香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr HUNG Cheung Kin (孔祥堅醫生) (Reg. no M04005)
Date of hearing: 24 October 2012 and 2 December 2012

1. The charges alleged against the Defendant, Dr HUNG Cheung Kin, are that:

> "In the period between September 2008 and October 2008, he, being a registered medical practitioner, had disregarded his professional responsibility to his patient Madam [redacted] ("the Patient") in that :-
>
> (i) during the surgery on 20 October 2008, he failed to differentiate the submandibular gland from the tumour in the parapharyngeal space as shown in the MRI taken on 25 September 2008;
>
> (ii) he failed to arrange a follow-up MRI to monitor the Patient's post-operative progress when the Patient complained of persistent symptom of tumour in the parapharyngeal region; and
>
> (iii) he failed to arrange a follow-up MRI to monitor the Patient's post-operative progress when the specimen removed by surgery was not consistent with the findings in the MRI report of 25 September 2008.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

2. Charge (ii) has been dismissed at the no-case-to-answer stage, for the reason that after the operation the Patient had not complained to the Defendant any symptom of the tumour. Therefore, we shall deal with only Charges (i) and (iii).

Facts of the case

3. On 18 September 2008, the Patient consulted the Defendant for a neck mass. The Defendant conducted an ultrasound examination and made a finding of "*vague mass at R para-tracheal region 3 cm diameter*", and ordered that MRI of the neck region be performed.

4. The MRI examination was conducted on 25 September 2008. The MRI report issued by the radiologist stated, inter alia, the following findings:-

    (a) There was a mass about 4.3cm x 3.2cm x 2.9cm in the parapharyngeal space.

    (b) The appearance and location of the mass raise the suspicion of a benign salivary gland tumour arising from minor salivary gland within the parapharyngeal space, but the possibility of a nerilemmoma or neurofibroma has to be kept in mind.

    (c) There was no other mass or enlarged lymph node.

    (d) The parotid and submandibular glands are not enlarged.

5. The Defendant advised the Patient to remove the neck mass by surgery. The Patient was admitted to hospital. During the surgery on 20 October 2008, the Defendant removed the right submandibular gland and concluded that it was the neck mass found in the MRI examination. The Patient was discharged from hospital on 21 October 2008.

6. On 27 October 2008 when the Patient returned to the Defendant's clinic for removing the sutures, the Defendant told the Patient that the neck mass was removed and it was alright. No arrangement was made for further follow up.

7. Later the Patient felt that the neck mass was still present. She consulted a specialist in Otorhinolaryngology. Upon MRI examination on 21 March 2009, it was discovered that the mass in the parapharyngeal space was still

present. On 15 May 2009, the mass in the parapharyngeal space was removed by another surgery.

<u>Findings of Council</u>

<u>Charge (i)</u>

8. It is not disputed that the Defendant failed to remove the neck mass in the parapharyngeal space found in the MRI examination. The question is whether there was an acceptable reason for the Defendant not to have done so.

9. In the Ultrasound Report on 18 September 2008, the Defendant stated "*A vague mass at R [right] para-tracheal region*". In the clinical record on 18 September 2008, he recorded "*USG: mass at R [right] para-tracheal region*". In the clinical record on 4 October 2008, he recorded "*MRI Mass at R [right] Submandibular region*". In the consent form for the surgery dated 19 October 2008, he wrote down "*Excision right Submandibular Mass*". In the Operation Record on 20 October 2008, he wrote down "*R sub [right submandibular] gland grossly enlarged. No hard tumour found inside.*" In the Discharge Summary on 21 October 2008, he wrote down "*Submandibular gland infection*" under Principal Diagnosis, and "*Enlarged R sub. [right submandibular] mass*" under History, Essential Findings. In the clinical record on 27 October 2008, he recorded "*Exploration done. R [right] submandibular gland. Active chronic sialoadenitis. Post-op smooth.*"

10. To put it simply, in all the documentation before the explanation to the Preliminary Investigation Committee, the Defendant never referred to the parapharyngeal space. The first time he referred to the parapharyngeal space was in his written explanation to the Preliminary Investigation Committee.

11. The Defendant's written explanation dated 19 November 2010 to the Preliminary Investigation Committee was as follows:-

> "*A grossly enlarged submandibular gland was found in the parapharyngeal space. There was no other hard tumour found inside after exploration….The parapharyngeal space had been meticulously searched and no other tumour mass or enlarged lymph node was*

detected. I therefore came to the view that the inflamed salivary gland was the lesion shown in the MRI. After resection of the salivary gland, the area was thoroughly viewed again to make sure that there was no suspicious mass before I closed the wound….Therefore, I did not have any suspicion during and after surgery that there was in fact another mass in the region of Madam █'s right neck."

12. It is a matter of human anatomy that the parapharyngeal space is distinct from the submandibular space. The submandibular gland (which is the second largest salivary gland) is in the submandibular space, and cannot be located in the parapharyngeal space. The Defendant's written explanation that "*A grossly enlarged submandibular gland was found in the parapharyngeal space*" simply cannot be true.

13. Judging by the Defendant's explanation to the Preliminary Investigation Committee and his reference in the various documentation to the location of the mass, we are of the view that he had always considered the lesion to be in the submandibular space, while the MRI reported it to be in the parapharyngeal space. He mistakenly, and wrongly, believed that the submandibular space was the same as the parapharyngeal space. The only reasonable inference is that his knowledge of the anatomy of the neck was limited and he was not aware that the parapharyngeal space is distinct from the submandibular space.

14. In his oral testimony, the Defendant changed his position and said that he had in mind removal of the mass in the parapharyngeal space, and that after resecting the submandibular gland he had palpated for the mass from the outside without opening up the deep fascia covering the parapharyngeal space. We are of the view that this was an ex *post-facto* justification of his faulted explanation to the Preliminary Investigation Committee dated 19 November 2010, after reading the report of the Secretary's expert dated 4 July 2012.

15. It is a fundamental rule that every doctor must know his limitation, and must not proceed with a treatment if he does not have the necessary competence.

16. The neck has complicated anatomical features. The Defendant did not have the necessary knowledge of the relevant anatomically features to enable him to

properly plan for the operation. Furthermore, he has never operated on the parapharyngeal space before.

17. This is not a situation of emergency requiring immediate operation. In the circumstances, it was wrong in the first place for him to proceed to the operation without referring the Patient to a doctor with the necessary competence. At least he should have sought help from doctors with the necessary expertise. It was plainly wrong for him to proceed on the assumption that the MRI report was wrong without seeking clarification, such as from the radiologist who issued the MRI report as to the actual location of the lesion.

18. According to the Secretary's expert whose evidence we accept, the proper approach to removal of a lesion in the parapharyngeal space involves removal of the submandibular gland and reflection of the sternomastoid muscle, in order to gain access to the parapharyngeal space which lies underneath.

19. The Defendant has only removed the submandibular gland, which alone could not have allowed him to gain access to the parapharyngeal space for proper exploration. If he had the necessary knowledge of the anatomical features and had properly studied the MRI report, he would have realized that the submandibular gland could not be the lesion identified in the MRI report for two reasons: (1) it was not in the right location; and (2) the MRI report stated that the submandibular glands were not enlarged.

20. We are satisfied that he did not have the knowledge and the competence to differentiate the submandibular gland from the tumour in the parapharyngeal space. In proceeding with the operation without the necessary competence, his conduct has clearly fallen below the standard expected amongst registered medical practitioners, and such conduct constitutes professional misconduct.

21. We find him guilty of Charge (i).

Charge (iii)

22. We then turn to Charge (iii). The charge is narrowly framed in respect of the failure to arrange a follow-up MRI to monitor the post-operative progress when the specimen removed by surgery was not consistent with the findings in the pre-operation MRI report.

23. It is not disputed that the Defendant did not arrange for a post-operative MRI examination. The questions are whether the specimen removed was inconsistent with the findings of the pre-operation MRI findings, and whether there was a duty to arrange for a post-operative MRI examination for monitoring the progress.

24. The Defendant's position is that because the removed specimen was pathologically consistent with the MRI finding that the lesion was suspected to be a benign salivary gland tumour, therefore it was acceptable for him to come to the conclusion that he had removed the lesion.

25. We must point out that the findings of the MRI report involved two elements, i.e. the location and the histopathology of the lesion.

26. The removed specimen, although histopathologically not inconsistent with the MRI finding, was inconsistent with the location of the lesion. As we have remarked earlier, a doctor with the necessary knowledge and competence should have known that the submandibular gland cannot be the mass in the parapharyngeal space. In the circumstances, a reasonably competent doctor exercising reasonable care would have the duty to take further follow-up action to ascertain whether the lesion had been removed. In telling the Patient that the tumour had been removed and it was alright, without making arrangement for follow-up or at least explaining to the Patient to return for follow-up upon noticing further symptoms, the Defendant had failed to discharge that duty.

27. However, we cannot say that follow-up action is necessarily by way of a further MRI examination. There could have been other manners of follow-up action. Given the limitation of the narrow wording of Charge (iii), we cannot say that the allegation has been proven to the required standard. In the

circumstances, we have no alternative but to find him not guilty of Charge (iii).

Sentencing

28. The Defendant has a clear record.

29. Despite the clear findings of the MRI report, the Defendant sought to justify his fault by playing around with the terminology. There can be no mitigation for insight or remorse.

30. We accept that this is an isolated incident. We are of the view that he has learned a hard lesson, and the likelihood of re-offending is low.

31. Given the deep location of the lesion, this is a difficult operation which should be performed by doctors who are specialized in head and neck surgery.

32. Having regard to the gravity of the case and the mitigating factors, we order that the Defendant be reprimanded. The order would be published in the Gazette in accordance with the provisions of section 21 of the Medical Registration Ordinance.

Other remarks

33. 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 any action should be taken under section 20N of the Medical Registration Ordinance in respect of his specialist registration, we are of the view that the case being an isolated incident does not reflect adversely upon his specialist competence as a general surgeon.

34. We advise the Defendant to treasure the opportunity and to ensure that he has the necessary competence before proceeding with an operation in the future.

Dr TSE Hung-hing
Temporary Chairman, Medical Council