香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr LI Kin Wah (李建華醫生) (Reg. No.: M04394)

Date of hearing: 22 September 2020 (Tuesday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS
(Chairperson of the Inquiry Panel)
Dr CHOW Yu-fat
Dr FUNG Tak-kwan, James
Mr HUNG Hin-ching, Joseph
Mr LAI Kwan-ho, Raymond

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Ms Alison SCOTT of Messrs. Howse Williams

Government Counsel representing the Secretary: Miss Cassandra FUNG

1. The charge against the Defendant, Dr LI Kin Wah, is:

> "That on or about 28 July 2016, he, being a registered medical practitioner, disregarded his professional responsibility to his patient, in that he failed to report the presence of a foreign object on the X-ray examination taken on the Patient.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect. "

Facts of the case

2. The name of the Defendant Dr LI Kin Wah has been included in the General Register from 11 August 1981 to present. His name has been included in the Specialist Register under the specialty of Radiology since 4 March 1998 to the present.

3. On 17 July 2015, the Patient had a robotic prostatectomy for cancer. The following day he developed severe abdominal pain due to peritonitis from an iatrogenic perforation of his sigmoid colon. He was explored by a Dr CHUNG who repaired the perforation and concluded with a Hartmann's operation.

4. On 23 October 2015, a reversal of the Hartmann's operation was undertaken by a Dr X in the Hong Kong Sanatorium & Hospital Limited ("the Hospital"). The following day, the Patient developed generalized peritonitis and was re-explored by Dr X. A transverse colostomy was done. The Patient was discharged from the Hospital on 3 November 2015.

5. The pain did not subside. On 18 November 2015, the Patient consulted a Dr Langenberg, who detected a wide area of induration in the epigastrium medial to the colostomy. This was tender to palpation and seemed to indicate an inflammatory process, possibly an abscess. According to the complainant, Dr Langenberg suggested that on follow up with Dr X a CT scan might be helpful in clarifying any pathology.

6. The Patient later suggested to Dr X to arrange for a CT scan, which was not done. The Patient was treated conservatively.

7. The abdominal pain did not go away. The Patient was seen at Caritas Medical Centre A&E twice, on 8 and 16 July 2016, complaining of severe abdominal pain and vomiting. On 22 July 2016, the Patient was sent for a CT scan. CT scan showed dilation of the jejunum with suspicion of mechanical obstruction. An incidental finding was that of a radio-opague, ribbon like structure in the epigastrium the nature of which was difficult to define.

8. According to the complainant, this finding was later brought to the attention of Dr X. Dr X proceeded to order a gastrografin enema which was done by the Defendant on 28 July 2016 at the Hospital. The x-ray examination showed the presence of a foreign object, but the Defendant did not mention it in his radiology report.

9. On 1 August 2016, the Patient consulted Dr Langenberg, who arranged an urgent referral to a Prof. LAW in Queen Mary Hospital. The Patient consulted Prof. LAW on 3 August 2016. Rapid deterioration in the next two days prompted an emergency operation on 6 August 2016. A large fist-sized mass comprising a surgical gauze was found in the Patient's abdomen. This gauze had already eroded through several sections of the small bowel requiring multiple bowel resections.

10. 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

11. 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.

12. 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

13. The Defendant admitted the factual particulars of the charge against him. However, it remains for us to determine whether the Defendant was guilty of misconduct in a professional respect.

14. In our view, the central issue in this case is whether the Defendant's failure to report the presence of a foreign object on the x-ray examination taken on the Patient on 28 July 2016 was below the standard expected amongst registered medical practitioners in Hong Kong.

15. We gratefully adopt the following observations in *Jackson & Powell on Professional Negligence* (8th ed.) at [1000]:

*"**Bolam test applies.** In relation to the roles of diagnosis... the standard of care and skill required of a medical practitioner continues to be governed by the Bolam test. They are roles falling within the expertise of members of the medical profession...*

***Standard of skill and care determined by reference to the specialization of the defendant.** A practitioner who specialises in any particular area of medicine must be judged by the standard of skill and care of that specialty."*

16. We have looked at the 20 x-ray images taken by the Defendant on the Patient on 28 July 2016. 12 of the said 20 x-ray images clearly showed a radio-opaque, ribbon like structure in the epigastrium. It was a foreign object and was large in size. Another x-ray examination taken by a Dr WONG, another radiologist, a few days later also showed the radio-opaque foreign object, and that Dr WONG had reported in his radiology report. In our view, no specialist in radiology exercising reasonable skill and care would have missed this foreign object and not reported the presence of it.

17. Accordingly, the Defendant's failure to report the presence of the foreign object on the x-ray examination taken on the Patient had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of professional misconduct as per the charge above.

Sentencing

18. The Defendant has a clear disciplinary record.

19. In line with published policy, we shall give credit to the Defendant for his frank admission in this inquiry and full cooperation during the preliminary investigation stage.

20. 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.

21. The Defendant is remorseful and accepts full responsibility for his mistake. Since the incident, he has taken remedial steps such as changing his reporting practice and ensuring that his reports will be as full as possible even including incidental findings. The Defendant has complied with all CME requirements, including all college CMEs. We consider that the Defendant has taken steps to improve himself.

22. In this case, in view that the foreign object could be obviously seen from 12 x-ray images, and the Defendant had a duty to report it, which he had failed to do so, we consider that his failure was serious. Having regard to the nature and gravity of the case and what we have heard and read in mitigation, we consider that an order of removal from the General Register for a period of 2 months is appropriate. We also order that the operation of the removal order be suspended for 18 months.

Remarks

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

Prof. LAU Wan-yee, Joseph, SBS
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong