香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHAN Hoi Yuk (陳凱旭醫生)(Reg. No.: M13020)

Date of hearing: 10 January 2018 (Wednesday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS (Chairman)
Dr HO Chung-ping, MH JP
Dr TSE Hung-hing, JP
Dr WONG Yee-him, John
Ms LAU Wai-yee, Monita
Prof. CHAN Tak-cheung, Anthony
Ms HUI Mei-sheung, Tennessy, MH JP

Legal Adviser: Mr Edward SHUM

Defence Solicitor representing the Defendant: Dr David KAN of Messrs. Howse Williams Bowers

Senior Assistant Law Officer (Acting) representing the Secretary: Mr William LIU

1. The amended charge against the Defendant, Dr CHAN Hoi Yuk, is :

"That, on or about 3 February 2014, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] (transliteration of [redacted]) ("the Patient") in that he mistakenly put another patient's name on the labels of the medication bags dispensed to the Patient ("the Mistake") or failed to prevent the Mistake.

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

Facts of the case

2. The Defendant was at all material times a registered medical practitioner. His name has been included in the General Register from 3 July 2001 to present.

3. The Defendant admits the factual particulars of the amended charge against him.

4. Briefly stated, the Patient consulted the Defendant at his clinic located at Amoy Garden, Kowloon, on 3 February 2014 complaining of fever. Upon assessment, the Defendant found the Patient to be suffering from tonsillitis and upper respiratory tract infection. The Defendant then prescribed to the Patient Azithromycin, Ambroxol, Camgesic, Acemet, Lysozyme and herbal lozenge.

5. There is no dispute that the prescribed medications were subsequently dispensed to the Patient through the Defendant's clinic assistant.

6. The Patient returned home and took the prescribed medications. In the early hours of 5 February 2014, the Patient began to experience symptoms of palpitations and breathing difficulty. The Patient tried to get hold of the Defendant via WhatsApp but in vain.

7. The Defendant replied to the Patient via WhatsApp later in the morning of 5 February 2014. The Defendant asked the Patient to send him photographs of the dispensed medications. The Defendant then advised the Patient that Acemet might have stimulated the aforesaid symptoms and told the Patient to stop taking Acemet.

8. However, the Patient continued to experience the aforesaid symptoms. In the early hours of 6 February 2014, the Patient was about to contact the Defendant again via WhatsApp when her friend suddenly found out from reading the medication bags that the name printed on each of the medication labels was not the name of the Patient. The Patient informed the Defendant via WhatsApp of this finding.

9. The Defendant soon replied to the Patient via WhatsApp and asked the Patient if he might call her immediately. Upon her consent, the Defendant telephoned the Patient and apologized for the mistake in dispensation. Having enquired about her condition, the Defendant advised the Patient to visit his clinic at Amoy Garden later in the morning at around 09:15 hours and he would come over to see her.

However, the Patient replied that this would be too early for her and she preferred to come later in the day at around 20:00 hours and the Defendant agreed.

10. According to the Defendant, he instructed his clinic assistant to contact the patient whose name was printed on the medication bags given to the Patient later in the morning of 6 February 2014 and it was then confirmed that the medications received by him were correct.

11. In the afternoon of 6 February 2014, the Defendant enquired with the Patient again via WhatsApp about her condition. Meanwhile, according to the Defendant, he also retrieved the consultation record to check and confirm that the medications dispensed to the Patient actually tallied with his prescriptions on 3 February 2014.

12. Later in the evening of 6 February 2014, the Patient visited the Defendant's clinic at Amoy Garden. Having reviewed her condition, the Defendant prescribed further treatment to the Patient. The Defendant did not charge any fee for this consultation. The Defendant also offered the Patient a box of chocolate as a gesture of goodwill but she declined to accept.

13. The Patient subsequently lodged this complaint against the Defendant with the Medical Council.

Burden and Standard of Proof

14. 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.

15. There is no doubt that the allegation made against the Defendant here is a serious one. Indeed, it is always a serious matter to accuse any registered medical practitioner of misconduct in a professional respect. We need to look at all the evidence and to consider and determine the amended disciplinary charge against the Defendant carefully.

Findings of the Medical Council

16. The Defendant admits the factual particulars of the amended disciplinary charge against him but it remains for us to determine on the evidence whether he is guilty of misconduct in a professional respect.

17. Registered medical practitioners in Hong Kong are in a unique position in that they can prescribe and dispense medications to patients. As a registered medical practitioner who dispensed medications to his patient, the Defendant had the personal responsibility to prevent all dispensing errors including but not limited to wrong label information. Labelling of dispensed medications should be clear and legible. All medications should be labeled with a name that properly identifies the patient.

18. We acknowledge that the medications dispensed to the Patient were in fact the ones intended for her. Indeed, all the medications were properly and separately put in the respective medication bags. Each medication bag was labeled with information on the name and dosage of the medication as well as and the date of dispensation. However, the anxiety or distress that the Patient might develop after realizing that the name printed on each of the medication labels was that of another person must not be overlooked.

19. In our view, the Defendant ought to have checked the medication bags against the consultation record before dispensing them to the Patient. The Defendant's conduct has fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of professional misconduct as charged.

Sentencing

20. The Defendant has a previous disciplinary record back in 2010 relating to unauthorized practice promotion for which a warning letter was issued to him. We accept that the nature of the disciplinary offence in this case is different.

21. In line with published policy, we shall give him credit in sentencing for admitting the factual particulars of the amended disciplinary charge against him and his cooperation throughout these disciplinary proceedings.

22. We bear in mind that the 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 the high standards and good reputation of the profession.

23. We accept that this case did not involve medication errors. The only dispensing error laid in the wrong patient name being printed on the medication labels. We also accept the Defendant promptly responded to the Patient's concerns.

24. We are told in mitigation that a number of remedial measures have been taken by the Defendant's clinic after the incident to prevent this mishap from happening again. In particular, the prescribing doctor is required to check the medications against the consultation record before allowing the clinic assistant to dispense them to the patient. Moreover, the clinic assistant who hands the medications over to the patient is required to check the patient's name against the prescription and request for his or her identity card for verification.

25. We accept that the Defendant has learnt his lesson and we believe that the chance of his committing the same or similar disciplinary offence in the future is low.

26. Taking into consideration the nature and gravity of this case and what we have heard and read in mitigation, we order that the Defendant be reprimanded.

Prof. LAU Wan-yee, Joseph, SBS
Chairman,
The Medical Council of Hong Kong