香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

1st Defendant: Dr CHAN Pui Kan (陳沛勤醫生) (Reg. No.: M16408)
2nd Defendant: Dr LO Hung Kwong (羅孔光醫生) (Reg. No.: M07027)

Date of hearing: 21 August 2024 (Wednesday)

Present at the hearing

Council Members/Assessors: Prof. FOK Tai-fai, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHEUNG Chin-pang
Dr CHIU Shing-ping, James
Ms LIU Lai-yun, Amanda
Ms WONG HY Careen

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendants: Mr Alfred FUNG as instructed by
Messrs. Mayer Brown

Senior Government Counsel representing the Secretary: Mr Edward CHIK

1. The amended charges against the 1st Defendant, Dr CHAN Pui Kan, are:

"That from May to August 2019, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] *("the Patient"), deceased, in that he :*

(a) failed to adequately interpret the history and X-rays of the Patient; and/or

(b) failed to carry out appropriate investigation on the underlying cause(s) for fracture of femur of the Patient during the Patient's admission to Yan Chai Hospital and when the fracture healing was slow and dubious.

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

2. The amended charges against the 2nd Defendant, Dr LO Hung Kwong, are:

"That from May to August 2019, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), deceased, in that he :

(a) failed to adequately interpret the history and X-rays of the Patient; and/or

(b) failed to carry out appropriate investigation on the underlying cause(s) for fracture of femur of the Patient during the Patient's admission to Yan Chai Hospital and when the fracture healing was slow and dubious.

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

Facts of the case

3. The name of the 1st Defendant has been included in the General Register from 1 July 2011 to the present. His name has been included in the Specialist Register under the specialty of Orthopaedics & Traumatology since 6 March 2019.

4. The name of the 2nd Defendant has been included in the General Register from 13 August 1988 to the present. His name has been included in the Specialist Register under the specialty of Orthopaedics & Traumatology since 4 March 1998.

5. Briefly stated, the Patient, then aged 9, attended the Accident & Emergency Department ("AED") of the Yan Chai Hospital ("YCH") in the evening of 4 April 2019 complaining of "*right distal thigh pain after being kicked during swimming*" two weeks ago.

6. According to the AED record kept on the Patient by YCH, the Patient presented with "*limping gait*". The attending AED doctor also wrote down "*private x-ray: ? [suspected] # [fracture] distal femur*". The Patient was subsequently admitted to the Department of Orthopaedics & Traumatology ("O&T") of YCH for further management.

7. The Patient was seen by one Dr LEUNG, a Resident Officer of the Department of O&T of YCH, later in the evening of 4 April 2019. In his Admission Note on the Patient, Dr LEUNG put down *inter alia* the following:-

> "*Good past health*
> *E[mergency] adm[ission] x [for] right thigh pain*
> *Suspected injury 2/52 ago, was kicked at right thigh (patient unsure about the injury herself)*
> *c/o [complained of] right thigh pain since then*
> *walk with limping gait*
> *no hip pain/knee pain*
> *no fever*
> *no constitutional symptoms*
> *no premorbid pain*
>
> *P/E [Physical Examination]*
> *Stable, afebrile*
> *no mass palpated over right thigh*
> *tenderness over right medial lower thigh*
> *ROM [Range of Motion] hip F/E [Flexion] 0-140, IR [Internal Rotation] 40, no hip tenderness*
> *Knee ROM 0-140, no effusion tenderness*
> *Distal NV [Neurovascular] [status] intact*
> *LL [Lower Limbs] power full*
> *no clinical LLD [Leg Length Discrepancy], walking with right limping gait*
>
> *Xray from private: left femur: crack at right medial thigh, no gross displacement …*"

8. Dr LEUNG then ordered X-rays of both knees, pelvis and both femur for the Patient. Meanwhile, the Patient was advised to keep bed rest pending x-rays.

9. According to the Integrated Patient Notes on the Patient obtained from YCH, physical examination on 5 April 2019 revealed tenderness at the supracondylar region of the Patient's right medial thigh; and the Patient still had a limping gait. Blood tests were ordered for complete blood count, erythrocyte sedimentation rate, C-reactive protein, Alkaline phosphatase, calcium level; and phosphate level. The results of blood tests showed normal findings within reference range.

10. There is no dispute that the Patient was granted home leave on 6 April 2019. On 7 April 2019, the Patient returned to YCH and complained of right thigh pain with difficulty in right knee movement after a fall at home. According to the Integrated Patient Notes obtained from YCH, repeated x-rays showed fracture of right distal femur with mild angulation. The attending doctor(s) from the Department of O&T of YCH then ordered a long leg cast to be applied to the Patient's right lower limb; and a post-cast x-ray of her right femur was also ordered.

11. The 2nd Defendant first saw the Patient during the grand round in the morning of 8 April 2019. From 15 April 2019, the 1st Defendant saw the Patient every day until she was discharged home on 22 April 2019.

12. On 6 May 2019, the Patient visited the Outpatient O&T Clinic of YCH for follow-up and was seen by one Dr TAM, a specialist in O&T. According to the Consultation Summary obtained from YCH, Dr TAM wrote down *inter alia* on 6 May 2019 that the Patient:-

> "…
> *came with parents, on wheelchair*
> *…*
> *XR [X-ray] today: alignment maintained, callus +/-*
> *…*
> *cast no impingement*
> *…*
> *FU [Follow Up] 2/52 with XR*
> *plan off cast next visit*
> *…*"

13. On 17 May 2019, the 2nd Defendant saw the Patient again at the Outpatient O&T Clinic of YCH. According to the Consultation Summary obtained from YCH, the 2nd Defendant wrote down *inter alia* on 17 May 2019 that:-

"*XR increase varus tilting and anterior angulation*
off cast
 # nontender
? some mobility at # site
admit for OR [Open Reduction] +/- ORIF [Open Reduction Internal Fixation] next Monday…"

14. On 20 May 2019, the Patient was readmitted to the Department of O&T of YCH. On 21 May 2019, the 1st and 2nd Defendants performed the said operation for the Patient. According to the 1st Defendant's Statement to the Preliminary Investigation Committee ("PIC") dated 14 December 2022, "*Post-operative x-ray scan of the Patient's right femur showed good alignment. Callus formation was noted*"; and "*Repeat x-ray scan of the Patient's right femur was done on 27 May 2019 and showed that callus size were similar to that on the scan of 21 May 2019... The Patient was discharged on 28 May 2019 and was advised to return to the Orthopaedic Fracture Clinic of YCH on 5 June 2019 for follow-up…*"

15. The Patient returned to the Outpatient O&T Clinic of YCH for follow-up on 5 June 2019 and was seen by the 2nd Defendant. According to the Consultation Summary obtained from YCH, the 2nd Defendant wrote down *inter alia* on 5 June 2019 that:-

"*XR alignment good, callus +ve*
toes, hip mvt [movement], cast OK
noticed swelling of lower hip 1 hr after taking of kiwi, no problem of eating kiwi previously
keep cast for total 8/52
FU 3/52
…"

16. On 26 June 2019, the Patient visited the Outpatient O&T Clinic of YCH for follow-up and was seen by a Resident Specialist in O&T.

17. On 17 July 2019, the Patient visited the Outpatient O&T Clinic of YCH for follow-up and was seen by the 1st Defendant. According to the Consultation Summary obtained from YCH, the 1st Defendant wrote down *inter alia* on 17 July 2019 that the Patient:-

"…
Came with parents
On wheelchair
No pain
Cast fit
Distal NV intact
XR: alignment maintained, K wire not loosen, minimal callus compared to last XR
… plan keep cast x 2/52 more
If XR showed # healing in next FU, then off cast and K wires, otherwise admit for CT to look for bone union first
…"

18. On 31 July 2019, the Patient visited the Outpatient O&T Clinic of YCH for follow-up and was seen by the 1st and 2nd Defendants. According to the Consultation Summary obtained from YCH, the 1st Defendant wrote down *inter alia* on 31 July 2019 that the Patient:-

"…
Came with parents
On wheelchair
No pain
Cast fit
Distal NV intact
XR: alignment maintained, K wire not loosen, more callus compared to last XR
D/w [discuss with] Dr Lo, off cast before XR next visit
Plan off K wires of XR showed healed fracture
Otherwise may need bracing for protection…"

19. On 6 August 2019, the Patient attended the AED of YCH complaining of "*intermittent [right] thigh and calf numbness… x [for] >[over] 1 week*". The Patient was subsequently discharged without hospitalization.

20. On 7 August 2019, the Patient returned to the Outpatient O&T Clinic of YCH and was seen by the 1st and 2nd Defendants. According to the 1st Defendant's Statement to the PIC dated 14 December 2022:-

"*…Right thigh and leg numbness was reportedly similar to before. There was no reported rest pain or nocturnal pain in the Patient's right leg…*

With the leg cast removed, the right thigh pin track was found to be clean with no pus. There was however firm swelling and tenderness over the right thigh region. Distal neurovascular status was intact…

Repeat x-ray scan showed that the alignment was the same as the previous scan on 31 July 2019 with no loosening of pin… In view of the suspected osteopenia and the recent history of fever, deep infection was suspected…

The K-wires were removed and dressing was done. Long leg brace was arranged [for the Patient]. Blood tests were ordered to rule out infection and the Patient was advised to return for follow-up 2 days later… for another x-ray and another follow-up assessment."

21. On 9 August 2019, the Patient returned to the Outpatient O&T Clinic of YCH and was seen by the 1st and 2nd Defendants. According to the 1st Defendant's Statement to the PIC dated 14 December 2022:-

"*…X-ray scan of the Patient's right femur showed slight fracture displacement compared with the previously scan on 7 August 2019. A patchy osteolytic lesion was also noted…*

…The results of the blood tests taken on 7 August 2019… revealed… normal white blood cell count but elevated C-Reactive Protein at 64 mg/L (reference range <5 mg/L) and ESR [Erythrocyte Sedimentation Rate] at 56 mm/hr (reference range <31 mm/hr).

In view of the above findings, it was decided that the Patient should be admitted immediately to rule out deep and bone infection (e.g. osteomyelitis). Wound swab was also taken and further blood tests were ordered for culture. An urgent CT scan right thigh scan with contrast was ordered.

… The Patient and CT film were reviewed by [the 2nd Defendant] and me on 10 August 2019. Initially, an operation for debridement of the abscess was arranged. We explained to the Patient's parents that there was a chance of malignancy other than abscess which could not be ruled out from the CT film. Therefore, with the parents' agreement, the said operation was cancelled and the Division Head of the Division of General Orthopaedics and Oncology of Queen Mary Hospital (specializing in orthopaedic tumour surgery) was

consulted for his comments on the x-ray and CT findings, and he believed that malignancy could not be ruled out. Magnetic resonance imaging ("MRI") scan of the right thigh was therefore recommended to investigate the possibility of malignancy and home leave was arranged for the scan to be done on 12 August 2019 in the private sector."

22. The Patient was subsequently transferred to the Duchess of Kent Children's Hospital where an operation of bone biopsy of femur was done on 14 August 2019. Intraoperative findings showed nonunion with soft tissue mass and frozen section showed high-grade sarcoma.

23. A Positron Emission Tomography scan was done on 16 August 2019 at the Hong Kong Sanatorium & Hospital. The scan report then showed likely primary malignant neoplasm with bone invasion locally in the right femur; and presence of bilateral lung and bone metastasis, including right mid shaft femur, right patella, proximal and distal right tibia, proximal right fibula, proximal left tibia, left femoral head and right humeral head.

24. The Patient was later transferred to the Hong Kong Children Hospital for further management on 21 August 2019. From 4 to 12 November 2019, the Patient stayed in the Queen Mary Hospital and received an operation for amputation of the right leg at the level of the right hip. Thereafter, the Patient was transferred back to the Hong Kong Children Hospital for management of the metastasis problem and chemotherapy. Unfortunately, the Patient's condition continued to deteriorate and eventually she passed away on 23 May 2020.

25. On 17 August 2020, the Secretary of the Medical Council received from the Patient's father this complaint against the 1st and 2nd Defendants.

Burden and Standard of Proof

26. We bear in mind that the burden of proof is always on the Secretary and the Defendants 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.

27. There is no doubt that each of the allegations made against the Defendants 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 them separately and carefully.

Findings of the Inquiry Panel

28. The 1st and 2nd Defendants admit the factual particulars of the amended disciplinary charges against them. It remains for us to consider and determine on the evidence whether they have been guilty of misconduct in a professional respect.

29. As Professor Michael A Jones aptly summarized in his book: Medical Negligence (6th edition):-

> "*4-036 Keeping the diagnosis under review A doctor should always keep the diagnosis under review as the treatment progresses, and keep an open mind about the causes of the patient's condition if it does not respond to treatment… The need to explore all the alternative diagnoses was especially important when it became increasingly evident that the original diagnosis may have been incomplete or erroneous.*
>
> *4-037 Keeping alternative diagnoses in mind The need to consider alternatives was stressed by Hewak J in Rietze v Bruser (No.2):*
>
> > *"It is not sufficient in my view for a medical practitioner to say 'of the two or three probable diagnoses I have chosen diagnosis (A) or diagnosis (B) or (C)'. It must be expected that the practitioner would choose diagnosis (A) over (B) or (C) because all of the facts available to that practitioner and all of the methods available to check the accuracy of those facts and that diagnosis had been exercised with the result that diagnosis (A) remains as the most probable of all..."*
>
> *This point becomes even more important where the consequences of the alternative diagnosis, if it turns out to be the correct diagnosis, are likely to be serious… Moreover, in making a differential*

diagnosis the doctor must take into account the degree of risk faced by the patient and the seriousness of the consequences of the risk should it materialise…

4-038 *In Lankenau v Dutton, the medical evidence was that a surgeon confronted with a patient with paralysis after major surgery should not only attempt to diagnose the cause but also:*

> *"… should make a differential diagnosis, that is to say that he should consider other likely causes of her condition and test them against her symptoms and be ready with an alternative theory to direct her treatment if his first diagnosis and treatment should fail to produce an improvement in her condition."*

The defendant had diagnosed an aortic dissection occurring during surgery, which initially was a reasonable diagnosis. As the patient's symptoms progressed, however, he failed to reassess the diagnosis, which resulted in the paralysis becoming permanent. He clung to the original diagnosis although the symptoms should have made him question it: he failed to test his theory by X-ray, and he failed to seek the assistance of neurological experts quickly enough. The surgeon was held negligent.

4-039 *[Footnote 119]*
… Physicians cannot claim that a misdiagnosis is or continues to be a non-negligent error in judgment if they fail to properly monitor, assess or care for the patient. Negligent monitoring, assessment and care is itself negligence but it also attacks the adequacy of the basis on which the initial diagnosis and treatments were based or continued…"

30. It is the unchallenged opinion of the Secretary's expert, Dr CHEUNG, in his first expert report dated 11 December 2021, which we accept that:-

"*70.* *Distal Femoral shaft and metaphysical fracture in children around adolescent age group is commonly caused by high-energy trauma such as motor vehicle accident. Fracture of femoral shaft or metaphysical region from trauma without high velocity or energy impact should alert clinician to look for underlying pathologic*

condition such as generalized osteopenia or brittleness of bone condition, e.g. cerebral palsy, myelomeningocele, osteogenesis imperfecta. Benign and malignant conditions, such as bone cyst and osteogenic sarcoma should be looked for when X-rays are evaluated. This is because pathologic cause is common in the fracture of this region, and should always be sought."

31. We agree with the Secretary's expert that the history of injury described by the Patient and/or her parents would raise a doubt as to why the Patient would present with a "*suspected right femur fracture*" and "*right limping gait*" when she attended the AED of YCH two weeks later. Indeed, according to Dr LEUNG's Admission Note, "*patient [was] unsure about the injury herself*".

32. Be that as it may, we agree with the Secretary's expert that the Patient's clinical presentation after her right femur was encased in a cast was "*in contradiction against usual course of fracture healing in a normal child… The fracture appeared to be more stable in the initial phase and [the P]atient could 'walk with limp' in the first admission. However, the fracture deteriorated despite being put into a cast and was apparently more unstable on 17 May 2019. A thorough review of the situation should be performed at this juncture…* "

33. In this regard, it is the unchallenged opinion of the Secretary's expert in his first expert report dated 11 December 2021, which we accept, that:-

> "*85. … On 17 May 20[19](?), the fracture was 43 days after first presentation on 4 April 2019. One should expect a good union and healing of the fracture instead of a situation with very doubtful and scanty bone healing. If that was a usual traumatic type of fracture but the healing was slowed down due to inadequate immobilization, hypertrophic nonunion would be more likely. Hypertrophic nonunion is a situation with abundant callus as the bone tries to get united but the movement around fracture is too much. The fracture will react by forming more callus to try to overcome the mobility. There was no sign of hypertrophic union in [the Patient's] fracture and she instead had scanty to nil callus, i.e. her fracture had no or very low potential of healing.*

> *86.* *As the femur alignment became angulated on 17 May 2019, it was evident that the healing and union was much delayed at the fracture site…*
>
> *87.* *In my opinion, the management team was not alerted by the delay in healing during the follow-up visits. They also did not pick up the lytic and sclerotic shadows in the medullary canal of the bone. I would opine that failure to be alert when healing is much delayed and inability to pick up sclerotic and lytic lesion in the bone were both below the standard of care by an average Orthopaedic Specialist.*"

34. In our view, a doctor should always keep the diagnosis under review as the treatment progresses. This is especially important when it becomes increasingly evident that the original diagnosis may have been incomplete or erroneous. This becomes even more important where the consequences of the alternative diagnosis, if it turns out to be the correct diagnosis, are likely to be serious.

35. In this case, not only did repeated X-rays show unexpected delay in healing of fracture, it is the unchallenged opinion of the Secretary's expert in his expert reports dated 11 December 2021 and 23 March 2023, which we accept, that X-rays taken on 17 May 2019 began to show "*soft tissue shadow around fracture site*" with "*suspicious osteolytic lesion was present in the cortex of bone around the fracture site.*" Moreover, it is the unchallenged opinion of the Secretary's expert in his expert report dated 11 December 2021, which we accept, that *"Review of X-rays from June to July 2019 showed that the right femur bone was showing both lytic and sclerotic lesions inside the medullary canal. There was no healing of fracture. Soft tissue swelling continued to enlarge with time. Destruction of cortex became more obvious in the X-rays of right femur.*" And we agree with the Secretary's expert that these findings from X-rays were not consistent with the history of injury of the Patient.

36. For these reasons, in failing to adequately interpret the history and X-rays of the Patient, the 1st and 2nd Defendants have in our view by their conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find them guilty of the amended disciplinary charge (a) as charged.

37. Regardless of whether the initial diagnosis was a reasonable one, the 1st and 2nd Defendants ought in our view to be on the alert when scanty bone healing were noted

on repeated X-rays. This is particularly important when X-rays taken on and after 17 May 2019 further showed "*soft tissue shadow around fracture site*" with "*suspicious osteolytic lesion was present in the cortex of bone around the fracture site.*"

38. It is the unchallenged opinion of the Secretary's expert in his first expert report dated 11 December 2021, which we accept, that:-

> "*71. Osteosarcoma is the most common malignant bone tumour in children and adolescents. The classic osteosarcoma develops in medullary cavity of a bone, usually in metaphysis of a long bone. As the bone is weakened by the destructive osteolytic process, it is common to have a fracture after a minor or trivial injury and it is called pathologic fracture. The most common sites are the lower end of femur and upper end of tibia.*
>
> *72. The presenting complaint of osteosarcoma is usually local pain. It is described to be intermittent initially but becomes severe and constant after a matter of weeks. Limp occurs often. History of trauma may mask the history and affect interpretation. Local mass and swelling due to the tumour growth will gradually appear with time. Diagnosis may be delayed as patient may not look sick and they may not have fever or weight loss.*
>
> *73. Although the typical radiographic picture of osteosarcoma is characterized by destructive and osteoblastic changes in the bone, the signs may be subtle in early stages and may be radiolucent… Clinical suspicion should be raised if a teenager presents with unexplained pain about knee or shoulder, especially if pain does not resolve quickly or is present at rest or night.*
>
> *…*
>
> *89. Review of X-ray taken on 21 May 2019 showed that there was possibly an area of cortex erosion from medullary cavity in the posterior cortex just proximal to fracture and K-wires. The erosion of cortex indicated possibility of bone destruction and a suspicion of malignant cause of the fracture should be raised. The right thigh soft tissue swelling also appeared to exist from film taken on 17 May 2019.*"

39. It is also the unchallenged opinion of the Secretary's expert in his supplemental expert report dated 23 March 2023, which we accept, that:-

> "*23. All the above findings were in contradiction against usual course of fracture healing in a normal child. We expect the fracture should have healed well with callus formation at around or earlier than 6 weeks. Nonunion would be a rare occurrence at this age in close accidental injuries. The fracture appeared to be more stable in the initial phase and patient could 'walk with limp' in the first admission. However, the fracture deteriorated despite being put into a cast and was apparently more unstable on 17 May 2019. A thorough review of the situation should be performed at this juncture. The search for possible underlying cause should be done again and sincerely carried out.*
>
> *24. Apart from blood tests to look for infection and haematological malignancy, imaging studies should be done to look for any pathological lesions. A CT scan of the fracture site with contrast injection might help to explain why there was swelling around the fracture site. CT scan might reveal soft tissue mass and also bone destruction. CT scan would also be helpful in infection, be it osteomyelitis, or abscess formation… MRI imaging, if available, could be another option…*"

40. For these reasons, in failing to carry out appropriate investigation on the underlying cause(s) for fracture of femur of the Patient during the Patient's admission to YCH when the fracture healing was slow and dubious, the 1st and 2nd Defendants have by their conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we also find them guilty of the amended disciplinary charge (b) as charged.

<u>Sentencing</u>

41. In line with our published policy, we shall give the 1st and 2nd Defendants credit in sentencing for their admission and not contesting the issue of professional misconduct.

42. We need to remind ourselves that the primary purpose of any disciplinary order is not to punish the Defendants 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.

43. The gravamen of this case lies in that the 1st and 2nd Defendants failed to keep an open mind about the possible underlying cause(s) for fracture of femur when there was, as the Secretary's expert said in his supplemental expert report, "*a significant deviation of the usual experience of swift union in a child's femoral fracture*". This was aggravated by their "*tunnel vision*" of the Patient's condition and focus on alignment and healing of her femoral fracture.

44. We are told in mitigation that the 1st and 2nd Defendants have reflected on their shortcomings after the incident. In particular, they had attended a clinical attachment programme in the Division of Oncology & Limb Preservation Surgery. During the attachment period of 3 months, they had learned how to manage patients with musculoskeletal tumours and engaged in regular multidisciplinary meetings with colleagues from other subspecialties for patient's care. Meanwhile, the 1st and 2nd Defendants had prepared Guidelines for Management of Suspected Malignant Musculoskeletal Tumour for the use of the Department of O&T of YCH. Moreover, at the instigation of the 1st and 2nd Defendants, they and colleagues from departments of O&T of the Kowloon West Cluster would meet regularly with senior specialists in Radiology to discuss about difficult or unusual cases.

45. We appreciate the 1st and 2nd Defendants' insight into their shortcomings and we also note that the 1st and 2nd Defendants both have a clear disciplinary record.

46. Taking into consideration the nature and gravity of the disciplinary charges for which we find the 1st and 2nd Defendants guilty and what we have heard and read in mitigation, we order in respect of:-

<u>1st Defendant (Dr CHAN Pui Kan)</u>

47. The name of the 1st Defendant be removed from the General Register for a period of 6 months; and that the removal order be suspended for a period of 24 months.

2nd Defendant (Dr LO Hung Kwong)

48. The name of the 2nd Defendant be removed from the General Register for a period of 6 months; and that the removal order be suspended for a period of 24 months.

49. We wish to emphasize that but for genuine insight into their shortcomings and the steps that they have taken to remedy their shortcomings, the 1st and 2nd Defendants would be expecting more severe sanction from us.

Remark

50. The names of the 1st and 2nd Defendants are registered in the Specialist Register under the specialty of Orthopaedics & Traumatology; and we shall leave it to the Education and Accreditation Committee to decide on whether anything needs to be done in respect of their specialist registrations.

Prof. FOK Tai-fai, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong