香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Dates of hearing: 24 January 2013 (Day 1), 13 April 2013 (Day 2), 14 April 2013 (Day 3), 21 April 2013 (Day 4), 24 April 2013 (Day 5)

Defendant: Dr CHAN Po Sum (陳溥深 醫生) (Reg. No.: M06318)

1. The charges against the Defendant, Dr CHAN Po Sum, are that:-

"He, being a registered medical practitioner, disregarded his professional responsibility to his patient Mr A ("the Patient") in that:-

(1) he failed to obtain informed consent from the Patient before performing the Stapled Haemorrhoidopexy ("the Operation") on the Patient on 23 February 2010 in St. Teresa's Hospital ("the Hospital");

(2) during the post-operative period up to the time of discharge from the Hospital, he failed to properly examine and investigate the Patient despite his repeated complaints of severe abdominal pain after the Operation;

(3) on 24 February 2010, he failed to properly examine and investigate the Patient before he was discharged from the Hospital despite his repeated complaints of persistent abdominal pain;

(4) from 25 February 2010 to 1 March 2010, he failed to properly advise the Patient when the Patient repeatedly complained of persistent abdominal pain.

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

2. For the purposes of this judgment, the terms “Stapled Haemorrhoidopexy”, “Stapled Haemorrhoidectomy” and “Procedure for Prolapse and Haemorrhoids” are used interchangeably to mean the same procedure. For ease of reference, we shall refer to them collectively as “PPH”.

Facts of the case

3. The Patient consulted the Defendant on 7 December 2009 for his haemorrhoid problem. The Defendant advised the Patient to try conservative treatment by medication first. He also advised that PPH was appropriate if the Patient wished to undergo surgery.

4. On 4 February 2010, the Patient returned indicating that he was considering surgery. After further explanation by the Defendant, the Patient decided to undergo PPH.

5. The Defendant performed PPH in a private hospital between 12:30 pm and 1:05 pm on 23 February 2010. When the Patient woke up from the anaesthesia, the Defendant had left the hospital. The nurse gave him an injection of an analgesic, pethidine, at 2:40 pm.

6. Postoperatively the Patient had difficulties in passing urine. He also complained of lower abdominal pain. Record shows that another injection of pethidine was given at 3:10 am on 24 February 2010. The patient was catheterized at 6:45am after having refused the procedure earlier.

7. When the Defendant did the ward round at about 8:30 am on 24 February 2010, he did not examine the Patient.

8. The Patient was discharged from the hospital at noon on 24 February 2010, after having successfully passed urine by himself but without seeing the Defendant again.

9. On 25 February 2010, the Patient telephoned the Defendant’s clinic and spoke to the clinic assistant but not the Defendant.

10. On 26 February 2010, the Patient telephoned the Defendant’s clinic again but was only able to talk to the clinic assistant but not the Defendant.

11. On 27 February 2010, the Patient had a telephone discussion with the Defendant when he was in the Accident and Emergency Department of a

public hospital. He received analgesic injection and medications from the hospital.

12. In the early hours of 1 March 2010 the Defendant was informed that the Patient had developed intense abdominal pain. The Patient was taken by ambulance to a public hospital, diagnosed with peritonitis and emergency laparotomy was performed. At the operation a 4x3 cm. perforation was noted at the anterior wall of the rectum above the peritoneal reflection. End colostomy and second look laparotomy were performed later in the afternoon.

13. The Patient was discharged from the public hospital on 2 April 2010 after staying for 1 month in the hospital

Findings of the Council

14. The main dispute of facts is whether during the post-operative stay in the private hospital, the patient had repeatedly complained of severe abdominal pain, and if he had, whether the nurses had notified the Defendant of the complaints. There is also dispute on whether the Patient had, during the telephone calls to the Defendant's clinic, complained of severe abdominal pain. Such complaints are relevant to Charges (2), (3) and (4). We shall deal with those disputes later.

Charge (1)

15. We shall deal with Charge (1) first in relation to informed consent for PPH.

16. The evidence in this respect is not much in dispute. According to the Defendant, at the first consultation on 7 December 2009, he advised the Patient that the haemorrhoids could be treated by 2 surgical options: PPH or conventional open haemorrhoidectomy. PPH would have the advantages of significantly less pain, less post-operative wound care, shorter recovery time, and not much risk involved. At the second consultation on 4 February 2010, as the Patient had already decided to undergo PPH, the Defendant gave a more detailed description of the PPH procedure with little mention of conventional haemorrhoidectomy.

17. According to the Patient and agreed by the Defendant, throughout the second consultation the Defendant impressed upon the patient that conventional haemorrhoidectomy was very painful and PPH was a newer procedure with less pain. Some of the risks were mentioned. There was

no mention of the recurrence rate or the risk of rectal perforation.

18. On 23 February 2010, the consent form for PPH was signed at the private hospital with no further explanation.

19. We have heard expert evidence on both sides as to the comparative advantages and disadvantages of conventional haemorrhoidectomy and PPH, as well as the need to explain the risk of rectal perforation and the recurrence rates.

20. A doctor cannot perform medical treatment on a patient unless the patient has given informed consent for the treatment. Informed consent requires that the doctor has given proper explanation of the nature, effect and risks of the proposed treatment and other treatment options.

21. Where there are equally suitable treatment options, the doctor should explain the advantages and disadvantages of the respective options so that the patient can make an informed choice and decide which option to adopt. The explanation should be balanced and sufficient to enable the patient to make an informed decision. It should cover not only significant risks, but also risks of serious consequence even though the probability is low.

22. In this respect, we must point out that patients are not medically trained and rely on doctors to give them proper professional advice. That the patient is inquisitive and may have done research on his own is not an excuse for not giving proper explanation.

23. In cases of emergency, time may not allow for an explanation as detailed as would be required in a non-emergency situation. In the present case, surgical treatment of the Patient's haemorrhoids is an elective procedure. There is no reason to rush into a decision without providing the necessary explanation.

24. In the present case, there are two equally suitable options: conventional haemorrhoidectomy and PPH. The explanation should cover the pros and cons of both options and the significant difference between the options, especially the defining difference between the two.

25. Rectal perforation is a known risk of PPH. Although the probability is low, it is a serious risk which is life-threatening. However, by reason of the nature of the operation, there is no risk of rectal perforation involved in conventional haemorrhoidectomy. This is the defining difference between the two options which must be explained to the patient, so that he can make

an informed decision.

26. PPH is a relatively new procedure which, at the beginning of its development, was hailed as a superior treatment option for haemorrhoids. As time went on, more reliable studies revealed that there are disadvantages of PPH which were not known before. By July 2007, it was known that PPH is associated with a higher long-term recurrence rate of internal haemorrhoids than conventional haemorrhoidectomy, and a reliable study concluded that conventional haemorrhoidectomy is superior to PPH for prevention of post-operative recurrence of internal haemorrhoids. This is a significant difference between the two options which should be explained in order that the patient can make an informed decision.

27. The Defendant admits that he has not explained the risk of rectal perforation and the recurrence rates to the Patient. In our view, from the beginning he was promoting PPH to the Patient, emphasizing that conventional haemorrhoidectomy was very painful and PPH involved little pain and few risks. This is not a balanced explanation.

28. We are satisfied that the Defendant has failed to give a proper explanation to the Patient before obtaining consent for PPH, thus the Patient's consent was not informed consent. We are satisfied that this is conduct below the standard expected amongst registered medical practitioners. We find him guilty of professional misconduct on Charge (1).

Charges (2), (3), (4)

29. We now turn to Charge (2) which concerns the Defendant's failure to examine the Patient during the Patient's post-operative stay in the private hospital, Charge (3) which concerns the Defendant's decision to discharge the Patient without examination, and Charge (4) which concerns the Defendant's failure to advise the Patient properly after discharge from the hospital.

30. The Patient says that immediately after waking up from the anaesthesia, he had severe abdominal pain. He rang the bell twice to complain to the nurse, and eventually a pethidine injection was given at 2:40 pm. Thereafter, the pain persisted after the analgesic effect waned off. He complained several times to the nurse, and after consulting the Defendant the nurse catheterized the Patient to drain the urine. Record shows that a pethidine injection was given at 3:10 am on 24 February 2010.

31. The Patient says that he complained of severe pain in the front abdomen to the Defendant next morning when the Defendant did the ward round, and asked why the pain was in the front given that the operation was in the anus. The Defendant told him that it was his illusion, and the operation was very successful.

32. The Defendant denies that the Patient complained of abdominal pain during the post-operative hospital stay. The Patient only complained of mild discomfort in the lower abdomen, and inability to pass urine, have bowel motions or to pass flatus. A hospital nurse on duty was also called to support his evidence that the Patient did not complain of severe abdominal pain.

33. The Defendant admits that the Patient had telephoned his clinic several times but the discussion was about the dosage of laxative, not abdominal pain.

34. The hospital nurse admits that after 3 years she had no independent memory of the Patient, but memory came back upon reading the Nurses' Report. The Nurses' Report is clearly incomplete, given that some significant events which had taken place were not recorded. We cannot rely on the nurse's evidence based on such incomplete record, especially in relation to events which were not recorded.

35. Having considered the oral evidence of all witnesses and the documentary evidence, we accept the evidence of the Patient for the following reasons:-

    (a) The Patient's evidence of severe abdominal pain is consistent with, and corroborated by, the following facts:-

        (i) a potent analgesic, pethidine, was injected on two occasions, respectively 1.5 hours and 14 hours after the operation;

        (ii) the Patient's subsequent diagnosis of rectal perforation and acute peritonitis on 1 March 2010;

        (iii) an entry in the Nurses' Report that: "*Pt Still complained he could not pass urine after operation and lower abdominal pain. Dr. P S Chan was inform [sic] at 02:35. Cath once was prescribed but patient refused. Pethidine 75 mg IMI was injected at 03:10. Pt insisted to try passing urine by himself.*".

    (b) There is no reason for the Patient not to tell the doctor when he was

experiencing severe pain.

(c) The Patient had to go to the Accident and Emergency Department of a public hospital and receive analgesic injection and medications on 27 February 2010.

(d) The Patient had to be taken by ambulance to the public hospital on 1 March 2010, at which acute peritonitis was diagnosed.

36. Severe abdominal pain after an operation is a danger sign, particularly when the pain persists for a significant period. It is incumbent upon the doctor to immediately examine the patient to find out the cause of the pain and to rule out any complications.

37. In the present case, given that rectal perforation is a known risk of PPH, and that the Patient was having severe abdominal pain and was unable to pass flatus, a competent doctor exercising reasonable care should examine the Patient immediately. There is no reason, and it is unacceptable, for the Defendant to say that the Patient was having illusion. It is entirely unacceptable for the Defendant to do nothing other than telling the patient that the operation was very successful.

38. Even according to the Defendant's version, the Patient's inability to pass flatus after the operation was a danger sign that something untoward could have happened which would warrant immediate abdominal examination.

39. It is a simple task of performing abdominal examination to find out whether there was any guarding or rebound tenderness. We can see no reason why the Defendant did not even take this measure.

40. In any case, even without signs of abdominal pain, before a patient is discharged after a surgical operation a doctor should, at least as a matter of good practice, examine the patient to ensure that he/she is fit for discharge. Where the patient is complaining of severe abdominal pain, as is in the present case, it is mandatory for the doctor to examine the patient before allowing him/her to be discharged.

41. After discharge on 24 February 2010, the Patient had telephoned the Defendant's clinic a number of times but was unable to speak to the Defendant. The Defendant's explanation is that he was seeing other patients and he had confidence in the clinic assistant whose husband had also undergone PPH and therefore would be able to give proper advice to the Patient.

42. While the Defendant might not be able to speak to the Patient immediately, he should have returned the call after he had finished seeing his other patients. It is entirely improper to rely on a clinic assistant who was not medically trained to give advice to the Patient, especially when the Patient had called up a number of times.

43. When the Patient complained of abdominal pain after discharge, the Defendant should have directly communicated with the Patient and insisted that he either return to his clinic or the private hospital to be followed up by him, or to immediately go to the Accident and Emergency Department of a public hospital to seek immediate treatment. Even if the Patient had refused, the Defendant should have advised him of the danger involved and the consequence of delay in treatment. The Defendant had not done any of these.

44. It was fortunate that the Patient had been taken to the public hospital in time for emergency treatment, otherwise the Patient could have died if there was further delay caused by the Defendant's reassurance that the operation was very successful and that the Patient was having illusion.

45. We have considered each of the Charges (2), (3) and (4) separately and independently. We are satisfied that the Defendant's conduct in respect of each of these 3 charges is seriously below the standard expected amongst registered medical practitioners. We find him guilty of professional misconduct on each of the 3 charges.

46. In summary, the Defendant is found guilty Charges (1), (2), (3) and (4).

Sentencing

47. The Defendant has a clear record.

48. Other than this, there is no mitigation of weight. He strenuously argued that the Patient had not made any complaint of abdominal pain, which we have rebutted after trial.

49. This is not a case of a lapse of attention. The Patient had repeatedly complained of severe abdominal pain. It was a clear warning to any doctor exercising reasonable care that something was wrong and proper action had to be taken. This is a fundamental duty of a doctor. Nevertheless, the Defendant ignored the Patient's complaints for a number of times, over

several days.

50. Worse than turning a blind eye to the Patient's complaints, he told the Patient that he was having illusion and that the operation was very successful, thus discouraging the Patient from seeking treatment from other doctors. This is illustrated by the Patient refusing to be examined even though he had gone to the Accident and Emergency Department of the public hospital, after being reassured by the Defendant over the telephone.

51. We must have regard to the potential consequence of the Defendant's misconduct. As we have said, if there had been further delay, the Patient could have died.

52. We hope that the Defendant has learned a lesson, and seriously review his approach to patients' complaints.

53. Having considered the gravity of the case and the mitigation, we make the following orders:-

    (a) In respect of Charge (1), a warning letter be served on the Defendant. The order shall be published in the Gazette.

    (b) In respect of Charges (2), (3) and (4), the Defendant's name be removed from the General Register for the period of 1 month on each charge, and the removal orders on all 3 charges to run concurrently.

54. We have considered and have decided that the orders cannot be suspended.

<u>Other remarks</u>

55. 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 the Defendant's specialist registration, we are of the view that:-

    (a) this present case is directly relevant to his specialist competence in surgery; and

    (b) upon implementation of the removal order the Defendant will lose the prerequisite for his name to remain on the Specialist Register,

and it is mandatory that his name be removed from the Specialist Register.

56. It is for the Defendant's application for restoration to the General Register (if any) to be considered by the Council as and when it is made. We recommend that the application should not be approved unless there is cogent evidence that the Defendant has taken proper measures to rehabilitate himself in respect of post-operative patient management and improve his knowledge on informed consent.

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