香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY

MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr LEUNG Ho Chiu (梁浩照醫生) (Reg. no M02866)

Date of hearing: 13 November 2013

1. The amended charges against the Defendant, Dr LEUNG Ho Chiu, are that:-

   "He, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam A ("the Patient") in that:

   (1) he failed to adequately and/or properly advise or explain to the Patient the risks and/or complications of the operation of excisional biopsy of right breast mass ("the Operation") before it was done on 13 August 2009;

   (2) he failed to locate the right breast mass during the Operation;

   (3) he failed to remove the right breast mass during the Operation; and

   (4) he failed to adequately and/or properly treat and/or care for and/or advise the Patient after the Operation when she complained that there was a mass in the same position in her right breast and/or after the histopathology report had been made available to him.

   In relation to the facts alleged, whether singularly or cumulatively, he has been guilty of misconduct in a professional respect."

Facts of the case

2. It is not disputed that the Patient first consulted the Defendant on 30 July 2009 for her right breast mass ("the Mass"). On that occasion, the Patient produced and showed to the

Defendant an ultrasound film taken on 8 April 2009 ("the Film"). She also produced an ultrasound report ("the Ultrasound Report") dated 8 April 2009 to the Defendant.

3. In the Ultrasound Report, a radiologist put down "*A 6 x 9 x 11mm hypoechoic solid palpable nodule is noted over 9:30 o'clock position of outer zone of right breast 7 cm from nipple… The lesion is well circumscribed" and commented "Fibrocystic mastopathy. Right benign looking hypoechoic solid breast nodule. Finding is more likely due to adenosis or fibroadenoma than CA. US-guided FNAC is helpful for differentiation."*

4. According to the Defendant, his reading of the Film and the Ultrasound Report was that the Mass could be cystic or a solid lesion.

5. On the Defendant's advice, the Patient was admitted into Hong Kong Baptist Hospital ("the Hospital") on 13 August 2009 for excisional biopsy of the Mass ("the Operation").

6. Prior to the Operation, the Defendant had given pre-operative advice about certain risks and complications of the Operation to the Patient. It is however undisputed that the Defendant had not specifically warned the Patient about the possibility that the Operation might fail to remove the Mass or that the Operation might fail to remove the Mass completely.

7. The Defendant performed the Operation on the Patient by way of subareolar incision under general anaesthesia on 13 August 2009. According to the Defendant, he punctured one cyst and removed the ruptured cyst with the wall en bloc during the Operation. He thought he had removed the Mass and sent the resected mass for pathology.

8. The Patient was discharged from the Hospital on 14 August 2009 and a follow-up appointment was scheduled for 17 August 2009.

9. Meanwhile, in the histopathology report dated 15 August 2009 ("the Pathology Report"), the diagnosis of the resected mass was said to be "*fibrocystic disease with no evidence of malignancy*". And the Pathology Report had already been made available to the Defendant prior to the scheduled follow-up appointment on 17 August 2009.

10. On 17 August 2009, the Patient duly attended follow-up at the Defendant's clinic. Dressing was done. The Patient did not complain of any lesion or mass during the consultation. According to the Defendant, no palpable mass was noted.

11. On 24 August 2009, the Patient returned for follow-up at the Defendant's clinic. The stitches were removed. The wound healed well and was clean. Again, the Patient did not complain of any lesion and mass during the consultation.

12. On 22 February 2010, the Patient came to the Defendant's clinic and complained of swelling on her right breast in the same position as before the Operation. According to the Defendant, he advised the Patient that the swelling on her right breast could be different from the Mass. The Defendant also advised the Patient to have an ultrasound scan and then return to see him. The Defendant further discussed with the Patient the option of excision and advised her on percutaneous biopsy.

13. The Patient did not return to consult the Defendant after 22 February 2010.

14. The ultrasound film taken on 24 February 2010 and ultrasound report of the same date confirm that the Mass had not been removed in the Operation.

Burden and Standard of Proof

15. We bear in mind that the burden of proof is always on the Legal Officer 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.

16. There is no doubt that each of the allegations made against the Defendant here are very serious. We need to look at all the evidence and to consider and determine each of the charges separately.

Findings of the Council

17. The Defendant admits the factual allegations of all the amended charges and he also admits that he had failed to locate and remove the Mass during the Operation. Nevertheless, it remains our responsibility to determine whether the Defendant's conduct constituted professional misconduct.

18. There is no dispute that the Defendant had not specifically mentioned the possibility that the Operation might fail to remove the Mass. It is however not common practice to mention the risk of failure to remove the Mass completely when it is obvious and

circumscribed. We do not consider it a professional misconduct not to warn the Patient of such a risk in the circumstances of this case. Accordingly, Charge 1 is not proven on the evidence and is therefore dismissed.

19. As to Charges 2 and 3, the Defendant took a more difficult surgical approach to remove the Mass and he should therefore exercise more caution. The Defendant had marked the position of the Mass on the Patient's right breast. Had he checked again with reasonable care by palpation on the marked point after the excision, the Defendant ought to have known that it was highly likely that the Mass was not removed. We are of the view that his failure to locate and remove the right breast mass during the Operation is a professional misconduct.

20. As to Charge 4, we are of the view that the Defendant was all along under a wrong belief that the Mass was excised. But given that the Pathology Report revealed some positive findings supportive of fibrocystic disease in the Ultrasound Report dated 8 April 2009, the Defendant could not be faulted in his treatment and care of the Patient after the Pathology Report had been made available to him. The Defendant had also advised the Patient to have another ultrasound scan. Accordingly, Charge 4 is not proven on the evidence and is therefore dismissed.

21. We are satisfied after considering all the evidence that the Defendant's conduct in failing to locate and remove the Mass during the Operation, whether taken singularly or cumulatively, had clearly fallen below the standards of conduct which is expected of members of the medical profession. We therefore find him guilty of professional misconduct as charged in Charges 2 and 3.

Sentencing

22. The Defendant has a clear record.

23. In accordance with our policy, we shall give him credit in sentencing for admitting the factual allegations in respect of Charges 2 and 3 in the Inquiry.

24. We bear in mind that the 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 the reputation of the profession.

25. We accept this was an isolated incident and the Defendant is unlikely to commit similar professional misconduct in the future. Taking into account the whole circumstances of the case and what was said in the mitigation address, we consider that an order for

reprimand would be sufficient to reflect the gravity of the case and to maintain public confidence in the medical profession. Therefore, we order that the Defendant be reprimanded in respect of both Charges 2 and 3.

Further remarks

26. The Defendant's name is included in the Specialist Register under the specialty of "General Surgery".

27. We are of the view that the present case is directly relevant to the Defendant's specialty. We shall leave it to the Education and Accreditation Committee to consider whether any action should be taken in respect of the Defendant's specialist registration under section 20N of the Medical Registration Ordinance.

Professor Felice LIEH-MAK, GBS, CBE, JP
Temporary Chairman, Medical Council