香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY

MEDICAL REGISTRATION ORDINANCE, CAP. 161

1st Defendant : Dr CHOY Christine Ming Yan (蔡明欣醫生) (Reg. No. M10799)

2nd Defendant : Dr WAN [redacted] (尹[redacted]醫生)[redacted]

Dates of hearing: 16 October 2013 (Day 1), 5 January 2014 (Day 2), 12 January 2014 (Day 3), 18 January 2014 (Day 4), 19 January 2014 (Day 5), 26 January 2014 (Day 6), 29 March 2014 (Day 7), 30 March 2014 (Day 8), 31 March 2014 (Day 9), 6 April 2014 (Day 10), 11 May 2014 (Day 11) and 25 May 2014 (Day 12)

1. The amended charges alleged against the 1st Defendant, Dr CHOY Christine Ming Yan, are that:-

"From 18 February 2005 to 20 February 2005, she, being a registered medical practitioner, disregarded her professional responsibility to her patient Madam [redacted] ("Madam [redacted]") in that:

(a) she performed amniotomy on Madam [redacted] without proper justification and/or without informed consent on 18 February 2005;

(b) she performed the said amniotomy on Madam [redacted] at her clinic, which was inappropriate in the circumstances;

(c) she failed to properly assess Madam [redacted]'s conditions to determine the progress of labour both prior to her order of Syntocinon infusion and afterwards to determine her response to Syntocinon infusion;

(d) she failed to arrange a paediatrician to stand by for resuscitation of Madam [redacted]'s baby at the time of his birth when she should have anticipated that the baby would be born requiring resuscitation ;

(e) she failed to recognise the presence of fetal distress when Madam [redacted] was in the first and/or the second stages of labour;

(f) she failed to perform proper and effective resuscitation on Madam [redacted]'s baby; and

(g) she failed to arrange for Madam [redacted]'s baby to be resuscitated by a paediatrician when the baby was born requiring resuscitation.

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

2. The amended charge against the 2nd Defendant, Dr WAN [redacted], is that:-

"From 19 February 2005 to 20 February 2005, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), a newborn, who was suffering from subaponeurotic haemorrhage in that he failed to properly transfer the Patient to neonatal intensive care unit or a hospital capable of providing proper and effective neonatal intensive care for treatment and/or care as and when it was required.

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

Facts of the Case

3. We wish to mention at the outset that lengthy evidence on the factual circumstances of this case was placed before us in the course of this Inquiry. To avoid any doubt, we need to emphasize that we have already considered all the evidence, including those facts and matters that we have not recited below. The reason why they are not recited is simply because of the need to keep this

Decision to an appropriate length. It does not mean that we have not taken them into consideration.

4. It is not disputed that Madam [redacted] started consulting the 1st Defendant ("Dr CHOY") for antenatal care since 12 July 2004. Madam [redacted]'s expected date of delivery ("EDD") was on 11 March 2005. Throughout the course of pregnancy, Madam [redacted] consulted Dr CHOY at her clinic in Central ("the Clinic") on some 20 occasions. Various antenatal examinations by Dr CHOY did not reveal any maternal or fetal irregularities.

5. On 18 February 2005, Madam [redacted] visited the Clinic again at around 10:30 hours in the morning. Madam [redacted] was then at 37 weeks gestation. According to Madam [redacted], this was a pre-arranged antenatal check-up. Dr CHOY disagreed. According to Dr CHOY, Madam [redacted] called her up earlier that morning and complained of painful contractions once every 15 to 20 minutes during the night before. Dr CHOY also testified that Madam [redacted] mentioned in the telephone conversation that she wanted Dr CHOY rather than the midwife at hospital to make or refute the diagnosis of labour.

6. But according to Madam [redacted], she only had some abdominal discomfort which affected her sleep for a few nights before the consultation. Madam [redacted] also testified that she did not anticipate before the consultation that she would deliver on that day and this was the reason why she did not bring along with her the "runaway bag". However that may be, the upshot was that Madam [redacted] was told by Dr CHOY in the course of this consultation that she was ready to give birth later in the day.

7. It is also not disputed that Dr CHOY performed amniotomy, which involved the artificial rupture of amniotic membrane ("ARM"), on Madam [redacted] shortly before she left the Clinic. There is conflicting evidence as to whether Dr CHOY had actually explained to Madam [redacted] the nature, implications and indications for such procedure. According to Madam [redacted], Dr CHOY merely asked her nurse to fetch the hook for rupturing the membrane. Madam [redacted] was adamant that Dr CHOY did not explain to her the nature, implications and indications for such procedure. Dr CHOY disagreed. According to Dr CHOY, not only did she show Madam [redacted] the hook before performing the amniotomy but she had also explained to Madam [redacted], amongst other things, the nature, implications and

indications for such procedure.

8. But then again, it is not disputed that Madam [redacted] was asked by Dr CHOY to go to St Teresa Hospital ("the Hospital") on Kowloon side by herself and her husband after performing amniotomy. Madam [redacted] and her husband were also unaware of the possibility of continuous leakage of liquor and dripping of liquor on the way in public.

9. Madam [redacted] was later admitted to the Hospital at or around 12:44 hours. In the Admission Initial Assessment Form, Madam [redacted]'s chief complaints on admission were noted down as "slight pain since yesterday. ARM (illegible) 11:30 at Dr's clinic". According to the Nurses' Report, the findings on vaginal examination at 12:45 hours were that the liquor was clear; fetal vertex ("Vx") was at 3 cm above ischial spine ("S-3"); and the cervix was "2F".

10. There is conflicting evidence on what "2F" really meant. According to the Legal Officer's expert, Professor Lao, "2F" in local obstetric practice meant Madam [redacted]'s cervix was admitting only 2 fingers. Professor Lao also testified that the use of "2F" in local obstetric practice connoted that the cervix was still tubular; but if the cervix had become dilated, "cm" would be used. In fact, the entries made in the Hospital's Labour Record were consistent with the local obstetric practice mentioned by Professor Lao.

11. Dr CHOY's testimony, on the other hand, is that "2F" should mean that Madam [redacted]'s cervix had become 3 cm dilated. In this connection, Professor Walker, the expert witness for Dr CHOY, fairly conceded that he had no knowledge of local obstetric practice on this point.

12. However that may be, it was noted down in the "Progress of Labour" table in the Hospital's Labour Record that Madam [redacted]'s uterine contraction was irregular at 12:45 hours and 17:15 hours. Moreover, no pain had been recorded at 15:00 hours and 16:55 hours. Vx remained high at "S-3" during the period from 12:45 hours to 18:00 hours.

13. Meanwhile, according to the Hospital's Prescription and Progress Sheet, Dr CHOY had ordered by phone at 13:15 hours for intravenous infusion of Syntocinon, a drug that stimulates uterine contraction, to be given to Madam

[redacted] after epidural anaesthesia.

14. At or around 16:55 hours, Dr FAN Tak Yan Lawrence ("Dr FAN"), an anesthetist, arrived at the Hospital and gave Madam [redacted] epidural anaesthesia. Thereafter, Syntocinon infusion was started. But still, Madam [redacted]'s uterine contractions were irregular and Dr CHOY was informed.

15. According to Dr CHOY, she first came to know that the midwife had failed to give Syntocinon infusion according to her own standing order when she discussed with the midwife over the phone on the progress of labour at 18:00 hours. Dr CHOY also testified that the midwife had reassured her that the rate of infusion would be increased right away. In this connection, Dr CHOY's testimony was that she used at that time Syntoncion according to a protocol which she gave routinely to midwives. However, the only record in the Hospital's Prescription and Progress Sheet was to give "Syntocinon 10 u (units) start 15 ml/hr after epidural". There was no mention of how and when to increase Syntocinon infusion.

16. Syntocinon infusion was stepped up progressively from 5 drops per minute at 18:00 hours to 50 drops per minute at 21:45 hours. And yet, according to the Hospital's Progress of Labour Table, Madam [redacted]'s cervix was still "2F" at 19:45 hours. Although Vx had descended in the meantime to "S-2", it remained at the same station until the last record was made at 23:30 hours.

17. According to Dr CHOY, she received a phone call at 22:45 hours from the midwife, who informed her that Madam [redacted] was in moderate pain. Dr CHOY also testified that the midwife had told her over the phone that Madam [redacted]'s cervix was 6 cm dilated. However, there was no record about this telephone conversation in the Nurses' Report. To the contrary, it was actually recorded in both the Nurses' Report at 23:30 hours that Madam [redacted]'s cervix "was 4-5 cm dilated [and] Dr CHOY was informed". And in the Progress of Labour table, it was also recorded at 23:30 hours that the cervix was "4-5" cm dilated.

18. There is no dispute that Dr CHOY did not arrive at the Hospital until 23:40 hours. It is evident from the DVD footage captured by Madam [redacted]'s husband ["the DVD"] that upon entering the Labour Room, Dr CHOY immediately performed a vaginal examination on Madam [redacted]. Despite her evidence that Madam

[redacted]'s cervix was "3 cm dilated and effaced" during the consultation at the Clinic in the morning, Dr CHOY still asked the midwife when Madam [redacted]'s cervix was fully effaced. The midwife replied that the cervix was fully effaced at 21:00 hours and this reply was neither questioned nor refuted by Dr CHOY.

19. According to the Nurses' Report, Dr CHOY found Madam [redacted]'s cervix to be fully dilated at 23:50 hours, which meant that Madam [redacted] was in the second stage of labour. It is evident from watching the DVD footage on the second stage of labour that Madam [redacted] was asked from time to time by Dr CHOY to bear down and push during the period from 23:50 hours to 00:19 hours.

20. Meanwhile, an epidural top-up was administered to Madam [redacted] at around midnight. At or around 00:09 hours, another epidural top-up was administered. On the instruction of Dr CHOY, the rate of Syntocinon infusion was further increased at or around 00:16 hours.

21. According to Dr CHOY, she showed and described to Madam [redacted] the shape, texture and mechanism of the vacuum extractor cup sometime at or around 00:19 hours. When being cross-examined on this point, Madam [redacted]'s husband disagreed and he was adamant that no explanation was given by Dr CHOY at all.

22. However that may be, there is no dispute that Dr CHOY began to apply vacuum extraction at 00:30 hours. It is evident from watching the DVD footage on the second stage of labour that the vacuum extraction was by no means a smooth one. It took some 26 minutes before the Patient was born at 00:56 hours.

23. According to the Hospital's Infant's Record, Apgar score of 7 at 1 minute and 8 at 5 minute were assessed by Dr CHOY but Dr CHOY disagreed that the Apgar score at 1 minute was given by her. However that may be, according to the Nurses' Report, the Patient was pale looking and required ventilation support by face mask bagging right after his birth. It is also evident from the DVD footage captured after his birth that despite repeated vigorous stimulation by the midwives, the Patient remained motionless and failed to react to the environment and handling. The Patient was given continuous ventilation support by face mask bagging for at least the first 6 minutes after birth.

24. According to the Nurses' Report, the Patient's colour was pale and dusky when

he was admitted to the Nursery. Despite being put in an incubator and oxygen was given at full rate, the Hospital's Infant Observation Chart recorded at 01:20 hours still showed that oxygen saturation was low at 89% and the rectal temperature was at 35.8 C. The Nurses' Report also recorded that the Patient was flaccid with poor movement and respiratory rate of 34/min before Dr FAN came to the Nursery at 01:20 hours.

25. According to the Nurses' Report, the Patient was intubated by Dr FAN in the Nursery. Dr FAN continued to support his respiration by bagging until the 2nd Defendant ("Dr WAN") arrived at or around 01:45 hours.

26. According to the Hospital's Prescription and Progress Sheet, Dr WAN recorded after his first physical examination of the Patient that the Patient was born at "37 weeks [with] difficult VE (vacuum extraction); poor respiratory effort at birth; poor peripheral circulation; (and) subaponeurotic haemorrhage".

27. The Patient was put on full ventilation support, intravenous fluid treatment and continuous oximeter monitoring. Dr WAN ordered blood transfusion of 40 ml packed cells after cross match and he continued to stay with the Patient until 04:30 hours.

28. Despite Dr WAN's instruction to monitor the Patient's blood pressure regularly, the nurses at the Hospital neglected to take the Patient's blood pressure at 06:00 hours and Dr WAN was not informed of the Patient's continuous low blood pressure throughout the period from 05:00 hours to 09:00 hours.

29. Moreover, it was not until 08:45 hours that Dr WAN was informed by the nurses at the Hospital that there were no packed cells available in the Hospital. According to Dr WAN, he immediately ordered 40 ml of whole blood to be given via the umbilical vein catheter over 4 hours rather than packed cells. Yet, transfusion of whole blood was started only at 10:30 hours.

30. Meanwhile, Dr WAN reassessed the Patient at 09:45 hours during his morning round. His assessment was that the Patient's general condition was stable but he was pale. The Patient's blood pressure remained low and Dr WAN ordered the infusion of dopamine, an inotropic agent aiming to improve the blood pressure by strengthening the heart's contractility.

31. It is not disputed that Dr WAN only returned to see the Patient at 17:10 hours. Meanwhile, from 10:20 hours to 16:30 hours, Dr WAN gave the nurses orders over the phone to administer NaHCO3 (sodium bicarbonate) for correction of metabolic acidosis; to readjust the rate of blood transfusion; and to increase the rate of dopamine infusion. However, the improvement in the blood pressure was transient and the Patient remained persistently hypotensive and acidotic.

32. According to Dr WAN, when he returned to see the Patient at 17:10 hours, he found the Patient was in an unstable condition with poor peripheral circulation, persistent metabolic acidosis, low blood pressure, no urine output, increased peripheral edema and scalp swelling. There is no dispute that Dr WAN then explained the Patient's critical conditions to his parents and advised them to transfer the Patient to the Queen Elizabeth Hospital for further management.

33. The Patient was later transferred out of the Hospital at 19:10 hours. Unfortunately, the Patient did not recover and he passed away at 03:22 hours on 20 February 2005.

Burden and Standard of Proof

34. We bear in mind that the burden of proof is always on the Legal Officer and Dr CHOY and Dr WAN do not have to prove their 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.

35. There is no doubt that each of the allegations made against the Defendants here is a serious one. It is always a serious matter to accuse a 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 charges separately.

36. We also remind ourselves this Inquiry is not about the cause of the unfortunate death of the Patient. Rather, our task is to determine in the light of all the evidence before us whether the alleged conduct of Dr CHOY and of Dr WAN has fallen below the standard reasonably expected of a registered medical practitioner in Hong Kong. In this connection, we must consider only the separate charge(s) that they are facing.

37. In their respective Closing Submissions, the Legal Officer and Counsel for the Defendants have raised a number of points. The mere fact that we have not dealt with them separately here does not mean that we have not taken them into consideration. The same equally applies to the expert evidence adduced by both sides. This is so only because of the need to balance between the length of this Decision and its comprehension. It does not mean that those other points have been overlooked.

Findings of Council

38. Counsel for Dr CHOY puts a lot of emphasis in his Closing Submissions on the question whether Madam [redacted] was in labour when she visited the Clinic in the morning of 18 February 2005. But in our view, even if Madam [redacted] was actually in labour at the time, this alone could not be a proper justification for Dr CHOY to perform the amniotomy. There must be medical indication(s) for this invasive procedure.

39. Initially, Dr CHOY sought to justify the amniotomy on the ground that it would reduce the risk of undetected cord prolapse due to spontaneous rupture of membrane by slowly releasing the liquor and the pressure. Dr CHOY was compelled to accept that it was a rare (i.e. approximately 0.1%) complication. Dr CHOY described the fetal head was well applied to the cervix and we agree with Professor Lao that the risk of cord prolapse after spontaneous rupture of the membrane in such situation would be negligible. We are therefore unable to accept that the amniotomy was indicated for the reduction of the risk of cord prolapse.

40. Dr CHOY also claimed that amniotomy was performed on Madam [redacted] because she was keen to ascertain the colour of the liquor in order to rule out the presence of meconium or blood in the liquor. But this begs the question as to why Dr CHOY had to rule out the possibility of such conditions when various antenatal examinations by Dr CHOY did not reveal any maternal or fetal irregularities. In fact, the CTG (Cardiotocogram), a standard non-invasive test for assessing fetal wellbeing, taken shortly before the amniotomy was normal and this indicated that the fetus was in a healthy condition. So we are unable to find any clinical suspicion of fetal distress that justified the performance of amniotomy on Madam [redacted].

41. Moreover, if Madam [redacted] was actually in labour with bulging forewater at the time of the consultation and if Dr CHOY had ensured that the fetal head was well applied to the cervix, Dr CHOY would not be able to check the colour of the hindwater. We do not accept the amniotomy would serve any useful purpose under the circumstances here.

42. In view of the above finding on lack of proper justification, it may not be necessary for us to deal with the question whether the amniotomy was performed without Madam [redacted]'s informed consent. If we were to decide on this question, we find it improbable that Dr CHOY could adequately advise Madam [redacted] about amniotomy and explained the procedure within less than 5 minutes. The real point is that Dr CHOY should ensure that Madam [redacted] fully understood not only the indication, benefit and risk for but also the alternative to such procedure being performed in a hospital. In addition, Dr CHOY ought to have informed Madam [redacted] of the possibility that an urgent Caesarian delivery being required if cord prolapse ensued. In failing to so, we are not satisfied that the amniotomy was performed with Madam [redacted]'s informed consent.

43. We therefore find Dr CHOY guilty of the amended charge (a).

44. In view of the above finding on absence of medical indications for performing amniotomy, we are firmly of the view that it would be inappropriate for Dr CHOY to perform such procedure at the Clinic.

45. We accept that amniotomy carries with it the risk of cord prolapse and there is always a possibility that a woman in labour may have her membrane ruptured spontaneously on the way to hospital. However, we fully agree with Professor Lao that spontaneous rupture of the membrane on the way to hospital is no more than a possibility, but once an amniotomy has been performed, there is a risk of cord prolapse. By performing amniotomy on Madam [redacted] in the Clinic, Dr CHOY would expose Madam [redacted] to a further risk of not having timely medical intervention if cord prolapse actually occurs before arrival at the Hospital. Moreover, there is always a risk that amniotomy may hasten the labour process resulting in delivery before arrival at the Hospital.

46. In our view, Dr CHOY failed to advise Madam [redacted] of the possibility of continuous leakage of liquor after the amniotomy. We fully appreciate the embarrassment of Madam [redacted] having to travel to the Hospital from the Clinic with her liquor dripping on the way in public. We also find on the evidence that Dr CHOY did not advise Madam [redacted] of the need to go to the Hospital immediately after the amniotomy. As a matter of fact, Madam [redacted] and her husband stopped by their home to pick up the "runaway bag" and video camera before going to the Hospital.

47. For these reasons, we are of the view that the amniotomy performed by Dr CHOY on Madam [redacted] at the Clinic was inappropriate in the circumstances. Therefore, we also find Dr CHOY guilty of the amended charge (b).

48. There is no dispute that Dr CHOY never attended the Hospital to assess Madam [redacted]'s conditions to determine the progress of labour prior to her order of Syntocinon infusion and afterwards to determine Madam [redacted]'s response to Syntocinon infusion. Instead, Dr CHOY relied on the nurses at the Hospital to monitor and report to her from time to time the progress of labour and response

to Syntocinon. As a matter of fact, Dr CHOY only arrived at the Hospital at 23:40 hours.

49. Despite the misunderstanding between Dr CHOY and the nursing staff of the Hospital over the rate of infusion of Syntocinon, we agree with Counsel for Dr CHOY that there was no medical reason that would dictate or necessitate the personal attendance of Dr CHOY at any time before 23:40 hours. Dr CHOY was certainly entitled to rely on the monitoring and reporting by nursing staff of the Hospital.

50. We therefore find Dr CHOY not guilty of the amended charge (c).

51. It is evident from watching the DVD footage on the second stage of labour that the vacuum extraction had been a difficult and prolonged one. It is equally evident that a difficult and prolonged vacuum extraction would increase the risk of birth asphyxia and fetal trauma requiring immediate resuscitation by a paediatrician. We agree with Dr LEUNG, the expert witness for Dr WAN, that if a paediatrician was present at the time, intubation could have been done immediately to ensure adequate oxygen supply for the Patient. More importantly, the presence of a paediatrician would ensure all advanced medical treatments can be offered promptly to the Patient as and when necessary.

52. In failing to anticipate that the Patient would be born requiring resuscitation when the circumstances were obvious and thus failing to arrange a paediatrician to stand by for resuscitation, Dr CHOY was guilty of the amended charge (d).

53. There is no doubt that the fetus was under a lot of stress during the first stage of labour. The unusually high dose of Syntocinon infusion led to frequent uterine contractions thus resulting in progressively rising basal heart rate as evidenced by the CTG tracings. However, it is not entirely clear from the CTG tracings that fetal distress was actually present. In our view, the CTG tracings did raise a suspicion that the fetus was in distress in the second stage of labour. However, the CTG tracings were not of a sufficient quality to allow a conclusive judgment on whether fetal distress was present. Reluctantly, we have to find Dr CHOY not guilty of the amended charge (e).

54. We are firmly of the view that an obstetrician owes the same duty of care to both the mother and the baby. As to the amended charge (f), we agree with Counsel for Dr CHOY that in standard obstetrics practice, basic resuscitation of the newborn may be carried out by midwives. However, this is definitely not a case where only basic resuscitation was required.

55. It is evident from watching the DVD footage that Apgar score at 1 and 5 minute could not be 7 and 8 respectively. Both expert witnesses, Dr Lam and Dr Leung, agreed in their respective expert reports that the Apgar score at 5 minute was at most 3. This indicated that the Patient was in a dire state requiring immediate advanced resuscitation.

56. Dr CHOY sought to impress upon us that Dr FAN was well experienced in providing resuscitation to the newborns. We fully agree with Dr Lam and Dr Leung that intubation was definitely required right after the birth in order to achieve proper and effective oxygenation of the Patient. And yet, intubation was not done until after the Patient was transferred to the Nursery.

57. But then again, the real point is that resuscitation performed on the Patient in the Labour Room was far from being proper and effective. In our view, proper and effective resuscitation in the circumstances here clearly required the concerted actions of both Dr CHOY and Dr FAN to clear and establish the airway; to provide assisted ventilation by intubation; and to maintain effective circulation.

58. However, according to Dr CHOY, the only resuscitation that she had performed on the Patient was by bagging him via a mask for two minutes or so shortly after 01:02 hours. Worse still, resuscitation was allowed to be interrupted at 01:04 hours when Mr [redacted] was asked to cut the umbilical cord and when the nurses handed over the Patient to Madam [redacted] for photo taking. These interruptions were clearly inappropriate when the Patient was still in a dire state.

59. Dr CHOY's evidence was that she was still worried about bleeding of Madam [redacted], as the placenta had not yet been expelled. Consequently, she had to return to Madam [redacted] to complete the third stage of labour sometime shortly before 01:05 hours. However, in our view, given the dire state of the Patient, priority ought to be given to him rather than to Madam [redacted] who was apparently in a

stable condition.

60. By reasons of the foregoing, we are satisfied on the evidence that Dr CHOY had failed to perform proper and effective resuscitation on the Patient. We therefore find Dr CHOY guilty of the amended charge (f).

61. As to the amended charge (g), there is no dispute that Dr CHOY instructed the midwife at or around 00:57 hours to summon for the resident paediatrician to come. When being told that the resident paediatrician would not be coming, Dr CHOY immediately arranged for Dr WAN to be contacted. In our view, Dr CHOY ought to be more proactive in arranging for a paediatrician to come immediately. But we are not satisfied on the evidence that Dr CHOY had failed to arrange for the Patient to be resuscitated by a paediatrician when he was born requiring resuscitation. We therefore find Dr CHOY not guilty of the amended charge (g).

62. Turning to the amended charge against Dr WAN, there is no doubt that the Patient was in a dire condition and he definitely required neonatal intensive care. He was suffering from subaponeurotic haemorrhage and birth asphyxia. His blood pressure was dangerously low and his condition was all material times critical.

63. And yet, blood pressure was not regularly monitored after Dr WAN had left the Hospital at around 04:30 hours. The Patient's blood pressure readings from 05:00 to 00:90 hours were low, even reaching an extremely low level (of mean blood pressure of 10 mmHg) at 09:00 hours. Dr WAN was not informed of the hypotension until he reassessed the Patient at or around 09:45 hours during his morning round.

64. We appreciate that there was no mandatory requirement for continuous blood pressure monitoring but it did not mean regular blood pressure monitoring would not be essential for neonatal intensive care. The real point is that the nurses in the Hospital had repeatedly failed to carry out Dr WAN's standing orders and to alert him of abnormal vital signs. This raised a real concern as to whether appropriate neonatal intensive care could be provided to the Patient in the Hospital.

65. We agree with Dr WAN that the Patient's condition had to be stabilized before the transfer. But then again, it was ultimately an analysis of the risk and benefit between an earlier and later transfer. We are of the view that Dr WAN ought to have considered the transfer of the Patient to a hospital with neonatal intensive unit capable of providing proper and effective neonatal intensive care for treatment and/or care at a much earlier time than he did. Dr WAN had made a wrong clinical judgment. However, we accept that wrong clinical judgment is not always to be equated with professional misconduct.

66. Accordingly, we are not satisfied on the evidence that Dr WAN's conduct has fallen below the standard reasonably expected of medical practitioners. We therefore find him not guilty of the amended charge.

Sentencing

67. We bear in mind that we are not here to punish the Defendant for the unfortunate death of the Patient. Rather, our task is to protect the public from persons who are unfit to practise medicine and to maintain public confidence in our medical profession.

68. A cardinal principle of medical practice is that registered medical practitioner should first of all do no harm on her patient. Any registered medical practitioner must ensure not only that there is proper justification for the invasive procedure but also that her patient was properly and adequately informed of the nature, effects, risks, complications and alternatives to such invasive procedure.

69. As we have found in respect of the amended charge (a) above, Dr CHOY performed the amniotomy on Madam [redacted] without any proper justification. Moreover, the amniotomy was performed without Madam [redacted]'s informed consent. In the course of the Inquiry which lasted for 12 days, we found nothing which indicated that Dr CHOY had any insight into her wrongdoings. We are particularly concerned about her flagrant disregard of Madam [redacted]'s autonomy.

70. In respect of the amended charge (a), we order her name to be removed from the General Register for a period of 12 months.

71. We are astonished to learn that any registered medical practitioner would perform amniotomy at her clinic. In this case, we can see no benefit and indeed only risk to both Madam [redacted] and the Patient by performing the amniotomy at the Clinic. We find Dr CHOY's conduct to have fallen far below the standard reasonably expected of medical practitioners in Hong Kong.

72. In respect of the amended charge (b), we order that Dr CHOY's name be removed from the General Register for a period of 6 months. We further order it to run concurrently with the removal order under the amended charge (a).

73. We are told that Dr CHOY now invariably arranges for a paediatrician to stand by for all deliveries. But this goes to show that she does not have sufficient insight into her wrongdoing. This approach cannot be a substitute for not exercising due diligence on her own part as an obstetrician. The real point is that she should always be on the alert of the fetal wellbeing and to arrange for a paediatrician to come in accordance with the actual clinical situations.

74. It ought to be obvious to Dr CHOY that the Patient would be born requiring resuscitation. Her total lack of anticipation was in our view inexcusable. In respect of the amended charge (d), we order that Dr CHOY's name be removed from the General Register for a period of 18 months. We further order it to run concurrently with the removal orders under the amended charges (a) and (b).

75. There is no dispute that the Patient was in a dire state after birth. Not only had Dr CHOY failed to perform proper and effective resuscitation on him, she actually asked the Patient's father to cut the umbilical cord and further allowed the nurses to hand the Patient over to Madam [redacted] for photo taking. In our view, her conduct has fallen far below the standard reasonably expected of registered medical practitioners in Hong Kong.

76. In respect of the amended charge (f), we order that Dr CHOY's name be removed from the General Register for a period of 24 months and we further order it to run concurrently with the removal orders under the amended charges (a), (b) and (d).

77. We have to consider whether to impose an immediate implementation order under section 21(iva) of the Medical Registration Ordinance ("MRO"). Counsel for Dr CHOY sought to impress upon us that 9 years had elapsed, nothing untoward happened to any of Dr CHOY's 4,000 odd patients; and Dr CHOY had in the meantime delivered almost 400 babies without another tragic event. And yet, in the course of the Inquiry, Dr CHOY was adamant that what she had done was proper and correct. This only showed her lack of insight into her wrongdoings remained unchanged.

78. Unless and until Dr CHOY has fully appreciated her shortcomings and made a real effort to improve herself, beside undergoing Continuing Medical Education (CME) which is mandatory for all specialists in any event, we have grave concern about the safety of the public if Dr CHOY is allowed to continue with her medical practice.

79. Therefore, we further order pursuant to section 21(1)(iva) of the MRO that all the above removal orders shall take effect upon publication in the Gazette.

Other remarks

80. Dr CHOY's name is also included in the Specialist Register under the specialty of Obstetrics and Gynaecology. We shall leave it to the Education and Accreditation Committee to consider whether any appropriate action needs to be taken.

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