香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHIANG Chay Kung (蔣在公醫生) (Reg. No.: M03489)

Date of hearing: 12 March 2025 (Wednesday) (Day 1); 13 March 2025 (Thursday) (Day 2); and 1 May 2025 (Thursday) (Day 3)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Prof. LEUNG Ka-li, Frankie
Dr LAI Wing-him
Mrs BIRCH LEE Suk-yee, Sandra, GBS, JP
Mr LI Pak-ki

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Ms Deanna LAW as instructed by Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Ms Carol LEE as instructed by Department of Justice

The Charges

1. The charges against the Defendant, Dr CHIANG Chay Kung, are:

"That on or about 12 March 2018, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] *("the Patient"), deceased, in that he -*

(a) *failed to timely refer the Patient to the Accident and Emergency ("A&E") Department of a hospital despite the Patient's presenting symptoms during the consultation(s);*

(b) *failed to advise or advise sufficiently the Patient of the warning symptoms and signs for A&E admission; and*

(c) *failed to maintain adequate and/or complete contemporaneous medical records of the Patient.*

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 21 March 1979 to the present. His name has never been included in the Specialist Register.

3. Briefly stated, the Patient was at all material times a domestic helper under the employment of the Complainant. According to the Complainant, the Patient had been working for her since 2011 and was generally of good health. On 7 March 2018, she saw a bruise-like mark on the Patient's left calf and asked the Patient what that was. The Patient replied that she did not know. The Patient thought that she might have been bitten by something that flew through the window but she was not sure. The Complainant then suggested the Patient to see the Defendant, whose clinic was quite close to their home.

4. The Defendant saw the Patient at his clinic later on the same day. According to the Defendant, he found upon physical examination of the Patient "*a follicular papule in the middle of an inflammatory plague in the middle of her medial left leg. The follicular papule and inflammatory plague both exhibited hotness and mild tenderness. Varicose vein was also noted in her left leg*". The Defendant made a diagnosis of "*chronic venous insufficiency and cellulitis*" and prescribed the Patient with, amongst other medications, a four-day course of Augmentin 375mg.

5. According to the Complainant, the Patient looked very tired on 11 March 2018, which was a Sunday and the Patient's day off. The Patient told her that "*she was feeling increasingly unwell and she had rashes on her torso and difficulties*

[in] swallowing". The Complainant then asked the Patient if she still wanted to go out and the Patient replied in the affirmative. When the Patient came back later in the evening, "*she looked terrible and lethargic. She told [the Complainant] that she had difficulties in breathing and that her heartbeat was fast*". The Patient's blood pressure and pulse were measured at 94/49 mmHg and 106/minute respectively. The Complainant then asked the Patient to go and see the Defendant again first thing in the following day.

6. There is no dispute that the Patient returned to see the Defendant at his clinic in the morning of 12 March 2018. According to the Defendant, the Patient complained of "*sore throat and breathlessness after taking Augmentin... The Patient was afebrile. Abdominal examination revealed a soft abdomen and per rect[um] examination showed yellowish stool. Her blood pressure and pulse were measured at 78/46 mmHg and 103 per minute respectively. [His] clinical suspicion was drug reaction to Augmentin*". He then administered an intramuscular injection of 1 ampule of Dexamethasone for her suspected drug allergy. Celestamine (dexchlorpheniramine 2 mg and betamethasone 0.25 mg), four times a day, was also prescribed to the Patient. The Patient "*was asked to come back in the afternoon of 12 March 2018*". When she returned to his clinic, "*[h]er blood pressure was found to be improved at 97/49 mmHg. Her pulse was also found normal at 100 per minute. She was advised to attend the Accident & Emergency Department of a public hospital if necessary*".

7. According to the Complainant, the Patient "*did not mention [to her] that [the Defendant] needed her to go back to his clinic for any re-assessment [later in the day but]... [t]he Patient used the blood pressure monitor to check her blood pressure again*". Her blood pressure and pulse were measured at 84/51mmHg and 104/minute respectively at 12:33 p.m. and 92/54mmHg and 99/minute respectively at 3:35 p.m.

8. Then on 13 March 2018, the Complainant "*noted that the Patient looked terrible. She looked weak and her face maintained to be flushed although [she] was not sure whether there were rashes thereon*". The Patient told the Complainant that "*she was having difficulties in breathing*"; and the Complainant "*also observed that she had to use a lot of effort to breathe and her breath was deep*". The Patient's blood pressure and pulse were measured at 91/55mmHg and 118/minute respectively at 7:12 a.m. The Complainant then told the Patient that she should go to the hospital and the Patient agreed. Before the Complainant took the Patient to the hospital, she called up the Defendant's clinic for a referral letter. After getting the referral letter from the Defendant's clinic later in the morning, the Complainant immediately accompanied the Patient to go to the Accident and Emergency ("A&E") Department of the

United Christian Hospital ("UCH").

9. But according to the Defendant, the Patient returned to see him at his clinic on 13 March 2018 "*complaining of breathlessness. She was afebrile... Physical examination showed no pallor, jaundice or ankle oedema. However, scattered erythematous papular drug rash was noted on her trunk. Her blood pressure and pulse were found at 88/59 mmHg and 107 per minute respectively. [His] clinical diagnosis was drug allergy... As the Patient's suspected condition of drug allergy had not improved, the Patient was advised to attend the Accident & Emergency Department of a public hospital immediately and [he] prepared a referral letter to United Christian Hospital...*"

10. Be that as it may, according to the medical records obtained from UCH, the Patient attended its A&E Department on 13 March 2018 complaining of, amongst others, "*SOB (shortness of breath) [for] 2 days*". The Patient was later transferred to the Medical Ward of UCH for further management. Initially, the Patient was treated as a case of "*anaphylaxis to Augmentin*". However, the Patient's condition continued to deteriorate and she was transferred to the Intensive Care Unit of UCH for close monitoring on 14 March 2018. However, the Patient's condition further deteriorated and then she developed cardiac arrest. Eventually, the Patient passed away after resuscitation failed at 12:53 hours on 16 March 2018.

11. The clinical suspicion of Ricketssial infection was confirmed after the Patient's death.

12. The Complainant subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council.

Burden and Standard of Proof

13. 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.

14. There is no doubt that each of the allegations against the Defendant here is a serious one. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine the disciplinary charges against him separately and carefully.

Ruling on No Case to Answer Submission

15. Counsel for the Defendant made a submission of "*No Case to Answer*" in respect of disciplinary charge (b) after the Secretary had closed her case. Although Counsel for the Defendant submitted that she intended to rely on both section 25(1)(a) and (b) of the Medical Practitioners (Registration and Disciplinary Procedure) Regulation, we could find nothing, be it in her submission or otherwise, to support her submission that "*the facts alleged in the charge are not such as to constitute the offence charged*".

16. Counsel for the Defendant sought to argue that the Secretary had "*failed to adduce [sufficient] evidence upon which the Inquiry Panel will be able to find that the facts alleged in charge (b) have been proved*". She submitted that "*neither the Complainant nor Professor LEE [the Secretary's expert] was present in any of the consultations. So the evidence is circumstantial... [and] whatever evidence that the Complainant said... which may touch upon the so-called giving of insufficient advice by [the Defendant] to the Patient is basically hearsay evidence*". She further submitted that "*it is clear that the Patient did not inform [the Complainant] of each and every detail of the consultations*"; and therefore "*any allegation by the Complainant... cannot even taken to the highest prove the allegation under charge (b)*". Also, "*it is wrong in principle for this Inquiry Panel to draw any inference that because the Patient did not mention to [the Complainant] the advice given to her by [the Defendant], [he] therefore must have failed to advise or advise sufficiently*".

17. We wish to point out that hearsay evidence is always admissible in disciplinary proceedings brought under the Medical Registration Ordinance. It is a matter of how much weight we are going to attach at the end of the day to the hearsay evidence.

18. It is clear to us from reading the legal authorities cited by the Legal Officer and Counsel for the Defendant that if the evidence adduced by the prosecution is such that its strength and weakness depends on the view to be taken on a witness's reliability, then it is a matter within the province of a jury. And the jury should be allowed the opportunity to decide on it at the end of the trial, having heard all the evidence both from the prosecution side as well as from the other side, if the defendant is going to adduce any evidence in support of his defence case.

19. Applying these legal principles to the present case, we need to remind ourselves that disciplinary charge (b) relates not only to failure "to advise" but is also about failure "to advise sufficiently". In considering the defence submission that the evidence adduced by the Secretary is of so tenuous a character that taken at its highest and properly directed, we could not properly convict on it, we need to look at all the evidence adduced by the Secretary, which included not only the evidence of the Complainant but also, amongst others, the medical records kept on the Patient by the Defendant.

20. Although the Defendant had put down in the electronic medical records for the consultation in the afternoon of 12 March 2018 "*advised to see A&E prn (as necessary)*", Professor LEE opined however that such an advice was insufficient because the Patient should be specifically advised to go to A&E Department of a hospital if she had "*difficulty in breathing*". It is open to us to accept at the end of the day Professor LEE's expert evidence on this point.

21. We do not agree with Counsel for the Defendant that the evidence adduced by the Secretary in respect of disciplinary charge (b) is of so tenuous a character that there should be no case to answer for that charge.

Findings of the Inquiry Panel

22. We need to bear in mind that the Defendant is not charged with failure to make the diagnosis of Rickettsial infection, the clinical features of which are, as Professor LEE said, "*non-specific and many common febrile illnesses can also mimic the condition so delay in diagnosis is common because of the undifferentiated nature of presentation*".

23. Expert witnesses from both sides spent a lot of time in debating whether the Patient was in shock when she consulted the Defendant on 12 March 2018. This is however beside the point. In our view, the real question to be asked in respect of disciplinary charge (a) is whether the presenting symptoms of the Patient on that day were so serious as to warrant admission to A&E Department. It does not matter therefore whether the presenting symptoms were typical of shock.

24. In his Statement to the Preliminary Investigation Committee ("PIC") dated 1 March 2019, the Defendant explained that in addition to his handwritten clinical records on the Patient, he also maintained a set of electronic clinical records in his clinic. The Defendant also mentioned in his Statement that he "*saw the Patient again when she returned on 12 March 2018 complaining of sore throat and breathlessness after taking Augmentin*".

25. In response to disciplinary charge (a), the Defendant further submitted in his Supplemental Statement to the PIC dated 26 March 2021 that "*[p]ursuant to [his] routine practice, a thorough physical examination was performed*" when he saw the Patient on 12 March 2018, "*including... performing a chest examination by auscultation to check the Patient's respiratory rate, air entry, breath sounds and heart beat...; and... check for signs of dyspnoea...However, [he] would not always document all of [his] examination findings if they were normal or if there was no abnormality*".

26. When being asked by his Counsel during examination-in-chief what he meant by "*breathlessness*" in his handwritten clinical notes for the consultation in the morning of 12 March 2018, the Defendant initially replied that "*breathlessness 就係氣緊緊。就唔係 shortness of breath*". However, in response to our query, the Defendant admitted that he communicated with the Patient in English. The words used by the Patient were "*tightness of chest*"; and "*氣緊緊*" was his understanding of what she meant by "*tightness of chest*".

27. We do not accept the Defendant's explanation of what he meant by "*breathlessness*" in his handwritten clinical notes for the consultation in the morning of 12 March 2018. Moreover, there was no mention of "*tightness of chest*" or "*氣緊緊*" in any of his statements to the PIC. It was only in response to our query that the Defendant mentioned for the first time in his evidence that the words used by the Patient were "*tightness of chest*". Regardless of how the

Defendant termed it, the real point is that the Patient had difficulty in breathing, which coupled with low blood pressure and high pulse rate were serious enough to warrant a timely referral for A&E admission.

28. The Defendant was adamant in his evidence under cross examination that he would only put down "*positive findings*" in his handwritten clinical notes but not "*negative findings*", albeit sometimes the "*negative findings*" might be put down in the electronic medical records by his clinic assistant as a matter of routine. But when being asked by us why he put down the "*negative findings*" of per rectum examination in his handwritten clinical notes for the consultation in the morning of 12 March 2018, the Defendant replied that it was an important procedure and he needed to put down the Patient was negative for gastrointestinal bleeding.

29. We agree that per rectum examination was an important procedure for ruling out that the Patient's low blood pressure was caused by gastrointestinal bleeding. This reinforced our view that the Patient's presenting symptoms of low blood pressure, high pulse rate and difficulty in breathing were serious enough to warrant a timely referral to A&E admission. But then again, if the Defendant had truly performed, which we do not accept, a "*thorough physical examination*" pursuant to his "*routine practice*" to check for, amongst others, "*signs for dyspnoea*", we find it implausible for the Defendant not to put down in his handwritten clinical notes the important "*negative finding*" to rule out "*dyspnoea*".

30. We do not accept that the Defendant's evidence that the words "*chest clear*", which he put down in his handwritten clinical notes for the consultation in the morning of 12 March 2018, connoted the meaning that the Patient was "*negative for dyspnoea*". We do not accept the Defendant's evidence in examination-in-chief that the Patient breathed without using "*accessory muscle*". There was no mention in the Defendant's handwritten consultation notes or electronic medical records or indeed any of his statements to the PIC about this finding.

31. We find the Complainant to be a reliable and honest witness. Although she did not accompany the Patient to see the Defendant on 12 March 2018, her evidence on the Patient's condition and physical complaints on that day was corroborated by the readings shown in photographs that she took of the blood pressure monitor. Her evidence was also corroborated by the independent

medical records obtained from UCH which showed that the Patient had shortness of breath, dizziness and rashes over her face and trunk after taking Augmentin and before the Defendant saw her on 12 March 2018.

32. Although we do not have the benefit of hearing the direct evidence from the Patient, we have no reason to doubt the accuracy of the medical history documented in the medical records obtained from UCH, which was corroborated by the evidence of the Complainant. We find it implausible that the Patient would tell the Defendant something different about her condition and physical complaints from what she had told the Complainant or the doctors at UCH.

33. In this regard, we noted from reading the referral letter written by the Defendant for the Patient's admission to A&E Department on 13 March 2018 that the Patient was "*[s]een by [him] on 07/03/2018 for Chronic venous insufficiency & cellutitis, dispensed with Augmentin... Has developed breathlessness, hypotension after taking Augmentin. Dexamethasone injection given...*" This reinforced our view that the Patient presented with symptoms of, amongst others, low blood pressure, high pulse rate and difficulty in breathing, which were so serious as to warrant a timely referral for A&E admission.

34. For these reasons, in failing to timely refer the Patient to the A&E Department of a hospital despite the Patient's presenting symptoms during the consultation(s) on 12 March 2018, the Defendant had by his conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (a).

35. We do not agree with the defence expert witness, Dr IP, that a general advice for patients to admit to A&E "*they do not feel well*" would be sufficient for the case of the Patient here.

36. We agree with Professor LEE that the Patient should be advised to go to the A&E Department if her difficulty in breathing persisted. However, the Defendant merely put down in his handwritten clinical notes "*advised to see A&E prn*".

37. When being asked by his counsel in examination-in-chief to repeat in verbatim how he advised the Patient, the Defendant replied that he advised the Patient to

go to A&E Department of a public hospital "*if you feel dyspnoea*". There is however nothing in either his handwritten clinical notes or what he called the "*complementary*" electronic medical records that he had advised the Patient as such. There was also no mention in any of the Defendant's statements to the PIC of this advice to the Patient.

38. When further asked by us how he could know that the Patient understood what was meant by "*dyspnoea*", the Defendant replied that the Patient nodded her head. It is essential in our view that explanation should be given in clear and simple language; and we have grave doubt about the Patient's ability to understand this medical term. Even if the Defendant had so advised the Patient, which we do not accept, he ought in our view to ascertain with the Patient whether she truly understood that she should go to A&E department of a hospital in case her difficulty in breathing persisted.

39. In failing to advise the Patient sufficiently of the warning symptoms and signs for A&E admission, the Defendant had in our view by his conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of disciplinary charge (b).

40. We are taken aback by the expert evidence, which we do not accept, of Dr IP, who was a former President of the Hong Kong College of Family Physicians, that putting down "*negative findings*" in the medical records is a good practice for specialists in Family Medicine and not the standard practice of "*average general practitioners*".

41. It was clearly stated in section 1.1 of the Code of Professional Conduct (2016 edition) that:-

> "...
>
> *1.1.2* *A medical record documents the basis for the clinical management of a patient. It reflects on the quality of care and is necessary for continuity of care...*
>
> *1.1.3* *All doctors have the responsibility to maintain systematic, true, adequate, clear and contemporaneous medical records...*"

42. We wish to supplement that medical records are kept not only for a registered medical practitioner's own use. They also provide essential information for any

registered medical practitioner who subsequently takes over the care and management of the same patient.

43. Our view is echoed by the recommendations of the UK Medical Protection Society in 2013 that a medical record should include, amongst others, "*[r]elevant details of the history, including important negatives... [e]xamination findings, including important negatives...; and [w]hat [a doctor] had told/discussed with the patient*".

44. It is evident to us from reading the Defendant's handwritten clinical notes and electronic medical records that he had failed to maintain adequate contemporaneous medical records of the Patient's medical history. In this connection, although the Defendant had told us in his evidence that he had asked the Patient about her body temperature in between 7 and 11 March 2018, there was nothing in either his handwritten clinical notes or electronic medical records about this part of the Patient's medical history.

45. In failing to maintain adequate contemporaneous medical records of the Patient for the consultation(s) on 12 March 2018, the Defendant had in our view by his conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (c).

Sentencing

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

47. We are particularly concerned about the Defendant's failure to make a timely referral to A&E Department of a hospital when the Patient's condition was so serious.

48. We are told in mitigation that the Defendant has reflected on the case and would ensure in future that his patient can understand his advice. If necessary, he would talk to the patients' family members and would follow up with

patients on their conditions by phone. Moreover, the Defendant would improve on his medical record keeping by putting down negative findings.

49. Taking into consideration the nature and gravity of this case and what we have read and heard in mitigation, we shall make a global order in respect of disciplinary charges (a), (b) and (c) that the name of the Defendant be removed from the General Register for a period of 6 months; and that the operation of the removal order be suspended for a period of 24 months on condition that the Defendant shall complete courses, to be pre-approved by the Council Chairman, on medical record keeping to the equivalent of 10 CME points.

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