香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHAN Raymond Tsz Tong (陳子棠醫生) (Reg. No.: M09073)

Dates of hearing: 5 November 2024 (Tuesday) (Day 1); 7 November 2024 (Thursday) (Day 2); 4 February 2025 (Tuesday) (Day 3); and 23 February 2025 (Sunday) (Day 4)

Present at the hearing

Council Members/Assessors:	Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel) Dr LING Siu-chi, Tony Dr KWOK Siu-yin, Janette Ms FUNG Dun-mi, Amy, MH, JP Ms MA Man-chi
Legal Adviser:	Mr Edward SHUM
Defence Counsel representing the Defendant:	Mr Ashok K. Sakhrani as instructed by Messrs. Kennedys
Legal Officer representing the Secretary:	Ms Carol LEE as instructed by Department of Justice

1. The charges against the Defendant, Dr CHAN Raymond Tsz Tong, are:

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

(a) from about April to May 2012, he failed to arrange any imaging investigation before starting chemotherapy on the Patient;

(b) he inappropriately or without proper justification stated in the medical records of the Patient on 17 July 2012: "Untreated 2-4/12, Treated 18/12", when in fact the Patient's condition was extremely poor; and

(c) from 26 June 2012 to 19 July 2012, he inappropriately or without proper justification advised the Patient to undergo further (or second line) chemotherapy.

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 12 July 1993 to the present. His name has been included in the Specialist Register under the Specialty of Clinical Oncology since 7 July 2004.

3. Briefly stated, the Patient underwent a body check in January 2010 and discovered an ovarian mass. The Patient later accepted the medical advice of one Dr SUM and underwent on 18 April 2012 laparotomy and left salpingo-oophorectomy (the "1st Surgery") at the Hong Kong Baptist Hospital ("HKBH").

4. Prior to the 1st Surgery, Dr SUM had arranged for a pelvic ultrasound examination which showed a 9+cm left ovarian cyst with solid areas but uterus and right ovary were found to be normal.

5. Histopathology after the 1st Surgery then showed mucinous carcinosarcoma of the left ovary.

6. The Patient was referred by Dr SUM to see one Dr CHAN, who later saw her at her bedside at HKBH on 19 April 2012. According to the medical records obtained from HKBH, Dr CHAN explained the histopathology findings to the Patient and advised her of the need for further surgery and chemotherapy. Dr CHAN also ordered chest x-ray ("CXR") for the Patient. The CXR done on 20 April 2012 however showed no obvious lung lesions.

7. With the consent from the Patient, "*laparotomy, THRSO, omentectomy, pelvic and para-arotic lymph node dissection, small bowel resection, end to end*

reanastomoses, debulking operation" (the "2nd Surgery") were performed at HKBH by Dr CHAN and another surgeon on 21 April 2012.

8. According to the Operation Record kept by HKBH for the 2nd Surgery, "*8 x 4 cm tumour deposit at the left peritoneum*" was found. There were "*[m]ultiple tumour nodules in the remaining omentum*". "*Enlarged pelvic & small bowel mesenteric & para-aortic lymph nodes (up to 3 cm in diameter)*" and "*4 tumour masses along the small bowel, at the ileum and jejunum*," were found. In addition, there were "*2 enlarged para-aortic lymph node at the supra-renal levels near the subdiaphragm area, 2 cm and 3 cm in diameter*".

9. Specimen taken from "*1. uterus + right ovary + right tube + pelvic peritoneum 2. Left pelvic lymph nodes 3. Right pelvic lymph nodes 4. Peritoneal biopsy 5. Colic mesentery 6. Small bowel mesenteric lymph node 7. Omentum 8. Para-aortic lymph node [and] 9. Small bowel*" were sent for histopathology reporting.

10. In the Histopathology Report dated 25 April 2012, the following findings were noted:-

"*1. Uterus + right ovary + right tube + pelvic peritoneum*

- *The pelvic peritoneum shows carcinosarcoma, consistent with metastasis.*
- *A uterine leiomyoma.*
- *The uterine cervix shows focal cervical intraepithelial neoplasia grade II (CIN II).*
- *The right fallopian tube and right ovary are negative for malignancy.*

2. Left pelvic lymph nodes

- *No evidence of malignancy. (0 out of 10 lymph nodes)*

3. Right pelvic lymph nodes

- *No evidence of malignancy. (0 out of 17 lymph nodes)*

4. Peritoneal biopsy

- *No evidence of malignancy.*

5. Colic mesentery

- *No evidence of malignancy.*

6. *Small bowel mesenteric lymph nodes*
- *5 out 7 of lymph nodes show metastatic carcinosarcoma.*

7. *Omentum*
- *No malignancy seen.*

8. *Para-aortic lymph nodes*
- *No evidence of malignancy. (0 out of 6 lymph nodes)*

9. *Small bowel*
- *The small bowel segments show involvement by carcinosarcoma in multiple nodules, compatible with metastases.*
- *Extensive lymphovascular permeation is seen.*
- *Resection margins are clear.*"

11. Upon the referral of Dr CHAN, the Defendant first saw the Patient on 28 April 2012 at her bedside at HKBH. According to his statement to the Preliminary Investigation Committee ("PIC") of the Council dated 29 October 2019, the Defendant "*knew from Dr... Chan about the Patient's condition through a phone call on 27th April 2012... and Dr... Chan... informed [him] of the presence of ovarian carcinosarcoma and that she was surgically staged; and she has stage IIIC disease and it carried a poor prognosis; and that she would need postoperative adjuvant therapy. [Dr Chan] also told [him] that he had already informed the Patient and her family the details of the operative findings and histopathology report and that she needed adjuvant therapy... Based on the documents reviewed by [him], including the operative report and pathology reports, [he] noted that she was already adequately staged surgically for her intra-abdominal disease, along with a CXR that showed absence of distant visceral involvement and [he] had at no stage mentioned the necessity of a PET/CT...*"

12. There is no dispute that in accordance with the Defendant's advice, first cycle of chemotherapy using Taxol and Carbolplatin once every 3 weeks was given to the Patient on 7 May 2012. This was followed by a second cycle of chemotherapy using the same drugs on 29 May 2012.

13. Due to "*worsening chronic back pain with low limb weakness*", urgent MRI was arranged for the Patient on 12 June 2012 which showed extensive para-spinal metastases from T12 to L2. Some of these tumour tissues extended through the

intervertebral foramina into the intraspinal extrathecal space compressing on the spinal cord and nerve roots from T12/L1 to L1/L2. PET-CT on 13 June 2012 further showed tumour extension to left renal hilum, causing left hydronephrosis. There were also metastatic lymphadenopathy, deposits in the pelvic cavity, right buttock and left vulva and multiple bony sites.

14. Palliative radiotherapy to the spinal metastases was started on 13 June 2012. However, after 4 fractions of radiotherapy treatment, there was no apparent response noted. On 20 June 2012, spinal decompression was done by a neurosurgeon. Thereafter, the Patient was further treated with 14 fractions of conformal radiotherapy.

15. There is conflicting evidence as to whether the Defendant had advised the Patient to undergo further (or second line) chemotherapy when the first two cycles of chemotherapy failed to yield the desired therapeutic results.

16. There is however no dispute that the Patient was referred by the Defendant to consult the Consultant of the Clinical Oncology Department of Queen Elizabeth Hospital ("QEH"). There is conflicting evidence as to the purpose of the referral. Be that as it may, the material parts of the Defendant's referral letter dated 11 July 2012 read as follows:-

> "*Grateful if you can kindly review Ms. [redacted], a 40 yo female with a L ovarian carcinosarcoma diagnosed on 20/4/12. She had TAHBSO/ Omentectomy/ Small bowel resection and multiple lymph nodes were noted along with palpable paraaortic lymph nodes. Postop course was complicated by severe wound infection and dehiscence that required second operation for stitching and prolonged antibiotics.*
>
> *Ultimately started on adjuvant chemotherapy with Q3W Taxol and Carboplatin in late 5/2012 and after 2nd cycle, Ms. [redacted] developed bilateral leg weakness and lower back pain. MRI showed cord compression at T12, L1, L2 levels. She was seen by Dr. Fung... before and after the 4 fractions of radiotherapy and ultimately had laminectomy on 20/6/12. Again no improvement was noted, PETCT showed multiple paraaortic lymph nodes, pelvic lymph nodes, L vulva metastasis, pelvic bony metastases. Palliative radiotherapy to residual paraaortic lymph nodes and all visible metastases on PETCT was delivered: 45 Gy in 15 fractions. She is due to finish her radiotherapy on 16/7/12 and I intend to try her on Ifx (infosfamide) and*

CDDP (cisplatin) but I'll be grateful for your opinion. Given her paralysis, she'd also require long-term inpatient care and it is not viable to remain in private during the entire course. I'll be grateful if you can kindly advise me on further management."

17. Meanwhile, the Patient's condition continued to deteriorate. The Patient received left percutaneous nephrostomy on 14 July 2012 for the obstructive uropathy. CT scan on 17 July 2012 showed a new metastatic lesion over her liver of about 2 cm in size and also a large para-aortic mass of about 4 cm in size in the left lower hemithorax.

18. On 18 July 2012, the Patient visited QEH and was seen by one Dr WONG, Resident Specialist of the Department of Clinical Oncology. In his reply letter to the Defendant, Dr WONG specifically mentioned that:-

"*Ms.* [redacted] *was seen on 18 Jul 2012.*

...

In view of poor [general condition], further chemo[therapy] is unlikely to be helpful and we would like to suggest palliative care."

19. In order to relieve the Patient's abdominal ascites, abdominal paracentesis was performed on 19 July 2012. However, her condition deteriorated rapidly and eventually the Patient passed away on 21 July 2012.

20. The Patient's brother (the "Complainant") subsequently lodged this complaint with the Secretary of the Council.

Burden and Standard of Proof

21. 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.

22. 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. We must therefore take into account all the evidence and to consider and determine each of the disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

23. It is not disputed that the Defendant did not arrange for any imaging investigation before starting chemotherapy on the Patient.

24. Dr YING, the Secretary's expert witness, and Dr FOO, the defence expert witness, agreed and we accept that there was at all material times and still is no guideline or consensus statement on the need for imaging investigations after surgical removal of tumour and before chemotherapy.

25. Our attention was drawn by the Legal Officer to the recommendation in the National Comprehensive Cancer Network Guidelines Version 2.2011 on Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer ("2011 NCCN Guidelines") that one of the workups in the light of clinical presentation of carcinosarcoma (which should be treated as per epithelial ovarian cancer) from "*Diagnosis by previous surgery or tissue biopsy*" was "*Ultrasound and/or abdominal/pelvic CT*". From this, the Legal Officer sought to convince us that the Defendant's failure to arrange any imaging investigation before starting chemotherapy on the Patient was in breach of the 2011 NCCN Guidelines.

26. Whilst "*Ultrasound and/or abdominal/pelvic CT*" were listed under the heading of "*Work Up*" along with other recommended workups at page OV-1 of the 2011 NCCN Guidelines, it is a quantum leap in our view for the Legal Officer to submit that the Defendant had by his failure to arrange any imaging investigation before starting chemotherapy on the Patient fallen below the standard expected of registered medical practitioners in Hong Kong. We agree with Dr FOO that the recommended workups were not meant to be mandatory.

27. It is important to read the 2011 NCCN Guidelines as a whole. According to page OV-2 of the 2011 NCCN Guidelines, recommendation for "*Primary Treatment*" of Stage III ovarian carcinosarcoma with "*[s]uspect unresectable*

residual disease" was said to be "*[c]hemotherapy for a total of 6-8 cycles*"; and "*[c]onsider completion surgery after 3-6 cycles followed by postoperative chemotherapy*". Although "*patient evaluation by a gynecologic oncologist*" was said to be a "*[s]tandard recommendation*", there was no recommendation on page OV-2 of the 2011 NCCN Guidelines for imaging before starting chemotherapy.

28. We also agree with Dr FOO that when the Defendant first saw the Patient on 28 April 2012, he was presented with a diagnosis of Stage III ovarian carcinosarcoma with "*[i]ncomplete previous surgery and/or staging*". In this connection, we noted from reading page MS-15 of the 2011 NCCN Guidelines that:-

> "*Carcinosarcoma (Malignant Mixed Mullerian Tumors)*
>
> *MMMT are rare tumors with a poor prognosis. Many pathologists now consider MMMT to be a variant of poor risk, poorly differentiated epithelial ovarian cancer. The staging system for ovarian and primary peritoneal cancer is also used for MMMT... After complete surgical staging, patients with stage II-IV carcinosarcoma (MMMT) at the time of surgery should have postoperative chemotherapy... The type of chemotherapy is variable, because there are no data to specifically define the optimal chemotherapeutic regimen; ifosfamide-based regimens have been used. Patients with stage II-IV MMMT or recurrence are treated using recommendations for epithelial ovarian cancer (see OV-3)...*"

29. There was again no recommendation on page OV-3 of the 2011 NCCN Guidelines for imaging before starting chemotherapy.

30. We do not accept the Secretary's primary case that the Defendant had failed to follow relevant guidelines. As a fallback argument, the Legal Officer submitted that "*by failing to give proper and/or sufficient regard to the Patient's then characteristics, [the Defendant] had wrongly decided not to undergo any imaging investigation before commencing chemotherapy and such decision clearly fell outside the reasonable scope of disagreement and different approaches as suggested*" by Counsel for the Defendant to Dr YING in the course of cross-examination.

31. In this connection, Dr YING opined that "*it would be prudent for [the Defendant] to consider arranging imaging investigation before starting chemotherapy*" because "*[w]ithout the proper imaging, an appropriate plan of disease cannot be made and assessment of response cannot be accurate*".

32. Dr FOO opined on the other hand that detailed surgical findings in the 2nd Surgery would make redundant the need for a baseline imaging before starting chemotherapy because "*[p]rogress imaging findings can always be compared to surgical findings*".

33. Dr YING further opined that "*proper staging of malignancy is important before starting treatment*" because of the "*need to decide whether the aim of treatment is for cure or for palliation*".

34. Dr FOO opined on the other hand that "*[c]arcinosarcoma of the ovary... is an aggressive cancer with very poor prognosis*"; and "*[t]he combination of carboplatin and paclitaxel is the recognized chemotherapy regimen for carcinosarcoma of ovary*". It is idle in our view to distinguish between "*whether the aim of [chemotherapy] treatment [in this case] is for cure or for palliation*".

35. Counsel for the Defendant referred us to the English High Court decision of *Jones v Conwy and Denbighshire NHS Trust* [2008] EWHC 3172. In that case, the claimant accused the defendant hospital staff of failure to conduct a CT scan on the claimant's child on the day of her admission for sinus infection, which developed into orbital cellulitis with a subperiosteal abscess that spread and causing an intra-cranial collection of pus necessitating a craniotomy which unfortunately caused her to develop epilepsy. The claimant's experts were of the view that a CT scan on admission to hospital was necessary either on the basis that in a case of suspected orbital cellulitis, which would be a medical emergency, such a scan was mandatory, or, if not always mandatory, was required in respect of the child, having regard to the symptoms with which was presented. A CT scan on admission would give valuable information as to the site of the disease and its stage and would provide a baseline from which to determine treatment and, if necessary, to plan surgery; and from which to observe the progress of the disease. Defence experts took a different view. They opined that in most cases of orbital cellulitis a CT scan would not be needed because most such cases resolve themselves by the use of intravenous antibiotics. The immediate treatment was going to be the same whatever the findings of the

CT scan. A reasonable course to treat the child, whose ophthalmologic parameters were normal upon admission to hospital, was to treat her with such antibiotics and see whether or not that would occur. Clarke J applied the *Bolam* test as refined by the House of Lords in *Bolitho v City and Hackney Health Authority* [1998] AC 232 and concluded that the body of opinion which would not require an immediate CT scan was neither irresponsible nor unreasonable given the child's presenting symptoms and that the result of the CT scan was unlikely to alter the immediate treatment plan.

36. In our view, it all boils down whether the body of opinion which would not require imaging before starting chemotherapy after surgical staging has been done is irresponsible or unreasonable.

37. We agree with the Defendant that "*[t]here was no clinical sign which suggested any risk of any distant, extra-abdominal metastasis*"; and we also agree with Dr FOO that the treatment plan was going to be the same regardless of whether imaging investigation had been arranged before starting chemotherapy on the Patient. In our view, Dr FOO's expert opinion that chemotherapy for carcinosarcoma could be started without arranging for prior imaging investigation is neither irresponsible nor unreasonable.

38. Applying the *Bolam* test (as refined) to the present case, we cannot find the Defendant's failure to arrange for imaging investigation before starting chemotherapy on the Patient to have fallen below the standard expected of registered medical practitioners, merely because there was a body of opinion which would take a contrary view. Having said that, it might well be more prudent in our view to arrange for imaging investigation before starting chemotherapy given the rarity of carcinosarcoma.

39. For these reasons, we are not satisfied on the evidence before us that the Secretary's case in respect of disciplinary charge (a) has been made out. Accordingly, we find the Defendant not guilty of that charge.

40. The Defendant admitted that he put down in his medical record for the consultation with the Patient on 17 July 2012, amongst others, the following:-

> "*Details of disease, prognosis and complications fully discussed [with patient] + her family*

Grave prognosis ➔ *untreated 2-4/12,*
treated ~18/12".

41. In his statement to the PIC dated 29 October 2019, the Defendant explained that:-

> "*70. However, due to long lapse of time, I cannot recall the details about the communication between the Patient and/or the Complainant and me. Whilst it is my recollection that I had discussed with the Patient and her family the "best and worst" case scenarios and against this context, I made the entry "Untreated 2-3/12, Treated 18/12", and it was probably made with reference to the data from studies involving epithelial ovarian cancers due to the limited data regarding ovarian carcinosarcoma at the material time. It may well be that I mentioned those data as a backdrop for further discussion as these were data generally true for advanced carcinosarcoma in the first-line setting. And any discussion regarding her then condition and decision regarding further treatment intent should take these into account. It might also be that I was telling the family that should she in a rare event improve and chemotherapy became an option, those figures would be applicable in that setting. Such data were only quoted as an indicator of her overall disease history and prognosis and it helped to set the scene i.e. context of her disease, for discussion into conservative care alone. I greatly regret that the family felt that they were misled in this regard and I would sincerely apologize for such mishaps in communications that caused so much distress to them...*"

42. We agree with Counsel for the Defendant that the meaning of the phrase "*untreated 2-4/12 treated ~18/12*" must be construed in its proper context. What the phrase "*untreated 2-4/12 treated ~18/12*" connoted in the medical records of the Patient on 17 July 2012 is a matter for the Defendant to explain.

43. In his supplemental statement dated 21 June 2023, the Defendant further explained that:-

> "*15. As explained in the 1st statement, due to the long lapse of time, I cannot recall the details about the communication between the Patient and/or the Complainant and me. However, I would like to stress that, I was fully aware that the Patient's condition at the*

material time was poor, in a deteriorating trend despite completion of two cycles of chemotherapy. Therefore, upon completion of radiotherapy on 16 July 2012 as planned, I reviewed the management plan for the Patient and considered that the appropriate management was to provide conservative treatments, without having any plan for further (or second line) chemotherapy. I therefore arranged an interview with the Patient and the Complainant, which took place on 17 July 2012, to advise on my plan for the Patient, i.e. to provide conservative treatments. Even before the interview on 17 July 2012, there had been earlier discussions with them regarding the Patient's poor condition and unsuitability for the Patient further (or second line) chemotherapy...

16. *... I would like to stress that based on my recollection, the phrase of "untreated 2-4/12 treated ~18/12" was only reference to some study data, including data of the original disease of the Patient before any complications set in. I can only think that the reason why I made such reference was to facilitate my discussion with the Patient about further management for her, including that she was not suitable for further chemotherapy, when the Patient and the Complainant still hoped to explore possibility of further treatment. The data set out a backdrop that the average survival of stage III carcinosarcoma with paraaortic lymph nodes involvement and without metastases would be around 18 months if treated in the first line setting; whereas the average survival of the disease with paraaortic lymph nodes which had rapidly developed metastases, if not treated, would be around 2 to 4 months, consistent with international clinical study that I had came across throughout my practice... Therefore, the prognosis of the Patient would even be poorer, even if she was fit for further chemotherapy, which she in fact was not, especially when she had developed metastases with rapid progression despite completion of two cycles of chemotherapy.*

17. *As reflected in the above entry, no further (or second line) chemotherapy was planned for the Patient on 17 July 2012. In view of the Patient's "Grave prognosis", which was an even poorer condition than "untreated 2-4/12 treated ~18/12" at the time of the interview on 17 July 2012."*

44. The Complainant was however adamant that the Defendant had made it clear to the Patient and her family that without further (or second line) chemotherapy, the Patient might only survive for 2 to 4 months; whereas with further (or second line) chemotherapy, the Patient might survive for 18 months.

45. When being cross-examined, the Complainant produced 3 sets of handwritten notes, which he claimed to be contemporaneous or made soon thereafter.

46. It is pertinent to note however that there was no mention in the first set of handwritten notes that the Defendant had ever told the Patient and the Complainant on 17 July 2012 that without further (or second line) chemotherapy, the Patient might only survive for 2 to 4 months; whereas with further (or second line) chemotherapy, the Patient might survive for 18 months. We find it implausible that the Complainant would omit this had the Defendant told him and the Patient of the same. This is particularly true because the whole point in making these notes was to keep a contemporaneous record of what had happened to the Patient in case he wished to complain against her treating doctors.

47. We cannot dismiss on the evidence before us the Defendant's explanation that "*the phrase of "untreated 2-4/12 treated 18/12" was only reference to some study data, including data of the original disease of the Patient before any complications set in*".

48. In the course of cross-examination, the Defendant was also asked to look at section 1.1.3 of the Code of Professional Conduct (2009 edition) ("the Code") which stipulated *inter alia* that "*All doctors have the responsibility to maintain ... clear, and contemporaneous medical records*" of their patients. From this, the Legal Officer now submits to us that "*even if the phrase in question did not refer to the Patient's specific conditions on 17 July 2012, it is unclear as a medical record*".

49. It is pertinent to note in this regard that the term "*medical records*" in section 1.1.3 of the Code should be read in conjunction with section 1.1.1 of the Code which stipulated that "*[t]he medical record is the formal documentation maintained by a doctor on his patients' history, physical findings, investigations, treatment, and clinical progress.*" It does not mean that every single phrase that the Defendant put down in the medical records had to be "*clear*" in its meaning "*even if the phrase in question did not refer to the Patient's specific conditions*

on 17 July 2012."

50. Bearing in mind that the burden of proof is always on the Secretary, we are not satisfied on the evidence the Secretary's case against the Defendant in respect of disciplinary charge (b) has been made out. Accordingly, we find the Defendant not guilty of that charge.

51. According to the Complainant, the Defendant had advised further (or second line) chemotherapy for the Patient; and he also learned from the Patient's short message of 10 July 2012 the names of the chemotherapy drugs were "*ifosfamide*" and "*cisplatin*". When being cross-examined, the Defendant denied having told the Patient the names of these chemotherapy drugs. There is however no dispute that the names of these chemotherapy drugs were specifically mentioned in the referral letter for the Patient to consult the Consultant of the Department of Clinical Oncology of QEH.

52. In the Consultation Summary written by the Resident Specialist of the Department of Clinical Oncology of QEH who saw the Patient on 18 July 2012, it was also mentioned that:-

> "*2nd line palliative chemo[therapy] Ifx (ifosfamide) and CDDP (cisplatin) was suggested by Dr Chan*".

53. In his Supplemental Statement dated 21 June 2023, the Defendant explained that:-

> "*Upon reviewing of the referral letter issued by me to QEH... as disclosed under the Complainant's Statement, it is noted that I referred the Patient to the Department of Clinical Oncology of QEH on 11 July 2012... I recalled that on the same day, I made an urgent phone call to Dr Wong... consultant of the Department of Clinical Oncology of QEH, detailing the Patient's intention to attempt second line chemotherapy despite her poor condition. I requested for arrangement of an urgent consultation for the Patient, so QEH doctor could revert with their opinion as soon as possible. I did not expressly state my view that the Patient was not suitable for further chemotherapy as I did not wish to interfere with the independent opinion of the QEH doctor. In view of the strong wish of the Patient and the Complainant for second line chemotherapy, which the Patient was not fit for, I also stated the names of the drugs that would usually be used in*

chemotherapy for carcinosarcoma according to my professional knowledge: I intend[ed] to try her on IFx and CDDP but I'll be grateful for [their opinion]". In such case, in the unlikely event that QEH doctor considers the Patient was suitable for further chemotherapy, she could also be advised on whether the two drugs, which were available at QEH, were deemed appropriate for her disease and whether she could receive further management at QEH, if and only if QEH doctor sees fit. In any event, regardless of whether the Patient would decide to pursue further chemotherapy treatment. In view of the Patient's paralysis which necessitated long-term in-patient care, I also sought for advice on the appropriateness of the Patient's further management at QEH, so the Patient could consider this option."

54. When being cross-examined, the Defendant initially told us that "*I've been trying my best to help the patient and if I couldn't do it, I refer her on*". But when being further cross-examined why he did not make this clear in his referral letter, the Defendant told us that "[*t]he letter was written in the situation when I was asked by the family to provide improvement, to provide the likely agents I use in that scenario. So I just put down two drugs by deliberately [choosing...] not the wrong ones but the very strong ones so that they will say no. Again that is consistent with my diplomatic approach. I was silently inviting the Queen Elizabeth people to say no.*"

55. It is however evident to us from reading the referral letter for the Patient to consult the Consultant of the Department of Clinical Oncology of QEH that the Defendant used the words "*I intend to try her on Ifx (infosfamide) and CDDP (cisplatin)*". If the Defendant genuinely wished to tell the Patient through the mouth of the clinical oncology specialist that further (or second) line chemotherapy was not suitable for her case, there was no reason in our view why he needed to mention any names of chemotherapy drugs. We do not accept the Defendant's explanations.

56. We agree with Dr YING that for a patient who "*had spinal cord compression and irreversibly paralyzed, second line chemotherapy would be dangerous as paralyzed patient tolerate[s] chemotherapy poorly with higher rate of complications like sepsis*".

57. Dr YING and Dr FOO also agreed and we accept that given her grave situation and multiple metastases, the Patient was not suitable for further (or second line)

chemotherapy after she had failed to respond to two cycles of chemotherapy treatment and radiotherapy treatment as planned. In our view, the Defendant's advice for the Patient to undergo further (or second line) chemotherapy was without proper justification.

58. We wish to supplement that even if the Defendant genuinely wished to tell the Patient through the mouth of the clinical oncology specialist that further (or second) line chemotherapy was not suitable for her case, his advice to the Patient in this case was nevertheless inappropriate. The Defendant ought in our view to be open and honest with the Patient and told her directly that further (second line) chemotherapy was not suitable for her case and would be dangerous for her. This could save the Patient from the ordeal of having to travel from HKBH to QEH on 18 July 2012 when her condition was so frail that she succumbed three days later.

59. For these reasons, we are satisfied on the evidence that the Secretary's case against the Defendant in respect of disciplinary charge (c) has been made out. By advising inappropriately or without proper justification the Patient to undergo further (or second line) chemotherapy, the Defendant had by his conduct fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect.

Sentencing

60. The Defendant has one previous disciplinary record for unnecessary / inappropriate treatment for a patient back in or about April to August 2009. On 8 March 2023, his name was ordered to be removed from the General Register for a period of 6 months and the operation of the removal order was suspended for a period of 18 months.

61. 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.

62. We accept that both the present case and the incident relating to the previous disciplinary case of the Defendant happened long time ago.

63. We acknowledge that the Defendant has tremendous support from his professional colleagues and patients.

64. We are however particularly concerned that the Defendant had changed his stories as he went along when they suited his case, which we do not accept.

65. We are told in mitigation that in addition to taking CME courses, which exceeded the minimum of 90 CME points per 3-year cycle, the Defendant had taken a certificate course co-organized by the Federation of Medical Societies of Hong Kong and the Hong Kong Society for Healthcare Mediation through which he learned the importance of open and honest communications with professional colleagues and patients, particularly in difficult cases.

66. Whilst we believe the Defendant had learned his lesson and we hope the Defendant would put in practice what he had learned to rectify the shortcomings which underlay his misconduct in this case, we need to make sure that the Defendant will not commit the same or similar misconduct in the future.

67. Taking into consideration the nature and gravity of the disciplinary charge for which we find the Defendant guilty and what we have read and heard in mitigation, we order in respect of disciplinary charge (c) that the name of the Defendant be removed from the General Register for a period of 9 months. We further order that the operation of the removal order be suspended for a period of 36 months.

Remark

68. The name of Defendant is included in the Specialist Register under the Specialty of Clinical Oncology. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

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