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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHENG On Cheong (鄭安昌醫生) (Reg. No.: M03228)

Date of hearing: 25 February 2026 (Wednesday)

Present at the hearing

Council Members/Assessors:	Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel) Prof. WONG Chi-sang, Martin Dr CHUANG Shuk-kwan, JP Mr WONG Hin-wing, Simon, MH, JP Dr CHUNG Yat-ming, Danny
Legal Adviser:	Mr Edward SHUM
Defence Solicitor representing the Defendant:	Mr Chris HOWSE of Messrs. Howse Williams
Legal Officer representing the Secretary:	Mr Martin KOK as instructed by Department of Justice

The Charges

1. The charges against the Defendant, Dr CHENG On Cheong, are:

"The particulars of the complaint are that in or about November 2021, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam [redacted] ("the Patient"), in that he failed to:

(a) properly prepare two X-ray reports of the Patient; and/or

(b) properly inform or arrange his staff to inform the Patient's attending doctor and/or the staff of the Patient's attending doctor's clinic of the substantive changes made to the first X-ray report in the second X-ray report.

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 16 June 1978 to the present. His name was included in the Specialist Register under the specialty of Radiology from 3 March 1999 to 5 September 2023.

3. Briefly stated, the Patient sprained her right foot whilst hiking. On 9 November 2021, the Patient consulted one Dr LAW, a private general medical practitioner, who then referred her to Hercules Medical Diagnostic & Laboratory Group Limited ("Hercules") for X-ray examination to rule out bone fracture in her right foot.

4. According to the Patient, whose evidence in this respect is unchallenged by the Defendant, she was subsequently told by Dr LAW's clinic assistant that no fracture was revealed from X-ray examination of her right foot. The Patient later collected the relevant X-ray films taken at Hercules on 10 November 2021 and the radiology report from Dr LAW's clinic and no further consultation was arranged.

5. On 17 December 2021, the Patient consulted one Dr WONG because of persistent pain in her right foot. Dr WONG reviewed the X-ray films taken at Hercules on 10 November 2021 and found the fractures in 2nd, 3rd and 4th metatarsal bones on the Patient's right foot. Through the arrangement of Dr WONG, the Patient underwent another X-ray examination of her right foot on 24 December 2021 whereby the fractures were confirmed.

6. With the assistance of the Chairman of the Kwun Tong Sau Mau Ping Area Committee, the Patient lodged the present complaint to the Director of Health, who then relayed the same to the Secretary of the Medical Council sometime in 2022.

Burden and Standard of Proof

7. 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.

8. There is no doubt that the allegations against the Defendant here are serious ones. 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 him separately and carefully.

Findings of the Inquiry Panel

9. There is no dispute that the Defendant had issued two radiology reports on his findings of the X-ray examination taken of the Patient's right foot at Hercules on 10 November 2021. One of the two radiology reports bears the print date of "11/11/2021 09:21" (the "1st Report") whilst the other bears the print date of "17/12/2021 15:10" (the "2nd Report"). Copies of these two radiology reports, both dated 11 November 2021, were placed by the Secretary before us for our consideration. It is not entirely clear to us how Dr WONG obtained the 2nd Report. But then again, it is unchallenged evidence of the Complainant that she was provided with the 2nd Report when she collected the X-ray films and the 1st Report from Dr WONG's clinic assistant after the consultation on 24 December 2021.

10. The material parts of the 1st Report read as follows:-

"*X-RAY RIGHT FOOT*

FINDINGS:
Normal bony articulations of right foot are noted.
No abnormal bony erosion or sclerosis is seen.
Articular surfaces are smooth.
No significant narrowing of joint spaces is noted.
No fracture is seen.
No abnormal soft tissue calcification is present.

COMMENT:
No definite bony fracture is noted."

11. The material parts of the 2nd Report read as follows:-

"*X-RAY RIGHT FOOT*

FINDINGS:
Normal bony articulations of right foot are noted.
Oblique crack fracture of distal shaft of 2nd metatarsal bone and transverse fracture of distal metaphyseal region of 3rd metatarsal bone are noted.
No abnormal bony erosion or sclerosis is seen.
Articular surfaces are smooth.
No significant narrowing of joint spaces is noted.
No abnormal soft tissue calcification is present.

COMMENT:
Oblique crack fracture of distal shaft of 2nd metatarsal bone and transverse fracture of distal metaphyseal region of 3rd metatarsal bone."

12. In response to the complaint against him, the Defendant explained to the Preliminary Investigation Committee ("PIC") of the Medical Council (the "Council") by letter dated 21 January 2025 *inter alia* that:-

"*...The report comment of "no definite bony fracture" was made on the films given to me in the morning of 11 November 2021 was due to the image quality that shows no definite fracture, and it did not mean definitely no fracture.*

The second report comment of multiple bony fractures was made on films sent to me in the afternoon of 11 November 2021, after the 1st report had been sent out. The difference in comment is due to difference in appearance of the 2nd set of printed films, which were of better quality and showed definite bony fractures. The 2nd set of films and report were later collected and returned to the referrer.

How and why two sets of films were printed and sent to me for report were determined by the referral company and not my decision and order, and was definitely not due to my purpose to amend the 'nothing wrong' first report."

13. In his subsequent letter to the PIC dated 6 September 2025, the Defendant reiterated that:-

"*As a semi-retire part-time diagnostic radiologist, my main work is to report on radiographs sent to my office room. Where, when and how the radiographs are taken and the further handling of my reports and the radiographs are not under my control. I had no meeting or contact with the imagined patients. The management and treatment of the imaged patients are handled by their referring doctors and/or clinics. I am not involved nor have the power to handle their further treatment and management by these clinics.*

That is to say, who, when, where, why and how the radiographs are taken and sent to and further management and treatment of the patients are totally not under my control and knowledge, but are totally the medical professional responsibility of the referring doctors and/or clinics, i.e. Madam Chan Kin Oi is not 'my patient' and I had only given my reports on her radiographs taken."

14. At the heart of the Defendant's submissions to the PIC lies the misconception that there was no doctor-patient relationship between him and the Patient; and he "*only reported on X-ray radiographs given to [him by Hercules]*". The true legal position was summarized by Professor Michael A Jones in paragraph 2-038 of *Medical Negligence* (6th ed.) as follows:-

"*From ancient times medical practitioners have been held accountable for a failure to exercise reasonable care in treating their patients, independently of any contractual relationship with those patients...*

Today the duty arises from the tort of negligence, but it does not depend upon a doctor's status, qualifications or expertise. Rather it is imposed by law when a doctor undertakes the task of providing advice, diagnosis or treatment. It is irrelevant who called the doctor to the patient or who pays the bill..."

15. As a reporting radiologist, the Defendant owed in our view a professional responsibility to the Patient to take reasonable care to ensure that the radiology report bearing his signature is accurate in all material respects. In case significant error in reporting is discovered after the radiology report has been issued, correct information or advice should be communicated in time to Dr LAW or when appropriate, for example in case where Dr LAW cannot be contacted in good time, to the Patient directly.

16. Our view is echoed in the following extracts from the Hong Kong College of Radiologists: Guide on Good Medical Practice for Radiologists:

"*4.11 A doctor's signature... on a report signifies that the doctor has taken reasonable steps to ensure that the content of the report is accurate in every respect...*

5.1 Radiology (or imaging) reports are medical reports... In fact, the written radiology report constitutes the legal record of the radiology investigation or procedure. It is therefore vital that the information contained within this record is accurate, explicit, understandable and informative.

5.2 Relevant medical information should be communicated in time to relevant parties for prompt medical care of patients...

...

5.4 For the communication of critical, urgent or unexpected significant radiological findings, the responsibilities of the radiologists are:

... To contact the referring clinician or another appropriate member of their clinical team, and to ensure them receive the information..."

17. The Defendant sought to attribute the error in reporting to the quality of the X-rays films given to him by Hercules. And yet, Dr WONG, a Specialist in Orthopaedics & Traumatology, whom the Patient subsequently consulted had no difficulty in identifying from the X-ray films fractures in her right foot. We have no idea whether the Defendant was looking at the original X-ray films or copy images of the same. But then again, the real point is that the Defendant ought to exercise reasonable care and ensure that the X-ray films were of sufficiently good quality before issuing the 1st Report. Or else, the Defendant would have to qualify his findings and comment in the 1st Report.

18. We appreciate that "*[w]hilst it may be acceptable from a procedural standpoint for an accurate X-ray report to be issued on the same day to address an initial diagnostic error*", but as Dr WONG, the Secretary's expert witness, said "*the problem with the second report was that it did not expressly and properly state that it superseded the first X-ray report.*"

19. For these reasons, we are satisfied on the evidence before us that the Defendant failed to properly prepare the 1st and 2nd Reports.

20. In failing to properly prepare two X-ray reports of the Patient, the Defendant has in our view by his conduct in this 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 per disciplinary charge (a).

21. In our view, the assumption of responsibility by a radiologist is an undertaking that reasonable care will be taken in delivering effective and safe medical care for the patient under investigation. It extends beyond routine reporting of imaging findings and covers, amongst others, as the Secretary's expert witness quoted from the Hong Kong College of Radiologists: Guide on Good Medical Practice for Radiologists issued in June 2021, "*[e]ffective communication of radiology*"; and "*the necessity for direct communication of significant findings to referring clinicians*".

22. We are particularly concerned about the Defendant's submission to the PIC by letter dated 17 April 2023 that "*I am a part time worker and only reported on X-ray radiographs given to me... how the radiograph images were taken and printed... are totally under the management of the referral company... the complaint of Ms Chan Kin Oi should be against the involved referral company, not me; because I am not the owner or even a staff of that company.*"

23. This demonstrates to us the Defendant's lack of understanding of his professional responsibility as a reporting radiologist.

24. In failing to properly inform the Patient's attending doctor and/or the staff of the Patient's attending doctor's clinic of the substantive changes made to the first X-ray report in the second X-ray report, the Defendant has by his conduct in this case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we also find him guilty of misconduct in a professional respect as per disciplinary charge (b).

Sentencing

25. The Defendant has one previous disciplinary record relating to practice promotion. A warning letter was ordered to be served on the Defendant back in 1990.

26. 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.

27. We appreciate that there is no evidence that the Patient has suffered permanent disability as a result of the delay in diagnosis of the fractures in her right foot. However, the additional pain and suffering occasioned by the delay should not be underestimated.

28. Taking into consideration the nature and gravity of this case, we shall make a global order in respect of disciplinary charges (a) and (b) that the name of the Defendant be removed from the General Register for a period of 3 months and we further order that the removal order be suspended for a period of 24 months.

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