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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 10 November 2010

Defendants: Dr MA Kin Loong Francis (馬健隆醫生) (1st Defendant)
Dr LEONG Daisie (梁銀萍醫生) (2nd Defendant)

1. This is a consolidated hearing of 2 cases, i.e. Case A and Case B. There are 2 defendants: Dr MA Kin Loong Francis (1st Defendant) and Dr LEONG Daisie (2nd Defendant). Case A is against the 1st Defendant only. Case B is against both the 1st Defendant and the 2nd Defendant.

2. The charges against the 1st Defendant are that:-

Case A

"On or about 26 July 2007, he, being a registered medical practitioner, disregarded his professional responsibility to his patient CHEUNG [redacted] ("the Patient") in that:-

(a) he gave a steroid injection to the Patient without informing the Patient in advance that the injection contained steroid;

(b) he gave the injection inappropriately to the Patient's back near the inferior angle of the right scapula which resulted in right pneumothorax.

In relation to the facts alleged, he has been guilty of professional misconduct."

Case B

"In January 2007, he, being a registered medical practitioner, disregarded his professional responsibility to his patient, late Mr. YAM [redacted] ([redacted]) ("Mr. YAM") in that he:

(i) failed to carry out adequate investigation and assessment on Mr. YAM before performing laminectomy upon Mr. YAM;

(ii) made inappropriate diagnosis in respect of Mr. YAM's back pain;

(iii) performed laminectomy on Mr. YAM which was inappropriate in the circumstances; and

(iv) failed to diagnose that Mr. YAM was suffering from carcinoma of the lung.

In relation to the facts alleged, he has been guilty of professional misconduct."

3. The charge against the 2nd Defendant is that:

"In the period between 21 January and 22 January 2007, she, being a registered medical practitioner, disregarded her professional responsibility to her patient, late Mr. YAM [redacted] ([redacted]) in that she failed to carry out adequate assessment on the patient before giving anaesthesia to the patient.

In relation to the facts alleged, she has been guilty of professional misconduct."

4. The 2nd Defendant is absent from the inquiry but is legally represented. We draw no adverse inference from her absence.

Facts of the cases

Case A

5. The patient in Case A was 40 years old when he consulted the 1st Defendant on 26 July 2007 at a private hospital for his right shoulder pain. After conducting physical examination the 1st Defendant told the patient that he would give him an injection. No explanation was given as to either the nature of the medicine

or the side effects and risks of the injection. The 1st Defendant then proceeded to administer the injection at the patient's back near the inferior angle of the right scapula.

6. During the injection, the patient complained of pain different from the usual pain in injections. The 1st Defendant told him that it was normal reaction and that he could leave after getting the medicines.

7. The patient felt a swelling pain in his chest when he was getting the medicines from the dispensary. He returned to his company. The pain persisted and he also felt weak. About 1 hour after the injection, he telephoned the hospital but the 1st Defendant had left.

8. The next morning the patient's chest pain intensified. He had to walk very slowly, otherwise he had difficulty in breathing. He telephoned the hospital twice to look for the 1st Defendant. When the 1st Defendant returned call, he told the patient that there should be no problem and the reaction might be drug allergy. The 1st Defendant told the patient to return to the hospital on 30 July 2007 for follow up.

9. On 30 July 2007, the patient returned to see the 1st Defendant. The 1st Defendant again said that it might be drug allergy. When the patient kept on pursuing the question about the severe chest pain and weakness, the 1st Defendant arranged for radiological examination. After seeing the radiograph, the 1st Defendant said that he could have injected the medicine into the lung and he was responsible. The 1st Defendant sent for the radiologist but the radiologist had left. The 1st Defendant reassured the patient that it was alright and asked him to leave after getting the medicine. He asked the patient to come back on 2 August 2007 for follow up.

10. Around noon on the same day, the 1st Defendant telephoned the patient and asked him to return on the next day instead of waiting until 2 August 2007. The patient sensed that there was something wrong. As the problem was getting worse, he immediately sought treatment at the Accident and Emergency Department of a public hospital.

11. The doctor at the public hospital based on the chest X ray diagnosed pneumothorax with partial collapse of the right lung. The patient was

admitted into the hospital and a right chest drain was inserted. The patient was discharged on 3 August 2007. The patient had to rest and could not resume work until September 2008. The chest pain eventually subsided but the pain at the site of injection persisted.

Case B

12. In Case B, the patient was 70 years old when he consulted the 1st Defendant for low back pain in January 2007. The 1st Defendant made a diagnosis of spinal stenosis at L4-L5 level. He recommended surgical removal of the osteophytes, and the patient agreed.

13. On 19 January 2007, the patient was referred by the 1st Defendant to the same private hospital as in Case A for radiological examination of the spine. In the discharge summary of the private hospital there was a handwritten note by the 1st Defendant under "Principal Procedure & Investigation" that a myelogram was done.

14. On 21 January 2007, the patient was admitted to the private hospital for laminectomy to be performed on 22 January 2007. According to the medical records of the hospital, a haematology report was issued at 12:51 pm showing that the patient was anaemic and had a markedly elevated white blood cell count of more than 3 times of the normal range.

15. On 22 January 2007, the 2nd Defendant as the anaesthetist examined the patient at the private hospital in preparation for the operation. This is contradictory to the entry in the Progress Sheet that the patient was examined by the anaesthetist on 21 January 2007 and was found fit for operation. Other than the entry "ASA 1" meaning healthy with no systemic disease, there was no record of what pre-operative assessment was done by the 2nd Defendant.

16. Laminectomy at the L4-L5 level was performed by the 1st Defendant. The operation was performed under general anaesthesia administered by the 2nd Defendant. The 1st Defendant said that he did not notice any carcinoma during the operation, although PET-CT scan on 21 February 2007 showed that there were widespread bone metastases involving, inter alia, L1-L5.

17. Post-operatively, the progress notes kept by the Defendant doctor showed that

on 23 January, 2007 the patient had mild cough, which persisted till 30 January, 2007.

18. The patient was discharged on 31 January 2007. The 1st Defendant arranged for him to be followed up 10 days later.

19. On 7 February 2007, the patient was taken by ambulance to a public hospital because of serious shortness of breath and leg pain. Radiological examination showed that there was serious pleural effusion in the left chest cavity of the patient. The white blood cell count was very high. Pleural drainage was performed on 8 February 2007, with about 6 litres of fluid drained out in the next 7 days.

20. On 8 February 2007, the patient was confirmed to have terminal lung cancer with widespread metastases. PET-CT scan on 21 February 2007 showed that there was a primary lung cancer measuring 12.4 cm with extensive left pleural metastases and associated pleural effusion. There was widespread bone metastases in the skeleton involving the skull base, left mandible, left humeral shaft, right humeral neck, T2, T5, T12, L1, L2, L3, L4, L5, bilateral sacral ala, multiple sites in bilateral bony pelvis, bilateral acetabula, bilateral ischia, bilateral proximal femora and multiple ribs bilaterally.

21. On 9 March 2007, the patient died.

Findings of the Council

22. Both Defendants do not contest the allegations in the charges and the facts of the cases. However, it is the responsibility of this Council to determine whether the respective conduct of each Defendant constitutes professional misconduct.

23. We shall deal with each charge separately.

1st Defendant

Case A Charge (a)

24. It is admitted that the 1st Defendant did not inform the patient that the injection

contained steroid. We accept the patient's evidence that the 1st Defendant did not give any explanation about the nature of the medicine to be injected or the side-effects and risks.

25. Proper explanation is necessary to enable the patient to make an informed decision on the proposed medical treatment. We have emphasized on many occasions before that in view of the side effects of steroid and the public concern about them, doctors have a duty to inform the patients about any treatment with steroid and its common side effects. If after explanation the patient refuses the drug, the patient's decision must be respected.

26. Failure to give proper explanation is conduct below the standard expected amongst registered medical practitioners. The 1st Defendant's failure in this respect constitutes professional misconduct. We find him guilty of Charge (a) in Case A.

Case A Charge (b)

27. The patient did not have previous history of pneumothorax. It is admitted that the 1st Defendant administered the injection inappropriately resulting in the patient's right pneumothorax. According to expert evidence, the patient's pneumothorax was likely due to mechanical puncturing of the pleura with the needle.

28. The question for us is whether the 1st Defendant had exercised due care and competence in administering the injection.

29. Puncturing the pleura is a known risk of injections in the back near the scapula. Doctors performing a procedure with a known risk must be particularly careful to guard against the risk. Accidental penetration of the pleural cavity and injection of medicine into the cavity is potentially fatal.

30. In injections with the risk of penetration into the pleural cavity, proper precaution would include inserting the needle carefully and watching out for differential resistance in the course of insertion of the needle, withdrawing the plunger after inserting the needle to ensure that no blood or air can be drawn before injecting the medicine, and ascertaining the cause of pain if the patient complains of pain during injection.

31. The 1st Defendant's management of the patient after the injection showed that he was not even alert to the risk of puncturing the patient's pleural cavity when the patient complained of unusual pain and shortness of breath, which persisted for days. Upon seeing the chest X ray on 30 July 2007, the 1st Defendant suspected the presence of pneumothorax of the right lung with the collapse of the middle lobe, which should require emergency treatment. Nevertheless, he sent the patient home asking him to return 3 days later. It is an irresistible inference that the 1st Defendant was not even alert to the risk and, upon materialization of the risk, the seriousness of the condition.

32. It is the first and foremost rule in the International Code of Medical Ethics that a doctor shall always maintain the highest standards of professional conduct. The 1st Defendant's conduct has clearly fallen foul of such requirement and the standard expected amongst registered medical practitioners. We find him guilty of Charge (b) in Case A.

Case B Charges (i), (ii) and (iii)

33. It is admitted that the 1st Defendant made the diagnosis of spinal stenosis only on the basis of a myelogram and performed laminectomy for that diagnosed condition.

34. For a major operation under general anaesthesia, thorough and comprehensive investigation must be performed in order to ensure that the proposed surgery is necessary and appropriate. Where elderly patients are involved, a doctor should be particularly alert to other possible causes of the patient's symptoms commonly associated with elderly patients, such as malignancy.

35. If pre-operative investigations raised concern about other possibilities, the proposed operation should not proceed until such other possibilities have been eliminated, especially for elective surgeries with no urgency.

36. In the present case, the patient was 70 years old. The markedly elevated white blood cell count strongly suggested the possibility of infection. A patient suffering from infection has lowered immunity and the operation would put the patient at increased risk of spreading and worsening of the infection. It was unduly hasty and reckless for the 1st Defendant to rush into the operation

despite such contra-indications without exploring the other possibilities.

37. According to the expert opinion which was not disputed, the majority of spinal stenosis is degenerative in origin. If the onset of symptoms was of a short period, the proper approach is to advise a trial of conservative treatment first such as physical therapy and oral non-steroidal anti-inflammatory drugs. In case of limited response, a trial of epidural anaesthetic injection may be used, as such injections are very safe and at very little cost.

38. The expert opinion is that in order to make a diagnosis of spinal stenosis of lumber spine, MRI examination is the choice of investigation as it is non-invasive. Myelogram is an invasive procedure and involves risks to the patient.

39. In commenting on the expert's opinion that MRI is the preferred option, the 1st Defendant claimed that he ordered a myelogram instead of MRI because it was less expensive. However, we do not see any evidence that at the time of consultation he had considered the option of MRI or discussed the options with the patient. We are of the view that it is an ex post facto explanation with hindsight after seeing the expert opinion.

40. The Preliminary Investigation Committee asked for the documentations relating to the patient, but the 1st Defendant did not provide the myelogram or the radiological report. At the inquiry we asked whether there was any supporting document of the myelogram. The Legal Officer confirmed that there was no such documentation. This was not disputed by the Defence.

41. Given the admission that the diagnosis of spinal stenosis was inappropriate, either the 1st Defendant paid no regard to the myelogram or he interpreted it wrongly in making the diagnosis.

42. There is no evidence that the 1st Defendant performed other necessary assessments, including physical and neurological examination, for making a proper diagnosis of a patient with back pain.

43. We must say that the investigations and assessments performed by the 1st Defendant were wholly inadequate, both for the purpose of making a proper diagnosis and for formulating the proper treatment. To make a diagnosis on

such inadequate investigations and assessments and to recommend a major operation for an elderly patient based on such wrongful diagnosis is clearly conduct below the standard expected. A doctor exercising due care and competence would not have made the wrong diagnosis in this case. To rush into a major operation for which there was no urgency despite very abnormal blood investigations is reckless conduct.

44. We find the 1st Defendant guilty of Charges (i), (ii) and (iii) in Case B.

Case B Charge (iv)

45. Charge (iv) in Case B is not restricted to diagnosis at the pre-operative stage. The patient had been under the care of the 1st Defendant at least from 21 to 31 January 2007 before the patient was discharged from the private hospital. There were symptoms such as persistent cough and chest discomfort which pointed to the possibility of lung pathology and called for further investigation. Nevertheless, there was no evidence that the 1st Defendant did anything in this respect.

46. We are satisfied that based on the medical records the 1st Defendant had not exercised due care and competence in managing the patient's condition in the period up to 31 January 2007 and in making the proper diagnosis. In failing to diagnose the patient's lung cancer despite the symptoms and the widespread metastases, the 1st Defendant's conduct had fallen below the standard expected amongst registered medical practitioners. We find him guilty of Charge (iv) of Case B.

2nd Defendant

47. The charge against the 2nd Defendant is that she failed to carry out adequate assessment of the patient before anaesthesia.

48. The first thing that struck us, as well as the expert whose opinion is not disputed, is that there was no documentation by the 2nd Defendant of a formal pre-operative assessment. Although the 2nd Defendant is not charged with failing to keep proper medical records, the responsibility to maintain clear, accurate, adequate and contemporaneous medical records under paragraph 1.1.2 of the Professional Code and Conduct (November 2000 version) is a

matter we have to take into consideration in determining what pre-operative assessment had been done by the 2nd Defendant.

49. In pre-operative assessment for general anaesthesia, it is necessary to assess the vital signs, examine the airway, cardiovascular and respiratory systems, obtain a medication and allergy history, and past medical and surgical history. It is also necessary to explain the procedural risks of the proposed anaesthesia to the patient before obtaining consent for the anaesthesia. There is no record that any of such assessments had been done by the 2nd Defendant.

50. Although the 2nd Defendant confirmed that she saw the patient on 22 January 2007, strangely there was a handwritten note in the Progress Sheet that the patient was examined by the anaesthetist on 21 January 2007.

51. The complete blood picture showed a marked increase in the patient's white blood cell count, neutrophilia and microcytic anaemia. In such circumstances, the patient's renal and liver function should also be checked.

52. Despite the patient's blood picture, the 2nd Defendant stated in the Anaesthetic Record that the patient was "ASA 1" standing for "American Society of Anesthesiologists physical status classification 1", indicating that the patient was healthy with no systemic disease. Such conclusion was clearly incorrect in view of the patient's blood picture.

53. We are satisfied that the 2nd Defendant had not performed proper and adequate assessment before administration of anaesthesia. This is conduct clearly below the standard expected. We find her guilty as charged.

54. In summary, the 1st Defendant is guilty of all charges against him in Case A and Case B. The 2nd Defendant is guilty of the only charge against her in Case B.

Sentencing

55. Both the 1st Defendant and the 2nd Defendant have a clear record.

1st Defendant

56. The charges against the 1st Defendant are serious. The mistakes he made are serious and fundamental.

57. In respect of Case B, laminectomy under general anaesthesia was unnecessary as the first-line treatment for spinal stenosis. There were non-invasive and conservative treatment options which should be tried, especially for an elderly patient. Even in the face of markedly elevated white blood cell count, he recklessly proceeded with the operation.

58. Looking at the 2 cases which were 7 months apart, we are of the view that the 1st Defendant adopted a reckless attitude towards patient management. He can pose danger to the public if he continues with the same attitude.

59. The 1st Defendant accepted responsibility for the mistakes both during investigation by the Preliminary Investigation Committee and in the inquiry. He applied for consolidation of the 2 cases which saved significant time for the inquiries. His admissions also saved the complainants, particularly the complainant in case B, from having to go through the traumatic experience of giving evidence about their sad experience. We shall give him credit for his admissions in accordance with our published policy in the Practice Directions.

60. Having regard to the gravity of the cases but before mitigation, we consider that the following orders are appropriate:-

    (i) In respect of Charge (a) in Case A, a reprimand.

    (ii) In respect of Charge (b) in Case A, removal from the General Register for 6 months.

    (iii) In respect of Charges (i)-(iv) in Case B, a global order of removal from the General Register for 18 months, as all charges were different aspects of the same incident, and one mistake led to the other mistake.

61. We have particular regard to the fact that Case B is more complicated and the 1st Defendant's admission saved significant time. Giving credit for the 1st

Defendant's cooperation during preliminary investigation and honest admissions in the inquiry, we make the following orders:-

(i) In respect of Charge (a) in Case A, a warning letter be served on the 1st Defendant. The order will be published in the Gazette.

(ii) In respect of Charge (b) in Case A, the 1st Defendant's name be removed from the General Register for 4 months.

(iii) In respect of Charges (i)-(iv) in Case B, the 1st Defendant's name be removed from the General Register for 10 months.

(iv) The removal orders shall run consecutively. In other words, the 1st Defendant's name be removed from the General Register for a total of 14 months.

(v) We further order that the removal orders shall take effect upon its publication in the Gazette. Such order is necessary for the protection of the public.

2nd Defendant

62. In respect of the 2nd Defendant, she has the responsibility to assess the patient for his suitability to undergo anaesthesia. The responsibility is particularly important for general anaesthesia. If the assessment is not properly carried out, the patients may be put under significant risk.

63. The 2nd Defendant honestly admitted the charge and the facts. We shall give her credit.

64. Removal from the General Register for 3 months is appropriate for the gravity of the charge. Having regard to the mitigation advanced, we order that the 2nd Defendant's name be removed from the General Register for 2 months.

Other remarks

65. The 1st Defendant's name is included in the Specialist Register under the specialty of "Orthopaedics and Traumatology". While it is the function of the

Education and Accreditation Committee to consider whether to take any action in respect of his specialist registration under section 20N of the Medical Registration Ordinance, we are of the view that it is unsuitable to retain the 1st Defendant in the Specialist Register for the following reasons:-

(a) Inclusion in the General Register is a prerequisite for inclusion in the Specialist Register. A person who has ceased to be on the General Register has lost that prerequisite status and should be removed from the General Register.

(b) Both Case A and Case B involved orthopaedic work. The 1st Defendant's competence in this respect has been demonstrated to be below the competence required of specialists in the specialty of "Orthopaedics and Traumatology".

65. When either the 1st Defendant or the 2nd Defendant applies for restoration to the General register, we recommend that the Council should consider a condition of peer supervision and audit of the applicant's practice upon restoration.

Prof. Felice Lieh-Mak, CBE, JP
Chairman, Medical Council