

香港醫務委員會  
The Medical Council of Hong Kong

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DISCIPLINARY INQUIRY  
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TONG Anthony Kin Keung (唐建強醫生) (Reg. No.: M03793)

Date of hearing: 27 January 2026 (Tuesday) (Day 1); and  
28 January 2026 (Wednesday) (Day 2)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP  
(Chairperson of the Inquiry Panel)  
Prof. LAW Sheung-wai  
Dr CHENG Wai-tsoi, Frankie  
Ms LEE Yin-han, Yvonne  
Dr LO Pui-yin

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by  
Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Mr Micky YIP as instructed by the  
Department of Justice

The Charges

1. The charges against the Defendant, Dr TONG Anthony Kin Keung, are:

*“That, between April and July 2010, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [REDACTED] (“the Patient”), in that he:*

(a) failed to obtain informed consent from the Patient before performing an operation on the Patient for bilateral inguinal hernia on 26 April 2010 in that he failed to offer to the Patient the alternatives of the surgery in addition to the conventional open hernia repair based on sutures alone, which include laparoscopic surgery and open mesh repair;

(b) failed to carry out adequate examination and investigation on the Patient before performing a further operation on the Patient for recurrent inguinal hernia on 15 July 2010 ("the Second Operation"); and

(c) failed to obtain informed consent from the Patient before performing the Second Operation in that he failed to offer to the Patient the alternatives of the surgery in addition to the conventional open hernia repair based on sutures alone, which include laparoscopic surgery and open mesh repair.

*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 since 25 October 1979 to the present. His name has been included in the Specialist Register under the Specialty of General Surgery since 4 March 1998.
3. The Patient had history of lower midline laparotomy for ectopic pregnancy many years ago. On 9 April 2010, the Patient first consulted the Defendant upon referral by a Dr YAU, with the diagnosis of hernia. The Patient presented with an orange-sized bulge in her middle right groin area, which was causing her discomfort because of its gradual increase in size. The Patient told the Defendant that the bulge had been there for over 2 years.
4. The Defendant performed clinical examination with the Patient both standing up and lying down and noted that the Patient had a very lax abdomen and was a bit chubby for her height. Further examination revealed that the Patient had an inguinal hernia of the size of a tennis ball with a positive cough impulse on her right side. The hernia mass was found to be above the inguinal ligament according to the Defendant and located very laterally. Examination of the left groin also revealed another inguinal hernia. Hence a clinical diagnosis of

bilateral inguinal hernia was made. The Defendant explained to the Patient his clinical findings and advised her to undergo a bilateral inguinal herniorrhaphy, which the Patient agreed.

5. On 26 April 2010, the Patient was admitted to St Teresa's Hospital ("STH"). The Patient signed a consent form for the surgery for her bilateral inguinal hernia and a checklist of possible common and important complications for general surgery. Elective Bilateral Open Herniorrhaphy under general anesthesia was performed for the Patient by the Defendant on the same day. The whole procedure took about an hour. The hernia repair was performed by tightening of the transversalis fascia through suturing, followed by darning with nylon sutures over the posterior wall of the inguinal canal. The operative finding was bilateral direct inguinal hernia, with a 4-5cm fascial defect noted over the posterior wall of the right inguinal canal, and a 3cm defect over the left side. The content of the sacs contained only extraperitoneal fat. The Patient was discharged on 28 April 2010.
6. The Patient noticed the persistency of the right groin lump, and had two follow-up consultations (7 May 2010 and 18 May 2010) at the clinic of the Defendant. The wound was examined in both incidents. Recurrence of the groin hernia was not evident on the first consultation, but was suspected on 18 May 2010.
7. On 22 June 2010, the Patient attended the Defendant's clinic. Physical examination confirmed recurrence of right groin hernia, with a 3cm mass located laterally to the mid inguinal point and above the inguinal ligament. The right groin mass was considered by the Defendant to be located lateral to the first hernial repair site. Re-operation in form of open hernia repair by a similar suturing method was again advised by the Defendant. The Patient agreed to re-operation.
8. On 15 July 2010, open Right Herniorrhaphy (with the same technique as in the first operation on 26 April 2010) was performed by the Defendant for the Patient in STH. Operative finding was recurrent Right direct inguinal hernia, with the

fascial defect located lateral to the original repair site. The whole operation lasted for one and a half hour. The Patient was discharged from hospital on 17 July 2010.

9. The Patient was seen by the Defendant again on 20 July 2010 and 30 July 2010 and the wound was examined. No abnormality was noted.
10. On 7 September 2010, the Defendant saw the Patient again due to the persistent groin discomfort. Physical examination revealed a right groin mass, which was located inferior to the inguinal ligament, suspected to be a femoral hernia. The Defendant referred the Patient to Tuen Mun Hospital due to financial considerations.
11. On 28 January 2011, the Patient was seen by the surgical team of Pok Oi Hospital (“POH”) and bilateral femoral hernia was the initial diagnosis.
12. On 14 April 2011, the Patient had Bilateral Laparoscopic Total Extraperitoneal Hernioplasty performed in POH. The operative finding confirmed bilateral femoral hernia. The Patient had an uneventful recovery. She was last examined in the Surgical Specialist Out Patient Clinic of POH on 13 May 2011 and was well with no recurrence of hernia.
13. By a statutory declaration dated 29 July 2011, the Patient’s daughter 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 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 allegations made 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 the Defendant separately and carefully.

### **Findings of the Inquiry Panel**

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

17. We gratefully adopt as our guiding principles the following statements of law expounded in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11:-

*“87. ... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*

...

*90. ... the doctor’s advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor’s duty is not therefore fulfilled ... by routinely demanding her signature on a consent form.”*

18. Although the judgment on *Montgomery v Lanarkshire Health Board* was handed down on 11 March 2015, the UK Supreme Court was in our view stating what the law has always been.

19. Dr CHEUNG Ho Yin Michael (“Dr CHEUNG”), the Secretary’s expert, in his Expert report dated 3 November 2014 (“Expert Report”) said: “... 2. *Although inguinal hernias remain the most common abdominal hernias in female patients, it is worth to note that female patients are more prone than male to have coexisting femoral hernias. A well-known study ... had noted that more than 42% of female patients with inguinal hernia noted initially, actually had concomitant femoral hernias which were missed during the initial diagnosis or during the operative procedure. The European Hernia Society Guideline on the treatment of Inguinal Hernia in Adults Patients (2009) actually concluded that all female patients with groin mass should be screened for the existence of femoral hernias by adopting endoscopic (TEP) approach for the inguinal hernia repair, as the femoral orifice can be visualized clearly during the operation... There are many other well-known large series studies and national guidelines ... that compared Laparoscopic Hernioplasty versus open surgery in patients with inguinal hernias, and had confirmed that Laparoscopic approach gave superior results in terms of less wound infection, fewer incidences of haematoma formation, less chronic pain and earlier return to normal activities. Taken into account of the fact that Ms. MO had history of Lower Midline Laparotomy, the option of using Laparoscopic approach to repair the bilateral hernias should be discussed with the patient, as it might be technically more difficult to develop the space at the preperitoneal plane due to scar formation along the linea alba caused by the previous surgery. Whether Laparoscopic approach should be viewed as part of the investigation to rule out the presence of femoral hernia in female patients, especially when the condition is found to be bilateral, or remained solely as an option of surgical treatment, was not completely verbalized even up to this moment. Hence, whether offering open surgery for this female patient with preoperative diagnosis of bilateral inguinal hernia is an acceptable practice at the time when this case happened is debatable. In practical situation under the daily practice of most public hospitals, we can be pretty certain that unless the patient had poor risk for general anaesthesia, most of the surgical colleagues would always offer the choice of Laparoscopic Surgery to this type of patient with this clinical scenario.*

*3. Moreover, all published papers had pointed out that even if open repair is offered, due to the inherent technical difficulty of Shouldice Repair, the recurrence rate of Open Repair without the use of Mesh is always higher. The extremely low incidence of recurrence by Shouldice repair (Shouldice Centre) was never reproduced in another world centre. Lichenstein's Repair which adopt*

*the use of Artificial Mesh (mostly prolene) to reinforce the posterior wall offers the lowest rate of recurrence, is now regarded as the gold standard for anyone who attempted open repair. For this particular case, only Nylon Darning suture repair was done and resulted in an early recurrence. Open Mesh repair should always be offered to patients with clinical diagnosis of inguinal hernia but it was not being mentioned to the patient before both operations during the consent process by Dr. Tong.”*

20. We agree with Dr CHEUNG that Laparoscopic approach gave superior results in terms of less wound infection, fewer incidences of haematoma formation, less chronic pain and earlier return to normal activities. Apart from the benefit of using the Laparoscopic approach for treatment purposes, it could also act as intra-operative tools to ensure the nature of hernia. Given in this case that the Patient was obese, and clinical examination of obese patients for differentiating femoral and inguinal hernia would be difficult, the offering of Laparoscopic Assessment should be discussed with the Patient. We also agree with Dr CHEUNG that the Patient should have been informed of the alternative of open mesh repair for its low incidence of recurrence, but the Defendant had not done so.
21. The Defendant’s conduct had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (a).
22. Dr CHEUNG in his Expert Report said: “... 5. *Early recurrence of direct inguinal hernia repair signified either a technical failure or missed diagnosis. Together with the wound swelling, patient obesity and the unusual site of recurrence, reliance on physical examination alone to ascertain the diagnosis of recurrent inguinal hernia in a female patient as the only assessment for preoperative workup is not acceptable, especially if the second repair was planned to be conventional open surgery...*”
23. Dr CHEUNG in his Supplementary Expert report dated 4 October 2025 said: “[t]he patient was noted to have recurrence of a groin mass after the first surgery on 26 April 2010. The diagnosis of recurrence was confirmed by Dr. TONG on the third subsequent follow up dated 22 June 2010. Surgeon should not rely solely on clinical examination before the second surgery, and should be more cautious and utilize scanning investigations which are already known at that juncture to be superior to clinical examinations to ensure that the subsequent

*surgery could be rightly done. In fact, preoperative MRIs or CT scan were already documented to be superior than physical examination alone. Physical examination appeared to have an inferior accuracy in fact even for patients with no previous surgery. MRI, in particular, was found to be useful for assessing post surgical hernia repair cases as early as 2000. As pointed out in my previous report in 2014, the European Guideline in 2009 also recommend MRI being the preoperative investigation for recurrent inguinal hernia.”*

24. We agree with what Dr CHEUNG said. The Defendant should have in this case carried out adequate examination by utilizing scanning investigations before performing a further operation for recurrent inguinal hernia on 15 July 2010, but he had failed to do so.
25. The Defendant’s conduct had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (b).
26. Dr CHEUNG in his Expert Report said: “...*The scarring and residual inflammation induced by the first surgery would be still very extensive as the second surgery was just 11 weeks after the first. The chance of successfully exploring the femoral canal to rule out a missed femoral hernia was remote. Most surgeons would suggest adopting the laparoscopic approach to avoid entering the already scarred anterior inguinal plane, and allowed examination of all the hernia orifices simultaneously as well. In fact, the EHS guideline also recommend the use of Endoscopic (= Laparoscopic) surgery for recurrence of hernia, if the first surgery is done by an open method... Since Madame MO complained mostly about the pain in the groin after the first surgery, with the understanding that Laparoscopic Hernia repair is associated with less chronic pain, this additional benefit should be mentioned to Ms MO as an alternative treatment to open surgery to the patient, to allow her to have the relevant information about the pain that might be experienced, and let her to make the best decision. Together with the knowledge that Open Mesh Repair had less rate of hernia recurrence, even with the presumed impression of recurrent inguinal hernia by Dr. Tong, both Laparoscopic repair and Open Mesh repair should be offered as surgical alternatives to the patient before the second operation on 15 July 2010.*”
27. We agree with what Dr CHEUNG said. The Defendant should have offered the Patient the alternatives of laparoscopic surgery and open mesh repair before

performing the second operation for recurrent inguinal hernia on 15 July 2010, but had not done so.

28. The Defendant's conduct had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (c).

### **Sentencing**

29. The Defendant has one previous disciplinary record back in 2008 relating to his failure in advising the patient of the possible complications and the applicable alternative treatment options before performing an operation on the patient. After due inquiry, the then Inquiry Panel ordered on 22 August 2013 that the Defendant's name be removed from the General Register for a period of 1 month and the removal order be suspended for a period of 6 months. We take note that the offences committed in the present case happened before the date of inquiry of the last case. We also take note that there has been no further proven complaint since the date of decision of the last case.
30. In line with our published policy, we shall give credit to the Defendant for his frank admission and full cooperation throughout these disciplinary proceedings.
31. We have considered the character reference letters and the CME record as submitted.
32. 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.
33. The offences committed by the Defendant in the present case were serious. In particular, the Defendant had not only failed once, but twice in offering appropriate alternative surgery options to the Patient. In view of the recurrence of the hernia, the Defendant should be more alert and cautious in investigating its nature. However, the Defendant still only carried out physical examination, which was inadequate. Had the Defendant examined adequately by utilizing scanning investigations, he would not have missed the diagnosis of femoral hernia. We have doubt that the Defendant is not up to date on his knowledge

about the different options of surgeries relating to hernias.

34. Having considered the serious nature and gravity of the disciplinary charges for which the Defendant was convicted and what we have heard and read in mitigation, we make a global order in respect of charges (a), (b) and (c) that the name of the Defendant be removed from the General Register for a period of 6 months. We further order that the removal order be suspended for a period of 18 months, subject to the condition that the Defendant shall complete continuing medical education (“CME”) courses in general surgery to be pre-approved by the Chairman of the Medical Council within the suspension period equivalent to 12 CME points that are not counted within CME points for Specialists. The Defendant should submit evidence of certification of the CME points by a CME Accreditor approved by the Council within one month after the expiry of the suspension period.

**Remark**

35. The name of the Defendant is included in the Specialist Register under the Specialty of General Surgery. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

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