香港醫務委員會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant:	Dr HO Kwok Keung (何國強醫生) (Reg. No.: M02652)
Date of hearing:	28 February 2024 (Wednesday) (Day 1);
	29 February 2024 (Thursday) (Day 2);
	1 May 2024 (Wednesday) (Day 3);
	17 August 2024 (Saturday) (Day 4); and
	21 September 2024 (Day 5)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP (Chairperson of the Inquiry Panel) Dr LEUNG Kit-hung. Anne Dr CHAN Pik-kei, Osburga Ms LIU Lai-yun, Amanda Ms LEE Suk-yee, Rosalind

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Ms Ann LUI as instructed by Messrs. Kennedys

Legal Officer representing the Secretary: Ms Deanna LAW as instructed by Department of Justice

The Defendant attends the Day 1 to Day 3 of the inquiry via remote video link.

1. The amended charges against the Defendant, Dr HO Kwok Keung, are:

"That in or about May 2018 to February 2019, he, being a registered medical practitioner, disregarded his professional

responsibility to his patient Patient"), in that he –

- (i) advised the Patient to undergo "Left Video Assisted Thoracoscopic (VAT) Surgery Excision of bullae plus Pleurodesis" (the "Operation") without sufficient clinical indication and/or proper justification;
- (ii) failed to order chest x-ray for the Patient or advise the Patient to undergo chest x-ray to rule out further deterioration of apical pneumothorax before the Patient was discharged;
- (iii) failed to order chest drain insertion and/or CT thorax to the Patient when there were increase in apical pneumothorax and presence of left basal pleural effusion and/or when circumstances so warranted; and
- (iv) caused and/or increased the risk of the Patient to suffer from permanent loss of lung function and/or exercise capacity.

In relation to the facts alleged, either individually or cumulatively, he has been guilty of misconduct in a professional respect."

Facts of the case

- 2. When opening the Secretary's case, the Legal Officer told us that the Secretary would not be calling the Patient to give evidence. The Legal Officer also told us that the Patient had refused to give the Secretary his consent to obtain other medical records than those placed before us in the Secretary's bundle.
- 3. At our instigation, the Secretary reached an agreement with the Defendant for the purpose of this inquiry as to the truth of the facts stated in the following Statement of Admitted Facts:-
 - "1. Dr HO's name was at all material times and still is included in the General Register and his name has been

included in the Specialist Register under the specialty of Cardio-thoracic Surgery since 4 March 1998.

2. At all material times, Dr HO was, and still is, a registered medical practitioner in Hong Kong.

3.

("Patient"), approaching 43 years old at the time, was first seen by Dr HO at the clinic in the afternoon of 8 May 2018. Large bullae, the largest was noted at the left upper lobe measuring 10.6 x 9.8 x 10.7 cm, were detected during a routine health check and CT thorax performed on 27 April 2018 (Attachment 1). There was evidence of compressive atelectasis of some of the left upper lobe lung parenchyma at the inferior aspect of the bulla as reported in the CT thorax. Mild pleural thickening was noted at right apical region, which might represent post-inflammatory change.

- 4. The Patient's lung function test which was done on 17 April 2018 was acceptable with FVC 3.97 liter and FEV1 2.82 liter. The clinical diagnosis on 8 May 2018 was cystic lung disease.
- 5. The Patient did not have symptoms such as shortness of breath, history of spontaneous pneumothorax, bleeding, infection, and reduction in lung function including Forced Expiratory Volume in 1 second, so he was relatively asymptomatic. There was evidence of compression atelectasis of the adjacent lung tissue.
- 6. Furthermore, the Patient was relatively young (approximately 43 years old) with relatively normal lung function test. The operative risk was assessed to be low.
- 7. The Patient returned to see Dr HO with his family members including his wife and another lady on 15 May 2018.
- 8. After deliberation, the Patient agreed to proceed with surgery. Admission into Union Hospital was scheduled for

6 June 2018 and surgery was scheduled on 7 June 2018.

- 9 In accordance with Dr HO's usual practice, the Patient was advised to attend the hospital early in the afternoon of 6 June 2018 to facilitate the admission procedure, pre-chest surgery preparations including blood taking for check-up, cross-match blood, chest physiotherapy instructions, and interview by the anesthetist. In addition, a 2-page Chinese information pamphlet of the procedure "Video Assisted Thoracoscopic Surgery Pleurodesis" (Attachment 4 – which was based on the Hospital Authority's template for such procedure) and consent form for surgery would be given to the Patient by hospital staff for his careful consideration. The information pamphlet is also similar to the pamphlet entitled "Pleurodesis - Information for patients" by Oxford University Hospitals / NHS Foundation Trust in the UK (Attachment 5).
- 10. After the above engagement, both the Patient and Dr HO signed the consent form in front of a nurse who stood next to the bed during the process of interview. The nursing staff also signed on the form as a witness. In the consent form, the Patient confirmed in paragraph 4 that he understood the contents of the information pamphlet.
- 11. The surgery was performed by Dr HO on 7 June 2018 at approximately 0900 hrs. On thoracoscopic inspection, there were large and multiple apical bullae with adhesion to the parietal pleura. The parietal pleurae were inflamed. The apical area of the left upper lobe bearing the bullae was excised with stapler reinforced with pericardial stripe and the suture line was reinforced with flow-seal (a chemical compound to prevent air-leakage).
- 12. Pleurodesis was then performed with mechanical abrasion to the mediastinal pleural aspect and lower parietal pleural aspect. 2 gm of Steritalc powder was sprayed on the apical parietal aspect. The inferior pulmonary ligament was released to allow upward shift of the lower lobe towards the

apex of the chest cavity in order to achieve a better apical pleurodesis. In short, the pleurodesis procedure was performed by lysis of the pulmonary ligament, mechanical and chemical pleurodesis with 2 gm of Steritalc powder.

- 13. The pathology report reported "subpleural bullae".
- 14. The Patient was returned to the ward at around 1430 hrs and was put on Atrium drainage system (wall suction system) with -15 cm water suction to expand the lung and to aim for a firm pleurodesis between lung and parietal pleurae. He was given intravenous pethidine infusion for pain relief and supplementary nasal oxygen. There was 1 out of 5 checks recording air-leakage according to nursing Chest X-ray taken reported record. "small left pneumothorax with the maximum width between the left pleural line and the left inner chest wall measuring ~ 0.7 cm... left lower zone atelectasis... No significant pleural effusion".
- 15. On 8 June 2018 (post-operative day 1), the Patient was stable. There was no record of air-leakage between 0100 hrs and 1000 hrs. The chest drain system was changed to Thopaz at around 1100 hrs. According to the manual for the Thopaz system, any air-leakage rate less than 80 ml per minute would not be marked as active air-leakage. According to the records, air-leakage was noted in 3 out of 5 records at the rates of 30 ml per minute, 20 ml per minute and 10 ml per minute respectively between 1100 hrs and 2400 hrs.
- 16. On 9 June 2018 (post-operative day 2), the Patient was stable. -15 cm water suction was applied. Air-leakage was recorded in 2 out of 5 records at the rates of 10 ml per minute and 10 ml per minute respectively. Chest X-ray showed a small left pneumothorax with the maximum width between the left pleural line and the left inner chest wall measuring ~1.1 cm at the apex.

- 17. On 10 June 2018 (post-operative day 3), the Patient was stable. -15 cm water suction was applied. No air-leakage was recorded.
- 18. In the Patient's case, the chest drain suction of -15 cm was continued until around 0400 hrs on 11 June 2018 i.e. approximately 86 hours. There was no record of active air-leakage and the drainage was minimal throughout the period.
- 19. On 11 June 2018 (post-operative day 4), the Patient was stable. -8 cm water suction (physiological mode) was applied between 0400 hrs and 1200 hrs. There was no record of air-leakage during that period. Chest X-ray reported at 1046 hrs on 11 June 2018 stated "The small left pneumothorax is similar. Surgical emphysema... less extent than before".
- 20. Thopaz system was disconnected at around 1200 hrs on 11 June 2018 and chest drain was spigotted under the Patient's clothing. The Patient was encouraged to be fully ambulatory (walk around the ward area) to facilitate quick recovery.
- 21. Repeat chest X-ray reported at 1929 hrs on 11 June 2018 showed "The small left apical pneumothorax is similar in size. Surgical emphysema... being similar" i.e. same findings. So during the period with dysfunctioned chest drain (drain was spigotted since around 1200 hrs on 11 June 2018), the size of pneumothorax remained the same at approximately 1.1 cm with no deterioration.
- 22. Chest drain was removed at around 1000 hrs on 12 June 2018 (post-operative day 5) after the chest drain had been spigotted for approximately 22 hours. There was no change in the Patient's clinical status before the removal of chest drain. Chest X-ray reported at 1634 hrs on the same day showed "The left pneumothorax is slightly more with thickness of ~1.9 cm from the chest wall. Surgical

emphysema... with similar extent". So the apical pneumothorax had increased from approximately 1.1 cm to 1.9 cm.

- 23. The Patient was kept under observation for 26 hours after the chest drain was removed at around 1000 hrs on 12 June 2018 to 1200 hrs on 13 June 2018 (post-operative day 6 and day of discharge) in order to check if he had any breathlessness or increase in size of surgical emphysema. The Patient was discharged from hospital in the afternoon of 13 June 2018. He was arranged to attend Dr HO's clinic on 16 June 2018 for follow up and close monitoring.
- 24. The Patient was followed up at clinic 3 days after discharge on 16 June 2018. He had no fever and no coughing. The surgical sites were intact. He complained that his breathing was not as good as it was in the hospital. Clinically, there was diminished airway entry over the left lung base.
- 25. Chest X-ray was ordered and reported "A moderate left hydropneumothorax is seen. The size of the pneumothorax component has significant increase when compared with previous radiograph. The pneumothorax component measures 4.2 cm in maximal depth in the left upper zone and 2.6 cm in maximal depth in the left lower zone. A small fluid component with an air fluid level is seen at the base of the left hemithorax". The X-ray findings showed there was no tension. There was atelectatic change over the mid and lower zones of the left lung.
- 26. The next post discharge consultation was 21 June 2018. Clinically, the Patient's breathlessness had improved and airway entry was improved on auscultation. Wound was intact. There was no increase in surgical emphysema.
- 27. The third post discharge consultation was on 5 July 2018. The Patient complained of left lower chest discomfort. There was no increase in breathlessness or surgical emphysema. Repeat chest X-ray reported "Comparison is

made with CXR 16-Jun-2018. Overall no significant change. Moderate left hydropneumothorax is seen, no tension. 4.3 cm in maximum thickness". This showed nil significant change compared with the findings noted on 16 June 2018. There was no tension pneumothorax.

- 28. The next clinical follow up was on 31 July 2018.
- 29. The Patient booked a follow up consultation and came to see Dr HO on 27 October 2018.
- 30. Dr HO asked his clinic nurse on 2 November 2018 to ask the Patient to provide all his previous chest X-ray films for a further detailed review. The Patient brought those films to the clinic some time later.
- 31. Dr HO then invited the Patient for a further interview on 17 November 2018.
- 32. Dr HO last saw Patient on 23 February 2019."
- 4. The Patient subsequently lodged this complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

- 5. 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.
- 6. 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. Therefore, we need to look at all the evidence and to consider and determine the

disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

- 7. We need to remind ourselves that the Defendant is not being charged under the amended disciplinary charge (i) with failure to advise the Patient properly and/or adequately of the clinical indication and/or justification for undergoing the Operation. The real issue is whether the advice that the Defendant gave to the Patient was "without sufficient clinical indication and/or proper justification".
- 8. In response to the allegation that his advice for the Patient to undergo the Operation was made "*without sufficient clinical indication and/or proper justification*", the Defendant explained in his medical report, which was submitted to the Preliminary Investigation Committee ("PIC") under the cover of his solicitors' letter dated 24 March 2022, that:-

"3. Patient did not have symptoms such as shortness of breath, history of spontaneous pneumothorax, bleeding, infection, and reduction in lung function including Forced Expiratory Volume in 1 second, so he was relatively asymptomatic. However, his bullae had occupied the entire left upper lobe i.e. about 1/3 of his left chest cavity, and there was evidence of compression atelectasis of the adjacent lung tissue. Late complications such as pneumothorax and pleural infection were expected to develop after some time. Left Video Assisted Thoracoscopic (VAT) Surgery to excise the bulla and Pleurodesis to prevent occurrence of pneumothorax and other late complications was therefore clinically indicated..."

9. The Defendant also drew the PIC's attention to the following passages from page 570 of the textbook: *Thoracic Surgery* by Pearson et. al.:-

"Patients who benefit from the surgical excision of bullae have space-occupying nonfunctioning air spaces or localized non-functioning parenchymal areas encroaching on normal or near-normal adjacent lung. Excision removes the space-occupying lesions, allows the compressed lung to expand, permits better ventilation and perfusion similar to the remaining lung, and decreases both dead space and residual volume ...

The general indications for surgical intervention are as follows:

1. Moderate to severe dyspnea

...

- 2. A bulla occupying more than one-third of the lung field
- 3. A pulmonary angiogram demonstrating reduced blood flow to the involved lung field...
- 4. Complications of bullous disease, for example, pneumothorax, infection in a bulla, or massive hemoptysis..."
- 10. The Defendant reiterated in his supplemental medical report on the Patient dated 5 December 2023 that:-
 - "1.3 The indications were:
 - a. The size of the giant bulla occupied 1/3 of the left lung field.
 - b. The presence of compression of the bulla on the adjacent lung tissue. The further delay to remove the bulla, the less chance for the compressed lung tissue to regain its function.
 - 1.4 The relative merits of recommending early elective surgery in this patient were:
 - a. As the patient was a chronic cigarette smoker, it is expected that there would be a progressive deterioration of the lung function. It is safer to operate when the lung function was still acceptable.
 - b. To avoid the risk of potential complications of giant bulla and its associated mental stress."
- 11. Dr AU, the Secretary's expert witness, and Dr WAN, the Defendant's expert witness, both agreed, and we accept, that "surgery is not a preventive measure" and should not be recommended to a patient "unless it is indicated".
- 12. We appreciate that there was no mention in the Defendant's consultation notes that he had studied the CT thorax scan taken in April 2018 and noticed that "[t]he size of the giant bulla occupied 1/3 of the left lung

field".

- 13. But then again, the real point is that without the benefit of sight of the CT thorax scan, we are unable to tell the relative position of the bulla and the edge of the apex of the left lung of the Patient.
- 14. We agree with the Defendant's expert witness, Dr WAN, that the estimation by Dr AU, the Secretary's expert witness, that the bulla occupied only 12% of the left lung field is "some sort of speculation". As Dr WAN aptly pointed out and we agree, if "we could not examine exactly the CT scan... before the operation for this particular Patient", it would not be possible for us to calculate the volume of the bulla.
- 15. We do not wish to speculate why the Secretary did not apply under section 22(1)(b) of the Medical Registration Ordinance for a witness summons to be issued to the person-in-charge of ProCare Medical Imaging and Laboratory Centre requiring him to attend this inquiry and to produce the CT thorax scan.
- 16. However, the burden of proof is on the Secretary who makes the allegation, it would not be fair in our view to draw any adverse inference against the Defendant merely because there was no mention in his consultation notes that he had studied the CT thorax scan taken in April 2018 and noticed that "[t]he size of the giant bulla occupied 1/3 of the left lung field".
- 17. We appreciate that there was at all material times no published guideline on clinical indication(s) for the Operation. And we agree with Dr WAN that what the authors had mentioned in the textbook *Thoracic Surgery* were "general indications"; and "up till now, there is no prospective randomized trial available that help us to make the decision".
- 18. Dr AU opined that "[a]part from the size of the giant bullae, another indication for surgical intervention is whether the Patient is with symptoms".
- 19. Our attention was drawn by Dr AU to the article by *Greenburg et al.*: *Giant bullous lung disease: evaluation, selection, techniques, and outcomes* in Chest Surg Clin N Am 2003; 13:631-649. While the authors of this article mentioned at the beginning that "[t]his article reviews...

indications for surgery... of this disease", it is unclear to us from reading the article from which clinical studies, and let alone how the clinical studies were conducted, they came to the view that "[a]symptomatic patients who have isolated bullae should be observed until they have problems oxygenating or they develop complications of their disease".

- 20. We agree with Dr WAN there was "no absolute contra-indication in this case" for the Patient to undergo the Operation. We also agree with Dr WAN that the choice between surgical intervention and conservative management of the Patient's giant bulla involved a risk and benefit analysis.
- 21. For these reasons, we are not satisfied on the evidence before us that the Defendant's advice to undergo the Operation was made without sufficient clinical indication and/or proper justification. Accordingly, we find the Defendant not guilty of the amended disciplinary charge (i).
- 22. There is no dispute that the Defendant did not order chest x-ray for the Patient or advise the Patient to undergo chest x-ray before discharging him home on 13 June 2018.
- 23. In response to the allegation that he "failed to order chest x-ray for the Patient or advise the Patient to undergo chest x-ray to rule out further deterioration of apical pneumothorax before the Patient was discharged" from Union Hospital, the Defendant explained in his supplemental medical report on the Patient dated 5 December 2023 that:-
 - "4.1 As shown from the nursing charting, there was no air leakage when the chest drain was in open drainage system for 36 hours for the whole day of 10 June 2018 till noon of 11 June 2018. The chest drain was spigotted from noon of 11 June 2018 onwards. There was no change in size of pneumothorax on the chest x-ray taken 7 hours later. The size of the pneumothorax was stationary at 1.1 cm on chest x-rays taken at 10:00 and 19:00 on 11 June 2018. So in total there was a confirmed period of 43 hours without indications of active air leakage...
 - 4.2 Size of the apical pneumothorax increased from 1.1 to 1.9

cm from chest x-ray reported at 16:34 of 12 June 2018. Such slight increase was a common phenomenon. There was an episode of in-sucking of air by the patient during the process of removal of chest drain.

4.4 As there was no indications of air-leakage before the removal of the drain, the slight increase in size of the apical pneumothorax would not be a cause of concern.

...

- 4.5 To avoid over-exposure of the patient to radiation (the patient had had 5 chest x-rays over a course of 6 days), I opted to keep the patient overnight for observation. There was no clinical evidence of air leakage. He was discharged after 26 hours of close monitoring since removal of chest drain. I did not order another chest x-ray prior to his discharge from the hospital."
- 24. Dr AU and Dr WAN both agreed, and we accept, that the increase in size of the apical pneumothorax, shown on the serial chest x-rays, from 1.1 to 1.9 cm was "*significant*".
- 25. We agree with the Defendant that we should "avoid viewing the matter from hindsight". However, there is a distinction, in our view, between a case "where all reasonable skill and judgment in diagnosing has been followed and a faulty diagnosis arrived at and one where all reasonable skill and judgment has not been exercised, resulting in a faulty diagnosis" [see: Rietze v Bruzer (No. 2) [1979] 1 WWR 32 at 46-47].
- 26. In this regard, we agree with Dr WAN that the Patient should be discharged from Union Hospital "only if the apical space remained static or decrease in size on repeated [chest X-rays]"; and the "Patient has to be observed if there is increase in the size of the apical space for at least one more day as this might signify slow parenchymal air leak." In our view, observation for breathlessness was insufficient to replace the need for chest x-ray.
- 27. In failing to order chest x-ray for the Patient or advise the Patient to undergo chest x-ray to rule out further deterioration of apical pneumothorax before discharging him home, the Defendant has in our

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view 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 the amended disciplinary charge (ii).

- 28. Turning to the amended disciplinary charge (iii), the Defendant sought to defend his failure to order chest drain insertion on the ground that this was his clinical judgment at the time. When being cross-examined, the Defendant told us for the first time that he had explained to the Patient on 16 June 2018 that chest drain would be an option for treating his medical condition. We have grave doubt about this part of his oral testimony when nothing was said in any of his earlier medical reports or written statement.
- 29. However that may be, the amended disciplinary charge (iii) is not confined to what happened on 16 June 2018. The allegation against the Defendant is also that he "failed to order chest drain insertion... when circumstances so warranted".
- 30. There is a distinction, in our view, between a case where a doctor, acting with reasonable skill and care, commits an error in clinical judgment and a case "where the condition of the patient is such that special attention is required and should be recognized by the doctor but is not or if doctor does not treat that condition in the required and medically acceptable manner" [see: Rietze v Bruzer (No. 2) [1979] 1 WWR 32 at 49].
- 31. In this regard, we agree with Dr WAN that "left hydropneumothorax with quite a sizable apical and basal spaces" could be found in the chest x-ray taken on 16 June 2018 indicating that "the rate of air leak is higher than the rate of absorption"; and "[c]onservative treatment is likely to be unsuccessful as the space was large and this also signified continuous slow lung parenchymal air leak. The usual sequence was to re-insert the chest drain and assess the degree of air leak."
- 32. When being cross-examined, Dr WAN further explained and we agree that "the rate of absorption of the air... is very slow. It will take a very long long time for it to kind of get the lung re-expanded after the lung absorption of the air".

- 33. There is no dispute that the Defendant did not order CT thorax for the Patient at any of the follow-up consultations after his discharge from Union Hospital. Dr AU opined and we accept that "plain chest x-ray may underestimate the extent of the lung collapsed and the loss of lung volume". When being cross-examined, Dr WAN initially told us that "[chest] x-ray itself can give us most of the information". But then again, Dr WAN supplemented and we agree that "if we plan for some sort of interventions like image-guided drainage then we will ask for CT scan and that will make a difference".
- 34. Given our findings in respect of the Defendant's failure to order chest drain insertion for the Patient, we are satisfied on the evidence before us that CT thorax was warranted in the circumstances of this case.
- 35. For these reasons, in failing to order chest drain insertion to the Patient and to order CT thorax for the Patient when there were increase in apical pneumothorax and presence of left basal pleural effusion, the Defendant has in our view 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 the amended disciplinary charge (iii).
- 36. Dr AU and Dr WAN both agreed, and we accept, that the chest x-rays taken on 27 October 2018 "showed further worsening of [the Patient's] collapsed left lung and with multiple loculated pneumothorax". We also agreed with Dr AU that "[o]bvious sign of pleural thickening", which was indicative of "trap lung syndrome with hydropneumothorax", was also shown on these chest x-rays.
- 37. Dr AU and Dr WAN both agreed, and we accept that, "*trap lung syndrome is salvageable*" by "*surgical decortication*". But since the Secretary did not call the Patient to give evidence, we are unable to know whether the loss in his lung function and exercise capacity has become permanent.
- 38. Having said that, the alternative case of the Secretary in respect of the amended disciplinary charge (iv) is that the Defendant had "increased the risk of the Patient to suffer from permanent loss of lung function and/or exercise capacity".

- 39. In this regard, we agree with Dr WAN that "[t]he development of hydropneumothorax after resection of giant bulla should be early chest drain insertion in an attempt to get the lung re-expanded early and to avoid the progression to trapped lung which will need redo surgery plus decortication. The restoration of lung expansion can help to preserve patient's lung function and exercise capacity".
- 40. Viewed from this perspective, the Defendant's continual conservative management of the Patient despite "*left hydropneumothorax with quite a sizable apical and basal spaces*" could be found in the chest x-ray taken on 16 June 2018 had in our view increased the risk of the Patient to suffer from permanent loss of lung function and/or exercise capacity.
- 41. For these reasons, in failing to arrange for early chest drain insertion, the Defendant had increased the risk of the Patient to suffer from permanent loss of lung function and/or exercise capacity. Accordingly, the Defendant has in our view by his conduct in the present case fallen below the standards expected of registered medical practitioners in Hong Kong. Therefore, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (iv).

Sentencing

- 42. The Defendant has a clear disciplinary record.
- 43. 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.
- 44. Despite the significant increase in size of the apical pneumothorax from 1.1 to 1.9 cm, the Defendant still tried to put up the excuse that he wished to "avoid unnecessary over-exposure of [the Patient] to radiation" by not ordering another chest x-ray prior to his discharge from Union Hospital.
- 45. We are particularly concerned that the Defendant did not insert a chest drain and/or order CT thorax for the Patient during any of the follow-up consultations on 21 June 2018, 5 July 2018 and 31 July 2018 when there were increase in apical pneumothorax and presence of left basal pleural

effusion.

- 46. This was aggravated by the Defendant's failure to order a plain CT thorax for the Patient when repeat chest x-ray on 5 July 2018 showed similar findings to the one taken on 16 June 2018.
- 47. Taking into consideration the nature and gravity of the disciplinary charges for which we find the Defendant guilty and what we have read and heard in mitigation, we order that:-
 - in respect of the amended disciplinary charge (ii) the name of the Defendant be removed from the General Register for a period of 3 months;
 - (2) in respect of the amended disciplinary charge (iii) the name of the Defendant be removed from the General Register for a period of 6 months;
 - (3) in respect of the amended disciplinary charge (iv) the name of the Defendant be removed from the General Register for a period of 6 months; and
 - (4) the above removal orders to run concurrently, making a total of 6 months; and be suspended for a period of 18 months.

Remark

48. The name of the Defendant is included in the Specialist Register under the Specialty of Cardio-thoracic Surgery. 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

Attachment 1 -

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73	皆良。 ProCare Medic Dimagray	

普康醫學影像及化驗中心 ProCare Medical Imaging & Laboratory Centre

Report to	1	Dr. Chan Ka Soon Belinda					
Your reference		12868	1. A.				
Name	j.			Sex		M	
HKID / Passport	2			Age	×.	42Y	
Transaction No.	12	CB1804-1489		Date	1	27/04/2018	

CT LOW DOSE THORAX (PLAIN)

HISTORY:

CXR L upper hemithorax bullae/loculated pneumothorax

FINDINGS:

Centrilobular and paraseptal emphysema is noted in both lungs with bilateral upper lobe predominance. The largest bulla is noted at left upper lobe, measuring 10.6 x 9.8 x 10.7 cm. Compressive atelectasis of some of the left upper lobe lung parenchyma is noted at the inferior aspect of bulla.

No pneumothorax.

Lung volume is normal. A 0.6 cm nodule is noted in left lingular segment, which may represent a granuloma. No other lung nodule is noted. No lung mass seen. No consolidation. No parenchymal scarring or atelectasis.

Large airways are patent. No filling defect or stenosis is noted. No bronchiectasis is noted. No bronchial wall thickening.

No pleural effusion. Mild pleural thickening is noted at right apical region, which may represent post-inflammatory change.

Mediastinum and hila show no enlarged lymph node. No mediastinal mass lesion seen.

Chest wall and lower neck are unremarkable.

Pulmonary artery and thoracic aortic size is normal.

Heart size is normal. No pericardial effusion.

No aggressive bone lesion is evident.

Dr. Wong Wai Mei, Katherine MBChB (CUHK), FRCR (UK), FHKCR, FHKAM (Radiology)

Room 19010, 19/F, East Point Centre, 555 Hennessy Road, Ciluseway Bay, Hong Kong Tel: 2577 9313 | Fax: 2577 9225 | Website: http://www.procaremedical.com.hk

Attachment 4 -



手術資料

<u>胸腔鏡胸膜固定術</u> Video Assisted Thoracoscopic Surgery Pleurodesis

简介

胸腔鏡胸膜固定衛是一項處理氣胸(空氣積聚於肺部與胸膜之間)和肺積水的微創手術。由於這兩種情況都會出現氣速,胸口痛,所以潛在一定的危險。醫生利用胸腔鏡及專用的內視鏡手術器械經切開的小傷口進入胸腔以減少創傷。清除氣胸/肺積水後,把化學性致粘連藥物慢慢地注入職層和壁層胸膜表面,使胸膜粘連。

治療成效

胸腔鏡胸膜固定術可將胸膜固定在適當位置,以防止復發。此手術可顯著幫助恢復正常的肺功能, 並減低出現氣胸和胸膜積液的風險及發病率。

手術過程

- 1. 手術會在全身麻醉下進行
- 2. 於胸腔壁切開一至兩個小傷口
- 3. 胸腔鏡及外科手術器械經小傷口進入胸腔
- 4. 醫生透過內視鏡影像觀察手術位置並進行手術
- 5. 利用影像引導醫生操作儀器以清除氣泡或積水
- 6. 將滑石紛平均噴撒在臟層和壁層胸膜表面
- 7. 取出內視鏡及其他儀器,再經合傷口
- 8. 胸腔會放置一至雨條引流管用作引流肺部之液體及空氣

可能出現的風險及併發症

- 1. 出血
- 2. 傷口感染
- 3. 血胸(血液積聚在胸腔內)
- 4. 氯胸(空氣積聚在胸膛內)
- 5. 皮下氣腫(空氣或氣體積聚在皮下組織內)
- 6. 其他器官受损
- ** 可能出現之風險或併發症未能盡錄。病人應明白無論手術如何妥善,仍有出現併發症的風險。 如其他器官受損,手術後嚴重出血或出現氣胸時,可能需要進行另一手術治療這些併發症。

手術前的預備

Ref: TRC-03c v2

- 1. 醫生會向病人解釋施行手術的原因、程序及可能出現之併發症,病人明白後便可簽署同意書。
- 2. 如正服用藥物,例如阿士匹靈(Aspirin)、華法林(Warfarin)、拜瑞妥(Xarelto)或 Pradaxa(百達生)等。請儘早通知醫生。

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- 3. 手術前6小時開始禁止飲食。
- 脫下身上所有衣物(例如內衣褲、假牙、飾物和隱形眼鏡等)⁵ 然後換上手術衣。
- 5. 手術前先排清小便。

手術後須知

一般情況

- 1. 全身麻醉後,病人可能會:
 - 因麻醉時曾插喉而引致喉部輕微不適或疼痛;
- 出現麻醉藥的副作用,包括疲倦、渴睡、噁心或嘔吐,如情況持續或加劇,請通知護士。
- 2. 如傷口感到疼痛,可通知護士,護士會按醫生指示為病人注射止痛針或提供口服止痛藥。
- 病人應採用半坐卧式姿勢以促進肺部擴張及定時轉換姿勢以助排出胸腔積液。
- 胸腔引流管可排出積聚在胸腔的體液、血液及空氣。病人應確保引流管固定在適當的位置, 請勿拉、扭、夾及壓着引流管。
- 5. 引流管會在手術後1-2天拆除。
- 6. 病人應保持敷料清潔及乾爽。
- 7. 按個別病情而定,病人一般需住院2-3天。
- 飲食

待麻醉藥效消退後,便可按指示恢復正常飲食。

出院後注意事項

- 1. 如有需要,可服用醫生處方之止痛藥。
- 2. 病人應保持敷料清潔及乾爽,需要時請更換敷料。
- 病人可逐漸恢復日常活動及均衡飲食。
- 如傷口部位的痛楚加劇及出現紅腫、滲膿或滲血、發熱(體溫高達 38°C 或 100°F 以上)等,請 即聯絡主診醫生或回院診治。
- 5. 請於指定日期、時間及地點覆診。

如病人對此手術有任何疑問或憂慮,請聯絡主診醫生,主診醫生會樂意為病人作出解釋。

經過醫生的悉心診治,相信病人會逐漸康復,並祝生活愉快!

若病人閱讀此單張後有任何查詢,請記下相關問題,以便醫生作出跟進。

由仁安醫院手術同意書委員會編輯

以上資料只供參考,詳情請向主診醫生查詢 本院保留一切删改此單張之權利,而不作另行通知

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Pleurodesis Information for patients



Your doctors have recommended that you have a procedure called pleurodesis. This involves attaching your lung to your chest wall, to control fluid or air in the space around your lung. This information leaflet has been written to help you understand what this treatment involves, what it aims to achieve and your recovery afterwards.

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What is pleurodesis?

Pleurodesis is a procedure which involves putting a mildly irritant drug into the space between your lung and chest wall (the pleural space), on one side of your chest. This is done to try to 'stick' your lung to the wall of your chest and prevent a further collection of fluid or air in this space. The drug will be put into your chest through the chest tube that you may already have.



If you are having a thoracoscopy procedure (where we use a small camera to look inside your chest), we will put the drug into your chest during the thoracoscopy.

Pleurodesis is an inpatient procedure, which means you will be admitted to hospital. It is usually carried out on the ward (with curtains or screens for privacy) or in a procedure room.

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How does pieurodesis work?

The drug that is put into your pleural space will cause irritation to the outer lining of your lung and your chest wall. This causes these surfaces to become sticky and to bond together – sealing up the space between them and preventing fluid or air from collecting there.

Why do I need to have pleurodesis?

We have suggested this treatment to you as you have had a collection of fluid or air in your pleural space. The doctors think this is likely to happen again in the future, if nothing is done to seal up the area where the fluid or air had collected. The pleurodesis will hopefully prevent this happening again.

Do I have to have 1?

No. It has been suggested to you as we believe this is the best way of stopping the problem in your chest from coming back, but it is your choice whether to go ahead with this treatment.

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What does the treatment involve?

The pleurodesis will usually be carried out through the tube (chest drain) that has already been put into your chest, to drain away the fluid or air that has collected in your pleural space. Once your chest has drained completely, the pleurodesis drug will be put into your chest through this drain. There are a few different medicines that can be used in pleurodesis, and the doctors and nurses looking after you will talk to you about the specific one they use. A commonly used pleurodesis drug is sterile medical talc.

The drug is usually injected in liquid form, but if you are having a thoracoscopy procedure, the pleurodesis drug will be applied as a powder.

Pleurodesis can cause some pain, but we will give you painkillers before the procedure to help with this. It is still quite common to feel some discomfort during the procedure. If this happens, please let the nurse or doctor know so that we can give you more painkillers.

After the pleurodesis drug has been put into your chest, your chest drain may be closed off for about 1 hour, to hold the drug in place. The drain will then be re-opened to allow drainage of fluid or air to begin again.

The chest drain is usually left in position for at least 24 to 48 hours, but it may be left in longer if the drainage of fluid or air continues. You will need to stay in hospital for a minimum of 24 hours after the pleurodesis. Once the drain is removed, the procedure is complete. A single stitch is sometimes needed to close the site where the chest drain was inserted. If a stitch is needed, it should be removed after 7 days; this can usually be done by your GP's practice nurse.

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How successful is pleurodesis?

We expect the pleurodesis to stop the collection of fluid or air from returning in about 7 out of 10 cases (70%). If it does come back, you may need to have further drainage and we may be able to attempt another treatment with pleurodesis. If a second pleurodesis treatment is needed, the success rate is often lower. If this happens your doctors will discuss this with you.

What are the expected benefits?

When fluid or air collects in the pleural space, it usually causes breathlessness. Pleurodesis prevents fluid or air from accumulating, and so improves breathing.

What are the risks?

Most people undergo pleurodesis without any major problems. However, like all medical treatments, it does have some risks:

- Some people experience chest pain after pleurodesis treatment. We will give you painkillers before the procedure to reduce this. If you do experience any pain after the procedure, you can be given more painkillers.
- Some people experience a fever (high temperature) during the first day or two after the procedure. This is usually controlled with paracetamol and is short-lived.
- Sometimes pleurodesis can cause breathlessness due to inflammation in the lung itself. This usually settles down over a few days with oxygen treatment, although very, very rarely (about 1 in 1,000 people) it can be serious or even fatal.
- All treatments that require a tube being inserted into the chest carry some risk of causing infection related to the tube itself. This happens in about 1 in 100 people. If this does happen, it usually settles with antibiotic treatment, although this may lead to a longer stay in hospital.

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What are the alternatives?

If you have a large collection of fluid, the following options are available. Your doctors will discuss these with you:

- Fluid can be taken out of your chest using a needle. The amount we can remove in this way is limited to around 1 litre (many people have a collection of 3-4 litres) because complications such as pain or breathlessness are more likely if we rapidly take more fluid off in one procedure. The fluid is also highly likely to return again. This treatment has the advantage that you can go home and do not need to have a chest drain, but the major disadvantage is that the fluid is likely to come back and you will need further treatment.
- A small flexible tube (called an indwelling pleural catheter) can be placed in your chest, which you can go home with and learn how to drain at home. This can work well but does potentially mean that the drain will need to remain in your chest permanently, if the fluid continues to be produced. If you would like to know more about this procedure, please speak to your doctors.

HIGAN TO CONTRACT US

If you have any questions or concerns, please let us know.

If you are an inpatient, please speak to the doctors and nurses on your ward.

If you are an outpatient (not currently staying in hospital), please contact:

Theatre Direct Admissions (Level 1, John Radcliffe Hospital) Tel: 01865 221 050 or 01865 221 055

(Monday to Friday, 8.00am to 4.00pm)

Outside these hours please phone the hospital switchboard: Tel: 01865 741 166

Ask for either the On-Call Respiratory doctor or the Chest Ward.

If you have a specific requirement, need an interpreter, a document in Easy Read, another language, large print, Braille or audio version, please call **01865 221 473** or email **PALSJR@ouh.nhs.uk**

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