G.N. 5694

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE MEDICAL COUNCIL OF HONG KONG DR YIU WAI CHUNG MICHAEL (REGISTRATION NO.: M11192)

It is hereby notified that after due inquiry held on 16 August 2016 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Medical Council of Hong Kong found Dr YIU Wai Chung Michael (Registration No.: M11192) guilty of the following disciplinary offence:—

'That in or about April 2011, he, being a registered medical practitioner, disregarded his professional responsibility to his patient late Madam X ('the Patient') in that he failed to promptly inform Dr LIU Chi Leung and/or the Patient and/or the Patient's relatives of his finding of pulmonary embolism in the lower division of the left pulmonary artery of the Patient.

In relation to the facts alleged, he has been guilty of misconduct in a professional respect.'

Dr YIU was at all material times a registered medical practitioner. His name has been included in the General Register from 31 August 1996 to present and his name has been included in the Specialist Register under the specialty of Radiology since 7 July 2004.

The Patient, now deceased, had a prior history of liver cyst. She was then 85 years old. On 7 April 2011, the Patient consulted one Dr LIU Chi Leung ('Dr LIU') for pain and shortness of breath. Upon the referral of Dr LIU, the Patient received CT scanning of the abdomen later the same day at Dr YIU's radiology centre.

According to the information on the CT scan request form, the purpose of the CT scanning was to investigate the Patient's liver cyst. Dr LIU made no request for early CT scanning as a matter of clinical urgency. Nor did Dr LIU indicate that the Patient was suspected of suffering from any chest condition.

There is no dispute that upon reviewing the CT scans, Dr YIU noted incidental hypodense clot at the left lower division of the Patient's left pulmonary artery suggesting recent thromboembolic event.

According to Dr LIU's submission to the Preliminary Investigation Committee ('PIC'), he made this finding of suspected pulmonary thromboembolism upon his review of the partial image of the Patient's left lower lung base included in the CT scans. He immediately went to the waiting room of his radiology centre to look for the Patient but was informed by his staff that she had already left. However, his staff confirmed to him that the Patient was fully mobile and able to converse. Also, the Patient did not appear to have any breathing difficulties and/or discomfort when she left his radiology centre.

Dr YIU attempted to contact Dr LIU with a view to informing him of the suspected pulmonary thromboembolism. However, Dr YIU was told that Dr LIU was unavailable because he was at the operating theatre. Dr YIU was also subsequently informed that Dr LIU could not be reached through his mobile phone at the time.

In the morning of the following day, Dr YIU asked his staff to contact Dr LIU by phone again but was later informed that Dr LIU was still unreachable because he was at the operating theatre. There is no dispute that Dr YIU did not make further attempt to get hold of Dr LIU. He merely instructed his staff to deliver by hand the CT films together with his finalized report to Dr LIU's clinic for his early reference.

Dr YIU also admitted that he failed to promptly inform the Patient and/or her relatives of his finding of suspected pulmonary thromboembolism. Indeed, he made no attempt to contact the Patient and/or her relatives at all.

On 11 April 2011, the Patient died from pulmonary thromboembolism at Ruttonjee & Tang Shiu Kin Hospital.

Dr YIU was fully aware that pulmonary thromboembolism was a potentially life threatening medical condition which required urgent medical attention. As a radiologist, Dr YIU owed his duty of prompt reporting to the referring doctor of this potentially life threatening medical

condition which required urgent medical attention. However, despite repeated attempts, Dr LIU still could not be reached, it beheld Dr YIU to advise the Patient to seek urgent medical attention.

In the Medical Council's view, Dr YIU ought to get hold of Dr LIU promptly given the potentially life threatening medical condition of the Patient. He could at least have left a message to Dr LIU's clinic assistant informing Dr LIU of his finding and urging him to call back as a matter of urgency. Moreover, the Medical Council was taken aback that Dr YIU made no further attempt to contact the Patient directly by phone or otherwise after his staff told him that she had already left his radiology centre.

The Medical Council therefore considered Dr YIU's conduct to have fallen below the standard reasonably expected of medical practitioners in Hong Kong and found him guilty of misconduct in a professional respect.

Taking into consideration the nature and gravity of the disciplinary charge, the mitigation advanced by Dr YIU's lawyer and particularly the genuine efforts taken by Dr YIU after the incident to remedy his shortcomings, the Medical Council ordered that a warning letter be served to Dr YIU and further that the order be published in the *Gazette*.

The orders are published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Medical Council is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*