香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
<u>MEDICAL REGISTRATION ORDINANCE, CAP. 161</u>

Defendant: Dr CHAN Cheung Wah (陳長華醫生) (Reg. No.: M06680)

Date of hearing: 5 May 2026 (Tuesday)

<u>Present at the hearing</u>

Council Members/Assessors: Prof. FOK Tai-fai, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHAN Pik-kei, Osburga
Prof. LAM Hung-san, Hugh Simon
Ms LIU Lai-yun, Amanda
Mr Vincent S. TSO

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Dr David KAN of
Messrs. Howse Williams

Legal Officer representing the Secretary: Ms Cherry XU, Outside Counsel,
as instructed by Department of Justice

<u>The Charges</u>

1. The re-amended charges against the Defendant, Dr CHAN Cheung Wah, are:

"That in or about May to July 2022, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ██████ ("the Patient"), in that:

(a) for the laparoscopic resection procedure performed on 24 June 2022 ("the laparoscopic resection procedure"), he failed to adequately explain the risks of progression of the possibly malignant polyp to obtain the Patient's informed consent, in the circumstances where:

(i) the margin of the polyp was reported as negative for invasive tumour and adenoma with a distance from invasive tumour of 2mm; and/or

(ii) pre-operative PET/CT suggested no residual tumour, lymph node or distant metastases; and/or

(iii) there was an available option of regular clinical surveillance as an alternative to laparoscopic resection procedure; and/or

(iv) it was generally accepted that the risk of lymph node metastases, residual tumour or recurrence varied from about 0-20% for malignant, sessile polyps with deep submucosal invasion where there was a clear margin of 2mm or more; and/or

(b) he failed to maintain adequate medical records in respect of the Patient, in that:

(i) he failed to document any explanations made to the Patient of the indication for the laparoscopic resection procedure; and/or

(ii) he failed to document the CT findings; and/or

(iii) when complications manifested, he failed to give sufficient account of the conditions and progression of the Patient on 2 July 2022, including the reasons for the cancellation of the CT scan, the reasons and/or explanations to the Patient or her family for the emergency laparotomy; and/or

(iv) he failed to document any explanations of the indication for ordering a CT scan on 12 July 2022; and/or

(v) he failed to document any explanation of the causes of complications caused to the Patient after the laparoscopic resection procedure and/or the laparotomy.

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 24 September 1987 to the present. His name has been included in the Specialist Register under the Specialty of General Surgery since 4 March 1998.

3. The Patient was a participant in the Government's Colorectal Cancer Screening Programme. She underwent a colonoscopy performed by the Defendant on 12 May 2022 during which a 16mm rectal polyp was discovered and removed. The site of the polyp was marked by injecting SPOT (a dye for marking the gut to help with locating the lesion if surgery is later required). Whether the polyp was "pedunculated" (with a stalk) or "sessile" (without a stalk) was not described in the colonoscopy report. Pathology of the polyp was reported as "Moderately differentiated adenocarcinoma arising in tubulovillous adenoma". In addition, it stated that the polyp's stalk was "absent"; resection margin was "negative for invasive tumour involvement"; and "negative for adenoma involvement".

4. The Defendant subsequently arranged a PET/CT scan for the Patient at St. Teresa's Hospital on 23 May 2022. It was reported that "no macroscopic residual tumour is noted at the surgical site", "no regional lymphadenopathy" and "no distant metastasis".

5. The next event was the Patient's admission to St. Paul's Hospital ("SPH") on 23 June 2022 for a "Laparoscopic anterior resection (non TME)" which was carried out by the Defendant on 24 June 2022. Noteworthy operative findings included "previous right hemicolectomy, adhesion +++, obesity +++". Noteworthy procedural points included "adhesion on right side lysed".

6. Pathology of the surgical specimen reported: "Negative for residual malignancy, status post polypectomy, negative for lymphovascular invasion, no lymph node metastasis".

7. The Patient appeared to be recovering well until 28 June 2022 (Day 4 post-operation) when the Defendant noted at 0700 hours that she had "mild abdominal distension" and "epigastric tenderness". At the same time, the nurse report noted "u/o (urine output) starts to decrease, and P (pulse) is increasing. Increase IVF (intravenous fluid) to 100ml/h".

8. The Patient was seen by the Defendant again in the same evening at 1900 hours. He noted "increase heart rate, low BP (blood pressure) and low u/o" and "mild distension" of the abdomen. An "urgent CT scan of the whole abdomen (P+C)" was ordered. It was noted by the Defendant at 2119 hours "CT scan - rectal anastomosis intact, no pelvic collection". He ordered some blood tests the next morning and put the Patient on fluid diet.

9. In addition to what the Defendant described above, the full CT scan report more importantly described "A collection containing gas, fluid... up to 10.5x4.9x20.1cm ... is noted over the right-sided abdomen... Mild wall thickenings up to 0.9cm are noted over the ascending colon in the right sided abdomen...". These findings were not noted anywhere in the Defendant's hospital notes.

10. The Patient's condition was said to be stable over the next few days. From the observation chart, her pulse rate remained high, ranging from 100-120/min. Her white blood cell count also raised from 7.5 to 11.5 K/uL (normal range 4-10) with neutrophilia. The antibiotics used changed from Invanz to Rocephin and Flagyl on 28 June 2022 to Meropenem on 1 July 2022. The nurse report on 29 June 2022 (Day 5) at 1315 hours noted "condition explained to patient and relatives". However, no other information on this meeting was recorded in the hospital notes.

11. On the evening of 30 June 2022 (Day 6), the Patient was noted to be "confused with mild abdominal distension".

12. The next morning (1 July 2022, Day 7), the Patient complained of "right loin pain" and was noted to have "mild cellulitis" in the right flank. Chest X-ray and blood tests were ordered for the following day.

13. On the morning of 2 July 2022 (Day 8), the Defendant noted "Pulse 105" and "mild to mod distension" of the abdomen. The nurses received a phone order by the Defendant at 1230 hours for a "CT whole abdomen now". Shortly after

at 1300 hours, the Defendant wrote "PPP × laparotomy +/- stoma ... cancel CT". No indication was given for this decision in the notes. The only relevant information was found in the nurse record at 1403 hours "condition explained to [the Patient]'s relative only, fluid and gas found after X ray". Chest and abdominal X-rays reported at 1310 hours on 2 July 2022 described "pneumoperitoneum" and "dilated small and large bowel and air-fluid levels". Presumably, that was the reason behind the urgent laparotomy.

14. The anaesthetist, a Dr CHENG, saw the Patient and her son at pre-anaesthetic assessment and noted "[the Patient] has got sepsis with compromised cardiovascular and respiratory condition and thrombocytopenia, may require post-operative ventilation if unstable +/- post op ICU care".

15. The Patient was brought to the operation theatre around 1930 hours (more than 7 hours after surgery was decided) and returned to the ward just before midnight. Intraoperatively, the Patient was found to have "perforated mid-ascending colon by acute kinking and adhesions, right paracolic abscess... anastomosis intact, no pelvic abscess". The colonic perforation was repaired, abscess was drained, and a loop ileostomy was made. A surgical drain was also placed at the right paracolic gutter.

16. Over the course of the next three weeks, the Patient made a slow recovery.

17. On 11 July 2022 (Day 9 post 2nd operation), at evening round, a CT scan of the whole abdomen was again ordered for the following day. No explanation for this CT can be found in the clinical records or nurse records. However, the nurse record did note "condition explained to [the Patient] and her relatives", "financial issues told".

18. The CT scan on 12 July 2022 (Day 10 post 2nd operation) showed a 11cm right pararenal fluid collection, a 6cm right psoas muscle collection and an 8cm collection "just beneath the lower surgical incision". An image-guided drain insertion into the right lateral abdominal wall fluid collection was performed on the same day. Bacterial culture of the drain fluid resulted in "moderate mixed growth of Enterococcus faecalis & Stenotrophomonas maltophilia".

19. In the following days, the Patient complained of on and off abdominal pain. There were also "gapping" of the abdominal wound and dehiscence of the ileostomy. Both were sutured under local anaesthesia in the ward. Drains

were removed on 14 July 2022 and 19 July 2022 but it was not documented which one was the surgical drain and which one was the percutaneous drain.

20. On 25 July 2022, the Patient was discharged from SPH. A referral to General Outpatient Clinic for dressing of the "infected mid line [midline] and lower abdominal wound" was made by the Defendant.

21. On 27 July 2022 (two days following her discharge from SPH), the Patient sought the care of another surgeon, a Dr POON ("Dr POON"), because of persistent right side abdominal and thigh pain. Dr POON noted that she had "main wound infection" which was laid open and dressed. Bacterial culture of the wound swab yielded Staphylococcus species and E. coli.

22. A CT scan carried out the following day (28 July 2022) at Hong Kong Integrated Diagnostic Imaging Centre (HKIDIC) described a "huge collection 148mm with air pockets" at the right retroperitoneum which "penetrates into the adjacent muscles" forming multiple collections in the abdominal wall muscles and psoas muscle.

23. The Patient was admitted to Gleneagles Hospital ("GH") on 29 July 2022 and had two drains inserted percutaneously under CT guidance into the abovementioned abscesses. Bacterial culture of the drain fluid yielded E. coli and Enterococcus faecalis.

24. Subsequent serial CT scans on 5 August 2022 and 1 September 2022 showed the retroperitoneal collection had decreased in size from 148mm to 36mm. The intramuscular collection had completely resolved.

25. The Patient underwent a colonoscopy by Dr POON on 5 December 2022 that showed normal postoperative findings. She also underwent another CT and PET/CT, which showed no recurrent/residual tumour and no residual collections before eventually having her ileotomy closed by Dr POON at GH on 7 January 2023. She was discharged from the hospital on 10 January 2023.

26. By a statutory declaration made on 7 November 2022, the Patient lodged a complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

27. We bear in mind that the burden of proof is always on the Secretary 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.

28. There is no doubt that the allegations against the Defendant here are serious ones. 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

29. The Defendant admits the factual particulars of re-amended charges (a) and (b) against him but it remains for us to consider and determine on the evidence whether he is guilty of misconduct in a professional respect.

30. We adopt as guiding principles the following statements of the law on informed consent as expounded in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11:

> *"87. ... An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.*
>
> ...
>
> *90. ... [T]he doctor's advisory role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of her*

condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible ..."

31. It is stipulated in the Code of Professional Conduct (2016 edition) ("Code") that:

> *"2.7 Consent is valid only if: -*
>
> *(a) ...*
>
> *(b) the doctor has provided proper explanation of the nature, effect and risks of the proposed treatment and other treatment options (including the option of no treatment) ..."*

32. Dr LI ("Dr LI"), the Secretary's expert, in his Expert Report dated 2 October 2023 said as follows:

> *"The purpose of subjecting a patient to radical surgery following endoscopic removal of a malignant polyp is to remove the risk, if significant, of progression of any residual disease. It is generally accepted that the risk of lymph node metastases, residual tumour or recurrence varies from 0-2% for malignant polyps where there is a clear margin of 2mm or more.*
>
> *For this Patient's polyp, the margin was reported as "negative for invasive tumour and adenoma with a distance from invasive tumour of 2mm". This is at most a Level 2 invasion according to the Haggitt Classification... The Patient also underwent a pre-operative PET/CT ... which cleared her of any residual tumour, lymph node or distant metastases.*
>
> *Given such a favourable prognosis, the Patient ought to have been informed of the very low risk of recurrence and at least offered the option of regular clinical surveillance as an alternative to radical surgery. One should really consider surgery only if the Patient could not accept a risk of progression as small as 0-2% and/or refused regular clinical surveillance. It is unclear if the Patient has been duly counselled and offered such an alternative.*

As it turned out, the surgical specimen contained no residual tumour and no metastatic lymph node... This operation has imparted no oncological benefit on the Patient whatsoever and the Patient should have been made aware of this possible outcome prior to deciding on surgery."

33. Although Dr LI mentioned in his Expert Report that the risk of cancer was 0-2%, both parties are in agreement that the polyp had no stalk and the potential risk of cancer was about 0-20%.

34. Dr LI in his Supplemental Expert Report dated 20 April 2024 said as follows:

> "2. *In Paragraph 8 of the Submission, it was said that Dr. Chan recommended [redacted] ("the Patient") to undergo a laparoscopic anterior resection as treatment for the Patient's malignant rectal polyp. Dr. Chan then went on to explain the nature and risks of the procedure to the Patient and her family members.*
>
> 3. *In the Code of Professional Conduct issued by The Medical Council of Hong Kong... Part II Section A 2.7 (b), it is stipulated that "[c]onsent is valid only if the doctor has provided... proper explanation... of the proposed treatment and other treatment options (including the option of no treatment)..."*
>
> 4. *In the Submission, it did not mention any discussion pertaining to other treatment options as well as the option of no treatment ever having taken place.*
>
> 5. *The option of "no treatment" is particularly important in this case. This is because even without further treatment, the prognosis of a malignant rectal polyp removed by colonoscopy with a clear margin (as in this case) is already very favourable (as explained in 1st section of p. 6 of my first expert report).*
>
> 6. *This is further supported by the histopathology findings which demonstrated no residual tumour anywhere in the resected specimen. Meaning that the operation did not impart any*

oncological benefit.

7. *It is imperative that the Patient was made aware of this during the consenting process in order to make an informed choice on treatment options."*

35. Dr LI in his Second Supplemental Expert Report dated 31 August 2025 said as follows:

"7. *The pathological stage for this Patient's malignant polyp is T1. It is further subcategorised as T1b/sm3 based on the presence of deep submucosal invasion (sm3). Pre-operative PET/CT imaging showed no evidence of lymph nodes or distant metastases.*

8. *In the 2nd Submission, both Dr. Chan (p.3, paragraph 11(c)) and Dr. Chung (p.7, paragraph 42) argued that **in the presence of sm3, radical surgery was the only reasonable treatment** for this Patient due to the high risk (up to 20% as quoted) of lymph node metastasis (LNM); and therefore, **it was not necessary to inform the Patient of any alternatives.** (Dr. Chan's report, p.3, paragraph 13; Dr.Chung's expert report p.8, paragraph 52).*

9. *I must, however, bring to the attention of the PIC members that **there exists a strong body of evidence supporting clinical surveillance (no surgery) as a reasonable alternative for this Patient as her polyp has none of the other high-risk factors**, namely:*

   a. *Close resection margin (<1mm)*
   b. *Presence of lymphovascular invasion (LVI)*
   c. *Poor differentiation*
   d. *Presence of tumour budding*
   e. *Radiological evidence of lymph node or distant metastases*

10. *A meta-analysis (Reference 2) reported that **deep submucosal invasion alone was not an independent risk factor for LNM in T1 colorectal cancer.** The absolute risk of LNM in T1b [colorectal cancers (CRC)] with clear margins and no other high-risk features was 2.6% or lower...*

*11. Several studies also provide survival and recurrence data that support endoscopic resection alone as treatment for patients with T1b/sm3 CRC (References 3, 4, 5). These studies reported a **<2% rate of LNM with only deep submucosal invasion in the absence of other high-risk factors** as mentioned in Point 9 above.*

*12. I would also reiterate that **this Patient's surgical specimen showed neither residual cancer nor LNM.** This means that the Patient underwent an operation that did not provide any additional benefit towards achieving a curative outcome for her cancer.*

13. This is not a statement made in hindsight as claimed by Dr. Chan's expert (Dr. Chung's report, p.7, paragraph 47). Rather, it is a very possible outcome that Dr. Chan should have considered and explained to the Patient when consenting her for the operation.

*14. Whereas immediate radical surgery is certainly a well-recognised treatment for T1b/sm3, I disagree with Dr. Chan and his expert Dr. Chung that it is the only reasonable treatment option. **Dr. Chan should have given the Patient the option of clinical surveillance (no surgery).**"*

36. We agree with the opinion of Dr LI. The Defendant should have given the Patient the option of clinical surveillance (no surgery), but he had failed to do so.

37. The Defendant had 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 re-amended charge (a).

38. There is no dispute that the Defendant had as a matter of fact not documented in his medical record the followings:

   (i) any explanations made to the Patient of the indication for the laparoscopic resection procedure;

(ii) the CT findings;

(iii) when complications manifested, a sufficient account of the conditions and progression of the Patient on 2 July 2022, including the reasons for the cancellation of the CT scan, the reasons and/or explanations to the Patient or her family for the emergency laparotomy;

(iv) any explanations of the indication for ordering a CT scan on 12 July 2022; and

(v) any explanation of the causes of complications caused to the Patient after the laparoscopic resection procedure and/or the laparotomy.

39. Section 1.1.3 of the Code provides that *"[a]ll doctors have the responsibility to maintain systematic, true, adequate, clear and contemporaneous medical records"*. In our view, the Defendant had failed to maintain adequate medical records in respect of the Patient.

40. The Defendant had 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 re-amended charge (b).

Sentencing

41. The Defendant has a clear disciplinary record.

42. 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.

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

44. We have considered the letters of support as provided by the Defendant and his letter of apology.

45. The Defendant told us that he has carefully reviewed all the medical literatures from these proceedings, and he accepts that he should have explained the risks of progression of the malignancy to the Patient in obtaining consent. He said he would take this into account when discussing treatment options with cancer patients in the future. The Defendant also accepts that he should have maintained more detailed and complete documentation of his clinical management and explanation to the patient. He told us that he would ensure full compliance with the requirements in record-keeping in the future, to ensure proper continuity of care of his patients. We accept that the Defendant has insight into his wrongdoings, and the risk of re-offending should be low.

46. Taking into consideration the nature and gravity of the offences in the Defendant's case and what we have heard and read in mitigation, we made a global order in respect of the re-amended charges (a) and (b) that the Defendant be reprimanded.

Remark

47. The name of the Defendant is included in the Specialist Register under the Specialty of General Surgery. 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