香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TANG Peggy (鄧蕙碧醫生) (Reg. No.: M15129)

Date of hearing: 6 March 2025 (Thursday)

Present at the hearing

Council Members/Assessors: Dr CHOI Kin, Gabriel
(Chairperson of the Inquiry Panel)
Dr LAU Ho-lim
Dr CHENG Wai-tsoi, Frankie
Miss LAU Queenie Fiona, SC
Mr LAM Ho-yan, Mike

Legal Adviser: Mr Edward SHUM

Defence Solicitor representing the Defendant: Ms Jaime LAM of
Messrs. Johnson Stokes & Master

Senior Government Counsel representing the Secretary: Mr Brian LEU

The Defendant is not present.

1. The charge against the Defendant, Dr TANG Peggy, is:

"That in or about February 2022, she, being a registered medical practitioner, disregarded her professional responsibility to her patient [redacted] *("the Patient"), in that she failed to report the presence of a ureteric stone on the CT image(s) taken on the Patient.*

In relation to the facts alleged, she 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 2006 to the present. Her name has been included in the Specialist Register under the Specialty of Radiology since 2 September 2015.

3. Briefly stated, the Patient attended the Hong Kong Health Check ("HKHC") on 14 February 2022 for a plain CT scan of her abdomen and pelvis upon referral from Princess Margaret Hospital ("PMH") for follow-up of a right vesicoureteric stone following the insertion of a double-J catheter on 19 December 2021.

4. It is not disputed that a ureteric stone of 0.5 cm in the distal right ureter could be seen on one of the many images of the CT scan and was partly obscured by the right ureteric stent.

5. However, the Defendant, who worked as a Consultant in the Department of Radiology of HKHC, failed to report the presence of the ureteric stone in her CT report of the same day after reviewing the CT scan images.

6. The Patient only came to know about the presence of the ureteric stone when her treating urologist at PMH, one Dr NG, told her during follow-up consultation on 8 March 2022.

7. The Patient later lodged this complaint against the Defendant on 15 March 2022.

8. In response to this complaint, the Defendant submitted to the Preliminary Investigation Committee ("PIC") by letter from her solicitors dated 30 December 2022 that:-

"*4. On review of the CT images after PIC Notice, Dr. Tang was able to detect the ureteric stone in question in <u>one out of 87</u> CT axial images taken on 14 February 2022. She fully accepts that she had failed to detect the renal stone and report in her CT report dated 14 February 2022, and would like to sincerely apologise to the Patient for any concern or inconvenience caused.*

5. Dr. Tang, nevertheless, is grateful to Dr. Ng, the Patient's urologist at

PMH, for his vigilance and timely management, as he promptly picked up the ureteric stone on 8 March 2022…"

Burden and Standard of Proof

9. We bear in mind that the burden of proof is always on the Secretary and the Defendant does not have to prove her 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.

10. 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 her carefully.

Findings of the Inquiry Panel

11. The Defendant admits the factual particulars of the disciplinary charge against her and does not contest that the facts alleged amount to misconduct in a professional respect. It however remains for us to consider and determine on the evidence whether she has been guilty of misconduct in a professional respect.

12. In our view, the central issue in this case is whether the Defendant's failure to notice the presence of a ureteric stone after reviewing the CT scan images taken on the Patient would amount to misconduct in a professional respect.

13. The relevant legal principles were enunciated by Professor M A Jones in his book, *Medical Negligence* (6th edition):-

at paragraphs 3-100 to 3-102:-

"*A specialist is expected to achieve the standard of care of a reasonably competent specialist in that field. He must "exercise the ordinary skill of his speciality". This is inherent in the Bolam test itself…*

References to "a doctor" in the Bolam test are simply shorthand for "a doctor undertaking this type of act or procedure"…

The standard of care within a specialist field is that of ordinary competent specialist, not the most experienced or most highly qualified within the specialty…"; and

at paragraph 4-044:-

"*Where tests are required there may be negligence… in failing to interpret the results properly…*

… The level of care required will vary with the nature and purpose of the test being conducted. In P v Leeds Teaching Hospitals NHS Trust, the defendants were held to have been negligent in failing to interpret an ultrasound scan of a foetus when the mother had been specifically referred for specialist investigation. The obligation on a hospital dealing with a tertiary referral for investigation of a suspected anomaly was said to be a high one because this was "a scan with a focus"…"

14. Applying these legal principles to the facts of the present case, we noted that the Patient underwent the subject CT scan at HKHC upon the specific referral by her treating urologists at PMH following the insertion of a double-J catheter on 19 December 2021. The level of care required of the Defendant in the context of a focused referral based upon the concern with presence of ureteric stone despite the insertion of a double-J catheter was a high one. It was therefore pertinent for the Defendant to focus her review on whether ureteric stone would be present in any of the CT scan images.

15. We agree with the Secretary's expert witness, Dr CHENG, whose expert report is unchallenged, that:-

"*…Dr… Tang who reported on the CT scan of 14.2.2022… should have noted from the clinical data given (actually written in her own CT report) that a 5mm stone has been present at the right vesico-ureteric junction (VUJ) before the study and that the ureteric stent was inserted to temporarily relieve the obstruction. Considering her qualifications and professional standard, Dr Tang should have spotted the stone particularly in the knowledge of the clinical*

history…"

16. In our view, her failure to interpret the result of the CT scan properly when the Patient had been specifically referred for specialist radiological investigation was below the standard expected of registered medical practitioners undertaking this type of act or procedure.

17. Accordingly, we find the Defendant guilty of misconduct in a professional respect as charged.

Sentencing

18. The Defendant has a clear disciplinary record.

19. In line with our published policy, we shall give credit to the Defendant for her frank admission and full cooperation throughout these disciplinary proceedings.

20. 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.

21. We accept that treatment of the Patient had not been delayed by the Defendant's failure to notice the presence of ureteric stone. This is however purely because of the vigilance of Dr NG, her treating urologist at PMH, for which we praise.

22. We appreciate the Defendant is taking full responsibility for her omission. We are also told in mitigation that the Defendant has reflected on the shortcomings in her practice and has implemented the following changes with a view to preventing a similar incident from occurring again:-

    (a) appropriate and careful adjustment of the CT window settings to ensure the structures of interest are properly displayed;
    (b) multiplanar reformatting of the CT images for better detection of pathology;

(c) if necessary, discussion with radiographer and/or contact patient and referring clinician for clarification when there is discrepancy between the imaging findings and the clinical information;
(d) reminding colleagues at HKHC that whenever a patient brings up a concern regarding an examination report, the reporting doctor must be informed at the first instance or as soon as practicable; and
(e) strives to review images and reports of difficult or complicated cases at least twice to avoid any possible omissions.

23. We accept that the Defendant has learned her lesson and she has tremendous support from her professional colleagues.

24. Taking into consideration the nature and gravity of the case and what we have heard and read 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 our removal order be suspended for a period of 6 months.

Remark

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

Dr CHOI Kin, Gabriel
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong