香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 22 June 2011
Defendant: Dr KAM Dominic Chun Ming (金振明醫生) (Reg. no: M02066)

1. The charges alleged against the Defendant, Dr KAM Dominic Chun Ming, are that:

> "He, being a registered medical practitioner, disregarded his professional responsibility to his patient Madam [redacted] ("the Patient"), the deceased, in that, in performing a subtotal gastrectomy ("the Operation") on 5 October 2006:
>
> (a) he failed to carry out proper and adequate investigation on the Patient's condition before carrying out the Operation;
>
> (b) he transected or caused the transection of the Patient's portal vein and common bile duct during the Operation.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of the case

2. The patient was 42 years old when she was diagnosed with adenocarcinoma of the stomach by another doctor. A PET-CT scan as well as various blood tests including tumour markers were ordered. The patient was referred to the Defendant for treatment, and further blood tests for CBT, PT, PTT, glucose, liver and renal functions were performed.

3. The PET-CT scan showed focal wall thickening at the greater curve of the stomach. There was small amount of ascites observed at the pelvis which

was suspicious of miliary peritoneal spread. There was metastasis of the carcinoma to the regional lymph nodes.

4. The Defendant advised the patient to undergo subtotal gastrectomy. The operation was performed on 5 October 2006 in a private hospital by the Defendant under general anaesthesia. During the operation there was blood loss of 2 litres. According to the operation record of the Defendant, "*the stomach was mobilized with omentum detached from transverse colon and detached from underlying pancreas. Duodenum was dissected out just distal to pylorus and transected with GIA. The lesser sac as dissected out to proximal stomach with vessels doubly ligated and transected stomach resected with TA-90. Two-thirds of stomach was incision line was sutured with Vicryl. One-third of stomach incision line was left open for anastomosis with jejunum in a Billroth II anastomosis. Absolute hemostasis was ascertained*". In the Defendant's operation record, there was no record of any intra-operative difficulties or massive bleeding and the reason for the massive bleeding. According to the Coroner's summing up of the case at the death inquest, the Defendant admitted that during and at a later stage of the surgery, mainly at the later stage of the surgery, there was significant bleeding, and blood transfusion was required. Five blood units in total were transfused at the later stage of and after the surgery.

5. Postoperatively the patient was nursed in a general ward. In the morning of 6 October 2006, there was tea-coloured urine, and the patient's condition rapidly deteriorated with markedly deranged liver function. On 7 October 2006, ultrasound examination showed extensive infarct of the liver with loss of Doppler signal at the portal vein.

6. The patient was transferred to a public hospital on 8 October 2006. CT scan confirmed that there was complete absence of blood supply to the liver. After assessment by the surgeons of the public hospital, no specific therapy could be offered. The patient died on 12 October 2006.

7. Post-mortem autopsy showed that the portal vein and the common bile duct were completely transected, and the cut ends of both structures were sutured. The cause of death was (i) massive hepatic necrosis, (ii) transection of portal vein, and (iii) post partial gastrectomy for carcinoma of stomach.

Findings of Council

8. The question for us is whether transection of the portal vein and the common bile duct was caused by the Defendant during the operation. At the death inquest, the Defendant denied having done so. Given that the only operation was performed by the Defendant and no one else could have access to the abdominal organs of the patient, the only reasonable inference is that the transection of the portal vein and the common bile duct and the subsequent suturing of the transected ends were done by the Defendant.

9. A doctor of reasonable competence exercising reasonable care must identify and isolate these two structures before proceeding to gastrectomy. Transection of these two vital structures is an extremely rare and serious complication, and should not happen if a doctor of reasonable competence exercises reasonable care.

10. We note that in the death inquest, the Defendant said he had not transected the portal vein and the common bile duct, and he was surprised at the autopsy finding that the vein and the duct were transected and sutured. We are of the view that he was unaware that he had transected the portal vein and the common bile duct, even at the time when he sutured these tubular structures. If he had isolated these two structures before performing the gastrectomy, the damage would not have happened. Moreover, if he had recognized that he had transected the portal vein and the common bile duct, he would not have sutured the cut ends as it would certainly result in liver infarction and then death.

11. The Defendant's postoperative management of the patient was consistent with our finding that he did not even recognize that the portal vein had been transected as he was under the impression that the patient only had renal failure.

12. Given our findings above, we are of the view that the transection of the portal vein and common bile duct was the result of the Defendant's failure to isolate these structures before the gastrectomy. These are fundamental issues required of all doctors, and the Defendant's conduct in performing the gastrectomy was far below the standard expected amongst registered medical practitioners.

13. In the circumstances, we find the Defendant guilty of charge (b).

14. Although charge (b) is not related to failure to take remedial measures after transection of the portal vein and the common bile duct, it is a basic requirement in all surgical procedures to ascertain whether any unintended damage had been caused by the procedure and if so, to take necessary remedial actions. Had the Defendant been charged with such failure, we see no reason why he should not be found guilty.

15. As to the pre-operative investigation, we accept that there has been an international trend towards the use of laparoscopic staging in carcinoma of stomach with suspected peritoneal metastasis before proceeding to further surgical intervention. We recognize that this trend has not yet been adopted locally as a standard guideline. The expert witness is of the view that the traditional exploratory laparotomy before proceeding to gastrectomy is still acceptable. In the circumstances, we cannot say that the Defendant's failure to perform pre-operative staging laparoscopy was below the standard expected amongst registered medical practitioners in 2006. In the circumstances, we find the Defendant not guilty of charge (a).

16. Nevertheless, we must emphasize that with the development of new modalities of management of carcinoma of stomach in recent years, all doctors are expected to take note of and consider such development. If guidelines in this respect are issued by the relevant specialty colleges, such guidelines should be followed.

Sentencing

17. The Defendant has a clear record.

18. We give credit to the Defendant for his honest admissions during preliminary investigation and in this inquiry. We accept that he is remorseful and the likelihood of re-offending is low.

19. The misconduct in question is a fundamental issue. Firstly, he did not take the necessary precaution in performing gastrectomy. Secondly, after transection of the portal vein and the common bile duct he did not take any

remedial measure to save the patient's life. This resulted in the death of the patient.

20. In view of the gravity of the case, we are of the view that unsuspended removal from the General Register for 18 months is appropriate. Giving him credit for the mitigating factors, we order that his name be removed from the General Register for a period of 12 months. The order shall be published in the Gazette in accordance with the provisions of the Medical Registration Ordinance.

Other remarks

21. The Defendant's name is included in the Specialist Register under the specialty of 'General Surgery'. While it is for the Education and Accreditation Committee to decide whether action should be taken in respect of his specialist registration, we are of the view that this case reflects adversely upon his competence as a specialist in General Surgery. In addition, he will lose the prerequisite status to remain on the Specialist Register upon removal of his name from the General Register, and naturally his name should be removed from the Specialist Register.

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