was relayed to him for instructions. He believed that the shadow in the Patient's eye would not be caused by the eye drop that he prescribed. Nevertheless, he considered that the Patient should attend an earlier follow-up in view of such new symptom. He therefore noted down his instructions in the Internal Communication Record of the Clinic and asked the clinic nurse to inform the Patient of the same immediately.

8. According to the medical records obtained from UH, the Patient returned to the Clinic on 24 September 2018 and was diagnosed by another doctor to be suffering from macular haemorrhage.

9. According to the Patient, she consulted another private ophthalmologist on 26 September 2018 and was subsequently referred by the latter to the Hospital Authority for treatment of her left eye vitreous haemorrhage.

10. Meanwhile, the Patient lodged this complaint against the Defendant with the Secretary of the Medical Council.

Burden and Standard of Proof

11. 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.

12. 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 amended disciplinary charge against him carefully.

Findings of the Inquiry Panel

13. The Defendant admits the factual particulars of the amended disciplinary charge 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.

14. It is the unchallenged opinion of the Secretary's expert witness, Dr LAI, and we accept that:

"*The clinical notes on 20 September 2018 are inadequate. There was no documentation of patient's history and examination findings. There was only a diagnosis and the prescription… A proper clinical notes in this case should contain the patient's chief complaint, the duration of onset of the symptom(s), the visual acuity, the eye pressure, the cornea clarity, the distribution of the conjunctival injection, the eye involved, the anterior chamber clarity, the optic disc and macula if patient was examined with 90D lens. In Dr Chung's statement dated 18 February 2021…, he stated that he had performed all the above and also confrontation visual field test and Amsler grid test and the findings were all normal. However, all these examinations findings were not recorded in the clinical notes…*"

15. It is clearly stated in section 1.1 of the Code of Professional Conduct (2016 edition) (the "Code") that:

"*1.1 Medical records*

1.1.1 The medical record is the formal documentation maintained by a doctor on his patients' history, physical findings, investigations, treatment, and clinical progress...

1.1.2 A medical record documents the basis for the clinical management of a patient. It reflects on the quality of care and is necessary for continuity of care…

1.1.3 All doctors have the responsibility to maintain systematic, true, adequate, clear, and contemporaneous medical records…"

16. In failing to keep proper and adequate medical records in respect of the Patient, the Defendant has in our view by his conduct in the present case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as charged.

Sentencing

17. The Defendant has a clear disciplinary record.

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

19. We take a serious view on the Defendant's failure to comply with section 1.1 of the Code. We are most concerned about the substantial lack of details in the medical records kept by the Defendant on his consultation with the Patient, which are in our view essential for the management and continuity of care for the Patient, be it by the Defendant or other professional colleagues.

20. We are told in mitigation that apart from taking a course organized by the Medical Protection Society on important issues in relation to medical records and skills on improvement of record keeping, the Defendant has since the incident taken remedial steps to improve his medical record keeping. However, we need to make sure that the Defendant will not commit the same or similar breach in the future.

21. Taking into consideration the nature and gravity of the disciplinary charge for which we find the Defendant guilty and what we have read and heard in mitigation, we order that the name of the Defendant be removed from the General Register for a period of 1 month. We further order that the operation of the removal order be suspended for a period of 6 months, subject to the conditions 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 medical records keeping and management of 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 6-month 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. 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 6-month suspension period, unless otherwise ordered by the Council, the peer audit shall automatically extend until the completion of 6-month suspension period; and

(g) in case of change of Practice Monitor at any time before the end of the 6-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.

Remark

22. The name of the Defendant is included in the Specialist Register under the Specialty of Ophthalmology. We shall leave it to the Education and Accreditation Committee to decide on whether anything may need to be done to his specialist registration.

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