香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr WONG Kar Mau (黃嘉謀醫生) (Reg. No.: M02124)

Date of hearing: 9 August 2022 (Tuesday)

Present at the hearing

Council Members/Assessors: Dr HO Pak-leung, JP
(Chairperson of the Inquiry Panel)
Dr LAU Chor-chiu, GMSM, MH, JP
Dr CHENG Chi-kin, Ashley
Ms LI Siu-hung
Ms LAU Sze-wan, Serena, JP

Legal Adviser: Mr Edward SHUM

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

Senior Government Counsel representing the Secretary: Miss Vienne LUK

The Defendant is not present.

1. The amended charges against the Defendant, Dr WONG Kar Mau, are:

"That, in about April 2010, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] *("the Patient"), deceased, in that he:*

(a) *failed to obtain an informed consent from the Patient before performing the breasts augmentation surgery ("the Surgery"), by properly and adequately advising the Patient about the nature,*

procedure, all possible risks and complications of the Surgery;

(b) failed to keep and maintain proper record for the Patient;

(c) performed the Surgery on the Patient when he did not have the appropriate training, equipment, expertise, personnel and/or experience in performing the Surgery;

(d) failed to maintain an optimal standard of monitoring the Patient's conditions whilst putting the Patient under sedation for the Surgery;

(e) administered anaesthetics on the Patient during the Surgery which ran the risks of causing cardiorespiratory distress to the Patient;

(f) failed to properly and adequately follow up the Patient's conditions after the Surgery.

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 16 July 1973 to the present. His name has been included in the Specialist Register under the Specialty of Obstetrics and Gynaecology since 5 November 2003.

3. Briefly stated, the Patient first consulted the Defendant at his clinic on 17 April 2010 for breasts augmentation. According to the Defendant, after examining the Patient's breasts, he explained to her that "*there were two treatment options, namely 1) breast augmentation by inserting a prosthesis into each breast, and 2) injection of Restylene*". Although "*the latter option would be more comfortable and result in a more attractive appearance*", the Patient "*preferred insertion of a prosthesis/implant, as she did not want future injections*". The Defendant then explained to the Patient that "*the appearance could appear awkward, in that the breast prosthesis could result in a bulging effect… The prosthesis would be inserted through a periaerolar incision made along the inferior edge of the areolar [and the] procedure would be performed under local anaesthesia*". He also explained "*the risks of complications of the*

surgery including bleeding and infection". Furthermore, he "*obtained informed consent for performing sedation*". Although he did not mention the names of the anaesthetics, namely, Xylocaine and Pethidine, he had "*explained [to the Patient] that generally the procedure is safe but there is a possibility of drug reaction.*"

4. Eventually, arrangements were made for the Patient to return to the Defendant's clinic on 30 April 2010 for breasts augmentation surgery (the "Surgery").

5. The Patient arrived at the Defendant's clinic at around 3:00 p.m. in the afternoon of 30 April 2010. The Patient was invited to go to the consultation room where she was asked to sign on a consent form in Chinese before the Surgery began. The material part of the consent form reads as follows:-

"本人 [redacted] … 同意… 接受隆胸手術及施行 … 局部麻醉 … 亦明白有關該項手術及麻醉之性質、效果、及可能引致之危險及併發症，有關手術已由本人之主診醫生向本人解釋明白，在施行該手術期間，如認為應作更進一步的手術，或須施行另一項手術，本人亦同意進行。本人同意[授]權當值姑娘/職員拍照手術前及後作病人病歷記錄，相片只限本公司病歷記錄用途。"

6. According to the Defendant, he then prepared a diluted local anaesthetic solution by mixing 40 ml of a 2% Xylocaine (the trade name of Lignocaine) with 1:200,000 adrenaline solution into 80 ml of normal saline (i.e. 0.67% Lignocaine with 1 in 600,000 Adrenaline). This was however different from what the Defendant wrote down in the Patient's medical record. After establishing IV access in the cubital fossa of the Patient's right arm at around 3:20 p.m., 50 mg of Pethidine was injected intravenously. This was followed by two injections of 20 ml of the said anaesthetics first into the Patient's right and then left breast. Two more 3 ml doses of the said anaesthetics were locally infiltrated into the areas around the nipples on both sides.

7. The Defendant made a skin incision on the Patient's right breast at around 3:25 p.m. The Patient complained of pain when the Defendant dissected into the sub-mammary space. According to the Defendant, he gave the Patient another 10 mg of Pethidine intravenously and another 5 ml of the said anaesthetics was injected into the dissection site.

8. The Patient was noted to have reduced consciousness followed by generalized convulsions at around 3:28 p.m. Erythema over her face and chest was also observed. Assisted ventilation was initiated first with an oral airway followed by bag-valve-mask bagging. Ambulance was summoned and other doctors nearby were asked to assist.

9. Eventually, the Patient was sent by ambulance and arrived at the Accident & Emergency Department of Queen Elizabeth Hospital at 5:06 p.m. Respiratory and cardiovascular supportive treatments were initiated and she was admitted into the Intensive Care Unit ("ICU") for further management. She remained comatose with fixed and dilated pupils all along despite improvement in her blood pressure and pulse. Computer tomography suggested swelling of her brain. Supportive treatment was continued in the ICU but the Patient remained vegetative with no sign of neurological recovery. Brain death was confirmed on 11 May 2010. Autopsy was performed on 17 May 2010. Hypoxic brain injury and bronchopneumonia were found to be the direct cause of death. Adverse effect of the drug lignocaine was said to be the intervening antecedent cause of the death.

Burden and Standard of Proof

10. 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.

11. There is no doubt that each of the allegations 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 each of the disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

12. The Defendant admits the factual particulars of all the amended disciplinary charges against him. It remains however for us to consider and determine on

all the evidence whether the Defendant had by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong.

13. It was clearly stated in section 2.1 of the Code of Professional Conduct (2009 edition) that:-

"*Consent to medical treatment is part of quality care and also a legal requirement. Consent has to be given voluntarily by the patient after having been informed of the relevant aspects of the medical procedure including the general nature, effect and risks involved."*

14. There was no contemporaneous record of what advice had been given to the Patient. The Defendant merely wrote down in his record for the consultation with the Patient on 17 April 2010 the words "*sign consent form*".

15. We need to emphasize that a doctor's duty to obtain informed consent is not fulfilled by routinely asking a patient to sign on a *pro-forma* consent form. In order to discharge this duty, it is prerequisite in our view for a doctor to provide proper explanation of the nature, effect and risks of the proposed treatment and other treatment options (including the option of no treatment). Moreover, the explanation should be balanced and sufficient to enable the patient to make an informed decision.

16. According to the Defendant, he merely advised the Patient with regard to the use of anaesthetics that "*there is a possibility of drug reaction*". It is however insufficient in our view for the Defendant to mention the possibility of drug reaction happening only. Before the Patient decided whether to undergo the Surgery, she should be informed of the significant risk (albeit a much smaller one) of a grave outcome, which could be potentially life threatening, in case of adverse reactions or toxicity from anaesthetics. This is particularly true because the Surgery was an elective one.

17. Moreover, the Defendant ought in our view to have advised the Patient properly and adequately as to the risk of undergoing the Surgery in his clinic with limited equipment and without the assistance of an anaesthetist and/or other qualified personnel.

18. In failing to properly and adequately advising the Patient about the nature, procedure, all possible risks and complications of the Surgery, in particular,

with regard to the use of anaesthetics, the Defendant had failed to obtain an informed consent from the Patient before the Surgery. Accordingly, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (a).

19. It is clearly stated in sections 1.1.1 and 1.1.3 of the Code that:-

"*The medical record is the formal documentation maintained by a doctor on his patient's history, physical findings…"*

"*All doctors have the responsibility to maintain systematic, true, adequate, clear, and contemporaneous medical records…*"

20. It is however evident to us from reading the medical record kept by the Defendant on his consultation with the Patient before the Surgery that he merely wrote down the words "*past health – good*". There was nothing about the Patient's medical history, body weight or physical findings such as blood pressure and pulse.

21. Moreover, the operation record was improper in that there were inadequate details of how the said anaesthetics were prepared and administered. There was no record of the Patient's vital signs after the Surgery began and before she developed generalized convulsions. There was no mention of the Patient's complaint of pain after skin incision on her right breast or the additional dose of the said anaesthetics being given. There were also inadequate details of the time of and responses to resuscitation procedures.

22. In failing to keep and maintain proper record for the Patient, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (b).

23. In our view, any doctor who operates on a patient under sedation must ensure that he has the appropriate training, equipment, expertise, personnel and/or experience in performing the surgery.

24. It is evident to us from reading the Coroner's Verdict in the Death Inquest of

the Patient that the Defendant had not demonstrated the required competency to ensure that the Patient would be safe whilst she was being put under sedation. We are particularly concerned that the Defendant was unable to tell the Coroner for sure how the said anaesthetics were prepared and hence the amount and concentration of Lignocaine given to the Patient.

25. We agree with the Secretary's expert, Dr TSE, that the Defendant "*had been ignorant of the toxicity of the local anaesthetic drug lignocaine… [and he] had not properly assessed and evaluated the potential risk of his anaesthetic method… with little established evidence of efficacy and safety…He had failed to recognize the early signs of life-threatening lignocaine overdose, i.e. convulsion and hypotension so that timely drug treatment was not given…*"

26. Moreover, the fact that Dormicum (Midazolam) and Adrenaline were not given to the Patient soon after she had developed generalized convulsions reinforces our view that the Defendant was not conversant with how to handle grave outcome of adverse reactions or toxicity from anaesthetics.

27. By performing the Surgery on the Patient when he did not have the appropriate training, equipment, expertise, personnel and/or experience in performing the Surgery, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (c).

28. We agree with the Legal Officer that "optimal standard" connotes in the context of disciplinary charge (d) what is reasonably expected of registered medical practitioners in the circumstances of this case.

29. It is pertinent to note in this case that the Defendant had chosen to perform the Surgery in his clinic without the assistance of an anaesthetist. It follows in our view that the Defendant bore the full responsibility to ensure that the Patient's conditions would be properly and adequately monitored throughout the Surgery. However, apart from the use of an oximeter, the Defendant monitored the Patient's condition during the Surgery merely by talking to her, which was in our view inadequate in the circumstances.

30. In failing to maintain an optimal standard of monitoring her conditions whilst putting the Patient under sedation for the Surgery, the Defendant had in our

view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (d).

31. We agree with the Legal Officer that the clinical features of the Patient when she developed generalized convulsions at around 3:28 p.m. on 30 April 2010 were consistent with Lignocaine toxicity on the central nervous system. There is no doubt in our minds that the speed at which the Defendant administered the said anaesthetics on the Patient during the Surgery coupled with the short interval in between the last two doses ran (and indeed increased) the risks of causing cardiorespiratory distress to the Patient. This is further aggravated by the fact the Defendant was unable to tell for sure how the said anaesthetics were prepared and hence the amount and concentration of Lignocaine given to the Patient.

32. For these reasons, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (e).

33. It is not disputed that the Defendant had failed to properly and adequately follow up the conditions of the Patient after the Surgery was abandoned in that he (i) delayed in providing adequate ventilatory support for her; (ii) failed to provide Dormicum treatment for her; and (iii) delayed in administering Adrenaline to her.

34. We agree with Dr TSE that all these measures should be taken promptly when the Patient developed generalized convulsions; and the Defendant's failure in providing adequate ventilatory support and early drug treatment had contributed significantly to the subsequent death of the Patient.

35. For these reasons, the Defendant had in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find the Defendant guilty of misconduct in a professional respect as per disciplinary charge (f).

Sentencing

36. The Defendant has one previous disciplinary record back in 2014 in that he

performed dilatation and curettage on a Patient without proper justification. The Defendant's name was ordered to be removed from the General Register for a period of 4 months with suspension for a period of 24 months. The Defendant subsequently lodged an appeal against the removal orders but the appeal was dismissed by the Court of Appeal on 6 January 2015.

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

38. 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.

39. We are told in mitigation that the Defendant had closed his clinic and ceased to practice for fees after December 2020. From this, solicitor for the Defendant submits that the chance of the Defendant committing the same or similar breaches in the future would be low.

40. Seven years had elapsed since the incident when the Defendant made his submission to the Preliminary Investigation Committee by letter dated 3 October 2017. In that letter, the Defendant still defended the disciplinary charges by referring to various parts of the transcript and expert evidence in the Death Inquest although the expert evidence of Dr TSE was already known to him.

41. Solicitor for the Defendant refers us to pretty much the same parts of the transcript and expert evidence in the Death Inquest and submits that the Defendant has genuine insight into his wrongdoings. We do not accept. In our view, the Defendant is trying to minimize the gravity of his wrongdoings by referring us to parts of the transcript and expert evidence to his favour. It is long after the issue of the Notice of Inquiry to the Defendant by letter on 29 May 2019 that the Defendant told us through his solicitor today for the first time that he has genuine insight into his wrongdoings. There is moreover hardly anything in the defence mitigation bundle to support this claim.

42. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we order that:-

(1) in respect of disciplinary charge (a) that the name of the Defendant be removed from the General Register for a period of 2 months;
(2) in respect of disciplinary charge (b) that the name of the Defendant be removed from the General Register for a period of 1 month;
(3) in respect of disciplinary charge (c) that the name of the Defendant be removed from the General Register for a period of 5 months;
(4) in respect of disciplinary charge (d) that the name of the Defendant be removed from the General Register for a period of 3 months;
(5) in respect of disciplinary charge (e) that the name of the Defendant be removed from the General Register for a period of 5 months;
(6) in respect of disciplinary charge (f) that the name of the Defendant be removed from the General Register for a period of 3 months; and
(7) the removal orders to run concurrently making a period of 5 months.

43. We have considered whether it is appropriate to suspend the removal orders. For the reasons above, we do not consider this to be a suitable case for suspension.

Dr HO Pak-leung JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong