香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr LAM Ricky Wai Fat (林偉發醫生) (Reg. No.: M10919)

Date of hearing: 9 December 2024 (Monday) (Day 1); 10 December 2024 (Tuesday) (Day 2); 21 February 2025 (Friday) (Day 3); 26 February 2025 (Wednesday) (Day 4); and 23 March 2025 (Sunday) (Day 5)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr CHEUNG Chin-pang
Prof. KONG Pik-shan, Alice
Ms LIU Lai-yun, Amanda
Ms CHOW Anna M W

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Alfred FUNG as instructed by Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Ms Mavis LAM as instructed by Department of Justice

1. The amended charges against the Defendant, Dr LAM Ricky Wai Fat, are:

"That on 6 September 2011, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient") in that:-

(a) he failed to properly advise the Patient about the tracings of the electrocardiogram ("ECG");

(b) *he performed a coronary angiogram on the Patient without proper justification; and*

(c) *he performed an intravascular ultrasound ("IVUS") study on the Patient without proper justification.*

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

Facts of the case

2. The name of the Defendant has been included in the General Register from 28 August 1996 to the present. His name has been included in the Specialist Register under the Specialty of Cardiology since 2 February 2005.

3. Briefly stated, the Patient, then 64 years old, consulted one Dr CHAN for, amongst others, chest pain and body check. After consultation, the Patient was referred by Dr CHAN to go to the Hong Kong Baptist Hospital ("HKBH") for an exercise treadmill test ("ETT") under the supervision of the Defendant.

4. Dr CHAN wrote down in the Admission Letter to HKBH that the Patient had "*chest pain since 29/8/11*" and "*1st seen [on] 30/8/11*". He also wrote down under the heading of "*Investigation*", among others, "*Book treadmill by Dr Lam Wai Fat*".

5. On 5 September 2011, the Patient was admitted to HKBH. The ward nurse noted in the Nursing Assessment that the reason for the Patient's admission to HKBH was "*c/o [complained of] chest pain on & off x [for] ½ years*". A chest x-ray was done later on the same day and the Consultant Radiologist of HKBH also noted in his report dated 6 September 2011 that "*[c]ardiac size is slightly enlarged*".

6. Under the supervision of the Defendant, the Patient underwent an ETT in the morning of 6 September 2011 at HKBH during which a set of electrocardiogram ("ECG") was obtained.

7. In the "Q-Stress Final Report" signed by the Defendant after the ETT, it was stated under the heading of "*Observation*" that "*Overall Impression: [was] Positive stress test suggestive of ischemia*"; and it was also stated under the heading of "*Conclusion*" that the result of the ETT was "*Positive stress test suggestive of ischemia*".

8. According to the Defendant's statement to the Preliminary Investigation Committee ("PIC") dated 18 December 2014:-

> "*7. In view of the Patient's recent history of chest pain, before the commencement of the ETT, I specifically asked the Patient about her chest pain. She told me that she felt tightness in her heart. I then called Dr. Chan to find out more about the Patient's chest pain and Dr. Chan told me that the Patient had typical angina.*
>
> *8. I explained to the Patient that the purpose of the ETT was to ascertain whether she had coronary artery disease which could explain her recent chest pain or tightness. The Patient then underwent the ETT under my supervision. I was present throughout the procedure which lasted about 10 minutes.*
>
> *9. The ETT showed mild ST upsloping and some atrial ectopics...*
>
> *10. Taking into consideration the Patient's recent clinical history of chest pain or tightness, Dr. Chan's confirmation that the Patient had typical angina, the Patient's age, the chest X-ray finding of cardiomegaly on 5th September 2011 and the inconclusive ETT findings (in view of betablocker having been taken in the last 24 hours), I considered that further investigation, such as coronary angiogram or a CT angiogram, would be required to determine whether the Patient had ischemia or coronary heart disease.*
>
> *11. I explained to the Patient the ETT findings above and suggested that, in view of her recent history of chest pain or tightness, Dr. Chan's confirmation that she had typical angina, her age, the chest X-ray finding of mild cardiomegaly on 5th September 2011 and the inconclusive ETT findings (in view of betablocker having been taken in the last 24 hours), further investigation by way of a CT angiogram or a coronary angiogram +/- percutaneous*

coronary intervention ("PCI") could be carried out if she decided to undergo further investigation to determine whether she had ischemia or coronary heart disease. I told the Patient that having checked with HKBH, a CT angiogram would not be available that day but a coronary angiogram +/- PCI could be considered if she wished to undergo the investigation on the same day.

12. *In accordance with my routine practice, I explained to the Patient the procedures as well as the possible risks and complications of coronary angiogram +/- PCI...*

13. *No question was raised by the Patient at that time. The Patient agreed to undergo the coronary angiogram +/- PCI...*

14. *I then called Dr. Chan and informed him of the findings of the ETT...*

15. *After speaking with Dr. Chan, I attended the Patient in the ward. A consent form ... was then signed by the Patient, a nurse and myself for the procedure.*

...

19. *During the coronary angiogram, it was found that there was moderate coronary artery disease in the LCX (left circumflex artery) and RCA (right coronary artery). In view of these findings, I advised the Patient to undergo an intravascular ultrasound study ("IVUS study") in order to have a more accurate assessment of the vessel size, the lumen area and the extent of stenosis...*

20. *At that point, I also called the Patient's son and told him the findings of the coronary angiogram, my suggestion to perform an IVUS study and the additional costs involved. Both the Patient and her son agreed to proceed with the IVUS study.*

21. *The IVUS study showed borderline 50% lesion in mRCA (mid-right coronary artery) and 30 to 40% stenosis in mLCX (mid left circumflex artery), thus confirming that the Patient had coronary*

artery disease. Since the MLA (minimal luminal area) at mRCA was more than 4mm^2, no further intervention was considered necessary. The mRCA lesion was thus left alone without further interventions and PCI was not performed since the stenosis was less than 70%. I concluded that the Patient had moderate coronary artery disease."

9. There is no dispute that both the coronary angiogram and IVUS study were uneventfully performed; and the Patient was discharged home by Dr CHAN on 7 September 2011.

10. The Patient subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Application for Permanent Stay of Proceedings

11. At the beginning of this inquiry, the Defendant applied through his Counsel to us for permanent stay of the disciplinary proceedings against him. Having heard from the Legal Officer and Counsel for the Defendant in reply, we decided to refuse the stay application and indicated that we would give our reasons for refusal later.

12. It is trite law that delay in disciplinary proceedings resulting in prejudice may lead to the disciplinary proceedings being permanently stayed. However, even where the delay can be said to be unjustifiable, the imposition of a permanent stay should be the exception rather than the rule. And where delay is relied upon as the basis of abuse, one has to examine the prejudice that has occurred as a result of the delay.

13. There was a long period of delay in the present case but its cause and effect must be examined.

14. By a Notice of Inquiry dated 11 August 2016, the Secretary of the Council (the "Secretary") informed the Defendant that an inquiry would be held into the disciplinary charges against him in this case on 22 November 2017. On 15 June 2017, one Ms WU of the Secretary verbally informed one Ms CHIU of the Defendant's solicitors that the Secretary needed to look for a new expert because the previous expert would no longer be acting for the Secretary.

By a letter dated 19 October 2017, the Secretary informed the Defendant's solicitors that *"the Temporary Chairman approved the application from the Legal Officer for adjourning the inquiry to a later date."* Subsequent to this letter from the Secretary, the Defendant's solicitors had issued several chasers, ending with their letter dated 7 May 2018 to the Secretary, requesting for a copy of the report of the Secretary's new expert and the new proposed date(s) of the Inquiry. And yet, there was no reply until 20 February 2024 when the Secretary informed the Defendant's solicitors by letter of the same date that the inquiry in this case would be held on 9 and 10 December 2024.

15. Although the Secretary had delayed in rescheduling the inquiry and arranging for a report from her new expert, we are not prepared to accept, given the facts of this case, that this delay had caused prejudice to the Defendant. In fact no prejudice in terms of defence of the disciplinary proceedings was advanced by the Defendant until the first day of this inquiry.

16. For these reasons, the Defendant's application for permanent stay of the disciplinary proceedings against him is refused.

Burden and Standard of Proof

17. We bear in mind that the burden of proof is always on the Legal Officer and the Defendant does not have to prove his innocence. We also bear in mind that the standard of proof for disciplinary proceedings is the preponderance of probability. However, the more serious the act or omission alleged, the more inherently improbable must it be regarded. Therefore, the more inherently improbable it is regarded, the more compelling the evidence is required to prove it on the balance of probabilities.

18. There is no doubt that each of the allegations against the Defendant here is a serious one. Indeed, it is always a serious matter to accuse a registered medical practitioner of misconduct in a professional respect. Therefore, we need to look at all the evidence and to consider and determine each of the disciplinary charges against him separately and carefully.

Findings of the Inquiry Panel

19. Expert witnesses on both sides agreed and we accept that the tracings of the Patient's ECG taken during ETT were *"negative for ischemia"*.

20. The Defendant initially claimed in his Statement dated 18 December 2014 that the result of the ETT was *"inconclusive"* because the Patient has taken beta-blockers less than 24 hours before.

21. In the course of evidence-in-chief by his counsel, the Defendant then told us for the first time that the concluding remark of *"positive stress test suggestive of ischemia"* in the "Q-Stress Final Report" signed by him after the ETT was selected from a list of preset concluding remarks in the computer system; and although he decided that the result of the ETT should be reported as *"abnormal"* in the sense that it was *"inconclusive"*, this was not one of the items that he could tick from the list of preset concluding remarks.

22. However, when being cross-examined, the Defendant agreed with the Legal Officer that *"on the day of the test, [he] did agree that it was abnormal positive stress test suggestive of ischemia"*; and indeed the Defendant also admitted in re-examination that he had told the Patient that *"the treadmill test, [his] interpretation at that time was ... positive"*. In this connection, we also noted from reading the "Q-Stress Final Report" that the Defendant had put down, among many other things, under the heading *"Observation"* that his *"Overall Impression: [was] Positive stress test suggestive of ischemia"*.

23. We do not accept the Defendant's explanation on why he selected the concluding remark of *"positive stress test suggestive of ischemia"* in the "Q-Stress Final Report". If the Defendant was truly of the view that the result of the ETT was *"abnormal"* in the sense that it was *"inconclusive"*, he would not have told the Patient that the result of the ETT was according to his interpretation at the time *"positive"*.

24. But then again, we do not agree with the Legal Officer that the central issue of the amended disciplinary charge (a) against the Defendant is whether his failure to notice that the ECG of the Patient was *"negative for ischemia"* instead of *"positive for ischemia"* would amount to misconduct in a professional respect.

25. Regardless of whether the Defendant had failed to notice that the ECG of the Patient was in truth *"negative for ischemia"*, the real point in our view is that in advising the Patient that the result of the ETT was *"positive"* when the tracings of the ECG were in truth *"negative for ischemia"*, the Defendant had failed to properly advise the Patient about the tracings of the ECG.

26. In our view, the central issue in this case is whether the Defendant's failure to properly advise the Patient about the tracings of the ECG would amount to misconduct in a professional respect.

27. The relevant legal principles were enunciated by Professor Michael A. Jones in his book, *Medical Negligence (6th edition)* at paragraph 4-044:-

> *"Where tests are required there may be negligence ... in failing to interpret the results properly ...*
>
> *... The level of care required will vary with the nature and purpose of the test being conducted. In P v Leeds Teaching Hospitals NHS Trust, the defendants were held to have been negligent in failing to interpret an ultrasound scan of a foetus when the mother had been specifically referred for specialist investigation. The obligation on a hospital dealing with a tertiary referral for investigation of a suspected anomaly was said to be a high one because this was "a scan with a focus"..."*

28. Although the case of *P v Leeds Teaching Hospitals NHS Trust* involved a tertiary referral to a hospital, we agree with the Legal Officer that the same legal principles apply to the present case, which involved a focused referral albeit between two registered medical practitioners.

29. In this connection, there is no dispute that the Patient underwent the ETT at HKBH upon the specific referral by Dr CHAN. As the Defendant said in his PIC submission, *"the purpose of the ETT was to ascertain whether she had coronary artery disease which could explain her recent chest pain or tightness"*. It was therefore pertinent in our view for the Defendant to focus his advice to the Patient on whether the tracings of the ECG taken during the ETT were suggestive of *"coronary artery disease"*.

30. In failing to properly advise the Patient about the tracings of the ECG, the Defendant had in our view by his conduct in this case fallen below the

standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (a).

31. Turning to the amended disciplinary charge (b), expert witnesses on both sides agreed and we accept that the result of the ETT was *"negative for ischemia"*. And we agree with the Secretary's expert witness that the ECG tracings *"did not show any significant ST segment depression"* during the ETT; and the presence of *"atrial ectopics"*, which was not uncommon, would not be indicative of ischemia.

32. When being cross-examined, the defence expert witness accepted that *"there [was] only one ventricular ectopic being recorded"* at the recovery stage of the ETT. The defence expert witness further supplemented in re-examination by Counsel for the Defendant that *"[i]f the number of ectopic occurring is indeed one, not two, not three, not five, then it [is] unimportant"*. The defence expert also disagreed with the Defendant that *"ventricular ectopics"* were found on page 40 of the ECG tracings, when they were in truth *"atrial ectopics"*.

33. We further agree with the Secretary's expert witness that since *"[b]aseline ECG did not show any evidence of cardiac hypertrophy and clinically there was no documented sign and symptom of heart failure"*, the mild cardiomegaly from her chest X-ray report did not justify the performance of a coronary angiogram.

34. Counsel for the Defendant sought to argue that the Defendant did not at any time suggest to the Patient that a coronary angiogram had to be performed on the same day after the ETT. But then again, the real issue in our view is whether there was sufficient clinical indication for an invasive test of coronary angiogram to be performed on the Patient.

35. We agree with the Secretary's expert witness that given the Patient *"was at low risk according to clinical criteria"* for coronary artery disease, invasive test such as coronary angiogram should be the least priority; and even if the Defendant had concerns about the mild cardiomegaly from the Patient's chest X-rays report, functional tests should have been conducted instead of anatomic tests like a coronary angiogram. Indeed, the defence expert witness also agreed in cross-examination that coronary angiogram would not

be *"the first option"* and instead he would *"go for non-invasive investigation methods"*.

36. When being asked by Counsel for the Defendant in re-examination, the defence expert witness supplemented that *"[t]he justification for an urgent invasive coronary angiogram will be myocardial infarction, unstable angina, chest pain with elevation in the troponin ... For all other cases there is time for us to think and discuss with the Patient to see whether the Patient require[s] an early diagnosis or [she can] afford to wait ..."*.

37. It is evident to us however that there was nothing in the medical records to suggest that the Patient was suffering from any of the conditions. And there was in our view no sufficient clinical indication for an invasive coronary angiogram on the Patient.

38. For these reasons, we agree with the Legal Officer that the Defendant performed a coronary angiogram on the Patient without proper justification. We also agree with the Legal Officer that in doing so, the Defendant had by his conduct in this case fallen below the standard expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as per the amended disciplinary charge (b).

39. Turning to the amended disciplinary charge (c), we agree with Counsel for the Defendant that availability of an alternative and perhaps more suitable test like Fractional Flow Reserve ("FFR") test by itself does not render the IVUS Study unjustified. In our view, the real issue is whether there was clinical indication for undergoing an IVUS Study.

40. It is not disputed that a borderline stenosis (40-50% by QCA, "quantitative coronary angiography") in the Patient's mid-right coronary artery was shown in the coronary angiogram. We agree with the defence expert witness that this finding when coupled with the Patient's age and angina history warranted further investigation.

41. Although the IVUS Study would not come into the picture had the Defendant not performed a coronary angiogram on the Patient without proper justification, we do not agree with the Legal Officer that further investigation

of the borderline stenosis in the Patient's mid-right coronary artery by performing an IVUS Study must also be without proper justification.

42. We acknowledge that FFR test was a relatively new test in 2011 and the correlation between FFR and IVUS was debatable. We cannot find the performance of an IVUS Study on the Patient without proper justification merely because some registered medical practitioners might perform a FFR test instead.

43. Bearing in mind that the burden of proof is always on the Secretary, we are not satisfied on the evidence before us that the Secretary's case in respect of the amended disciplinary charge (c) has been made out. Accordingly, we find the Defendant not guilty of that charge.

Sentencing

44. The Defendant has a clear disciplinary record.

45. We bear in mind that the primary purpose of a disciplinary order is not to punish the Defendant but to protect the public from persons who are unfit to practise medicine and to maintain public confidence in the medical profession by upholding its high standards and good reputation.

46. We are told in mitigation that the Defendant had since the incident taken steps to improve on communication with patients and medical record keeping on discussion with patients.

47. But then again, the real point is that the Defendant had failed to properly advise the Patient about the tracings of the ECG and performed a coronary angiogram on the Patient without proper justification. And we are particularly concerned whether the Defendant would truly reflect on his misconduct and take steps to remedy the underlying shortcomings.

48. Taking into consideration the nature and gravity of the amended disciplinary charges for which we find the Defendant guilty and what we have heard and read in mitigation, we shall make a global order in respect of the amended disciplinary charges (a) and (b) that the name of the Defendant be removed from the General Register for a period of 3 months; and the operation of the

removal order be suspended for a period of 18 months, subject to the condition that the Defendant shall complete courses in cardiology (to be pre-approved by the Council Chairman) to the equivalent of 15 CME points during the suspension period.

Remark

49. The name of Defendant is included in the Specialist Register under the Specialty of Cardiology. It is for the Education and Accreditation Committee to consider whether any action should be taken in respect of his specialist registration.

Prof. TANG Wai-king, Grace, SBS, JP
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong