香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr FUNG Ching Fai (馮正輝醫生) (Reg. No.:M03660)

Date of hearing: 28 October 2024 (Monday)

Present at the hearing

Council Members/Assessors: Prof. FOK Tai-fai, SBS, JP
(Chairperson of the Inquiry Panel)
Dr IP Wing-yuk
Dr LAU Ho-lim
Mr CHAN Wing-kai
Mr LAM Ho-yan, Mike

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Mr Bernard Murphy of
Messrs. Howse Williams

Senior Government Counsel representing the Secretary: Miss Cassandra FUNG

1. The charges against the Defendant, Dr FUNG Ching Fai, are:

"That in or about October to December 2018, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ("the Patient"), deceased, in that he:

(a) failed to properly and adequately inform the Patient (or her husband) about the nature, procedure, possible risks and/or complications prior to the surgical operation performed on 1 November 2018 ("the Operation");

(b) failed to advise the Patient (or her husband), and/or to undertake, remedial treatment(s) in respect of the 2 aneurysm clips which had been applied at their locations in the attempts to control bleeding in the Operation;

(c) alternative to (b), failed to take any or adequate step(s) to assess the risk(s) in blood supply to the parietal lobe locations with the 2 applied aneurysm clips at their locations and/or the consequence(s) arising from such application;

(d) in the period from 2 to 6 November 2018, failed to timely undertake effective decompressive craniotomy and/or partial temporal lobectomy;

(e) failed to properly inform the Patient's husband of the application of 2 aneurysm clips at the Operation and/or discuss the treatment option(s) for restoring blood flow with the Patient's husband;

(f) failed to input the correct information or ensure the same being inputted in the Patient's operation record concerning the Operation;

(g) failed to properly and/or adequately observe the vital signs and/or neurological condition of the Patient after the Operation;

(h) failed to notice and/or rectify the discrepancies in terms of lateralization of the tumour in question between the Patient's operation record of the Operation and discharge summary; and/or

(i) failed to keep and/or maintain proper record for 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 10 August 1979 to the present. His name has been included in the Specialist Register under the Specialty of Neurosurgery since 4 March 1998.

3. The Patient had a history of blurry vision of right eye. She underwent cataract extraction of the right eye in April 2018. Her vision did not improve. MRI orbit and brain taken on 19 September 2018 revealed a large right parasellar region/sphenoidal ridge meningioma compressing adjacent right optic chiasm/optic tract, encasement of the right internal carotid artery (ICA) and proximal middle cerebral artery (MCA).

4. On 15 October 2018, the Patient, accompanied by her husband, consulted the Defendant. The Defendant discussed with them the MRI findings and suggested craniotomy as soon as possible.

5. On 24 October 2018, the Patient returned to see the Defendant. The Patient agreed to craniotomy and partial removal of brain tumour.

6. On 31 October 2018, the Patient was admitted to St. Teresa's Hospital for the surgery.

7. On 1 November 2018, right frontal craniotomy and partial removal of the brain tumour ("the Operation") was performed by the Defendant. There was intra-operative bleeding leading to the application of two aneurysm clips to bleeders in the tumour.

8. The Patient was sent to Intensive Care Unit for further management in the early morning of 2 November 2018. A CT scan was taken.

9. Post-operatively, the Patient developed progressive massive right cerebral infarction and edema requiring two decompressive surgery: craniectomy and right temporal lobectomy on 3 November 2018.

10. After these interventions, the Patient was successfully weaned off from ventilator. Sepsis was controlled after tracheostomy.

11. The Patient was transferred to Queen Mary Hospital for further management. The Defendant did not provide further clinical care to the Patient thereafter.

12. The Patient died in infirmary hospital in December 2020.

13. By a statutory declaration made on 15 March 2021, the Patient's husband lodged a complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

14. We bear in mind that the burden of proof is always on the Legal Officer 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.

15. There is no doubt that the allegations against the Defendant here are serious. 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 each of the disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

16. At the beginning of this inquiry, the Legal Officer informed us that the Secretary is offering no evidence against the Defendant in respect of disciplinary charges (a), (b), (c), (d), (e) and (g). Since the burden of proof is always on the Secretary, we have to find the Defendant not guilty of disciplinary charges (a), (b), (c), (d), (e) and (g).

17. The Defendant admitted the factual particulars of disciplinary charges (f), (h) and (i). In particular, for charge (f), the Defendant admitted that he had failed to input correct information in the Patient's operation record for the Operation in terms of lateralization, difference in origin of the tumour and/or clamped vessel. Despite the Defendant's admission, it however remains for us to

consider and determine on all the evidence whether the Defendant had by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong.

18. It is clearly stated in section 1 of the 2016 edition of the Code of Professional Conduct (the "Code") that:-

"1.1.1 The medical record is the formal documentation maintained by a doctor on his patients' history, physical findings, investigations, treatment, and clinical progress...

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..."

19. According to the operation record dated 1 November 2018, the "Pre-operative Diagnosis" and "Operative Diagnosis" were stated to be "Left suprasellar meningioma". This is obviously wrong in terms of lateralization. The "Operation" was stated to be "Left frontal craniotomy for removal of brain tumour". From the post-operative CT scan, there are two aneurysm clips applied to the supraclinoid portion of ICA. There is difference in the operation record which stated "Tumour removal continued however over M1branch eroded by tumour with jet of blood gushing from eroded branch, requiring placement of aneurysm clips proximal and distal to the eroded areas of the vessel" from the discharge note which stated "right medial sphenoidal ridge meningioma wiinvasion (sic) (with invasion) to rugth (sic) (right) ICA". Therefore, the operative record is not compatible with the post-operative CT scan finding as well as the record in the discharge summary. The information entered into the operation record was wrong in terms of lateralization, difference in origin of the tumour and clamped vessel.

20. We are satisfied on the evidence that the Defendant had failed to input correct information in the Patient's operation record for the Operation in terms of lateralization, difference in origin of the tumour and/or clamped vessel. On the Defendant's own admission, we are also satisfied that the Defendant had failed to notice and/or rectify the discrepancies in terms of lateralization between the operation record and the discharge summary.

21. We need to emphasize that the medical record kept by the Defendant of the Patient were not solely for his own reference. In our view, proper, adequate and correct medical record keeping was essential for the management and continuity of care of the Patient, be it by the Defendant or other professional colleagues.

22. The Defendant had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect for charges (f) and (h).

23. In respect of charge (i), the Secretary's case is that the Defendant had failed to keep and/or maintain proper record relating to consent given by the Patient. According to the Defendant's clinical record of the Patient, the only relevant information which had been documented was "large sphenoid ridge meningioma, encasing optic nerve and ICA". In the Hospital note of St. Teresa's Hospital, the consent form just listed those risks of standard craniotomy. There was no documentation to show that the risk(s) involved in the surgical excision were explained to the Patient and/or her relatives. In our view, the documentation of the Defendant was grossly inadequate in both the clinical and hospital record in terms of choices of treatment, risk and benefit of each choice, the Patient's preference and opinion of relatives. We agree with the Secretary's expert that a medical record of this quality could not protect the legal interest of the Patient.

24. The Defendant had in our view fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect for charge (i).

Sentencing

25. The Defendant has a clear disciplinary record.

26. In line with our published policy, we shall give the Defendant credit in sentencing for his admission.

27. 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.

28. The Defendant told us that the operation record of the Patient was prepared by his assistant neurosurgeon, and he had not performed careful checking of the operation record before he signed it. As remedial actions, the Defendant submitted that he would now ensure that he prepares the operation record himself and that he would carefully check before finalizing and signing it. The Defendant also submitted that details of communications with patients and family will be clearly documented by him in the patient's medical records, including treatment options and risks of treatment. We accept that the risk of re-offending is low.

29. Taking into consideration the nature and gravity of the disciplinary charges (f), (h) and (i) for which we find the Defendant guilty of and what we have heard and read in mitigation, we shall make a global order that the Defendant be reprimanded.

Remark

30. The name of Defendant is included in the Specialist Register under the Specialty of Neurosurgery. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

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