

香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHU Kin Wah (朱建華醫生) (Reg. No.: M04387)

Date of hearing: Day 1: 17 August 2021 (Tuesday)
Day 2: 18 August 2021 (Wednesday)
Day 3: 3 October 2021 (Sunday)
Day 4: 23 January 2022 (Sunday)
Day 5: 30 January 2022 (Sunday)
Day 6: 12 June 2022 (Sunday)
Day 7: 23 October 2022 (Sunday)
Day 8: 12 March 2023 (Sunday)
Day 9: 26 March 2023 (Sunday)
Day 10: 17 May 2023 (Wednesday)
Day 11: 4 June 2023 (Sunday)
Day 12: 6 June 2023 (Tuesday)
Day 13: 9 January 2024 (Tuesday)
Day 14: 28 April 2024 (Sunday)

Present at the hearing

Council Members/Assessors: Dr IP Wing Yuk (Chairperson of the Inquiry Panel)
Dr YEUNG Hip Wo, Victor
Dr SO Hing Yu
Mr LAM Chi Yau
Mr YEUNG Chi Wai, Edwin, MH

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Anthony NEOH, SC, the Leading Counsel, from Day 4 to Day 14 of the hearing and Mr Alfred FUNG from Day 1 to Day 14 of the hearing, as instructed by Messrs. Mayer Brown

Legal Officers representing the Secretary: Ms Deanna LAW, the Leading Counsel, from Day 4 to Day 13 of the hearing, and Miss Cassandra FUNG, from Day 1 to Day 14 of the hearing

1. The amended charges against the Defendant, Dr CHU Kin Wah, are:

“That in or about October to November 2015 and July 2016, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [REDACTED] (“the Patient”) in that:

- (a) in or around November 2015, he failed to take appropriate and/or adequate investigation (e.g. blood tests and/or CT scan) after he had been informed of the Patient’s complaints of abdominal pain and/or discomfort; and/or
- (b) in or around July 2016, he failed to properly and/or adequately attend to the possible presence of a foreign object in his abdominal cavity.

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 since 11 August 1981 to the present. His name has been included in the Specialist Register since 4 March 1998 under the Specialty of General Surgery.
3. The Patient had prostate cancer and robotic prostatectomy was performed on 17 July 2015 by Dr Lee (“Dr Lee”) at Hong Kong Sanatorium & Hospital (“HKSH”). The Patient experienced severe abdominal pain after defecation the following day. An emergency laparoscopy by Dr Chung (“Dr Chung”) on 18 July 2015 discovered a perforation at the sigmoid colon above the rectovesical pouch. The sigmoid colon was found to be thickened and shortened and had a large number of diverticuli. The perforation was suspected to have been among the diverticuli.
4. On 19 July 2015, the perforation was repaired and a loop sigmoid colostomy was performed by Dr Chung. Dr Chung’s plan was to perform sigmoid colectomy in a few weeks’ time. The Patient was referred by Dr Lee and another doctor to the Defendant for a second opinion as to whether there was another option instead of sigmoid colectomy.
5. The Defendant first saw the Patient on 14 August 2015. The Patient was accompanied by his daughter, [REDACTED] (“Daughter”) on this occasion. Option of sigmoid colectomy versus closure of colostomy was discussed.
6. The Patient also sought advice from Dr Langenberg (“Dr Langenberg”) on 21 August 2015. Barium enema was arranged by Dr Langenberg on 4 September 2015, which showed no evidence of diverticular disease. On 7 September 2015, the Patient saw Dr Langenberg again. Dr Langenberg wrote a letter dated 7 September 2015 to Dr Lee, advising that there was no need for resection and the colostomy might be closed in about 3 months’ time.

7. On 17 September 2015, the Defendant saw the Patient. Dr Langenberg's letter to Dr Lee dated 7 September 2015 was produced to the Defendant by the Daughter. The Defendant advised closure of colostomy subject to further investigation. The Defendant scheduled gastrografin enema ("GE") on 22 October 2015 and colonoscopy on 23 October 2015, to be followed by a closure of colostomy if these investigations justified going ahead.
8. The Patient was admitted to HKSH on 22 October 2015. GE showed no evidence of leakage of contrast from the rectum and sigmoid, and total colonoscopy showed mild diversion colitis in rectal stump with no other gross lesion.
9. On 23 October 2015, the Defendant performed closure of sigmoid colostomy on the Patient under general anesthesia. 10 pieces of surgical gauzes were employed during the operation.
10. On the day following the operation (24 October 2015), the Patient developed fever and abdominal pain. The provisional diagnosis was peritonitis with underlying suspicion of anastomotic leak. Emergency laparotomy was performed by the Defendant on the same day. Intra-abdominal collection of brownish fluid mainly over left paracolic gutter was found, and the anastomosis of sigmoid colon was intact. Pelvis was relatively clean and the rest of the peritoneal cavity was clean. The collection was drained and transverse colostomy was performed at right upper quadrant as proximal diversion. Distal limb was irrigated with normal saline and was then stapled with TLH 30. Abdominal drain was placed in pelvis. The Defendant also took a peritoneal swab soaking up some of the abdominal fluid for laboratory bacterial culture. Twenty pieces of gauzes and ten abdominal pads were used during the operation.
11. The Microbiology Report dated 28 October 2015 showed that the fluid contained five bacteria (i.e. *Enterococcus faecalis*, *Morganella morganii*, *Proteus vulgaris*, *Clostridium ramosum*, *Enterococcus avium*). Antibiotics were prescribed and administered. Tazocin was prescribed and administered intravenously.
12. Fever and pain subsided and the drain was removed on the 7th day after the operation (2 November 2015). On 3 November 2015, the Patient was discharged.
13. On 4 November 2015, the Patient attended the General Out-patient Clinic of Cheung Sha Wan Jockey Club ("GOPC") complaining abdominal discomfort and asking for analgesic. He was seen by Dr Chieng ("Dr Chieng") and abdominal tenderness was found on physical examination. He had no fever and the stoma functioned well. Dr Chieng referred the Patient to A&E Department ("AED") of Caritas Medical Centre ("CMC") for further management. The reason for referral as stated in Dr Chieng's referral letter was "recent abdo procedure; abdo percussion tenderness". The Patient however did not attend AED of CMC.
14. On 5 November 2015, the Patient consulted Dr Wong ("Dr Wong") at Surgical Clinic of CMC. The Patient was recorded to have no history of fever,

abdominal pain, nausea or vomiting. There was also no record that the Patient had pain on physical examination.

15. On 18 November 2015, the Patient attended the first post-operative consultation with the Defendant. The Defendant's clinical notes of that day showed that physical examination showed "tenderness of LUQ", which meant that the Patient had pain upon being pressed at the left upper quadrant. Colostomy (both the old and new wound) was written as "OK". Oral types of antibiotics (namely, Flagyl (Metronidazole) and Cefuroxime) were prescribed. A follow-up consultation was scheduled in the following week on 25 November 2015.
16. After this consultation with the Defendant, on the same day, the Patient sought advice from Dr Langenberg. According to Dr Langenberg's clinical notes, Dr Langenberg found tenderness and induration at upper abdomen, medial to the colostomy. CT scan was suggested.
17. On 25 November 2015, the Patient attended the second post-operative consultation with the Defendant. The Defendant's clinical notes of that day showed "Pain resolved", "Findings: PE: nad", which meant no abnormality was detected on physical examination, and colostomy was "OK". 3-month follow-up was given.
18. On 2 March 2016, the Patient attended the third post-operative consultation with the Defendant. There was weight gain of 22 lbs. with no complaint from the Patient. Physical examination revealed no abnormality, and the colostomy was "OK". The Defendant planned GE in 4 months, to be followed by closure of colostomy if justified.
19. On 25 April 2016, the Patient consulted Dr Langenberg. According to Dr Langenberg's clinical notes, Dr Langenberg noted that there were still indurated areas above umbilicus. Dr Langenberg noted the CT scan appointment scheduled by Hospital Authority ("HA") on 22 July 2016 and suggested decision on closure of colostomy after CT scan.
20. On 4 July 2016, the Patient attended the fourth post-operative consultation with the Defendant. The Defendant's clinical notes of that day showed that the body weight of the Patient had remained more or less the same as in his third post-operative consultation on 2 March 2016. Physical examination showed that no abnormality was detected. The colostomy was "Ok". The Defendant arranged GE to be done on 11 July 2016 as outpatient at HKSH. The Defendant also noticed that CT scan had been arranged for the Patient by HA on 22 July 2016.
21. On 8 July 2016, the Patient attended AED of CMC because of vomiting and hiccup on 7 July 2016. X-rays (chest and abdomen) were taken. On the same day, the Daughter called and informed the Defendant's nurse that the Patient had attended AED of CMC. The Daughter told the nurse that CMC had arranged a follow up for the Patient on 11 July 2016, the day originally scheduled by the Defendant for GE for the Patient, thus the said GE appointment had to be cancelled.

22. On 16 July 2016, the Patient attended AED of CMC for on-and-off nausea/acid reflux for one week. There was vomiting of undigested food. The Patient complained of mild abdominal pain. There was mild tenderness medial to the colostomy. X-rays (chest and abdomen) were taken during the consultation.
23. On 18 July 2016, the Patient attended the fifth post-operative consultation with the Defendant. This consultation was unscheduled. The Patient complained of abdominal pain and passing loose stool. No abnormality was found on physical examination. GE was re-scheduled to 28 July 2016 at HKSH. Probiotic Cleanse was prescribed.
24. On 22 July 2016, CT abdomen and pelvis with contrast was performed at CMC. According to the CT Examination Report dated 22 July 2016 ("CT Examination Report") prepared by Dr Chu ("Dr Chu"), Radiologist at CMC:

"... The proximal jejunum appears prominent with small faecal sign noted, transition of caliber at upper mid abdomen, mechanical intestinal obstruction cannot be excluded. Hyperdense to metallic materials is noted inside the dilated jejunum, ?ingested foreign body, it is present in the similar position in the AXR since 8-7-2016 but not seen on 15-9-2015, suggest clinical correlation. The wall of this segment of dilated jejunum appears thickened with increase in surrounding stranding, can be inflammatory change..."

25. Upon follow up by Dr Shum ("Dr Shum"), Associate Consultant of the Department of Oncology of Princess Margaret Hospital, on 26 July 2016, the Patient complained of abdominal colicky pain. Physical examination found tenderness over central abdomen and colostomy was functioning. Dr Shum noted the CT Examination Report. Dr Shum wrote a referral letter to AED of CMC for assessment and consideration of admission to Department of Surgery for further investigation ("the Referral Letter").
26. On 27 July 2016, the Patient attended the sixth (last) post-operative consultation with the Defendant. The Defendant recorded in his clinical notes that the Patient had attended AED of CMC twice on 8 and 16 July 2016. The CT Examination Report (without films) and the Referral Letter were produced to the Defendant. Physical examination showed normal colostomy. The words "likely GE" (i.e. likely gastroenteritis) were written. The Defendant asked the Patient to proceed to GE at HKSH the next day. The Patient also consulted Dr Langenberg on the same day.
27. On 28 July 2016, Dr Li ("Dr Li"), Radiologist of HKSH, conducted GE on the Patient. The GE report dated 28 July 2016 prepared by Dr Li was faxed to the Defendant's clinic sometime in the afternoon at 3:30 p.m. on the same day ("GE Report"). According to the Defendant, he did not come around to read the faxed GE Report until late at night, and he asked his nurse to call the Daughter to inform her of the GE findings and advise that the Patient could proceed to closure of colostomy. The Defendant's nurse called the Daughter that night.

28. On 29 July 2016, the Patient or his family members went to HKSH and took away the GE Report and the GE film. According to the Defendant, his nurse called up HKSH and was informed by HKSH that the Patient or someone on his behalf had taken away the GE film and the GE Report. The GE films were not sent to the Defendant's clinic on that day or shortly thereafter.

29. On 30 July 2016, the Patient consulted Dr Langenberg. The clinical notes of Dr Langenberg recorded the following:

*"...**Strange ribbon-like opacity in upper central abdomen, identity unclear, ??possible retained gauze?**..."*

30. On 1 August 2016, upon Dr Langenberg's referral, the Patient had an X-ray of the abdomen supine and erect and lateral. The Radiological Report dated 1 August 2016 recorded the following:

"... A radiopaque ribbonlike structure about 1 cm in width and with a curled and partly folded appearance is noted in the left anterior part of the abdomen at the L3/4 level. The outer margins of this structure measure about 3.5 x 3.5 x 2 cm. It may be located in the peritoneal cavity or inside a loop of bowel. There is suggestion of a poorly defined soft tissue shadow surrounding this structure. It measures about 7 cm in diameter Reviewing the previous Gastrografin study on 22 Oct 2015 (performed just before the abdominal operation on 23 Oct 2015), this ribbonlike structure was not present before the operation. Clinical correlation or follow up by a CT scan is suggested for localisation of this structure (which may be a foreign body) and to confirm or exclude the presence of a granuloma surrounding this structure..."

31. Dr Langenberg also wrote a referral letter to Professor Law ("Professor Law") of Queen Mary Hospital ("QMH") dated 1 August 2016 for his input and management.

32. On 3 August 2016, the Patient consulted Professor Law. On 6 August 2016, Professor Law performed an urgent operation on the Patient at QMH. A large fist-sized mass comprising surgical gauze was found in the Patient's abdomen.

33. On 8 September 2016, the Patient via his Daughter lodged a complaint against a number of doctors, including the Defendant, to the Medical Council.

Burden and Standard of Proof

34. 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.

35. 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 the disciplinary charges against him carefully and separately.

Findings of the Inquiry Panel

36. The Daughter gave evidence. She said since discharge from HKSH on 3 November 2015, the Patient had on-and-off pain, and sometimes would experience lots of pain and discomfort. She said on 4 November 2015 the Patient felt very painful and therefore went to GOPC, which was a few streets away from where they lived, for consultation. What the Daughter said about the Patient having pain on 4 November 2015 is supported by what was stated in the referral letter dated 4 November 2015 written by Dr Chieng of GOPC to AED of CMC. The referral letter recorded the Patient's complaint of "abdo discomfort" (i.e. abdominal discomfort) and that he came for analgesic, which is pain killer. The reasons for referral under the subject of the referral letter were written "recent abdo procedure; abdo percussion tenderness".
37. We note that on 5 November 2015 when the Patient consulted Dr Wong at Surgical Clinic of CMC, there was no complaint of pain and there was no pain elicited on physical examination. However, this cannot exclude the possibility that the Patient had on-and-off pain, or suddenly he would feel very painful and discomfort since discharge.
38. The Daughter said the reason the Patient went to see the Defendant on 18 November 2015, other than that it was a scheduled appointment, was because the Patient felt pain at the wound and at the para-umbilical region of the abdomen, and sometimes the Patient would complain of severe pain and discomfort. She said the Patient complained to the Defendant at that consultation that his abdomen had pain from time to time.
39. The Defendant on the other hand said that the Patient did not complain to him of abdominal pain at the consultation on 18 November 2015. The Defendant said he however detected tenderness on palpation. Therefore, in his clinical record for that consultation, he wrote down "Findings: PE: tenderness LUQ", meaning on physical examination, he detected tenderness at left upper quadrant of the abdomen.
40. When looking at the Defendant's clinical record, for the consultation on 14 August 2015, he positively put down "Abdominal pain: - ve", meaning when he asked the Patient of his symptoms and his medical history, the Patient did not complain of abdominal pain. The Defendant could have for the consultation on 18 November 2015 positively put down similar entry if the Patient did not complain to him of abdominal pain. However, we cannot see any such record.

41. Further, the next follow-up consultation with the Defendant after the consultation on 18 November 2015 would be the consultation on 25 November 2015. His clinical record for the consultation on 25 November 2015 showed the following entries:

*“Complaint: BW 156 lb
Pain resolved
Findings: PE: nad
Colostomy ok
Action : FU: 3/12”*

42. Pain is a symptom voiced out by patients, forming part of complaint/history in clinical record. Tenderness is a physical sign detected by doctors upon physical examination by palpation, and the patient informs the doctor of the pain. Generally in clinical record of doctors, in terms of order, complaint/history will come first before physical examination findings.
43. When we look at the Defendant’s clinical record for consultation dates other than 25 November 2015, we see that the Defendant most of the times would note down the complaint/history of the Patient before the entry “Findings: PE” or “PE” and “Findings”. Looking at the clinical record for 25 November 2015, it is very likely that the entry “Pain resolved”, which appeared as a separate entry and preceded the entry “Findings: PE: nad”, was the entry of complaint/history.
44. In the Defendant’s submission to the Preliminary Investigation Committee (“PIC”) dated 27 July 2017, the Defendant wrote:

“49. My Clinical Notes (Appendix III) of the follow up on 25 November 2015 (7 days later) indicate the Patient’s pain had subsided, no abnormalities were detected on physical examination, and the colostomy was “OK”...

52. My Clinical Notes (Appendix III) of 25 November 2015, when I saw the Patient, noted that “pain (had been) resolved” and physical examination revealed no abnormality and the colostomy was “OK”...

93. During the post-operative management process, the Patient’s pain had subsided by 25 November 2015 and I heard no complaint of any pain from the Patient or the Daughter until 8 July 2016, when she called my nurse ...” [underline our emphasis]

45. In the Defendant’s submission to the PIC dated 12 April 2018, the Defendant wrote:

“4...

(iv) The Patient came back for follow-up on 25 November 2015. His pain had resolved and physical examination revealed no abnormality; the tenderness observed in the Left Upper Quadrant of his abdomen had disappeared ...” [underline our emphasis]

46. All along as shown in the two PIC submissions, the words used by the Defendant clearly shows that he treated “pain resolved” and “physical examination” as two separate entries.
47. We do not believe what the Defendant said at the inquiry that the entry “pain resolved” meant “pain/tenderness on palpation resolved”. If this was really what he meant, there was no need to have two separate entries. In fact, these were not the words the Defendant used in the two PIC submissions. We do not find the Defendant credible in this regard.
48. We believe “Pain resolved” was an entry of complaint/history. It must be the case that the Patient had at the previous consultation complained of pain, but the pain had resolved on 25 November 2015. The previous consultation was 18 November 2015. This supports what the Patient said that he had complained to the Defendant of pain on 18 November 2015.
49. We also note that during evidence-in-chief, the Defendant for the first time claimed that tenderness detected at the consultation on 18 November 2015 was “slight”. However, the Defendant never mentioned “slight” tenderness in any of his PIC submissions and witness statement. His clinical notes for that consultation did not contain the word “slight” or words to that effect. It was only on cross-examination that the Defendant conceded that he could not remember very clearly the basis of saying that the tenderness was “slight”, and he accepted that the word “slight” was clearly not seen in his clinical notes or any of his PIC submissions. We do not believe what the Defendant said that he detected “slight” tenderness. The Defendant was not credible in this regard as well.
50. We do not see any reason or incentive for the Patient or the Daughter to lie that the Patient had told the Defendant of on-and-off abdominal pain at the consultation on 18 November 2015. The Defendant admitted that he saw many patients every day and every year throughout his long practice. We do not believe the Defendant would be able to recall accurately the details of the conversation between himself and the Patient and the Daughter, particularly when those alleged details were not written down anywhere in his record. Besides our findings above that the Defendant was not credible, we still find it more likely that the Patient/Daughter would have recalled accurately the details of the conversation between themselves and the Defendant at the consultation on 18 November 2015 as opposed to the Defendant.
51. We therefore believe that the Patient had complained to the Defendant of on-and-off abdominal pain at the consultation on 18 November 2015.
52. Pain and tenderness are correlated. Even if the Patient had not complained to the Defendant of on-and-off abdominal pain at the consultation on 18 November 2015, but which we have found otherwise above, the Defendant did as a fact elicit tenderness (i.e. pain) upon palpation at the left upper quadrant of the abdomen.

53. In his PIC submission dated 12 April 2018, the Defendant claimed that his clinical diagnosis on 18 November 2015 was “possible residual intra-abdominal infection that lasted from previous abdominal surgery on 25 October 2015”.
54. In his witness statement dated 14 June 2021, the Defendant however claimed that his clinical diagnosis on 18 November 2015 was “possible mild intra-abdominal infection arising from the operation on 25 October 2015, although post-operative delayed wound infection or muscle strain could not be ruled out”. It was the first time the Defendant said the intra-abdominal infection was “mild”, and that he also had in his mind at the time post-operative delayed wound infection or muscle strain.
55. There is no dispute that tenderness was elicited from the left upper quadrant, which was not the wound site. The pain and tenderness could not be accounted by wound pain since the wound was located at the left lower quadrant of the abdomen.
56. On the claim of wound infection, when cross-examined, the Defendant said “...Possible I would say, but not too likely because I inspect the wound. The wound is quite okay. Not much evidence of inflammation.” Therefore, despite what the Defendant claimed that wound infection was one of his differential diagnoses, he conceded that wound infection was very unlikely.
57. Further, both Dr Poon, the Secretary’s expert (“Dr Poon”), and Dr Lam, the Defendant’s expert (“Dr Lam”), did not agree that wound infection was a possible differential diagnosis because the pain was not over the wound. Both experts also took the view that muscle strain was not likely. We agree with Dr Poon that if there were muscle strain, that ought to happen below the wound. The Defendant also agreed in cross-examination that muscle strain meant the muscle layer beneath the wound was strained. Wound infection and muscle strain therefore could not be likely differential diagnosis of the Defendant on 18 November 2015. We also do not agree with what Dr Lam suggested that it could be persistent inflammation of the wound because according to the Defendant, the wound was “ok”. Further, antibiotics were not indicated for treating non-infective inflammation. Also, the Defendant never prescribed any non-steroidal anti-inflammatory drugs (NSAID) to the Patient.
58. Wound infection, wound inflammation and infection of muscle beneath the wound were not likely differential diagnoses on 18 November 2015. We do not believe that such differential diagnoses had even crossed the mind of the Defendant on that day. We do not believe the Defendant was truthful when he mentioned these differential diagnoses in his witness statement and evidence during the inquiry.
59. The Patient had undergone a number of operations in the second half of 2015. The operation performed by the Defendant on 24 October 2015 was in a situation of peritonitis. The operation was a heavily contaminated operation. The evidence was that the culture swab from the peritoneal cavity showed a number of bacterial growth, which was resistant to a number of antibiotics. It indicated that the operation was heavily contaminated. The consequence was that surgical site infection (“SSI”) could happen anytime after operation. SSI could

be simple wound infection, infection of muscle beneath the wound, or organ space infection, meaning intra-abdominal infection, which might progress to intra-abdominal abscess. Intra-abdominal abscess was a serious type of intra-abdominal infection with significant mortality and morbidity.

60. The presence of pain/tenderness in this case and the fact that it was only a few weeks after a contaminated surgery indicated possible post-operative complication. Having said above that wound infection, wound inflammation and infection of muscle beneath the wound were unlikely, what should be worrisome to the Defendant was possible intra-abdominal infection.
61. Apart from pain and tenderness, the other common clinical presentation of intra-abdominal infection would be fever, tachycardia and hypotension. Therefore, it was important to measure the pulse, blood pressure, and body temperature. Checking white cell count and infective markers through blood test can identify the possible presence of intra-abdominal infection.
62. Dr Lam agreed that intra-abdominal infection was a serious condition and associated with substantial morbidity and mortality. He agreed that if intra-abdominal infection progressed to intra-abdominal abscess, it would be an emergency situation. He agreed that intra-abdominal abscess could happen any time after operation.
63. Dr Lam also accepted that the possible infection involved in the Patient's case was likely hospital-acquired, which carried worse prognosis. It might be caused by resistant pathogens such as resistant strain of *Pseudomonas aeruginosa*, *E coli* or other organisms producing extended spectrum beta lactamases. The organisms found inside the Patient's gastrointestinal tract could be virulent.
64. The fact that the Defendant prescribed oral antibiotics on 18 November 2015 showed that in his mind there might be some form of infection. In any event, the Defendant's clinical diagnosis on 18 November 2015 was that there was the possibility of residual intra-abdominal infection arising from the operation on 25 October 2015.
65. Dr Lam accepted that if there was a suspicion of intra-abdominal infection, one must first do further investigations to confirm and find the source of infection and treat it accordingly.
66. Intra-abdominal infection can only be confirmed or excluded by further investigations. Further investigations include taking body temperature, blood pressure, checking pulse, blood test (i.e. white cell count, infective markers), blood culture, and/or CT scan, etc. However, the Defendant had not performed any of these investigations on the Patient on 18 November 2015. Without these further investigations, the Defendant could not confirm or exclude intra-abdominal infection. Without these investigation results, there was no scientific basis for the Defendant to even claim that intra-abdominal infection was "mild". Hence, what the Defendant said that his clinical diagnosis was "mild" intra-abdominal infection was not substantiated.

67. Instead of conducting further investigations, what the Defendant did was prescribing a 7-day course of oral antibiotics (namely, Flagyl (Metronidazole) and Cefuroxime) to treat any mild intra-abdominal infection or any wound infection. Given what we said above that wound infection was unlikely and that there was no investigation to support a diagnosis of “mild” intra-abdominal infection, we have serious doubt as to the reason given by the Defendant for the said prescription.
68. We further take the view that the prescription of these two oral antibiotics were not appropriate because they could hardly kill the bacteria that grew in the previous culture or hospital acquired intra-abdominal infections. The Defendant ought to have confirmed the diagnosis before deciding what type of treatment was appropriate, but he had not done so. The Defendant did not follow the principle of prescribing antibiotics.
69. What the Defendant also did in this case was to ask the Patient to come back 7 days later. Given that intra-abdominal infection could progress fast and could be life-threatening, seeing the Patient 7 days later without monitoring was totally inappropriate.
70. The Defendant claimed that Dr Langenberg saw the Patient on 18 November 2015, yet Dr Langenberg also did not do any clinical examination or investigations. We must say that this inquiry is not about the conduct of Dr Langenberg. We do not have the full information as to what was provided to Dr Langenberg at the material time. Without Dr Langenberg’s giving evidence before us, we are not in any position to judge, simply based on the documents provided to us, the correctness or otherwise of Dr Langenberg’s action or inaction.
71. We note that the Patient’s condition had improved on 25 November 2015. However, it was only fortunate that the Patient’s condition did not further worsen. That still does not justify what the Defendant had omitted to do after seeing the Patient on 18 November 2015. The Defendant had not performed any appropriate and/or adequate investigations that ought to be done on 18 November 2015 to confirm or exclude intra-abdominal infection.
72. We are satisfied that 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 charge (a).
73. There is no dispute that at the consultation on 27 July 2016, the Defendant was shown the CT Examination Report and the Referral Letter by the Daughter and the Patient.
74. The CT Examination Report was marked at the top of each page the words “***For Urgent Attention***”. A final remark of “***THIS REPORT REQUIRES ATTENTION***” (all in capital letters) was stated at the end of the second page.

75. On the interpretation of the technical findings in the CT Examination Report, the parties agreed to the following propositions:
- (i) “Small faecal sign”, which was a typo and should mean “small bowel faecal sign”, means there were some obstruction to the small bowel and holding up of the fluid inside it, leading to the drying up of bowel and faeces appearing in the small bowel. It was a CT feature suggesting intestinal obstruction.
 - (ii) “Proximal jejunum appears prominent” means the proximal jejunum was dilated. This finding, read together with small bowel faecal sign, suggested that there might be obstruction.
 - (iii) “Transition of caliber” means some part of the bowel was dilated and some part was not. There was a transition from a dilated part to a non-dilated part. This indicated some obstruction in the jejunum.
 - (iv) In view of the aforementioned findings, mechanical intestinal obstruction could not be excluded.
 - (v) There was a hyperdense to metallic material seen inside the dilated jejunum.
 - (vi) The foreign body had been inside the Patient’s abdomen in a similar position for at least 2 weeks since the X-ray taken on 8 July 2016 but not seen on 15 September 2015. Similar position means that the foreign body was in about the same position.
 - (vii) “The wall of this segment of dilated jejunum appears thickened with increase in surrounding stranding which can be inflammatory change” means there might be some inflammation.
76. With reference to the above interpretation, both Dr Poon and Dr Lam agreed that the CT Examination Report contained 3 abnormal findings: (i) the presence of foreign metallic body; (ii) some form of obstruction; and (iii) inflammation. Both Dr Poon and Dr Lam agreed that the CT Examination Report was alarming. Dr Lam said the most alarming thing to him was obstruction.
77. The Defendant claimed in his witness statement dated 14 June 2021 that he had explained to the Patient and the Daughter during the consultation on 27 July 2016 that gastroenteritis might give rise to some dilated bowel. He said he explained that he could not be certain as to the nature of the foreign body as detected by the CT Examination Report because there was no mention of its shape, geometry, size and length. He said he further explained that the foreign body might have been ingested as suggested by the CT Examination Report, and if the foreign body was small, it might be passed out with the faeces spontaneously. The Defendant said he thought of the possibility of post-operative adhesion.
78. The CT Examination Report wrote “... ?*ingested foreign body*...”. This means attending doctors had to look for clinical correlation if the foreign body could be ingested. Dr Shum saw the CT Examination Report. Dr Shum wrote in the

Referral Letter that there was no history of ingestion of foreign body. This means Dr Shum had already asked the Patient about history of ingestion of foreign object, and there was no such history.

79. At the consultation on 27 July 2016, the Defendant was clearly aware of what Dr Shum wrote in the Referral Letter that there was no history of ingestion of foreign body. In fact, this was also what the Defendant told us during cross-examination that it was because of what Dr Shum wrote, he therefore did not ask the Patient of history of ingestion of foreign body. The Defendant's evidence on this was clear and unambiguous. We do not see he was in any way mistaken when giving the answer. We find the Defendant not truthful when he later changed his evidence by saying that he was not clear if he had asked for history of ingestion.
80. What happened was that the Defendant did not ask the Patient for history of ingestion. This means that the Defendant himself did not believe the possibility that the foreign body was ingested was high.
81. We also find it not reasonable for the Defendant to say that the CT Examination Report did not mention the shape, geometry, size and length of the foreign body, and therefore it was a small ingested object. No mention of the shape, geometry, size and length does not mean that it must be a small ingested object. The foreign body was big enough to be picked up by an X-ray, and should be correlated with CT images.
82. Given multiple abdominal operations were performed beforehand, the possibility of retained surgical instrument ("RSI") should be considered. We expect a specialist in General Surgery should have this differential diagnosis in mind.
83. Dr Lam was of the opinion that RSI is a high-risk condition and warrants immediate attention. An X-ray should be ordered immediately in the circumstances to facilitate the surgery. Dr Lam also mentioned that if the diagnosis was possible RSI, a responsible surgeon should have taken steps to remove the retained item as soon as possible, and neither GE nor closure of the colostomy would be appropriate.
84. Both Dr Poon and Dr Lam agreed that complete obstruction could be excluded by reason of the Patient's positive output from colostomy during the consultation on 27 July 2016, but not partial obstruction. Both Dr Poon and Dr Lam also disagreed with what the Defendant claimed that there was no sign of partial or complete obstruction during the consultation because the Patient was so well. The Defendant however later conceded that the absence of clinical symptoms did not exclude the possibility of partial obstruction.
85. Dr Poon told us that it was the foreign body which caused the partial obstruction and inflammation. Dr Poon's evidence on this was not challenged.
86. Dr Lam however was of the view that the partial obstruction was caused by post-operative adhesion, and the inflammation could be explained by gastroenteritis.

87. However, we do not accept that inflammation could be explained by gastroenteritis because gastroenteritis would cause functional obstruction, instead of mechanical obstruction. Both Dr Poon and Dr Lam accepted that this was a case of mechanical obstruction, but not functional obstruction. Further, as said before, the Defendant did not believe the Patient had gastroenteritis on either 22 or 27 July 2016. The Defendant had not set out any other possible diagnosis to explain inflammation.
88. We accept that there was a high possibility that it was the foreign body that caused the partial obstruction and inflammation because the CT scan confirmed the presence of both foreign body and partial obstruction, suggesting that the foreign body might have caused erosion to the wall of the bowel. This was definitely an alarming and life-threatening situation. We do not accept that the partial obstruction was caused by adhesion.
89. It is undisputed that the foreign body had not moved inside the Patient's abdomen for at least 2 weeks from 8 to 22 July 2016. We do not accept what Dr Lam suggested that if the obstruction subsided, and with gastroenteritis in the Patient, the foreign body would pass out in the next 5 days. There was simply no basis to say that the obstruction would subside. Also, according to the Defendant, the Patient did not have gastroenteritis on either 22 or 27 July 2016.
90. In this alarming and life-threatening situation, in our view, as a responsible surgeon, the Defendant ought to have taken steps to remove the foreign body as soon as possible, and neither GE nor closure of the colostomy would be appropriate. An X-ray should be ordered immediately in the circumstances to confirm the presence of foreign body and facilitate the surgery. Arrangement should be immediately made for the Patient to be hospitalized for monitoring, and preparation for operation, and if necessary, for emergency operation.
91. The Defendant claimed that at the consultation on 27 July 2016, he told the Daughter and the Patient that the GE would serve dual purposes, namely to see whether the anastomosis had been healing well with no leakage, and to see whether the foreign body was still present.
92. On the other hand, the Daughter told us that at the consultation on 27 July 2016, the Defendant said that: (i) even one ton of swallowed gold could be passed out ("...即係正常你吞一噸金都可以自然排出..."); (ii) since the area concerned had been "dealt with" by other doctors, it could have been some other doctors who had left something behind; and (iii) he did not care about what others had done and would only deal with the closure of colostomy. The Daughter said the Defendant had never mentioned that one of the purposes of the GE was to see whether the foreign body had been removed.
93. GE was never intended to investigate a foreign body. It was wrong in principle for the Defendant to use GE to investigate the foreign body.
94. If it was really the case that the Defendant did intend to use GE to investigate the foreign body, we will expect the Defendant to take some real effort to ensure that the radiologist who performed the GE the next day would be brought to notice of this additional request plus the Patient's latest clinical condition (i.e.

possibility of the foreign object causing obstruction and/or inflammation). The Defendant could have amended the GE request form. The Defendant could have contacted the radiologist himself or via his nurse to relay the additional request and the Patient's latest clinical condition.

95. According to Dr Lam, his own practice would be calling the radiologist himself despite the difficulties claimed by the Defendant, as this was a life-and-death situation. Dr Lam also accepted the phenomenon called "intentional blindness" which demonstrates the importance of drawing people's attention to the right point and the relevant clinical information such that they know what to look for. This concept/phenomenon is not about whether to trust another specialist's finding, but concerned with the concept of "helping each other out".
96. However, we do not see the Defendant had taken any real effort to ensure that the radiologist was brought to the attention of this additional request plus the Patient's latest clinical condition (i.e. possibility of the foreign object causing obstruction and/or inflammation). We find it very hard to believe that the Defendant had the intention to use the GE for the additional purpose of investigating the foreign body. We prefer to believe the evidence of the Daughter in that she said the Defendant never told them that the GE was to serve another purpose of investigating the foreign body.
97. Further, the GE Report did not mention any foreign body seen in all the imaging, including scout film. The GE Report did not state that the CT Examination Report and the Referral Letter had been considered. The GE Report was silent as to the investigation and result of the foreign body.
98. At the inquiry, the Defendant told us that he was surprised to see that the GE Report did not mention about the foreign body.
99. Given that the GE Report was silent on any findings of the foreign body, according to Dr Lam, a reasonable doctor in the circumstances should have waited for the films before advising the Patient. However, the Defendant asked his nurse to call the Daughter to inform them to proceed with closure of colostomy, which his nurse did on the night of 28 July 2016. Even if the Defendant's claim that the Daughter had called on 28 July 2016 to chase for the GE result was true, the Defendant's clinical advice should be a matter based on his clinical judgment, which without the films should not be made. The Defendant could also have qualified his clinical advice to be a preliminary one pending his review of the films. However, the Defendant never did so. This further supports our findings above of not believing that it was the Defendant's intention to use the GE for the additional purpose of investigating the foreign object.
100. Even if it was true that the Defendant did intend the GE to serve the additional purpose of investigating the foreign body, and that he had so informed the Patient and the Daughter, but which we had found otherwise above, sending the Patient to GE the next day was still improper and inadequate. We repeat that in this alarming and potentially life-threatening situation, as a responsible surgeon, the Defendant ought to have taken steps to remove the foreign body as soon as possible. Neither GE nor closure of the colostomy would be appropriate.

101. The Defendant similarly claimed that Dr Langenberg and Professor Law, who subsequently saw the Patient, did not immediately hospitalize the Patient. This inquiry is not about the conduct of Dr Langenberg and/or Professor Law. We do not have the full information as to what was available to Dr Langenberg and/or to Professor Law at the material time. Without Dr Langenberg's and Professor Law's giving evidence before us, we are not in any position to judge, simply based on the documents provided to us, the correctness or otherwise of their action or inaction.
102. We are satisfied that 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 charge (b).

Sentencing

103. The Defendant has a clear disciplinary record.
104. We take note of the Defendant's submission that he has performed a great number of endoscopies and colorectal surgical procedures over the years and there have been no major problems and no complaints from any of these patients.
105. We bear in mind that the 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.
106. We have considered and will give credit to the character reference letters as submitted.
107. We will also give credit to the Defendant's contributions to the medical profession and to the general public.
108. The offences committed by the Defendant in this case were very serious in nature, which placed the Patient at risk of life-threatening situation. We have grave concern that the Defendant did not put the Patient's well-being as the top priority. For instance, in respect of charge (a), the Defendant had the possible diagnosis of residual intra-abdominal infection in his mind; however, he did not follow the basic diagnostic principles, and he also did not follow the basic principles of antibiotics prescription. In respect of charge (b), the highest concern was the presence of the foreign body and the possible need for its removal, but the Defendant put closure of the colostomy at a higher priority, which was inappropriate in those circumstances. We are not provided in mitigation with any concrete measure which the Defendant will take to ensure us that he will put patients' well-being as the top priority in the future.
109. For protection of the public, we need to ensure that the Defendant has insight into his inadequacies and will not repeat the same or similar breach in the future.

110. Taking into consideration the nature and gravity of the disciplinary charges and what we have heard and read in mitigation, we order that:
- (i) in respect of disciplinary charge (a), the Defendant's name be removed from the General Register for a period of 3 months;
 - (ii) in respect of disciplinary charge (b), the Defendant's name be removed from the General Register for a period of 6 months; and
 - (iii) the removal orders above to run concurrently.
111. We have considered carefully whether the operation of the removal orders should be suspended. We do not consider it appropriate to do so for the reasons aforesaid.

Dr IP Wing Yuk
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong