香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHEUNG Tat Man (張達文醫生) (Reg. No.: M08620)

Date of hearing: 15 November 2024 (Friday)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Prof. LIANG Hin-suen, Raymond, SBS, JP
Prof. SZETO Cheuk-chun
Mr CHAN Wing Kai
Mr WONG Ka-kin, Andy

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Eddie NG as instructed by
Messrs. Kennedys

Senior Government Counsel representing the Secretary: Mr Edward CHIK

1. The amended charges against the Defendant, Dr CHEUNG Tat Man, are:

"That from 20 to 24 January 2020, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] *("the Patient"), deceased, in that he :*

(a) failed to keep proper clinical notes on his physical examination findings of the Patient during the consultation(s) on 20 January 2020, 21 January 2020, 22 January 2020, 23 January 2020 and/or 24 January 2020;

(b) inappropriately prescribed systemic corticosteroid to the Patient consecutively from 20 to 23 January 2020; and/or

(c) failed to refer the Patient for a radiographic examination on 24 January 2020 to rule out the suspected lower chest infection.

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 27 July 1992 to the present. His name has never been included in the Specialist Register.

3. Briefly stated, the Patient, then 67 years of age and who had a history of asthma, consulted the Defendant on 20 January 2020 complaining of cough and wheezing for 1 to 2 days. According to the Defendant, he made a diagnosis of asthma relapse and gave the Patient 3-day medications for symptomatic relief.

4. However, the Patient returned to see the Defendant every day from 21 to 24 January 2020. According to the Defendant, when he saw the Patient on 24 January 2020, he noted that her condition had changed. The Patient had increased cough, wheezing, moderate runny nose and a low-grade fever. She also had loss of appetite, tiredness and shortness of breath. The Defendant made a diagnosis of bronchitis with suspected chest infection. Since this was the day before Chinese New Year, the Patient was given 6-day medications including a course of antibiotics; and was advised to monitor her condition closely and to go to the Accident & Emergency Department ("AED") of Government Hospital immediately if she did not get better with the medications.

5. The Patient's condition further deteriorated and she attended the AED of the Pamela Youde Nethersole Eastern Hospital ("PYNEH") on 28 January 2020. According to the medical records obtained from PYNEH, chest x-rays then revealed bilateral middle and lower zone patchy consolidation. The Patient was initially admitted to the General Medical Ward. However, her respiratory distress later worsened and had to be transferred to the Intensive Care Unit for

further management. The clinical diagnosis was severe community acquired pneumonia. On 4 February 2020, the Patient developed high fever and tachycardia. She also had raised high-sensitivity troponin I on blood test. The clinical impression was troponin elevation related to flare of sepsis. Her condition further deteriorated and the Patient passed away on 5 February 2020. The cause of death stated in her Death Certificate was pneumonia.

6. The Patient's son subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Burden and Standard of Proof

7. 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.

8. 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

9. The Defendant admits the factual particulars of the amended disciplinary charges against him. It remains for us to consider and determine on the evidence before us whether the Defendant had been guilty of misconduct in a professional respect.

10. It was clearly stated in section 1.1.3 of the Code of Professional Conduct (2016 edition) (the "Code") that:-

"*All doctors have the responsibility to maintain systematic, true, adequate, clear, and contemporaneous medical records…*"

11. We agree with the unchallenged opinion of the Secretary's expert witness, Dr IP, that "*[i]n order to provide a proper and appropriate management to a patient, doctors should formulate the management plan with reference to the clinical condition. Clinical condition of a patient should be assessed with a pertinent clinical history, properly performed clinical examination and, if necessary, radiographic studies or laboratory tests. It is equally important to record these findings in the clinical notes.*"

12. We need to emphasize that the medical records kept by the Defendant on the Patient were not solely for his own reference. In our view, proper and adequate medical record keeping is essential for the management and continuity of care of the Patient, be it by the Defendant or other professional colleagues. Save for the Patient's symptoms and names and dosages of medications prescribed to her, there was nothing in the Defendant's clinical notes about his clinical examination findings or management plan.

13. In failing to keep proper and adequate medical records in respect of the Patient, the Defendant had in our view by his conduct in the present case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (a).

14. With regard to the amended disciplinary charge (b), we agree with the unchallenged opinion of Dr IP that "*[t]hough the [P]atient had history of asthma, it would not be appropriate to give dexamethasone injection together with oral prednisolone and dexamethasone*" before she developed "*episodes of progressive increase in shortness of breath, cough, wheezing, or chest tightness or some combination of these symptoms*."

15. According to the Defendant, the Patient told him during the consultations on 21, 22 and 23 January 2020 that she was feeling better. It was only during the consultation on 24 January 2020 that he noted the Patient's clinical condition had deteriorated with, amongst others, increased cough, wheezing and shortness of breath.

16. It was clearly stated in the Code that "*[a] doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate.*"

17. In our view, there was no clinical indication for the Defendant to prescribe the Patient with systemic corticosteroid consecutively from 20 to 23 January 2020. In so doing, the Defendant had in our view by his conduct in the present case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (b).

18. With regard to the amended disciplinary charge (c), we agree with the unchallenged opinion of Dr IP that "*chest radiography is a critical component in diagnosing pneumonia or lower chest infection*". Our attention was also drawn by Dr IP to the article "*Diagnosis and Treatment of Community-Acquired Pneumonia*" by LUTFIYYA et al., which was published in Am Fam Physician 2006 Feb 1;73(3):442-50. We noted with agreement the authors' observation that "*[a]ge older than 65 years*" and history of "*[a]sthma*" were amongst the risk factors for community-acquired pneumonia ("CAP"); and "*all patients with suspected CAP should have a chest radiograph to establish the diagnosis and identify complications.*"

19. Given her history of asthma and the fact that her age was over 65 years, the Defendant ought in our view to have referred the Patient for radiographic examination to rule out the suspected lower chest infection. In failing to do so, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (c).

Sentencing

20. The Defendant has a clear disciplinary record.

21. In line with our published policy, we shall give the Defendant credit in sentencing for his admission and cooperation throughout these disciplinary proceedings.

22. 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.

23. The Defendant's clinical notes were extremely brief about the Patient's symptoms and clinical examination findings and management plan were all missing.

24. We are told in mitigation that the Defendant had since the incident taken courses on respiratory medicine and management of asthma.

25. We are particularly concerned about the Defendant's indiscriminate prescriptions of systemic corticosteroid to the Patient and his failure to refer her for chest x-ray.

26. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we order that:-

(1) in respect of the amended disciplinary charge (a), the name of the Defendant be removed from the General Register for a period of 1 month;

(2) in respect of the amended disciplinary charge (b), the name of the Defendant be removed from the General Register for a period of 3 months;

(3) in respect of the amended disciplinary charge (c), the name of the Defendant be removed from the General Register for a period of 3 months;

(4) the said removal orders to run concurrently making a total of 3 months;

(5) operation of the said removal orders be suspended for a period of 18 months, subject to the condition that the Defendant shall complete during the suspension period CME courses relating to medical records keeping and safe prescription and clinical management of patients to the equivalent of 5 and 10 CME points respectively; and such courses have to be preapproved by the Chairman of the Council.

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