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

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 8 February 2012 (Day 1); 10 February 2012 (Day 2).

Defendant: Dr LWIN Winnie (Reg. No. M04315)

1. The charge against the Defendant, Dr LWIN Winnie, is that:-

> "She, being a registered medical practitioner, failed to identify and state in the X-Ray Report dated 18 April 2006 the existence of a nodular lesion in the right upper lung field which should have been identifiable in a chest X-ray taken on 13 April 2006 in respect of Madam X.
>
> In relation to the facts alleged, she has been guilty of misconduct in a professional respect."

Facts of the Case

2. In April 2006, the patient Madam X went to a medical diagnostic centre for health check-up. A posterior-anterior view chest X-ray was taken on 13 April 2006. The Defendant reported on the X-ray film on 18 April 2006.

3. The X-ray report issued by the Defendant stated that:-

> "Chest
> Both lungs are clear.
> No evidence of pulmonary consolidation nor mass seen.
> Both hilar regions are normal.
> Both costophrenic angles are clear.

Comment:

NO ACTIVE LUNG LESION SEEN.

無活躍性肺損害 ”

4. The staff of the diagnostic centre gave the report to the patient and told her that all the results of the investigations were normal. Having seen the report and being assured that there was no problem, the patient did not take any follow up action.

5. In 2007, the patient had body check-up at the same centre, but she did not request for a chest X-ray. The staff of the centre told her that the results of the investigations were normal.

6. In a chest X-ray taken on 17 February 2009, a 4.5 cm mass lesion with ill-defined and irregular margin was found in the upper zone of the patient's right lung. The patient consulted a cardio-thoracic surgeon and a clinical oncologist and was diagnosed with lymphoepithelial carcinoma of the lung at stage IIIA. The patient then received induction chemotherapy in late February 2009 before surgical resection of the residual carcinoma in mid-April 2009. After surgery, the patient received further chemotherapy and then radiotherapy which was completed in mid-July 2009.

7. Upon the request of the patient, the clinical oncologist reviewed the X-ray film taken on 13 April 2006. He found that the 2006 X-ray film already showed a 1.5cm mass lesion with slightly spiculated margin, in the right upper zone corresponding to the site of primary lung tumour found in 2009. He was of the view that the spiculated mass should have been taken as suspicious of malignancy.

Council's findings

8. The question for us is whether the lesion was identifiable in 2006 when the Defendant reported on the chest X-ray film.

9. In her submission to the Preliminary Investigation Committee, the Defendant

admitted that it was a mistake for her to have missed the lung nodule in the 2006 chest X-ray film which should have been reported. She submitted that the nodule's overlap with two rib shadows and cartilage junctions caused her to miss the nodule, and she mistook the spiculated margin of the nodule as normal linear pulmonary bronchovascular lung markings.

10. We bear in mind that the Defendant's conduct should not be judged with hindsight, as a person reading the X-ray film in retrospect knowing that there was a nodule could identify the nodule more easily.

11. We accept the expert's written and oral evidence. The X-ray film was of good quality. The nodular lesion in the right upper thorax definitely existed at that time and was identifiable on the X-ray film, although it partially superimposed with the ribs. The nodule was obvious when the same area of the right and left lungs were compared. Comparing the corresponding areas of the left and right lungs is a very basic principle of reading chest X-ray films.

12. The primary concern in interpreting chest X-rays is whether there are suspicious lesions. We agree with the expert that a doctor who gives an X-ray report has the duty to point out suspicious abnormalities shown in the X-ray film, so that the referring doctor who reads the report can pursue further investigations in order to make a diagnosis. In a posterior-anterior chest X-ray film, 60% of the lung field is superimposed by other structures such as clavicles, ribs, thoracic spine, diaphragm and cardiac shadow. A lung nodule cannot be ignored and assumed to be immaterial for the reason of superimposition with other structures, otherwise many lung cancers will be missed.

13. An X-ray report concluding that there is no lesion when there are suspicious features in the X-ray film will mislead whoever is relying on the report, including the referring doctor and the patient. In the case of a missed malignant tumour, this will result in delayed diagnosis and treatment which can lead to serious consequences.

14. In the 2006 X-ray report, the Defendant was stated as both the referring doctor and

the reporting doctor. In other words, she was doubling up as the patient's clinician. In the circumstances, it was obvious to the Defendant that the patient would rely on the X-ray report. In all likelihood the X-ray film would not be seen and interpreted by another doctor, and she was the gate-keeper to decide whether the patient should take any follow-up action.

15. The Defendant in 2006 was not, and still is not, a specialist in Radiology, although in the 2006 X-ray report she represented herself as a "*Radiologist*". While issuing X-ray reports is not the monopoly of specialists in Radiology, it is an area of medical work requiring specific competence. A doctor who performs such medical work must have the relevant competence to properly interpret radiographs. It is professional misconduct for a doctor to perform medical work which is beyond his competence.

16. Having carefully considered all evidence, we are satisfied that a reasonably competent doctor exercising due care should be able to identify the nodular lesion. The Defendant should have identified and reported the nodular lesion, particularly given her training and long experience in radiology.

17. We are satisfied that the Defendant's conduct has fallen below the standard expected amongst registered medical practitioners and constituted professional misconduct. We find her guilty as charged.

Sentencing

18. The Defendant has a clear record.

19. We bear in mind that the purpose of a disciplinary order is not to punish the Defendant but to protect the public from those who are not fit to practise either because of incompetence or other reasons, and to maintain public confidence in the medical profession by upholding the reputation of the profession.

20. If the Defendant had exercised due care, the nodular lesion should have been identified and reported. The Defendant's failure to report the nodular lesion

resulted in a delay of diagnosis and treatment of the patient's cancer for nearly 3 years.

21. There is another factor which is relevant to sentencing. In radiological investigation, the proper arrangement is that after the reporting doctor has issued the X-ray report both the X-ray film and the X-ray report are sent to the referring doctor. The referring doctor will then review the film taking into consideration the reporting doctor's opinion set out in the report. This two-stage arrangement is a check and balance mechanism to minimize missing of suspicious abnormalities. However, in the present case the Defendant acted as both the referring and reporting doctor, thus removing the check and balance mechanism.

22. We have had regard to the previous sentences in similar cases, which spanned over a wide range from reprimand to suspended removal and direct removal from the General Register. While the previous sentences have reference value for sentencing in the present case, each case must be considered on its own facts and the mitigating factors.

23. In the present case, the Defendant's failure to identify and report the nodular lesion has given a false sense of security to the patient and resulted in a delay of diagnosis and treatment of her lung cancer for nearly 3 years. Some lung cancers can progress rapidly in a matter of months, and any delay in diagnosis can seriously prejudice the patient's chances of survival.

24. The Defendant practised extensively, if not exclusively, in radiology in the past 20 years. We have considered whether it is excusable for a doctor to make a mistake after reading numerous other X-ray films. We are of the view that this is not a mitigating factor, as a doctor cannot compromise his standard of practice because he is tired or not in a fit physical or mental condition. If he is not in a fit condition, he should not perform the medical work.

25. Having regard to the gravity of the case and the mitigating factors, we consider that an order of removal from the General Register for a period of 1 month is appropriate. We do not consider that suspension of the order is justified.

26. In the circumstances, we order that the Defendant's name be removed from the General Register for a period of 1 month. The order will be published in the Gazette in accordance with the provisions of the Medical Registration Ordinance.

Other remarks

27. While the Defendant's application for restoration to the General Register (if any) shall be considered as and when it is made, we recommend that the Council should require that there should be cogent evidence of a proper arrangement for the separation of the roles of the referring doctor and the reporting doctor in order to minimize the chances of suspicious abnormalities being missed.

28. The Defendant used the description of "*Radiologist*" when her name is not included in the Specialist Register under the specialty of Radiology. Under the Medical Registration Ordinance, only doctors whose names are included in the Specialist Register are permitted to use the title of specialist in the relevant specialty, and it is a criminal offence punishable by imprisonment for 3 years for a person whose name is not included in the Specialist Register to use any title or description implying that he is a specialist. In the Council's Newsletter issued in 2002, the Council has warned all doctors whose names are not included in the Specialist Register not to use titles with an indication of the field of practice such as "dermatologist". The same applies to the title "radiologist".

29. Although the Defendant has not been charged with the professional misconduct of using an impermissible title, the Defendant should immediately cease to use such a misleading title. There will be no excuse if she is found to be using the same title again.

30. For the avoidance of doubt, we have not taken this matter into consideration in sentencing.

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