G.N. 5289

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF THE MEDICAL COUNCIL OF HONG KONG

DR WONG KAR MAU (REGISTRATION NO.: M02124)

It is hereby notified that after due inquiry held on 9 August 2022 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong found Dr WONG Kar Mau (Registration No.: M02124) guilty of the following amended disciplinary charges:—

'That, in or about April 2010, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ('the Patient'), deceased, in that he:—

(a) failed to obtain an informed consent from the Patient before performing the breasts augmentation surgery ('the Surgery'), by properly and adequately advising the Patient about the nature, procedure, all possible risks and complications of the Surgery;

(b) failed to keep and maintain proper record for the Patient;

(c) performed the Surgery on the Patient when he did not have the appropriate training, equipment, expertise, personnel and/or experience in performing the Surgery;

(d) failed to maintain an optimal standard of monitoring the Patient's conditions whilst putting the Patient under sedation for the Surgery;

(e) administered anaesthetics on the Patient during the Surgery which ran the risks of causing cardiorespiratory distress to the Patient;

(f) failed to properly and adequately follow up the Patient's conditions after the Surgery.

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

Briefly stated, the Patient first consulted Dr WONG at his clinic on 17 April 2010 for breasts augmentation. According to Dr WONG, after examining the Patient's breasts, he explained to her that '*there were two treatment options, namely 1) breast augmentation by inserting a prosthesis into each breast, and 2) injection of Restylene*'. Although '*the latter option would be more comfortable and result in a more attractive appearance*', the Patient '*preferred insertion of a prosthesis/implant, as she did not want future injections*'. Dr WONG then explained to the Patient that '*the appearance could appear awkward, in that the breast prosthesis could result in a bulging effect… The prosthesis would be inserted through a periaerolar incision made along the inferior edge of the areolar [and the] procedure would be performed under local anaesthesia*'. He also explained '*the risks of complications of the surgery including bleeding and infection*'. Furthermore, he '*obtained informed consent for performing sedation*'. Although he did not mention the names of the anaesthetics, namely, Xylocaine and Pethidine, he had '*explained [to the Patient] that generally the procedure is safe but there is a possibility of drug reaction.*'

Eventually, arrangements were made for the Patient to return to Dr WONG's clinic on 30 April 2010 for breasts augmentation surgery (the 'Surgery').

The Patient arrived at Dr WONG's clinic at around 3.00 p.m. in the afternoon of 30 April 2010. The Patient was invited to go to the consultation room where she was asked to sign on a consent form in Chinese before the Surgery began.

According to Dr WONG, he then prepared a diluted local anaesthetic solution by mixing 40 ml of a 2% Xylocaine (the trade name of Lignocaine) with 1:200 000 adrenaline solution into 80 ml of normal saline (i.e. 0.67% Lignocaine with 1 in 600 000 Adrenaline). This was however different from what Dr WONG wrote down in the Patient's medical record. After establishing IV access in the cubital fossa of the Patient's right arm at around 3.20 p.m., 50 mg of Pethidine was injected intravenously. This was followed by two injections of 20 ml of the said anaesthetics first into the Patient's right and then left breast. Two more 3 ml doses of the said anaesthetics were locally infiltrated into the areas around the nipples on both sides.

Dr WONG made a skin incision on the Patient's right breast at around 3.25 p.m. The Patient complained of pain when Dr WONG dissected into the sub-mammary space. According to Dr WONG, he gave the Patient another 10 mg of Pethidine intravenously and another 5 ml of the said anaesthetics was injected into the dissection site.

The Patient was noted to have reduced consciousness followed by generalized convulsions at around 3.28 p.m. Erythema over her face and chest was also observed. Assisted ventilation was initiated first with an oral airway followed by bag-valve-mask bagging. Ambulance was summoned and other doctors nearby were asked to assist.

Eventually, the Patient was sent by ambulance and arrived at the Accident and Emergency Department of Queen Elizabeth Hospital at 5.06 p.m. Respiratory and cardiovascular supportive treatments were initiated and she was admitted into the Intensive Care Unit ('ICU') for further management. She remained comatose with fixed and dilated pupils all along despite improvement in her blood pressure and pulse. Computer tomography suggested swelling of her brain. Supportive treatment was continued in the ICU but the Patient remained vegetative with no sign of neurological recovery. Brain death was confirmed on 11 May 2010. Autopsy was performed on 17 May 2010. Hypoxic brain injury and bronchopneumonia were found to be the direct cause of death. Adverse effect of the drug lignocaine was said to be the intervening antecedent cause of the death.

Dr WONG admitted the factual particulars of all the amended disciplinary charges against him.

There was no contemporaneous record of what advice had been given to the Patient. Dr WONG merely wrote down in his record for the consultation with the Patient on 17 April 2010 the words '*sign consent form*'.

The Inquiry Panel needed to emphasize that a doctor's duty to obtain informed consent is not fulfilled by routinely asking a patient to sign on a *pro-forma* consent form. In order to discharge this duty, it is prerequisite in the Inquiry Panel's view for a doctor to provide proper explanation of the nature, effect and risks of the proposed treatment and other treatment options (including the option of no treatment). Moreover, the explanation should be balanced and sufficient to enable the patient to make an informed decision.

According to Dr WONG, he merely advised the Patient with regard to the use of anaesthetics that '*there is a possibility of drug reaction*'. It was however insufficient in the Inquiry Panel's view for Dr WONG to mention the possibility of drug reaction happening only. Before the Patient decided whether to undergo the Surgery, she should be informed of the significant risk (albeit a much smaller one) of a grave outcome, which could be potentially life threatening, in case of adverse reactions or toxicity from anaesthetics. This was particularly true because the Surgery was an elective one.

Moreover, Dr WONG ought in the Inquiry Panel's view to have advised the Patient properly and adequately as to the risk of undergoing the Surgery in his clinic with limited equipment and without the assistance of an anaesthetist and/or other qualified personnel.

In failing to properly and adequately advising the Patient about the nature, procedure, all possible risks and complications of the Surgery, in particular, with regard to the use of anaesthetics, Dr WONG had failed to obtain an informed consent from the Patient before the Surgery. Accordingly, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (a).

It was evident to the Inquiry Panel from reading the medical record kept by Dr WONG on his consultation with the Patient before the Surgery that he merely wrote down the words '*past health—good*'. There was nothing about the Patient's medical history, body weight or physical findings such as blood pressure and pulse.

Moreover, the operation record was improper in that there were inadequate details of how the said anaesthetics were prepared and administered. There was no record of the Patient's vital signs after the Surgery began and before she developed generalized convulsions. There was no mention of the Patient's complaint of pain after skin incision on her right breast or the additional dose of the said anaesthetics being given. There were also inadequate details of the time of and responses to resuscitation procedures.

In failing to keep and maintain proper record for the Patient, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (b).

In the Inquiry Panel's view, any doctor who operates on a patient under sedation must ensure that he has the appropriate training, equipment, expertise, personnel and/or experience in performing the surgery.

It was evident to the Inquiry Panel from reading the Coroner's Verdict in the Death Inquest of the Patient that Dr WONG had not demonstrated the required competency to ensure that the Patient would be safe whilst she was being put under sedation. The Inquiry Panel was particularly concerned that Dr WONG was unable to tell the Coroner for sure how the said anaesthetics were prepared and hence the amount and concentration of Lignocaine given to the Patient.

The Inquiry Panel agreed with the Secretary's expert, Dr TSE, that Dr WONG '*had been ignorant of the toxicity of the local anaesthetic drug lignocaine… [and he] had not properly assessed and evaluated the potential risk of his anaesthetic method… with little established evidence of efficacy and safety…He had failed to recognize the early signs of life-threatening lignocaine overdose, i.e. convulsion and hypotension so that timely drug treatment was not given…*'

Moreover, the fact that Dormicum (Midazolam) and Adrenaline were not given to the Patient soon after she had developed generalized convulsions reinforces the Inquiry Panel's view that Dr WONG was not conversant with how to handle grave outcome of adverse reactions or toxicity from anaesthetics.

By performing the Surgery on the Patient when he did not have the appropriate training, equipment, expertise, personnel and/or experience in performing the Surgery, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (c).

The Inquiry Panel agreed with the Legal Officer that 'optimal standard' connotes in the context of disciplinary charge (d) what is reasonably expected of registered medical practitioners in the circumstances of this case.

It was pertinent to note in this case that Dr WONG had chosen to perform the Surgery in his clinic without the assistance of an anaesthetist. It followed in the Inquiry Panel's view that Dr WONG bore the full responsibility to ensure that the Patient's conditions would be properly and adequately monitored throughout the Surgery. However, apart from the use of an oximeter, Dr WONG monitored the Patient's condition during the Surgery merely by talking to her, which was in the Inquiry Panel's view inadequate in the circumstances.

In failing to maintain an optimal standard of monitoring her conditions whilst putting the Patient under sedation for the Surgery, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (d).

The Inquiry Panel agreed with the Legal Officer that the clinical features of the Patient when she developed generalized convulsions at around 3.28 p.m. on 30 April 2010 were consistent with Lignocaine toxicity on the central nervous system. There was no doubt in the Inquiry Panel's minds that the speed at which Dr WONG administered the said anaesthetics on the Patient during the Surgery coupled with the short interval in between the last two doses ran (and indeed increased) the risks of causing cardiorespiratory distress to the Patient. This was further aggravated by the fact Dr WONG was unable to tell for sure how the said anaesthetics were prepared and hence the amount and concentration of Lignocaine given to the Patient.

For these reasons, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (e).

It was not disputed that Dr WONG had failed to properly and adequately follow up the conditions of the Patient after the Surgery was abandoned in that he (i) delayed in providing adequate ventilatory support for her; (ii) failed to provide Dormicum treatment for her; and (iii) delayed in administering Adrenaline to her.

The Inquiry Panel agreed with Dr TSE that all these measures should be taken promptly when the Patient developed generalized convulsions; and Dr WONG's failure in providing adequate ventilatory support and early drug treatment had contributed significantly to the subsequent death of the Patient.

For these reasons, Dr WONG had in the Inquiry Panel's view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. The Inquiry Panel therefore found Dr WONG guilty of misconduct in a professional respect as per disciplinary charge (f).

Dr WONG had one previous disciplinary record back in 2014 in that he performed dilatation and curettage on a Patient without proper justification. Dr WONG's name was ordered to be removed from the General Register for a period of 4 months with suspension for a period of 24 months.

Taking into consideration the nature and gravity of this case and what the Inquiry Panel had heard and read in mitigation, the Inquiry Panel ordered that:—

(1) in respect of disciplinary charge (a) that Dr WONG's name be removed from the General Register for a period of 2 months;

(2) in respect of disciplinary charge (b) that Dr WONG's name be removed from the General Register for a period of 1 month;

(3) in respect of disciplinary charge (c) that Dr WONG's name be removed from the General Register for a period of 5 months;

(4) in respect of disciplinary charge (d) that Dr WONG's name be removed from the General Register for a period of 3 months;

(5) in respect of disciplinary charge (e) that Dr WONG's name be removed from the General Register for a period of 5 months;

(6) in respect of disciplinary charge (f) that Dr WONG's name be removed from the General Register for a period of 3 months; and

(7) the removal orders to run concurrently making a period of 5 months.

Pursuant to the Inquiry Panel's orders, Dr WONG's name has been removed from the General Register on 23 September 2022; and pursuant to section 19(B)(1) of the Medical Registration Ordinance, Dr WONG's name has also been removed from the Specialist Register on the same day.

The orders are published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Inquiry Panel is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*