中華人民共和國香港特別行政區政府總部食物及衞生局
Food and Health Bureau, Government Secretariat
The Government of the Hong Kong Special Administrative Region
The People's Republic of China

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31 May 2018

Ms Maisie Lam
Clerk to Panel
Panel on Health Services
Legislative Council Complex
1 Legislative Council Road
Central

Dear Ms Lam,

Panel on Health Services
Follow-up to the meeting on 15 January 2018

During the discussion on the legislative proposal on paired/pooled organ donation and Thematic Household Survey findings on organ donation at the meeting of the Legislative Council Panel on Health Services held on 15 January 2018, Members requested supplementary information relating to findings of the examination of the provision of liver transplant service by the Hospital Authority (HA), in particular the directorship and manpower arrangement of the liver transplant team in the light of the incident concerning an intra-operative break during a liver transplant surgery in October 2017. Having consulted the HA, the requested supplementary information is provided in the ensuing paragraphs.

2. Regarding the interruption during a liver transplant surgery which was performed on 13 October 2017 in the Queen Mary Hospital (QMH), an investigation panel was set up to look into the incident and make recommendations to the hospital. After interviewing the related medical staff members and reviewing relevant documents, the investigation panel confirmed that the intra-operative break of three hours was unnecessary and avoidable. The investigation panel also found that the case was an isolated incident.

3. The investigation panel also examined the manpower and call arrangement of the liver transplant team of QMH, which is the only liver transplant centre in Hong Kong. It was noted that the manpower situation was similar to previous years and there was no similar incident happening before. The investigation panel concluded that manpower or call arrangement were irrelevant to the occurrence of the incident.

4. For details of the findings of the investigation panel, please refer to the enclosed press release issued by the HA.

Yours sincerely,

(Bernard Lo)
for Secretary for Food and Health

c.c. Chief Executive, Hospital Authority
(Attn.: Ms Dorothy Lam)

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東華醫院
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醫院管理局 HOSPITAL AUTHORITY

(Press Release)

Friday, 5 January 2018

Queen Mary Hospital Accepts Investigation Report on Intra-operative Break

The spokesperson of Queen Mary Hospital (QMH) today (5 January) announced the findings and recommendations of the investigation report regarding the surgical arrangement of a liver transplant operation, and accepted the panel's conclusions and recommendations.

QMH received a staff report on 18 October 2017 about an intra-operative break during a liver transplant surgery on 13 October. The hospital was very concerned about the incident. An investigation panel had been set up and the report was submitted to Hospital Chief Executive of QMH in late December.

"After interviewing the related medical staff members and reviewing relevant documents, the investigation panel confirmed that the there was an unnecessary and avoidable intra-operative break of three hours during the operation, while the case was an isolated incident, " the spokesperson said.

The investigation panel opined that Dr Ng Kwok-chai, Honorary Consultant of QMH's Department of Surgery did not make alternative arrangement to avoid the potential clash between his on-call duty and an elective surgery arranged in a private hospital. He also made a wrong judgement that Dr Tiffany Wong, Honorary Associate Consultant of QMH's Department of Surgery could complete the operation alone and did not discuss with Dr Wong in advance about any contingency arrangement.

The panel noted that Dr Wong decided to seek support from senior doctors to supervise the surgery after assessing the graft's condition. With due consideration, she decided not to complete the operation alone.

The anesthesia of the recipient and ischemic time of the graft had been prolonged for three hours by the break. The patient has recovered and been discharged, the panel however considered this intra-operative break not in the best interest of the patient. The panel also found it unacceptable for Dr Ng not to make any alternative arrangement for the operation to proceed and to avoid unnecessary delay.

The panel also examined the manpower and call arrangement of the liver transplant team. It was noted that the manpower situation was similar to previous years and there was no similar incident happening before. The panel concluded that manpower or call arrangement were irrelevant to the occurrence of the incident, the spokesperson added.

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The panel noted that the role of supervisor surgeons was mostly taken up by Dr Ng and another Associate Professor. In the past year, Dr Ng had performed and supervised the largest number of transplant operations.

The panel has made the following recommendations to QMH to prevent future occurrence of the incident:

1. Setting up a code of conduct for enhancement of communication and contingency measures inside the Operating Theatre
2. On appointing honorary medical staff, the hospital should issue the code of practice to regulate the roles and responsibilities, and specifically emphasise that that if the doctor is put on the call list, he/she should make timely response to attend to the need of the patients
3. Promoting Crew Resources Management concept to the Liver Transplant Team and the staff working in the Operating Theater so as to improve the timeliness and accuracy of communication
4. The Department of Surgery is recommended to review the job assignment of liver transplant surgeons in the Hepatobiliary & Pancreatic Surgery Division and Liver Transplantation Division with a view to optimise the use of each surgeon's expertise and at the same time, avoid potential burn out of individual surgeon.

The spokesperson said that QMH has accepted the recommendations from the investigation panel. "The hospital is highly concerned about patient safety. QMH will follow up the case in accordance with established human resources policy. The hospital also expressed its gratitude to the investigation panel."

Membership of the panel is as follows:

Chairman:
Dr Tong Hon-kuan
Deputy Hospital Chief Executive, Queen Mary Hospital

Members:
Mr Joseph Lo
Member of Queen Mary Hospital's Hospital Governing Committee

Professor Stephen Cheng
Head of Department of Surgery, Hong Kong University / Chief of Service, Department of Surgery, Queen Mary Hospital

Professor Joseph Lui
Clinical Director of Hong Kong University Health System

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