香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHEUNG Grace Wai Yan (Reg. No.: M10064)

Dates of hearing: 12 May 2026 (Day 1);
13 May 2026 (Day 2); and
20 June 2026 (Day 3)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr HO Hung-kwong, Duncan
Dr LEUNG Yiu-hong
Ms LEE Yin-han, Yvonne
Ms YAM Hoi-yin, Cecilia

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Mr Chris HOWSE of
Messrs. Howse Williams

Legal Officer representing the Secretary: Ms Carmen SIU,
Senior Government Counsel

The Charges

1. The charges against the Defendant, Dr CHEUNG Grace Wai Yan, are:

"That on or about 4 March 2020, she, being a registered medical practitioner, disregarded her professional responsibility to her patient Madam [redacted] ("the Patient"), in that:

(i) *she failed to attend to the multiparous Patient in person, during the time in between her attendances at 1450 and 1730, when:*

(a) *the progress of labour was slow or there was no progress; and/or*

(b) *the baby had non reassuring fetal heart status;*

(ii) *she failed to manage the multiparous Patient in person, during the time in between her attendances at 1450 and 1730, when:*

(a) *the progress of labour was slow or there was no progress; and/or*

(b) *the baby had non reassuring fetal heart status;*

(iii) *she failed to arrange other obstetrician colleague(s) to attend to the Patient in person in light of (i)(a) and/or (b) above;*

(iv) *alternative to (i), (ii) and (iii) above, she failed to appraise of the development in (i)(a) and/or (b) above for proper supervision of the management of the Patient;*

(v) *she failed to obtain the informed consent in performing ventouse delivery;*

(vi) *she improperly performed ventouse delivery when the circumstances of the Patient did not so warrant;*

(vii) *prior to 17:30 hours on 4 March 2020, she failed to take reasonable steps, either by attending to the Patient in person or through giving instructions to the midwives, to ensure the baby would not suffer fetal distress or compromise, and/or*

(viii) *she failed to keep proper contemporaneous records of the ventouse delivery, namely*

(a) *details about the fetal head position, station, caput and moulding after the cup slipped in the first time; and/or*

(b) *your peri-operative assessment of the Patient.*

In relation to the facts alleged, either singularly or cumulatively, she have 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 29 May 1995 and up to the present. Her name has been included in the Specialist Register under the Specialty of Obstetrics and Gynaecology since 4 April 2006.

3. At the material time, the Defendant ran her practice at Central Health Medical Practice at 3rd Floor, Baskerville House, 13 Duddell Street, Central, Hong Kong ("Central Clinic").

4. The Patient, aged 41, was a multiparous patient, having given birth naturally to her first baby in Russia in 2021 following 22 hours labour with epidural.

5. The Patient had been seen by another obstetrician at the Central Clinic for most of her antenatal checkups during her pregnancy.

6. On 20 February 2020, the Defendant first saw the Patient for follow up of antenatal care at 38 weeks and 3 days gestation.

7. On 4 March 2020, the Patient's water broke in the middle of the night. She was admitted to Matilda International Hospital ("Hospital") at around 0434 hours. At 0447 hours, Cardiotocography ("CTG") to monitor fetal heart rate ("FHR") and contractions commenced.

8. At around 0630 hours, CTG was discontinued at the attending midwife's own accord as the readings were reactive.

9. At 0730 hours, the Defendant was informed of the Patient's condition.

10. At around 0805 hours, the Patient complained of uterine contractions every 3 minutes and requested epidural anaesthesia ("EA"). CTG monitoring resumed. At about 0835 hours, the Patient was given EA.

11. At 0931 hours, the Defendant performed her ward round and saw the Patient. Vaginal examination ("VE") revealed that the Patient's cervix was 3 cm dilated, half a cm thick, foetal head was at S-2 with clear liquor draining. Fetal heart was reactive (heart rate was normal with accelerations and no decelerations) and FHR reassuring. Overall, the Patient and the fetus were stable. The Defendant ordered to keep the Patient under observation and to await spontaneous onset of labour.

12. Following the Defendant's attendance of the Patient, she left the Hospital to attend other patients at her Central Clinic. Between 0955 to 1405 hours, the Defendant monitored the Patient remotely through regular telephone discussions with the midwives. At around 1158 hours, the Patient requested and received a top up of EA. At around 1210 hours, the Defendant made a call to the Hospital. She ordered to start syntocinon drip at 15 ml/min for the purpose of augmenting labour. At 1220 hours, syntocinon started. At 1245 hours, VE showed that the cervix was 4 cm dilated.

13. Sometime around 1300 or 1305 hours, midwife Ms Ashley LI faxed the latest CTG tracing to the Defendant's Central Clinic and updated the Defendant on the Patient's condition and her plan of management (as agreed with midwife-in-charge, Ms [redacted]) to stop syntocinon drip. The Defendant *"agreed to stop Syntocinon drip & wait to see"*. VE showed that the cervix remained at 4 cm at the time.

14. At 1405 hours, the Patient's cervix dilated to 7 cm.

15. At around 1410 hours, the Defendant returned to the Hospital and assessed the Patient in person. Her cervix was 8 cm dilated with contractions. The baby's head was still at S-1 with no caput or molding. Liquor continued to be clear. CTG was satisfactory. The Defendant ordered to restart syntocinon drip.

16. At around 1435 hours, there were variable decelerations of FHR to 90+ bpm and syntocinon was stopped.

17. At around 1450 hours, the Defendant performed another VE, which showed similar findings to that at 1410 hours.

18. At around 1500 hours, the Defendant left the Hospital and went back to Central Clinic to see her outpatients.

19. Between 1500 to 1730 hours, the midwives made the following entries in their records:

1500	Rechecked BP 144/86 mgHg P: 83/min; now pain free; early to late deceleration x 1 noted; now [redacted] ~~site~~ still Rt *[right]* side-lying position; FHR *[foetal heart rate]* 150 bpm; Toco readjusted; await spontaneous onset
1515	Early deceleration to 130 bpm than return to baseline 150 bpm; now change client to sit up position; see if CTG *[cardiotocography]* trace more reactive
1530	Contracting 3 in 10 mins; but mild to palpate; restarts Syntocinon drip @ 15ml/min after explained to [redacted]; she agreed; FHR *[foetal heart rate]* 160 bpm
1545	FHR *[foetal heart rate]* 148 bpm; [redacted] sometimes feeling the urge to push; early to late deceleration to 120 bpm; variability ~ 5bpm; contracts 3 in 10 mins
1555	VE *[vaginal examination]*: 8 cm dilated, FHR *[foetal heart rate]* decreased to 90+ bpm, then now picking up to 125 bpm, client now lies on Rt *[right]* side
1610	Client requests to stand up; steady gait
1615	FHR *[foetal heart rate]* 157 bpm, now contracts 3 in 10 mins, sometimes early deceleration; variability ≥ 5 bpm
1630	CTG *[cardiotocography]:* baseline FHR *[foetal heart rate]* 155 bpm; shallow dip noted; but variability ≥5 bpm; contracts 3-4 in 10 mins
1635	[redacted] requested for EA *[epidural anaesthesia]* top up; advised her to do the VE *[vaginal examination]* first, VE *[vaginal examination]* still 8 CM dilated, 12 ml EA *[epidural anaesthesia]* top up given; Now lie on LT *[left]* side
1640	Informed Dr G Cheung about the progress; CTG *[cardiotocography]* trace, VE *[vaginal examination]* finding & keeping Syntocinon drip @ 15 ml/hr; she ordered to continue current management; BP 150/77 mmHg; P:87/min
1645	deceleration to 90 + bpm x 3 mins; stopped syntocinon drip; FHR *[foetal heart rate]* 128 bpm

1655	In-charge [redacted] informed about client's upset and CTG *[cardiotocography]* trace
1700	0.25% Marcaine 10 ml given for pain relief BP 136/81 mmHg; P: 80/min
1715	Now pain controlled more; CTG *[cardiotocography]* early to late deceleration in last 20 mins; discussed with In-charge [redacted]; will call Grace to inform about the CTG *[cardiotocography]* trace, & told her already Stop Syntocinon
1720	Assisted client to change to all fours position
1730	Dr. Grace Cheung arrived. FHR *[foetal heart rate]* 150 bpm; USG *[ultrasound]* done at bedside; baby is in OP *[occipital posterior]* position

20. The Defendant left Central Clinic at around 1710 hours. She returned to the Hospital and was at the Patient's bedside at around 1730 hours. The Defendant carried out a bedside ultrasound and vaginal examination. The baby's head was in the Occipital Posterior ("OP") position and the baby was at S+1 position. The cervix was confirmed to be fully dilated at 1745 hours. The Patient tried to push but was unsuccessful.

21. At around 1750 hours, meconium stained liquor was seen. At around 1820 hours, the Defendant applied suction cups on the baby's head twice, i.e. ventouse delivery, but did not achieve delivery.

22. At around 1842 hours, the Defendant proceeded to emergency cesarean section ("C-section"). The baby arrived safely at 1857 hours.

23. By a statutory declaration made on 4 August 2021, the Patient lodged a complaint against the Defendant with the Medical Council ("Council").

Burden and Standard of Proof

24. 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.

25. There is no doubt that the allegations 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 her separately and carefully.

Findings of the Inquiry Panel

26. The Defendant gave evidence. She told us that during her absence from the Hospital between around 1500 to 1730 hours, she was remote monitoring the Patient via the midwives. She admitted that during her absence, she did not make one single phone call to the Hospital to check on the progress of labour. She only gave one single instruction to the midwife at around 1640 hours when the midwife called her, namely, *"to continue current management"* of *"keeping Syntocinon drip @ 15ml/hr"*. The Defendant also admitted that between around 1500 hours and prior to the midwife's call at 1640 hours, she had no information of the CTG tracing and about the progress of labour, including cervical dilation, the baby's station, occiput, caput or moulding, which were essential for her assessment of the Patient. She only obtained the CTG tracing by fax during the call with the midwife at 1640 hours. Between 1640 and 1730 hours, there was another phone call from the midwife at 1715 hours, informing the Defendant about the CTG trace and the stop of syntocinon.

27. We agree with Dr LAM Siu Keung ("Dr LAM"), Secretary's expert, that for multiparous woman, the expected time for the cervix to dilate from 8cm to 10cm (fully dilated) is within 30 minutes to 1 hour. The Patient's cervix remained 8 cm dilated at 1450 hours. The cervix was only confirmed by the Defendant to be fully dilated (at 10 cm) at 1745 hours. The Patient's progress of labour was slow between 1450 and 1730 hours. The Defendant also agreed that the progress of labour during this period was slow.

28. In the present case, there were on and off syntocinon drip for a total of 3 times, and deceleration disappeared only after stopping syntocinon. Dr LEUNG Wing Cheong ("Dr LEUNG"), the Defendant's expert, classified the CTG traces between 1550 and 1730 hours as suspicious (as defined by the FIGO guidelines), but not pathological. His reason was because CTG returned to normal after stopping syntocinon. Dr LEUNG however agreed that if one sees suspicious FHR pattern, it is non-reassuring. Dr LEUNG said *"I would think for non-*

reassuring that means it is not assuring. You need to monitor closely..."

29. In our view, when CTG traces are non-reassuring, an obstetrician should be concerned and really needs to attend to and monitor the patient and the FHR very closely for the safety of the baby. When CTG traces are suspicious or non-reassuring, there is always the possibility of hypoxia and/or acidosis.

30. In this case, between 1500 and 1715 hours, there was only one fax and two phone calls from the midwife. There is no evidence to show how much CTG tracing was sent to the Defendant by fax. The Defendant had no real time knowledge of the on and off syntocinon given by the midwife, let alone titration. The Defendant completely left the giving and stopping syntocinon to the hands of the midwives. There was no pelvic examination indicating other parameters like station, position of the caput, moulding, etc. The Defendant did not even know that the baby had been in OP position until she returned to the Hospital after 1730 hours. The Defendant's remote monitoring between 1500 and 1730 hours was not satisfactory in attending to the Patient's slow progress of labour and the non-reassuring FHR.

31. Further, the whole purpose the Defendant gave syntocinon to the Patient was to augment labour. One would expect full dilation of cervix at anytime within 30 minutes to 1 hour. The Defendant should not have left the Hospital.

32. The Defendant ought to have managed the Patient in person earlier by (i) performing VE to check the progress of cervical dilation, descent of fetal head, caput and cephalopelvic disproportion; and/or (ii) performing fine titration of syntocinon to augment the progress of labour without compromising FHR and increase the chance of delivery. However, nothing as such was done during the Defendant's remote monitoring.

33. In our view, the Defendant had failed to attend to and manage the Patient in person between 1500 and 1730 hours, when the Patient's progress of labour was slow and the baby had non-reassuring FHR.

34. We are satisfied on the evidence before us that the Defendant has by her conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find her guilty of misconduct in a professional respect under both charges (i) and (ii).

35. The Defendant told us that the Hospital had a roster system which provided 24 hour 7 days a week on-call assistance from its Resident Specialist Obstetricians. All resident specialists were contractually required to provide this on-call system. When a specialist was on-call, they were required to remain in their apartment, located close to the Hospital. If a specialist was called, he/she could provide assistance within 5 minutes.

36. The Defendant said that in the event that a midwife or the senior midwife assessed that a patient's clinical condition required assistance from an on-call Obstetrician, the midwives were allowed to contact the on-call Obstetrician who would be able to provide assistance within 5 minutes.

37. We accept what the Defendant told us that a pre-arranged roster of specialists in obstetrics and gynaecology was in place at the Hospital at the material time.

38. We will therefore acquit the Defendant of charge (iii).

39. Charge (iv) is an alternative charge. Given that we have found the Defendant guilty of charges (i) and (ii), we do not find it necessary to consider this alternative charge.

40. The Defendant told us that when she attended the Patient for the first time on 20 February 2020, they mainly discussed the Patient's Birth Plan, which was completed by the Patient in or around February 2020. The Birth Plan is a questionnaire formulated by the Hospital, which enables an antenatal patient to state her particular concerns and wishes during the birthing journey. The Defendant told us that their discussion on the Birth Plan included ventouse delivery, its nature, procedures and risk of complications. The Defendant documented in her clinic records that at that consultation there was *"discussion about her birth plan"*.

41. According to the Patient's Birth Plan, her most important goal was to give birth naturally. She was fearful of the complications during labour, which might result in having to undergo assisted delivery and/or C-section. Whilst she accepted this in the Birth Plan, the Patient also accepted that measures to assist labour and delivery might become necessary if it was crucial for preserving her or her baby's life. In the Birth Plan, the Patient wrote *"**NO vacuum delivery, NO Episiotomy, NO forceps** (ONLY if it is crucial [sic] for my or baby's life)"*.

42. The Patient confirmed that she had attended antenatal classes run by the Defendant's Central Clinic in an email dated 13 February 2020 and in evidence. The PowerPoint presentation slides from these antenatal classes provided detailed information on ventouse delivery and the risks and complications involved in ventouse delivery. At inquiry, the Patient confirmed in evidence that she knew about assisted delivery.

43. The Defendant in her statement said that at 1815 hours FHR showed fetal distress and there was poor descent, and she explained to the Patient and her husband that it might be necessary to proceed with assisted delivery, namely ventouse delivery, in order to expedite delivery and to protect the well-being of the Patient and the baby. The Defendant also explained to the Patient and her husband that there might be a need for episiotomy and that, if ventouse delivery was unsuccessful, an emergency C-section might be required. The Defendant also explained to the Patient that they had an option of not attempting ventouse delivery but proceeding directly to C-section. The couple understood the Defendant's explanation and confirmed that they wished to attempt ventouse delivery, and if ventouse was unsuccessful, to proceed with C-section. The midwife documented in the notes that at 1815 hours, *"... Dr G Cheung explained to couple the need for ventouse now for fetal distress; Couple agreed"*.

44. In our view, there is clear evidence to show that there were discussions of ventouse delivery, and that the Patient knew of the nature, procedures, and risks of complications of it. We are satisfied that informed consent had been obtained before performing the ventouse delivery. We will therefore acquit the Defendant of charge (v).

45. After the Defendant returned to the Hospital at 1730 hours, she carried out an examination of the Patient including a bedside ultrasound, which showed that the fetus was in OP position. The Defendant tried to rotate the fetal head position by manual rotation to occipital anterior position, which would be easier for the fetus in cephalic presentation to pass down the birth canal, but was unsuccessful. The Patient had pushed for a period of time from when she was confirmed to be fully dilated at 1745 until 1815 hours. Despite pushing, the Patient's fetal descent was poor. There were also signs of suspected fetal distress (meconium-stained liquor at 1750 hours and pathological CTG traces at 1815 hours). In our view, all these clinical factors did warrant the attempt of performing ventouse delivery to expedite delivery and to protect the well being of the Patient and the baby. Ventouse delivery was one of the management

methods of the Patient. Both parties' experts were of the view that the decision to try ventouse was appropriate. We will therefore acquit the Defendant of charge (vi).

46. There was no evidence that the fetus suffered from fetal distress or compromise prior to 1730 hours. There was clear liquor. The FHR had no pathological features until around 1815 hours.

47. From the medical record, the only occasion on which the baby suffered suspected fetal distress was at 1750 hour when there was first evidence of meconium-stained liquor, which was an indication of fetal distress or compromise, or after 1805 hours when there were recurrent late decelerations.

48. The objective evidence is that there was no fetal distress or compromise prior to 1730 hours. We will therefore acquit the Defendant of charge (vii).

49. The Defendant's Progress Notes recorded the following:

Date/Time	**Patient's Progress**
4/3/2020 6:30	DOP *[direct occipito-posterior position]* Cx *[Cervix]* fully dilated Vx *[vertex]* S+1 Caput+
	Ventouse Extraction attempted for recurrent Type I deceleration Bladder cathetized
	Cup applied to Vx *[vertex]*. Pressure built up to 50mmHg
	Traction applied with maternal contraction and bearing
	down Cup slipped with 1st traction, reapplied
	and attempt 2nd traction, cup slipped again
	pressure lost, Ventouse abandoned &
	Tried spontaneous bearing down, no descent, still Type 2
	decelerations
	Advice C-section
	[Dr. Cheung's signature]

50. Prior to the 1st ventouse attempt, the Defendant recorded the position of the fetal head in direct OP position, that the cervix was fully dilated, that the position of the vertex station was S+1, and that there was caput.

51. The same details were however not recorded after the 1st ventouse attempt. The Defendant explained that there was no fetal descent, and the clinical conditions of the Patient and fetus remained the same as they were prior to the 1st ventouse attempt, and therefore she did not make the record.

52. However, the Defendant's expert, Dr LEUNG, agreed *"it would be better if the vaginal examination findings were documented again before the second traction."*

53. In our view, the Defendant had failed to keep proper contemporaneous records of the ventouse delivery, namely details about the fetal head position, station, caput and moulding after the cup slipped for the first time.

54. We are satisfied on the evidence before us that the Defendant has by her conduct in the present case fallen below the standards expected amongst registered medical practitioners in Hong Kong and we find her guilty of misconduct in a professional respect under charge (viii)(a).

55. A perioperative assessment is an assessment which refers to the three phases surrounding a surgical procedure being the pre-operative phase, the intra-operative phase and the post-operative phase.

56. The Defendant's Progress Notes clearly set out the findings regarding the Patient's condition prior to the ventouse procedure which was to be attempted. The same notes set out the intra-operative stage of that procedure, being the first and second attempts to perform assisted delivery by ventouse. The notes went on to record that the procedure was then abandoned, that the Patient then tried spontaneous bearing down, but there was still no descent, and that the advice that was then given to the Patient was to proceed with the C-section.

57. There were contemporaneous records of the peri-operative assessment of the Patient relating to ventouse delivery.

58. The legal officer has not submitted anything in her closing submission in relation to this charge (viii)(b).

59. We will therefore acquit the Defendant of charge (viii)(b).

Sentencing

60. The Defendant has a clear disciplinary record.

61. 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.

62. We have considered the character reference letters as submitted and the Defendant's letter to the Council.

63. Taking into consideration the nature and gravity of the disciplinary charges for which the Defendant is convicted and what we have heard and read in mitigation, we shall make a global order in respect of charges (i), (ii) and (viii)(a) that the name of the Defendant be removed from the General Register for a period of 3 months. We further order that the removal order be suspended for a period of 12 months, subject to the condition that the Defendant shall complete continuing medical education ("CME") courses in maternal fetal medicine to be pre-approved by the Chairman of the Medical Council within the suspension period equivalent to 10 CME points that are not counted within the CME points for Specialists. The Defendant should submit evidence of certification of the 10 CME points within one month after the expiry of the suspension period.

Remarks

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

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