香 港 醫 務 委 員 會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHAN Malcolm (Reg. No.: M01377)

Date of hearing: 24 March 2023 (Friday)

Present at the hearing

Council Members/Assessors: Dr CHOI Kin, Gabriel (Chairperson of the Inquiry Panel)
Dr LUNG David Christopher, MH
Dr LEUNG Hon-fai, Henry
Ms LI Siu-hung
Mr MO Pak-kuen

Legal Adviser: Mr Stanley NG

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by Messrs. Mayer Brown

Legal Officer representing the Secretary: Ms Tessa CHAN, Counsel as instructed by the Department of Justice

1. The charges against the Defendant, Dr CHAN Malcolm, are:

"That, he, being a registered medical practitioner, disregarded his professional responsibility to his patient … ("the Patient"), in that he:

(a) failed to excise the lipoma located near the Patient's right arm ("the Lipoma") in the operation performed on 18 January 2018 ("the Operation"); and

(b) failed to inform the Patient that the Lipoma was not found in the Operation during the Patient's hospitalization from 18 to 19 January 2018 and/or in the follow-up consultation on 26 January 2018.

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 20 June 1969 to the present. His name has been included in the Specialist Register under the Specialty of General Surgery since 6 May 1998.

3. The Patient attended the Defendant's clinic for the first time on 6 January 2018. She was referred to the Defendant by a General Practitioner, Dr KONG Ping Fai ("Dr Kong"). According to Dr Kong's referral letter dated 3 January 2018, the Patient developed a mass in her right upper arm which was likely to be a lipoma.

4. On 6 January 2018, the Defendant found a lipoma of approximately 6 x 7 cm in size in the Patient's right upper arm below deltoid ("the Lipoma").

5. On the same day, with the Patient's consent, the Defendant arranged for the Patient to undergo surgical excision of the Lipoma on 18 January 2018 ("the Operation").

6. The Operation was performed by the Defendant on the Patient at St. Teresa's Hospital ("Hospital") on 18 January 2018 under general anaesthesia. The Patient was in supine position and a pad was placed under her right shoulder for easier access. After skin preparation and towelling, the Defendant located a lumpy area in the deltoid by palpation. The Defendant then made a vertical incision of about 5 cm long in the Patient's right upper arm and explored the subcutaneous plane and the intra-muscular plane. The Defendant did not find the Lipoma. Instead, the Defendant removed some fatty subcutaneous tissues approximately 7-8 cm wide and submitted the same for further histopathological investigation.

7. The Defendant saw the Patient in the ward in the morning of 19 January 2018. The Patient was discharged from the Hospital on the same day.

8. According to the histopathology report dated 19 January 2018, macroscopic examination of the specimen submitted by the Defendant revealed that it was a piece of yellowish fatty tissue of approximately 4 x 2 x 0.5 cm in size, with cut surface showing mildly congested yellowish tissue without any abnormal whitish area identified. Microscopic examination showed mature adipose tissue traversed by some fibrous tissue. No lipoblast, atypical stromal cell or malignancy was found.

9. The Patient returned to the Defendant's clinic for a post-operative follow-up consultation on 26 January 2018, on which occasion her wound stitches were removed.

10. The Patient attended the Defendant's clinic again on 3 February 2018. She told the Defendant that the Lipoma was still there and requested for a further examination, upon which the Defendant agreed with the Patient that the Lipoma was still there and apologized to her for not having removed the Lipoma during the Operation. The Defendant offered to re-operate on the Patient free of charge if necessary.

11. By a statutory declaration made on 11 January 2019, the Patient lodged a complaint against the Defendant to the Medical Council.

Burden and Standard of Proof

12. 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.

13. There is no doubt that the allegation against the Defendant here is a serious one. 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 charge against him carefully.

Findings of the Inquiry Panel

14. In his medical report dated 22 November 2018, the Defendant said that on 6 January 2018 when he examined the Patient, he found a flattish nodular lipomatous patch of approximately 6 x 7 cm in size in the deltoid area. The mass was only bulging slightly and its boundaries were ill-defined. The Defendant said he noted the mass appeared to be different from typical lipomas, which should stand out as a lump with lobulations. The Defendant further said that on the day of the Operation, the reason he put the Patient under general anaesthesia was because he believed infiltration of anaesthetics under local anaesthesia might further obscure the boundaries of the lipomatous mass. After skin preparation and towelling, he found the lipomatous mass was even less recognizable. We have no doubt that the Defendant all along prior to the Operation knew that the boundaries of the Lipoma were ill-defined.

15. According to the Defendant's expert report dated 6 December 2018, failure to remove a lipoma at an operation is rare. Failure to find and remove a lipoma only happens when the features of a lipoma are not obvious and when they become even less so when the patient is put on the operating table. In the context of the Patient, the Defendant's expert listed a number of reasons for failure to locate the Lipoma i.e. (i) ill-defined border of the Lipoma; (ii) the Lipoma was flat contoured; (iii) the location of the Lipoma was at the deltoid region, which on account of the underlying muscles and long bone, had a very convex shape, so that a slight increase of convexity from the Lipoma might not be easily noticeable; (iv) lack of comparison, as the opposite side was covered; and (v) distortion by positioning, as the body shape, and by extension the contour of the Lipoma, changed when the Patient lied down, and there was further distortion when a pad was placed under the shoulder to bring the operation site away from the operation table.

16. According to the Secretary's expert report dated 26 April 2020, *"[t]here are many ways to accurately locate a lipoma for excision before and during an operation in order to minimize risk of missing it. Their application depends on the obviousness of the mass. i) Physical examination with palpation to locate the mass for excision is a standard practice, when the mass is obvious. ii) Mark the position of the mass on the skin with marker pen before the operation can help to prevent disorientation during the operation. iii) Double confirm the location of the mass by asking the patient to locate the mass he/she is referring to, and mark the position on the skin with a marker pen before the operation, is a common practice to minimize risk of disorientation during the operation. iv) When the mass is not obvious by palpation, imaging with Ultrasonogram before and during the operation can help to locate the mass. v) When the mass is deep, advance imaging e.g. Magnetic Resonance Imaging (MRI) can accurately locate the mass and show the anatomical details of the operative field… Excision of a lipoma in the arm is a very standard operation that all qualified surgeons should be capable of doing it. There are many ways to locate the lipoma accurately as described above. If such precautions are taken appropriately before and during the operation, the risk of missing the lipoma in an operation would be minimal. Surgeons performing the operation should be able to apply the above measures as necessary to locate the lipoma for excision.*"

17. The Secretary's expert further said in his Supplementary Expert Report dated 12 September 2022 that *"it is the surgeon's sole responsibility to assess the location of the mass to be excised, double confirm with the patient for the site of the mass if the mass is palpable by the patient, and decide on the surgical incision. All these should be done before anaesthesia when the patient is still awake …"*

18. Given that the Lipoma was ill-defined, flat-contoured, its location was at the deltoid region, and there might be distortion by positioning as the Patient was lying down and a pad was placed under her right shoulder, the Defendant should have carried out one or more of the other measures as suggested by the Secretary's expert to confirm the location of the Lipoma. However, pre-operatively, the Defendant did not personally mark the exact position of the Lipoma on the Patient's skin with a marker pen, or cross check with the Patient the exact location of the Lipoma. No ultrasound or imaging was performed to confirm the exact location of the Lipoma. The Defendant agrees that it was suboptimal that he attempted to excise the Lipoma without marking, cross-checking with the Patient and assisting with imaging beforehand, and ended up missing the Lipoma during the Operation.

19. The Defendant told us at the inquiry today that he did not even palpate before anaesthesia was given to the Patient. What the Defendant did was simply performing examination by palpation after anaesthesia, which was clearly not sufficient in this case.

20. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect under charge (a).

21. On charge (b), the Defendant's case is that he saw the Patient at the ward in the morning of 19 January 2018. The Defendant said he explained to the Patient in detail what a lipoma was (being a fatty mass bound by a definite capsule), and informed her that the Operation took longer than usual and the wound was larger because he had difficulty finding a lipoma and could only find excess fat. The Defendant said he also told her that a piece of fatty tissue had been removed and sent for histopathological investigation.

22. Whether or not the Defendant had informed the Patient as such is a question of fact and depends essentially on the credibility of the Defendant and the Patient.

23. We make reference to the following principles adopted by the Court on the assessment of credibility in ***Hui Cheung Fai v Daiwa Development Ltd*** (unrep, HCA 1734/2009, 8 April 2014), §§76-81 per DHCJ Eugene Fung SC:

    23.1 Generally speaking, contemporaneous written documents and documents which came into existence before the problems in question emerged are of the greatest importance.

    23.2 In deciding whether to accept the evidence of a witness, importance should be attached to the inherent likelihood or unlikelihood of an event having happened, or the apparent logic of such event.

23.3 In determining the credibility of a witness, importance should be attached to the consistency of such evidence with other undisputed or indisputable evidence and the internal consistency of such evidence. The latter type of consistency is often tested by a comparison between the oral testimony of the witness and his or her witness statement.

23.4 The truthfulness or reliability of witness cannot be determined solely or mainly from the appearance or demeanour of such witness.

23.5 In any case where the credibility of a witness features prominently in the court's determination, it is essential always to test his veracity by reference to the objective facts proved independently of his testimony, in particular, by reference to the documents in the case, and also to pay particular regard to his motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence, reference to the objective facts and documents, to the motives of the witness concerned and to the overall probabilities can be of very great assistance to a judge in ascertaining the truth.

24. In the Defendant's letter to the Hospital dated 6 January 2018, the Defendant asked the Hospital to arrange the following: "Excision under GA…". In the Hospital's fee note dated 18 January 2018, at entry "Operation", it was recorded "For EX", which meant for excision.

25. However, in the Hospital Operation Record dated 18 January 2018 ("Operation Record"), at the entry "Operation", it was recorded as "Exploration upper arm + Biopsies". At "Operative Findings", the Defendant wrote *"... No lipoma found"*. At "Procedure", the Defendant wrote "… No definite lipoma found". In the Hospital Histopathology Report, the Defendant also wrote at entry *"Microscopic Examination"* that *"there is no lipoblast"*, meaning no lipoma. Further, on 26 January 2018, the Defendant had written a letter to Dr Kong, the referring doctor ("the Letter"). In the Letter, the Defendant wrote *"... Only fatty accumulation and no encapsulation found ..."*.

26. No doubt, the Defendant's original plan was excision, but after the operation, the record shows that "excision" was changed to "exploration", and clearly it recorded in a number of entries that no lipoma was found. Both the Operation Record and the Letter are contemporaneous record and clearly show that the Defendant had never covered up or attempted to cover up the fact that no lipoma was found at the Operation. We cannot see there is any motive to cover up from the Patient, when the Defendant had indeed honestly written down, not only on just one occasion in the Operation Record, but also informing the referring doctor as such in the Letter, that no lipoma was found. There is no reason why the Defendant had to cover up this fact from the Patient.

27. The Patient gave evidence at the inquiry. As to what happened on 19 January 2018 when the Defendant saw her at the ward, her memory was not clear in many respects. When asked during examination-in-chief if the Defendant had told her that he could only find fatty tissues, the Patient even said that maybe the Defendant had explained to her, and perhaps she did not understand. Further, the Patient said in her witness statement dated 14 February 2023 that the Defendant had shown her the mass on 19 January 2018. This was impossible as the mass had been sent to the laboratory and it would have been already sectioned for histopathology. The Patient at the inquiry then told us that the Hospital's Histopathology Report ("Report") was shown to her by the Defendant on 19 January 2018, and from the Report she saw the mass. Again, this was impossible because the Defendant saw the Patient at the ward round on 19 January 2018 at 10:47 a.m. but the Report was only printed at 11:57 a.m. The Patient then changed her evidence and said that the Report was shown to her on 26 January 2018. In our view, the Patient's memory is unclear and unreliable.

28. On the overall probabilities, we believe that the Defendant had informed the Patient that he had difficulty finding a lipoma and could only find excess fat. We therefore acquit the Defendant of charge (b).

Sentencing

29. The Defendant has a clear disciplinary record.

30. In line with our published policy, we shall give credit to the Defendant for his full cooperation throughout these disciplinary proceedings on charge (a).

31. 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.

32. We accept that the Operation was performed by the Defendant in good faith, and he was remorseful.

33. The Defendant told us that he has already stopped performing all surgeries, and his practice now focuses on specialist consultations. In our view, the risk of re-offending is low.

34. We also give credit to the Defendant for his long service to the community.

35. Having considered the serious nature and gravity of disciplinary charge (a) for which the Defendant was found guilty and what we have heard and read in mitigation, we order that the Defendant be reprimanded.

Remark

36. The name of the Defendant is included in the Specialist Register under the Specialty of General Surgery. We shall leave it to the Education and Accreditation Committee to decide on whether anything may need to be done to his specialist registration.

Dr CHOI Kin, Gabriel
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong