## DCPI 563/2006

**IN THE DISTRICT COURT OF THE**

**HONG KONG SPECIAL ADMINISTRATIVE REGION**

PERSONAL INJURIES ACTION NO. 563 OF 2006

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##### BETWEEN

MAK SHU SANG Plaintiff

### and

HOSPITAL AUTHORITY Defendant

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Coram : Her Honour Judge Mimmie Chan in Court

Dates of hearing : 13-16 October & 6 November, 2008

Date of handing down Judgment : 6 January, 2009

# JUDGMENT

**Background**

1. The Plaintiff, Mr. Mak, suffered from abdominal pain and vomiting in August 2003. He was admitted to the Caritas Medical Centre in Shamshuipo ("**CMC**") for treatment. On 25 August 2003, an ultrasound examination was conducted on him by Dr. Lorraine Ho. She diagnosed him as suffering from gallstones. Mr. Mak was treated with analgesics and discharged on 26 August 2003, a cholecystectomy being arranged for 31 October 2003. After discharge, Mr. Mak continued to have abdominal pain and vomiting. On 6 October 2003, Mr. Mak was re-admitted to CMC. A second ultrasound was carried out on 7 October 2003, and Dr. Ho confirmed the diagnosis of gallstones. An endoscopy was also performed on 9 October 2003, which showed that Mr. Mak suffered from oesophagitis, duodenum diverticulum and chronic gastritis. Mr. Mak was treated with oral medication and discharged. On 29 October 2003, he was readmitted to CMC, complaining of increasing abdominal pain. A laparoscopic cholecystectomy was performed on 31 October 2003. After the cholecystectomy, no stones were found in his gallbladder : only what Dr. Leung at CMC described as a 5 mm polyp.
2. Some time after his discharge from CMC in November 2003, Mr. Mak's abdominal pain returned. He sought treatment at the Jiangmen City People Hospital (" **JCPH**") on the Mainland, and was diagnosed to have duodenal bulb ulcer, duodenal bulb obstruction, chronic gastritis and severe oesophagitis reflux. Mr. Mak received oral medication and treatment for these at JCPH, and his abdominal pain ceased after treatment. Mr. Mak therefore claims that he had been wrongly diagnosed by the doctors at CMC.
3. These proceedings are commenced by Mr. Mak against the Hospital Authority ("**HA**") in respect of the negligence of the doctors who had treated him at CMC, for whom the HA is vicariously liable. Stripped (as much as possible) of its legal and medical jargon, Mr. Mak's complaint is simply this. He did not have stones in his gallbladder, as the doctors at CMC had told him, and the pain and vomiting from which he suffered in August and October 2003 was not caused by the obstruction of any part of his gallbladder by stones. Mr. Mak claims that he had undergone an unnecessary and inappropriate cholecystectomy, and has sustained damages as a result.

**Issues**

1. It is Mr. Mak's case that the negligent diagnosis and treatment, and hence medical negligence of the HA, its servants or agents is evidenced by:
   1. the still images or snapshots of the ultrasound examination conducted by Dr. Ho, which, according to the opinion of Mr. Mak’s expert, showed that the lesions which were considered by Dr. Ho to be gallstones were not mobile and did not display any acoustic shadow (“**the non-mobile lesion argument**”); and
   2. the fact that Mr. Mak continued to suffer from abdominal pain and vomiting after the cholecystectomy performed on 31 October 2003, that he had to undergo further treatment at JCPH in November 2003, and that his symptoms of abdominal pain and vomiting ceased only after the treatment he received at JCPH (“**the alternative cause argument**”).
2. The issue for determination at trial is, simply, whether HA is negligent in relation to the treatment and diagnosis. If HA is negligent, the parties have agreed the quantum of damages to be $222,288.

**Legal principles applicable**

1. There is no serious dispute between the parties as to the legal principles which are applicable to the determination of the liability of HA and its agents. First, it is not disputed that HA is vicariously liable for any negligence on the part of Dr. Ho or any other doctor who had treated Mr. Mak at CMC. In relation to diagnoses and treatment, Counsel for Mr. Mak relies on the judgment in *Bolitho v. City and Hackney Health Authority* [1998] AC 232, at 241G, to make good his submissions that the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment or diagnosis accorded with sound medical practice. The defendant has to have acted in accordance with a standard of practice recognized as proper "by a responsible body of medical men" or "a competent reasonable body of opinion". Where the Court is presented with different expert opinions, it may prefer the evidence of one party's experts over that of the others.
2. In relation to a doctor who professes to exercise a special skill, such doctor must exercise the ordinary skill of his speciality, and in order to establish negligence on his part, Counsel for HA emphasized that, as is clear from the decision in *Lillywhite and anr v. University College London Hospitals' NHS Trust*, CA, [2005] EWCA Civ 1466, it is not sufficient that other experts would have reached a different diagnosis from the defendant. It has to be shown, on a balance of probabilities, that no reasonably competent specialist would have made the same error alleged to have been made negligently by the defendant.

**Whether the HA is negligent in relation to the treatment and diagnosis**

1. Applying the legal principles summarized above, has Mr. Mak shown that Dr. Ho and the HA were negligent in the diagnosis of gallbladder stones, and the treatment given to Mr. Mak?
2. Dr. Chong Kin Ki is the expert who gave evidence on behalf of Mr. Mak. Dr. Chong is a specialist in general surgery, with expertise in gastro intestinal endoscopy and surgery.
3. It is Dr. Chong's opinion that Mr. Mak suffered from reflux oesophagitis, duodenitis and helicobactor pylori gastritis at the material time. He considered that oesophagitis was the cause of Mr. Mak's symptoms in August and October 2003. On Dr. Chong's review of CMC's medical records, he considered that Mr. Mak had a gallbladder polyp, but no gallstone. Dr. Chong considered that the cholecystectomy was unnecessary and not beneficial to Mr. Mak's stomach disease.

***The alternative cause argument***

1. I will deal first with what I have summarized in paragraph 4 above as the alternative cause argument advanced on behalf of Mr. Mak.
2. Professor Fan Sheung Tat was called to give expert evidence in behalf of HA. Professor Fan holds 4 doctorate degrees (M.S., M.D., Ph.D., and D.Sc.) through clinical research and theses submission, and was Chief of Divisions of Liver Transplantation and Hepatobiliary Surgery of the Department of Surgery of Queen Mary Hospital since 1989. He is now Chief of the Service of the Department. He is also Chair Professor of Hepatobiliary Surgery of The University of Hong Kong since 1993.
3. According to the evidence of Professor Fan, Mr. Mak's physical symptoms upon his first admission to CMC on 24 August 2003 were typical of mild acute cholecystitis (in layman's terms, inflammation of the gallbladder). Professor Fan was further of the opinion that Mr. Mak's subsequent admission on 6 October 2003 and 29 October 2003 were due to gallstone colic. Although oesophagitis was detected by the endoscopy conducted on 9 October 2003, Professor Fan considered that it could not be responsible for Mr. Mak's pain because oesophagitis can be asymptomatic in some patients, and Mr. Mak had complained of pain in the right upper quadrant, whereas pain due to oesophagitis is usually felt at the lower end of the sternum.
4. Naturally, one would not expect a layman such as Mr. Mak to be able to describe his pain to his treating doctors as "right upper quadrant pain", or "pain in the epigastric region". As suggested in the explanation given by Mr. Mak to Professor Fan, he simply referred to "abdominal pain" in Chinese and assumed that that would be clear to the treating doctors. Both Counsel for Mr. Mak and Dr. Chong suggested that Mr. Mak could have been confused when describing the exact location or site of pain, Counsel emphasizing the point that there is an area of overlap between the epigastrium and the right upper quadrant of the human body.
5. However, Mr. Mak never disputed the accuracy of the contemporaneous hospital notes, and the contemporaneous notes made by the treating doctors specifically mentioned Mr. Mak's complaint as pain in the right upper quadrant area. When Mr. Mak was first admitted to CMC on 24 August 2003, the medical notes record that he had complained of suffering from "right upper quadrant pain for 5 days", which was constant in nature, and that he had been vomiting undigested food. According to these hospital notes, there was tenderness over the right upper quadrant area when Mr. Mak was examined on 24 August 2003. There were also positive findings of guarding and Murphy's sign. The notes made by the treating doctors at CMC on 25 August 2003 recorded further that Mr. Mak had fever on that day.
6. Dr. Michelle Lam who examined Mr. Mak on 11 September 2003 said in her evidence that doctors were specific in identifying the patient's site of pain because this is important to the clinical diagnosis. Dr. Lam said that generally, the patient would either say where the pain was or, if there is uncertainty, point out the site of the pain. According to Dr. Lam, the site of Mr. Mak's pain was very specific and was not pain due to oesophagitis as this would be in the epigastric region and not the upper right quadrant region. Dr. Francis Mok, a specialist in General Surgery with special interest in hepatobiliary-pancreatic surgery and upper gastrointestinal surgery, and Consultant and Chief of Service of the Department of Surgery of CMC, described Mr. Mak's clinical features at the material time as colicky right upper quadrant abdominal pain and typical of bilary colic. Dr. Mok also said that tenderness over the right upper quadrant region was highly significant as this showed that the organ that the doctor was touching was diseased.
7. Professor Fan highlighted the fact that CMC's contemporaneous medical records on Mr. Mak indicate that the site of tenderness located in Mr. Mak was at the right upper quadrant of the abdomen. According to Professor Fan's evidence, a doctor's palpation of the stomach or the body of the patient to check for tenderness is important because it helps to define the problematic organ. If an organ is inflamed, there would be pain and if the doctor puts his hand over that region of the patient's body, the patient may feel the pain or may complain of the pain, because if the abdomen is pressed, the abdominal wall touches the inflamed organ, and the doctor is thus able to identify the organ which is causing the pain. Professor Fan therefore considered that right upper quadrant tenderness is very reliable in determining the location of pain.
8. Professor Fan was of the opinion that if a patient should suffer from oesophagitis, palpation would not help in identifying the site of the problematic organ. This is because the oesophagus is an organ situated very deep within the human body and is covered by the liver, hence making it not possible to elicit any abnormality by palpation.
9. Dr. Chong conceded in cross-examination that at the material time of Mr. Mak's admission and examination at CMC in August and October, there was positive tenderness (as evidenced by the hospital notes) and this arises when the doctor specifically asked the patient to respond to his palpation. He accepted that the site of pain helps in the overall analysis and that in Mr. Mak's case it was noted to be pain in the right upper quadrant, which was not indicative of oesophagitis. Dr. Chong conceded that the positive findings of guarding and Murphy's sign in Mr. Mak indicated cholecystitis (or inflammation of the gallbladder), which on the evidence in this case would be due to blockage of the outlet of the gallbladder, i.e. the cystic duct, due to stones.
10. Counsel for Mr. Mak relies on the diagnosis made by the doctors at JCPH who had treated Mr. Mak in November 2003 as showing that the cause of Mr. Mak's abdominal pain and vomiting in August and October 2003 was oesophagitis, or causes other than gallbladder stone. On the available evidence, I do not accept that the diagnosis made at JCPH in November 2003 can show that the diagnosis made by the doctors at CMC in August and October 2003 was necessarily wrong.
11. Mr. Mak was discharged from CMC on 1 November 2003. Although Mr. Mak claims in his evidence in these proceedings that he had developed abdominal pain the day after surgery and that such pain continued until he sought treatment at JCPH, it is not in dispute that over this period from 1 November 2003 to 13 November 2003 when he was recorded to have been examined and treated at JCPH, Mr. Mak had not sought any medical treatment in Hong Kong, whether at CMC or from any other doctor in Hong Kong, besides returning to have his stitches removed about 10 days after the surgery on 31 October 2003. If he had indeed experienced increased abdominal pain shortly after surgery, it is inconceivable that he would not have complained to CMC or sought treatment at the time when his stitches were removed or at any other time during this period.
12. It is Mr. Mak's evidence that he went to China in November, not to seek medical treatment, but for convalescence. It is also his evidence that he had to go to JCPH for treatment only in mid November 2003, when he suffered from severe abdominal and stomach pain. According to the independent medical records of JCPH of 13 November 2003, Mr. Mak had been suffering from right upper abdominal pain for 3 days when he attended the hospital. According to the results of the endoscopy conducted at JCPH and dated 18 November 2003, Mr. Mak had severe oesophagitis, chronic superficial gastritis, duodenal bulb ulcer and duodenal bulb obstruction.
13. Mr. Mak informed Professor Fan that he did not have any pain symptoms immediately after the cholecystectomy, and that it was only 3 days after he had gone to the Mainland to recuperate that he developed right upper quadrant abdominal pain again. Dr. Chong accepts in cross-examination that if Mr. Mak did not suffer from stomach pain after the surgery performed on 31 October 2003, this indicated that the pain was relieved by the surgery, and that symptomatic improvement indicated that the diagnosis made at CMC was appropriate. He qualified this only by saying that symptomatic improvement lasting a week or so is not real symptomatic improvement.
14. As for oesophagitis being the cause of Mr. Mak's complaints at the material time in August and October 2003, Dr. Chong accepts that oesophagitis does not give rise to fever and hence oespohagitis does not explain the finding of fever in Mr. Mak on 24 August 2003 (as recorded in the CMC hospital notes for that day). Dr. Chong also accepts that oesophagitis does not present with pain and tenderness in the right upper quardrant region. Further, the evidence shows that when Mr. Mak was discharged from CMC on 1 November 2003, he was not given Pepcidine which suggests that there was either no oesophagitis or it was not symptomatic at the time. Importantly, as evidenced by the medical records maintained at JCPH, Mr. Mak's condition whilst he was at JCPH in November 2003 contained important differences from his condition at CMC : there were ulcers at the duodenal bulb and presence of helicobactor pylori, which were not present during treatment at CMC. According to Professor Fan, these new conditions explain the onset of the fresh pain Mr. Mak experienced in November, which pain was in Professor Fan's opinion unrelated to the gallbladder. Dr. Chong also accepts, on cross-examination, that Mr. Mak's complaints of abdominal pain in November 2003 could be explained by these new conditions, and that the ulcers could have developed only in November, after the surgery on 31 October 2003.
15. Professor Fan's evidence is that pain of oesophagitis is constant and happens during the night when the patient lies flat, and these conditions were not present in Mr. Mak. By way of contrast, in the case of pain caused by gallstones' obstruction of the gallbladder, the pain experienced by the patient is intermittent : the patient feeling pain when the stone obstructs the cystic duct, and the pain subsiding when the stone flows back into the gallbladder.
16. Dr. Lam who treated Mr. Mak also maintained that during the period of Mr. Mak's hospitalization in August and October, he did not have the main symptoms of oesophagitis, which are epigastric pain, reflux sensation and heartburn. Although the endoscopy conducted on 9 October 2003 revealed that Mr. Mak had oesophagitis, Dr. Lam pointed out that Mr. Mak was then given Pepcidine for 2 weeks, and this should have relieved the symptoms if Mr. Mak's abdominal pain was indeed caused by oesophagitis.
17. Further, although Dr. Chong claims that pain in the right upper quadrant could be due to reasons such as pain in the duodenal, liver, colon, etc., it is not disputed that there were no such pathologies during Mr. Mak's treatment at CMC. As pointed out by Dr. Tse Ho Wah, the findings on endoscopy and biopsy made on 9 October 2003 ruled out significant pathologies in the upper gastrointestinal tract.
18. To the extent that I have to be satisfied that there is a logical basis for the doctors at CMC not to have diagnosed Mr. Mak as suffering from oesophagitis, I am so satisfied on a balance of probabilities, from the evidence on the presentation of Mr. Mak's symptoms in August and October 2003, from the expert evidence of Professor Fan, and in light of the concessions made by Dr. Chong, that the doctors at HA had acted in accordance with a standard of practice recognized as proper by a reasonable or responsible body of medical opinion.

***The non-mobile lesion argument***

1. The diagnosis of gallbladder stones was made in reliance on 2 ultrasound examinations conducted on Mr. Mak by Dr. Lorraine Ho on 25 August 2003 and 7 October 2003. Dr. Ho obtained her Diploma of Diagnostic Radiology in the UK in 1987, and has worked in the Department of Diagnostic Radiology of the Queen Mary Hospital since 1984, first as Medical Officer, then Senior Medical Officer, then as Consultant Radiologist. Since 2000, Dr. Ho has been Consultant Radiologist to the Department of Diagnostic Radiology of CMC.
2. Images were captured by Dr. Ho during her ultrasound examination of Mr. Mak. According to Dr. Ho's analysis of her ultrasound examination conducted on 25 August 2003, small abnormal echogenic lesions were located at the dependent part of Mr. Mak's gallbladder, and she was of the opinion that the lesions were small gallbladder stones. Dr. Ho also considered that the ultrasound examination performed on Mr. Mak on 7 October 2003 showed a small gallbladder stone, but with no features of acute cholecystitis.
3. In the opinion of Dr. Chong, Dr. Ho's diagnosis of the presence of stones in Mr. Mak's gallbladder was wrong, as the images of the ultrasound examination showed that there was no acoustic shadow in the lesions detected, and there was no movement of the lesions. According to Dr. Chong, the fact that there is no acoustic shadow shows that the lesion or lesions detected are polyps.
4. The HA does not dispute that there is no acoustic shadow shown in the ultrasound of the lesions detected. Its case is that when the lesion is small and has a low calcium content, even a cholesterol stone has no acoustic shadow. Whether it is a small stone or a polyp, it is the case of HA that a cholecystectomy is necessary and appropriate when the lesion is symptomatic. Even Dr. Chong does not dispute that if a polyp breaks off and is symptomatic, removal of the gallbladder is indicated.
5. In the opinion of Dr. Chong, if a polyp is less than 10 mm in size, cholecystectomy is not necessary, and he relies on medical literature to support this. However, even in the medical literature to which Dr. Chong refers, the conclusion made was to suggest resection of polyps in patients with compatible symptoms, ***including biliary type pain***, and that ***asymptomatic individuals older than 50 years of age*** should undergo resection. Mr. Mak was 59 years old at the time of the cholecystectomy, and in the opinion of his treating doctors at CMC, he had displayed symptoms of biliary type pain in the right upper quadrant. Professor Fan agrees that Mr. Mak had typical symptoms of biliary colic when he was treated at CMC in August and October 2003, and that such symptoms can only be explained by inflammation of the gallbladder. I fail to see how the medical literature in question supports Dr. Chong’s case.
6. In my judgment, the mere size of the lesions detected in Mr. Mak, and the absence of acoustic shadow in the lesions, have not been demonstrated to establish negligence on the part of the doctors at CMC in advising cholecystectomy.
7. The doctors had used different terminology in describing the lesions. Dr. Ho called the lesions "stones". Dr. Leung who performed the surgery called the lesion found in the gallbladder a "cholesterol polyp". Dr. Chong described it as a "gallbladder polyp". Professor Fan considered that the proper term should be a "cholesterol stone", whether or not it adhered to the gallbladder mucosa. Part of the confusion and dispute arises because of the differences in opinion as to how a "polyp" should be described after it has become detached. I accept the submissions of HA's Counsel that the key issue is whether the lesion - be it a polyp or a stone – had moved, and whether it was the cause of Mr. Mak's symptoms. If the lesion was the cause of the symptoms, then the cholecystectomy was in my judgment reasonably and logically justified.
8. Much of the debate has centered on whether the lesions were mobile. According to the evidence of Dr. Ho, her diagnosis of the presence of stones in Mr. Mak's gallbladder was based on the real- time images seen on ultrasound and her analysis of these real-time images. In her opinion, a small gallstone with low calcium content may not produce a shadow on the ultrasound images, but the presence or absence of a shadow is not determinative of whether the lesion was a stone, or not. Dr. Ho explained that in reaching a diagnosis, it was necessary to see movement of the lesion, and she had detected movement when she asked Mr. Mak to turn his body when the ultrasound examinations were being conducted. She had described the lesion as a stone in her report on the ultrasound, and Dr. Ho maintained that this means for sure that she had seen movement. However, she claims that it is difficult to capture a satisfactory image of movement. According to Dr. Ho, so long as she could see from the real-time images that the lesion had moved, she was able to reach the diagnosis that the lesion was a stone, and it was not necessary for her to wait until the lesion had settled in a new position, and then to take a picture or image to show such movement. According to Dr. Ho, the images taken were intended to show the different planes of the scan of Mr. Mak in different positions, and not for the purpose of showing movement of the lesions detected.
9. Dr. Chong seeks to establish that the lesions captured on the ultrasound images show no or no significant movement, by comparing image No. 15 taken on 25 August 2003 ("**Image 15**") and image 2 taken on 7 October 2003 ("**Image 2**"), which in Dr. Chong's opinion demonstrate that the lesions stayed in the same position on both days.
10. Dr. Ho does not agree that it is appropriate to compare the position of the lesions by superimposing the transparency of Image 15 on the transparency of Image 2, in the manner suggested by Dr. Chong. She pointed out that the images show different planes of scans taken of Mr. Mak's body, with Mr. Mak lying in different positions, one supine and one on his side. According to Dr. Ho, before there can be a determination of whether the lesions had moved by way of comparison of two images, there must be the same reference points in the images being compared. In Dr. Ho's opinion, Image 15 and Image 2 do not have the same reference points. In any event, she was adamant that Image 2 and image 3 taken on 25 August 2003 show that the lesion was in the body of the gallbladder, whereas Image 15 and image 16 taken on 25 August 2003 ("**Image 16**") show that the lesion had moved and was in the neck of the gallbladder.
11. In relation to the scans taken on 7 October 2003, Dr. Ho was of the opinion that the images show the presence of one lesion, when the images of the scan taken on 25 August 2003 show the presence of 2 lesions. According to Dr. Ho, it is possible that one lesion had fallen off, and may have moved into the cystic duct.
12. In relation to Dr. Chong's evidence that the still images show that the lesions had either not moved or had no significant movement, there is a dispute as to whether all the still images show the neck of the gallbladder. The still images show the lesion or lesions being near the neck of the gallbladder, and Dr. Chong is of the opinion that the neck can be seen in all the still images, so that Image 15 and Image 2 can be compared. However, Dr. Ho, Dr. Mok and Professor Fan all consider that only Image 15 and Image 16 show the neck of the gallbladder. Dr. Mok, Dr. Ho and Professor Fan spoke of the importance of fixed reference points for the purpose of identifying the location of the lesion, and referred to the neck and the junctional fold as the reference points they used, which are not seen in Image 2, nor in any image other than Image 15 and Image 16.
13. Even if the lesion detected in Mr. Mak's gallbladder is considered to be a cholesterol polyp, there is no dispute that a cholesterol polyp, which is attached to the mucosa of the gallbladder by a slender stalk, can easily break off and when it does, it floats within the gallbladder and acts like a stone in that it can obstruct the outlet of the gallbladder (i.e. the cystic duct) and cause symptoms until it dislodges and the obstruction is removed. According to the evidence of the doctors at CMC who had treated Mr. Mak, this accounts for the on and off pain in the abdomen experienced by Mr. Mak at the material time. According to Professor Fan, Mr. Mak had symptoms of biliary colic at the material time in August and October, and the pathological examination of Mr. Mak's gallbladder show mural fibrosis, which occurs when the gallbladder was inflamed as a result of the obstruction of the gallbladder outlet by a stone. Dr. Chong accepts that when a cholesterol polyp breaks off, causes obstruction and is hence symptomatic, cholecystectomy is appropriate.
14. Professor Fan's evidence is that Dr. Ho's real-time examination of the ultrasound images provides her with an advantage in making an accurate diagnosis, as the still images, although fairly accurate in reflecting the images seen on real-time, may not be able to capture the appropriate image for supporting the radiologist's diagnosis. Dr. Chong himself concedes that a specialist radiologist performing a real-time ultrasound examination has a more superior view of the gallbladder than he would have by looking at snapshots or still images, and that reliance on still images for the purposes of a diagnosis is a disadvantage compared to reliance on real-time ultrasound examinations. In any event, from the still images, Professor Fan supports Dr. Ho's opinion that the lesions are gallstones; that the still images taken on 25 August 2003 show the presence of 2 lesions, whereas the still images taken on 7 October 2003 show the presence of one lesion only; and further, that the images taken on 25 August 2003 show that the lesions had moved.
15. Professor Fan was able to justify his opinion that the lesions had moved, first, by reference to the fact that the shapes of the gallbladder seen in Image 15 and in image 3 taken on 25 August 2003 ("**Image 3**") are different. Professor Fan explained that this means that different parts of the gallbladder are shown in the images, but because the lesions are seen at the bottom part of the gallbladder in both images, it indicates that the lesions had moved. Further, Professor Fan demonstrated movement of the lesion by reference to fixed reference points such as the common bile duct and the functional fold, as can be seen by comparing Image 2, Image 3 and Image 15, which show that the lesion had moved closer to the common bile duct which is in a fixed position.
16. Counsel for Mr. Mak emphasized the fact that the cystic duct was not blocked at the time of the ultrasound examinations, and there was no inflammation of the gallbladder as a result. According to the evidence of the doctors called on behalf of HA, stones or polyps can become lodged in the cystic duct, causing symptoms, and then dislodge. Professor Fan explained that gallstone colic does not usually cause continuous pain, but episodic pain instead - as in Mr. Mak's case. The obstruction caused by the stone moving to the duct can be transient, which accounts for the pain which Mr. Mak experienced at the time of his admission to CMC. When the stone is dislodged and moves away from the duct, the pain goes away.
17. Further, according to Professor Fan, the presentation of cholecystitis can disappear quite rapidly, within half a day, and the result is on and off colicky pain, which is the subject of Mr. Mak's complaint.
18. The absence of blockage in the cystic duct and inflammation of the gallbladder at the time of the ultrasound examinations, therefore, cannot be taken to mean that there was no inflammation of the gallbladder at any time. The pathological examination of the gallbladder on 1 November 2003 shows mural fibrosis, which is a consequence of inflammation of the gallbladder wall. Professor Fan explained that fibrosis should not be present in a normal gallbladder and its presence indicates previous inflammation. Mr. Mak had no history of gallstone disease prior to his admission to CMC. Hence, Professor Fan was able to conclude that the fibrosis indicated on the pathology shows that the inflammation of the gallbladder had occurred around or after the date of Mr. Mak's admission to CMC in August 2003, and that Mr. Mak's pain during the period of his first admission in August was due to cholecystitis. Professor Fan was of the opinion that once a gallstone has produced symptoms, the patient is likely to have more symptoms subsequently, indicating that the cholecystectomy was correctly performed.
19. Applying the test adopted in *Lillywhite* to this case, I have to be satisfied on a balance of probabilities that no reasonably competent radiologist in the position of Dr. Ho would have concluded from the ultrasound examination that there were stones in Mr. Mak's gallbladder.
20. Dr. Ho's evidence is that she had detected movement in the lesions from the real-time images. The other doctors at CMC, having regard to Mr. Mak's symptoms of biliary colic, the investigative results including Dr. Ho's findings on the ultrasound examinations, and the absence of other pathologies, recommended the cholecystectomy. Dr. Leung Chi Keung, who performed the cholecystectomy on 31 October 2003, said in evidence that he had reviewed the medical records of Mr. Mak the day before the surgery to confirm the appropriate treatment plan, and that if he had thought that the decision and diagnosis was wrong, he would have questioned it.
21. Having considered all the evidence presented on the analyses of the still images of the ultrasound, including the difference in opinion as to whether the lesion detected in Image 2 is located inside the neck of the gallbladder, I find that in the absence of the expert evidence of a specialist radiologist to challenge the evidence of Dr. Ho, Mr. Mak has failed to discharge his burden of proof in establishing that Dr. Ho was wrong or negligent in her diagnosis. Dr. Chong's expertise in gastro-intestinal surgery is not disputed, but he concedes that he is not a specialist radiologist like Dr. Ho, and that his training and experience in radiological examinations were substantially less than those of Dr. Ho. It is accepted by Dr. Chong that when a patient complains to him of what might appear to be abdominal pain due to gallstones, he would refer him to a radiologist because he did not have the authority to perform radiological examinations, and he would also have to rely on other specialists for a diagnosis. After hearing Dr. Ho's evidence, I am not persuaded by Dr. Chong, who lacks the relevant expertise in radiological examinations and who is not in a position to examine the real-time images of the ultrasound examinations conducted by Dr. Ho, that Dr. Ho's diagnosis of the presence of gallstones, and her observation of mobility in the lesions detected, were wrong, illogical, or without basis. I am persuaded, on the evidence presented, that the doctors at CMC had acted in accordance with a practice which is accepted as proper by a reasonable body of medical men skilled in that particular art, and had taken ordinary or reasonable care.

***The consent argument***

1. I will deal briefly with the final point raised on behalf of Mr. Mak in the evidence, that he was ***not*** advised prior to the cholecystectomy that he had a cholesterol polyp (and not a gallstone) in his gallbladder, and that had he been so told, he would not have undergone the surgery. Even if the doctors at CMC had been negligent in any way in failing to inform Mr. Mak that he had a polyp in his gallbladder, I am not satisfied on the evidence that Mr. Mak had sustained damage as a result of such alleged negligence. I have found that the doctors were not negligent in their diagnosis that Mr. Mak's abdominal pain was caused by lesions in his gallbladder which had caused obstruction and hence the on and off pain experienced by Mr. Mak. On the evidence adduced, I am satisfied that the cholecystectomy advised was appropriate in view of the symptoms displayed by Mr. Mak, and consider that the abdominal pain experienced by Mr. Mak in November 2003 has ***not*** been shown to be caused by or related to the symptoms he displayed in August and October 2003.
2. Further, Mr. Mak's evidence is that if he had known that it was a cholesterol polyp in his gallbladder, he would not have agreed to undergo the surgery, and that he had only followed the advice of his treating doctors. There is no evidence from Mr. Mak that, even if he had been advised that a detached polyp was the cause of his abdominal pain and fever, he would not have consented to the cholecystectomy. In these circumstances, I am not satisfied that there is sufficient basis for the Court to grant the relief sought by Mr. Mak.

**Conclusion**

1. Mr. Mak's claims are dismissed. I will make an order nisi that the costs of the action are to be paid by Mr. Mak to HA, with certificate for counsel, to be taxed if not agreed. Mr. Mak's own costs are to be taxed in accordance with the Legal Aid Regulations.

(Mimmie Chan)

District Judge

*Mr. Jackson Poon, instructed by Messrs. Huen & Partners (assigned by D.L.A.), for the Plaintiff*

*Mr. Ashok Sakhrani, instructed by Messrs. Kennedys, for the Defendant*