香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TONG Anthony Kin Keung (唐建強醫生) (Reg. No. M03793)

Date of hearing: 22 August 2013

1. The charges against the Defendant, Dr TONG Anthony Kin Keung, are that:

> "He, being a registered medical practitioner, disregarded his professional responsibilities to his patient A ("the Patient") in that he:
>
> (a) failed to properly and adequately inform the Patient of the possible complications of fistulectomy ("the Operation") before performing the Operation on the Patient on 16 October 2008; and
>
> (b) failed to properly and adequately explain to the Patient about the alternative treatment options before performing the Operation.
>
> 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 Patient first consulted the Defendant on 15 July 2008. On examination it appeared that he had an anal fistula. The Defendant prescribed antibiotics and painkiller to him.

3. On 10 October 2008, the Defendant conducted physical examination on the Patient and found that the fistula was still present. He recommended the

Patient to undergo a fistulectomy to remove the fistula. He advised the Patient that the operation would result in a wound around the size of a 5 dollar coin, which would require to be dealt with by potassium permanganate sitz bath for 2 to 3 weeks. There was no mention of the need for any further operation. The Patient agreed.

4. The operation was scheduled for 16 October 2008. On 15 October 2008, a pre-operative MRI was performed and it was revealed that the fistula was a Y-shaped high type anal fistula with complicated tract. The Defendant advised the Patient that the fistula was more complicated than originally estimated and the operation would result in a much larger wound. The Patient agreed to proceed with the operation and signed the consent form.

5. The Defendant never advised the Patient of the significant complications of the operation, including faecal and flatus incontinence. The Defendant never advised the Patient of the alternative treatment options, such as seton insertion. He neither mentioned the need for any further operation nor that the treatment plan was to perform multiple staged operations.

6. The operation was performed in a private hospital on 16 October 2008. After excision of the low fistula tract, the Defendant tried to remove the high fistula tract. However, before reaching the upper margin of the sphincter complex, the fistula tract broke. The Defendant stopped the operation because he considered it would risk further damage to the sphincter complex. There was a large wound.

7. After the operation, the Patient suffered from faecal incontinence. Despite the Patient's complaint, the Defendant failed to recognize the symptoms of faecal incontinence. Upon the Patient's persistent request for further treatment of symptoms, on 23 October 2008 the Defendant referred the Patient to a public hospital for further management.

8. The Patient was transferred to the public hospital by ambulance for further management. Up to August 2010, he received multiple operations in the public hospital for treating his fistula condition, including EUA anus and fistulotomy, seton insertion, defunctioning loop sigmoid colostomy, overlapping anal sphincteroplasty, release of perianal scar and closure of colostomy.

Findings of the Council

9. The Defendant admits the facts alleged in the charges. Nevertheless, it remains our responsibility to determine whether the Defendant's conduct constituted professional misconduct.

10. We remind ourselves that the charges are not about the propriety of the operation for treating the Patient's anal fistula, nor the manner in which the operation was performed. The charges were also not about the propriety of the post-operative management.

11. It is the duty of all doctors to give patients proper explanation of the proposed treatment and risks and to obtain informed consent before providing the treatment. The explanation should be balanced and sufficient to enable the patient to make an informed decision, and should cover significant risks as well as risks of serious consequence even if the probability is low. The doctor should also advise the patient on the applicable alternative treatment options and the pros and cons of the options, so that the patient can make an informed decision on the treatment option to adopt. Such long standing requirements have been codified in section 2 of the Code of Professional Conduct in 2011.

12. Treatment by fistulectomy would involve dividing or removing some internal anal sphincter muscle that covers the fistula tract, thus weakening the anal sphincter. Patients should be warned of the possibility of flatus incontinence, and faecal incontinence particularly in the treatment of high type anal fistula.

13. The Patient in the present case had a complicated anal fistulae involving a combination of both high type and low type fistulae.

14. For treatment of high type anal fistula, a widely accepted treatment is seton insertion which has a lower likelihood of the incontinence problem.

15. The Defendant neither told the Patient nor documented a treatment plan of multiple staged operations, with the first operation only for excision of the low type fistula tract and for assessing the high type fistula tract in order to plan

the way forward. In fact, in his explanation to the Preliminary Investigation Committee, his explanation was that he tried to remove both the low type fistula tract and the high type fistula tract in the same operation. The only irresistible inference is that he intended to remove both fistulae by a single operation.

16. Irrespective of whether a single operation or multiple operations were planned, the Defendant had the responsibility to properly advise the Patient of the possible complications and the applicable treatment options before performing the operation. He did neither, and had disregarded his professional responsibility.

17. We are satisfied that the Defendant's conduct, in failing to advise the patient of the possible complications and the applicable alternative treatment options, had clearly fallen below the standard expected amongst registered medical practitioners. We find him guilty of professional misconduct as charged in Charges (a) and (b).

Sentencing

18. The Defendant has a clear record.

19. In accordance with our policy, we shall give him credit in sentencing for admitting the factual allegations of the charges in the inquiry, although he disputed the allegation that he had failed to give proper advice to the Patient during preliminary investigation.

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 the reputation of the profession.

21. The charges involve the failure to give proper explanation of the possible complications and the alternatives. In the present case, given the impact of the complications on the Patient's daily life, it is a significant factor in making a decision on whether to adopt the proposed treatment.

22. We are of the view that the Defendant has learned a lesson, and the likelihood of re-offending is low.

23. Having regard to the gravity of the case and the mitigating factors, we order that in respect of both charges the Defendant's name be removed from the General Register for a period of 1 month. We further order that the removal order be suspended for a period of 6 months, subject to the condition that he shall not commit any further disciplinary offence within the suspension period. If he commits any further disciplinary offence within the suspension period (irrespective of whether he is convicted of such further offence within the suspension period), the removal order is liable to be activated in part or in full.

Other remarks

24. The Defendant's name is included in the Specialist Register under the specialty of "General Surgery".

25. We are of the view that the present case is directly relevant to the Defendant's specialty. We shall leave it to the Education and Accreditation Committee to consider whether any action should be taken in respect of the Defendant's specialist registration under section 20N of the Medical Registration Ordinance.

Prof. Felice Lieh-Mak, GBS, CBE, JP
Temporary Chairman, Medical Council