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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHEUNG Chi Peter (張智醫生) (Reg. No.: M12536)

Date of hearing: 29 November 2022 (Tuesday) (Day 1)
30 November 2022 (Wednesday) (Day 2) and
13 December 2022 (Tuesday) (Day 3)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai King, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHAN Yee-shing
Dr MOK Chun-keung, Francis
Mr HUNG Hin-ching, Joseph
Mr HUI Man-kit, Patrick

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Anthony Ismail instructed by
Messrs. Mayer Brown

Senior Government Counsel representing the Secretary: Miss Vienne LUK

1. The charges against the Defendant, Dr CHEUNG Chi Peter, are:

> *"That in or about October 2016, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam X ("the Patient"), in that he:*
>
> *(a) performed the removal of the ovaries for the Patient without proper justification(s); and/or*
>
> *(b) failed to obtain proper informed consent from the Patient for the surgical procedure(s) of laparoscopic assisted vaginal hysterectomy, bilateral salpingo-oophorectomy and/or pelvic floor repair beforehand."*
>
> *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 20 January 2000 to the present. His name has been included in the Specialist Register under the specialty of Obstetrics and Gynaecology ("O&G") since 7 February 2007.

3. Briefly stated, the Patient, then aged 72, first consulted the Defendant on 14 September 2015 complaining of vaginal bleeding for which she was previously put on conservative treatment with ring pessary but in vain.

4. According to the Defendant, *"[p]hysical examination [of the Patient] showed second degree uterine prolapse and cysotocele 3cm [in] size*." Having "*discussed with the Patient and her daughter the options of conservative management and operative treatment… [the Patient]… preferred to continue conservative treatment with ring pessary…*"

5. On 26 September 2016, the Patient returned to see the Defendant complaining of recurrent vaginal bleeding and pain.

6. There is no dispute that the Patient decided during this consultation to receive operation treatment. There is also no dispute that the Defendant had explained to the Patient the treatment options of open surgery and laparoscopic assisted surgery. There is however conflicting evidence as to what explanation and advice the Defendant had given to the Patient in relation to the need for and risk of bilateral salpingo-oophorectomy.

7. On 22 October 2016, the Patient was admitted to the Hong Kong Adventist Hospital at Tsuen Wan ("Adventist Hospital") under the care of the Defendant. According to the medical records obtained from Adventist Hospital, the Patient was admitted for "*LAVH* (laparoscopic assisted vaginal hysterectomy) + *BSO* (bilateral salpingo-oophorectomy) + *PFR* (pelvic floor repair)". These surgical procedures were done by the Defendant with the assistance of one Dr LAI and one Dr WONG, both specialists in O&G, on the following day. The Patient was later discharged home on 28 October 2016.

8. On 29 October 2016, the Patient returned to see the Defendant at his clinic because of abdominal pain. According to the Defendant, the Patient "*complained of colicky abdominal pain with one vomiting, but she had no fever. Physical examination showed [her] abdomen was soft with mild tenderness, but there was no guarding or rebound… Transabdominal ultrasound uterus absent no free fluid, both kidneys had no hydronephrosis. The provisional diagnosis was bowel colic*". The Defendant advised the Patient to call him if increased abdominal pain.

9. According to medical records obtained from the Hospital Authority, the Patient attended the Accident & Emergency Department of Princess Margaret Hospital ("PMH") on 30 October 2016 owing to increased abdominal pain and vomiting. The Patient was later transferred to the Department of O&G of PMH for further management. CT scan on the following day suggested perforated bowel.

Laparotomy was performed and her peritoneal cavity was found to be heavily contaminated. Also, there was a 5mm small bowel perforation at proximal ileum, 90 cm from ileocecal valve. After her small bowel was repaired, the Patient was transferred to the Surgical Ward for further management. The Patient was finally discharged home on 26 November 2016.

10. The Patient subsequently lodged this complaint against the Defendant with the Medical Council (the "Council").

Burden and Standard of Proof

11. 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.

12. There is no doubt that each of the allegations made against the Defendant here is a serious one. Indeed, it is always a serious matter to accuse any registered medical practitioner of misconduct in a professional respect. 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

13. In response to the query of Dr PUN, the Secretary's expert, on "*[w]hy laparoscopic assisted vaginal hysterectomy, not the vaginal operative route, was performed*", the Defendant explained to the Preliminary Investigation Committee ("PIC") of the Council through his solicitors' letter dated 4 April 2019 that:-

"*… In view of the Patient's recurrent postmenopausal bleeding, there was a risk of carcinoma of uterine corpus and a risk of oestrogen secreting tumour in the ovaries. Such risks cannot be excluded unless both ovaries are removed. From the medical records of PMH…, doctors at PMH also performed endometrial biopsies to try to rule out endometrial carcinoma of uterus.*"

14. Through his solicitors, the Defendant further submitted to the PIC in his statement dated 18 November 2020 that:-

"…[*he] did not mention VH (vaginal hysterectomy) and PFR in [his first] Medical Report because the Patient's initial complaint related to bowel perforation…*

…even though the Patient came to me to seek a second opinion for VH and PFR, the removal of ovaries (i.e. BSO) was nonetheless discussed as prophylaxis and/or treatment… the Patient and her daughter decided to remove the ovaries after our discussion."

15. The Defendant also appended a copy of his handwritten notes for the second consultation with the Patient on 26 September 2016 in which he recorded that:-

"*26/9/2016 came back decided for surgical treatment*
VH and PFR but waiting list very long in HA
Wants operation in private ASAP
Discussed in details about operation VH + PFR vs
LAVHBSO + PFR and if need to removed ovaries
will need laparoscopic assist vaginal hysterectomy + BSO + PFR
risk of Ca corpus in view of recurrent PMB may
need future operation told and high risk of
difficult operation if to remove ovaries later
They decided to remove the ovaries in the same
operation."

16. Our attention was drawn by Dr WONG, the Defence Expert, to an extract from the webpage of National Health Services at https://www.nhs.uk/conditions/hysterectomy/considerations/, which stated that:-

"*The National Institute for Health and Care Excellence (NICE) recommends that a woman's ovaries should only be removed if there's a significant risk of associated disease, such as ovarian cancer.*"

17. We agree that "*[o]varian cancer is a devastating malignancy that affects women 65 years and older more frequently than younger women*". And we agree with Dr PUN that oestrogen secreting tumours are rare.

18. But then again, Dr PUN also accepted that "*[r]emoval of ovaries during hysterectomy in a postmenopausal woman without any evidence of ovarian disease should be considered prophylactic in nature".*

19. We appreciate that there was, and probably still is, a debate between ovarian conservation and elective oophorectomy during hysterectomy.

20. Since the burden of proof is always on the Secretary, we are not satisfied on the evidence before us that the Defendant had performed the removal of the ovaries for the Patient without proper justification(s).

21. Accordingly, we find the Defendant not guilty of misconduct in a professional respect as per disciplinary charge (a).

22. According to the Patient's son-in-law, the Patient was accompanied by him and his wife during the second consultation on 26 September 2016. He remembered that the Defendant explained to them the treatment options of open surgery and

laparoscopic assisted surgery. The Defendant recommended the latter to the Patient because it would be safer, less invasive and hence quicker for her to recover. And yet, the Defendant never mentioned to them about the risk of development of ovarian cancer.

23. Our attention was drawn by the Legal Officer to the Defendant's contemporaneous handwritten notes for the second consultation with the Patient on 26 September 2016 in which there was no mention of the risk of "*ovarian cancer*". Again, there was no mention of the same in the Defendant's medical report to Adventist Hospital dated 19 September 2017.

24. We do not accept the Defendant's evidence that he had explained to the Patient during the second consultation on 26 September 2016 that removal of the ovaries was prophylactic in nature with regard to ovarian cancer.

25. The Defendant reiterated that he had the best interest of the Patient in mind because "*… if the ovaries were not removed, the risks of developing carcinoma of uterine corpus and oestrogen secreting tumour in the ovaries would remain. The risks of cancer in the Patient were especially a concern to [him]… and… there were no available tests that could completely eliminate such risks*".

26. But then again, the real point is, as the majority of the House of Lords said in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 [at 55]:-

"*…The obligation of the doctor "to have regard to the best interests of the patient but at the same time to make available to the patient sufficient information to enable the patient to reach a balanced judgment"… also arose as a matter of duty of care…*"

27. It was clearly stated in section 2 of the Code of Professional Conduct (January 2016 edition) that:-

"2.7 Consent is valid only if:-

…

(b) the doctor has provided proper explanation of the nature, effect and risks of the proposed treatment…

2.10 Proper explanation of proposed treatment and risks

…

2.10.2 The explanation should be balanced and sufficient to enable the patient to make an informed decision…"

28. We agree with the authors of the medical literature entitled: "*Oophorectomy: the debate between ovarian conservation and elective oophorectomy*" cited by Dr WONG that:-

"*… The implications of this elective procedure and the possible consequences without it require physicians to review the pros and cons with patients in the light of the patient's individual circumstances and ovarian cancer risk*".

29. Further or in the alternative, the advice given by the Defendant was in our view one sided in favour of removal of the ovaries prophylactically during hysterectomy. The Defendant did not review the pros and cons with the Patient in the light of her individual circumstances and ovarian cancer risk.

30. With regard to the defence argument that there is no evidence from the Patient on how much weight she would attach to the advice given by the Defendant, we respectfully agree with the Court of Appeal in *Dr To Chun Fung, Albert v The Medical Council of Hong Kong* [at 26] that:-

"*...It was the appellant's evidence that, amongst other things, the patient had signed her consent to the operation…. If the consent were given following incomplete and unsatisfactory advice, that consent could be no defence to the charge...*"

31. In the present case, there is no doubt in our minds that the Patient's consent to treatment was given following incomplete and unsatisfactory advice by the Defendant. On this ground alone, the Patient's consent to treatment was vitiated as a matter of law. It is irrelevant in our view to consider how much weight the Patient would attach to the advice then given by the Defendant.

32. In failing to obtain proper informed consent from the Patient for the surgical procedure(s) of LAVH, BSO and/or PFR beforehand, the Defendant has in our view by his conduct 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 (b).

Sentencing

33. 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 the public confidence in the medical profession by upholding its high standards and good reputation.

34. We appreciate that the Defendant had the best interest of the Patient in mind when recommending removal of ovaries during hysterectomy.

35. However, consent to medical treatment involves the exercise of a choice. Patients cannot make a real choice unless they are given proper explanation and sufficient information so as to enable them to make a reasoned choice.

36. Taking into consideration the nature and gravity of the disciplinary charge for which we find the Defendant guilty, we order that the Defendant be reprimanded.

Remark

37. The name of the Defendant is registered in the Specialist Register under the specialty of Obstetrics and Gynaecology; and we shall leave it to the Education and Accreditation Committee to decide on whether anything needs to be done in respect of his specialist registration.

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