G.N. 1439

VETERINARY SURGEONS REGISTRATION ORDINANCE (Chapter 529)

ORDER MADE BY AN INQUIRY COMMITTEE OF THE VETERINARY SURGEONS BOARD OF HONG KONG

It is hereby notified that on 5 October 2016 an inquiry committee of the Veterinary Surgeons Board of Hong Kong (the 'Board'), after due inquiry in accordance with section 18 of the Veterinary Surgeons Registration Ordinance, Chapter 529 of the Laws of Hong Kong (the 'Ordinance'), found Dr LO Gary Ka Shun ('Dr Lo') (Registration No.: R000666) guilty of misconduct or neglect in a professional respect in that on or about 9 January 2013, when discharging the complainant's dog from the clinic, Dr Lo failed to detect the presence of a foreign body in the caudal oesophagus of the dog, as shown on the radiographs taken on 8 January 2013.

Pursuant to section 19 of the Ordinance, the inquiry committee ordered on 5 October 2016 that: (1) Dr Lo be reprimanded in writing with the reprimand not to be recorded on the register; (2) Dr Lo be required to undertake 10 hours of continuing professional education in radiology, such courses to be approved by the Board in advance and not to count towards any continuing professional education certification scheme of the Board and to be completed within 24 months from the date thereof; and (3) in the event that Dr Lo fails to complete the said hours of continuing professional education within the said period, the Secretary shall remove his name from the register and no application for restoration of his name to the register pursuant to section 21(3) of the Ordinance shall be approved unless and until he has completed the continuing professional education ordered therein.

Particulars of the Matter to Which the Order Relates

In Dr Lo's own representation to the Preliminary Investigation Committee of the Board by letter dated 6 July 2013, he said he had reviewed the post-operative x-rays and noted there was no mineral density foreign body visible in the gastro-intestinal tract. He went on to say that there was some pooling of barium present in the oesophagus and that from prior experience, after removal of an oesophageal foreign body, there is often residual pooling of barium. The inquiry committee agreed with the opinion of the expert witness that the possibility of what was shown in the radiographs taken one and a half hours after the surgery and two days later on 8 January 2013 being pooling of barium was very low.

In the inquiry committee's view, Dr Lo's failure to conclude from the post-operative radiographs that it was likely that there was still a foreign body in the dog's caudal oesophagus was a falling short of the standard expected of a veterinary surgeon in general practice in Hong Kong at the material time and the inquiry committee found him guilty of misconduct or neglect in a professional respect as charged accordingly.

CHING Pak-chung *Chairman, the Veterinary Surgeons Board of Hong Kong*