香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY

MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr FUNG To Wa (馮杜華醫生) (Reg. no M06009)

Date of hearing: 28 November 2013

1. The amended charges against the Defendant, Dr FUNG To Wa, are that:-

   "That on or about 13 May 2010, she, being a registered medical practitioner, disregarded her professional responsibility to her patient Madam A ("the Patient") in that:

   (1) she failed to adequately examine and/or investigate the Patient's condition before performing suction dilatation and curettage ("the Operation") on the Patient for termination of pregnancy;

   (2) she failed to arrange for keeping adequate and proper records of the Operation;

   (3) having performed the Operation, she failed to make an urgent request for appropriate investigations to eliminate the possibility of ectopic pregnancy; and

   (4) she failed to arrange for sufficient period for monitoring the Patient's vital signs after the Operation.

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

Facts of the case

2. On 13 May 2010, the Patient was admitted into Hong Kong Central Hospital ("the Hospital") for suction dilatation and curettage ("the Operation"). There is no dispute that no ultrasound examination was done prior to the Operation. After doing vaginal examination for the Patient, the Defendant performed the Operation on the Patient under general anaesthesia.

3. The Operation started at 08:45 hours and finished at 08:55 hours. The Patient's vital signs were monitored at 09:05 hours; 10:05 hours and 11:05 hours respectively. During this period of time, her blood pressure was found to have dropped from 122/83 mmHg to 95/62 mm/Hg. And the Patient was discharged from the Hospital at 12:30 hours.

4. After the Operation, all the tissues were sent for histological examination on the same day. The histology report dated 18 May 2010 stated that "No chorionic villus or trophoblast, either viable or necrotic, is identified to confirm the presence of products of gestation".

5. Meanwhile, the Patient developed acute severe lower abdominal pain on the night of 13 May 2010 and she was admitted to the Accident & Emergency Department of the Prince of Wales Hospital (PWH) at 00:13 hours on 14 May 2010 for emergency treatment.

6. According to the medical report obtained from PWH, the Patient was found to have low blood pressure (60/34 mmHg) and haemocue was 9.2 g/dL. Urgent blood investigation was made and urine pregnancy test was positive. Bedside ultrasound examination revealed a large amount of free fluid and blood clot in the pelvis but the uterus was empty. Emergency operation was carried out after general anaesthesia and the Patient was found to have 3L haemoperitoneum and a 3x4 cm ruptured left tubal ectopic pregnancy with active bleeding. Histological report on the Patient's left fallopian tube after the emergency operation also confirmed ectopic pregnancy.

Burden and Standard of Proof

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

8. 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.

9. It is our responsibility to determine whether the Defendant's conduct constituted professional misconduct.

Findings of the Council

10. The Defendant admits that no ultrasound examination was done prior to the Operation. As a fact of matter, the clinical record kept by the Hospital merely stated that vaginal examination was done and the Patient's uterus was found to be of 6 weeks' size. The Defendant ought to have noted that the uterine size found on that day was smaller than the gestational age by LMP.

11. We fully accept the unchallenged expert evidence of Dr. Wong Yuen Kwan, Alice ("Dr. Wong") that a pre-operative ultrasound examination was warranted because the uterus size found on vaginal examination was smaller than what would be expected from the gestational age by LMP. If this was done and an empty uterus would be noted, ectopic pregnancy should be suspected and TOP (by suction evacuation) ought not to have been carried out.

12. Therefore, we find the Defendant guilty of professional misconduct as alleged in Charge 1.

13. Although the operation record (Form 72) was very brief, we do not consider it to be insufficient. Accordingly, Charge 2 is not proven on the evidence and is therefore dismissed.

14. The Defendant had failed to arrange for a pre-operative ultrasound examination and the tissue obtained from the Operation was much less than that expected for a gestation at 7 weeks and 3 days, we are of the view that an urgent request for histology report should be made to eliminate the possibility of ectopic pregnancy. Therefore, we find the Defendant guilty of professional misconduct as alleged in Charge 3.

15. We fully accept the expert evidence of Dr. Wong that since the Patient had undergone operation under general anaesthesia and her blood pressure was found to be dropping, the Defendant ought to have monitored her vital signs for longer than 2 hours before discharging her from the Hospital. We also noted from the Day Case Nursing Record (Form 27) that the Defendant had actually ordered the nursing staff to monitor the

Patient's vital signs for 3 hours but this was done for a period of 2 hours only. Hence, the Defendant could not be faulted for failing to arrange for sufficient period for monitoring the Patient's vital signs after the Operation.

16. Accordingly, Charge 4 is not proven on the evidence and is therefore dismissed.

17. We are satisfied after considering all the evidence that the Defendant's conduct in this case, 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 her guilty of professional misconduct as charged in Charges 1 and 3.

Sentencing

18. The Defendant has a clear record.

19. In accordance with our policy, we shall give her credit in sentencing for admitting the factual allegations in respect of Charges 1 and 3 in the Inquiry.

20. 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.

21. We accept this was an isolated incident and the Defendant has learnt her lesson. But we must also bear in mind that the Defendant's professional misconduct had a life threatening impact on the Patient.

22. We consider that an order for removal of the Defendant's name from the General Register is warranted in order to reflect the gravity of the case and to maintain public confidence in the medical profession. Therefore, we order in respect of Charges 1 and 3 that the Defendant's name be removed from the General Register for a period of 4 months. We further order that the removal order be suspended for 1 year.

Professor Felice LIEH-MAK, GBS, CBE, JP

Temporary Chairman, Medical Council