香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr FUNG Yee Leung Wilson (馮宜亮醫生) (Reg. No.: M03371)

Dates of hearing: 28 June 2016 (Day 1); 16 July 2016 (Day 2); 17 July 2016 (Day 3); 31 August 2016 (Day 4); 6 November 2016 (Day 5); 16 January 2017 (Day 6) & 17 January 2017 (pm) (Day 7)

Present at the hearing

Council Members/Assessors: Prof. Felice LIEH-MAK GBS CBE JP (Temporary Chairman)
Dr Hon CHAN Pierre
Miss CHAU Man-ki, Mabel MH
Dr IP Wing-yuk
Ms HUI Mei-sheung, Tennessy, MH JP
Dr KHOO Lai-san, Jennifer

Legal Adviser: Mr Edward SHUM

Defence Solicitor representing the Defendant: Mr Chris Howse of Messrs. Howse Williams Bowers

Senior Government Counsel representing the Secretary: Mr Mark CHAN

1. The amended charges against the Defendant, Dr FUNG Yee Leung Wilson, are:

"That from 31 December 2010 to 5 January 2011 (both inclusive), he, being a registered medical practitioner, disregarded his professional responsibility to his patient B ("the Patient"), an infant, in that:-

(a) he inappropriately or without proper justification prescribed the combined use of steroids, i.e. Allersan and Flixotide, to the Patient for his conditions;

(b) he failed to have properly and adequately explained to the Patient's parent on the use of, and/or on the combined use of high dosage of, steroids, i.e. Allersan and Flixotide;

(c) he inappropriately or without proper justification prescribed zimax antibiotics to the Patient for his conditions;

(d) he inappropriately or without proper justification prescribed Flixotide to the Patient for his conditions;

(e) he prescribed Flixotide to the Patient with an excessive dosage;

(f) he failed to closely monitor, or to advise the Patient's parent to closely monitor, the Patient in relation to the neubulization therapy of Flixotide prescribed for the Patient;

(g) he failed to have properly and adequately explained to the Patient's parent on the necessary follow-up arrangements for the use of inhaled steroid (i.e. Flixotide);

(h) he inappropriately or without proper justification prescribed systemic steroid (i.e. Allersan) to the Patient for his conditions; and

(i) he used Pro Bio Gold which was not a registered drug in Hong Kong.

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 Defendant was at all material times a registered medical practitioner. His name has been included in the General Register from 12 October 1978 to present and included in the Specialist Register under the specialty of Paediatrics since 4 March 1998.

3. There is no dispute that Madam A brought her son, Patient B, who was then about 10 months old, to see the Defendant on 31 December 2010. This was their first consultation with the Defendant. According to Madam A, Patient B started to have a mild cough only the day before. Nevertheless, Madam A

preferred to take Patient B to see the Defendant, whose clinic was close by their home, lest his condition might deteriorate during the New Year holidays.

4. There is conflicting evidence on what happened during the first consultation. According to Madam A, she brought Patient B to consult the Defendant because she believed Patient B was suffering from symptoms of common cold or influenza.

5. But according to the medical report prepared and submitted by the Defendant to the Preliminary Investigation Committee ("PIC statement"), Madam A complained to him during the first consultation that Patient B had localized skin irritation, itchiness and spottiness behind and around his ears. She also complained that Patient B had generalized skin rash scattered over his body and he had been coughing for one day. Madam A also told him that Patient B was afebrile and he had no symptoms of runny rose, diarrhoea or vomiting. After physical examination, the Defendant diagnosed Patient B to have eczema (allergic dermatitis) which overlapped with a mild fungal infection around his ears. The Defendant also prescribed to Patient B Pholcodine for relief of his cough and Ibuprofen in case he might have fever.

6. Madam A told us that Patient B certainly had no diarrhoea. However, she remembered that Patient B had a little bit of fever although he might not have fever when he was at the Defendant's clinic. Madam A could no longer remember whether the Defendant had explained to her what the rash around Patient B's ears was. However, she was adamant that the Defendant never mentioned to her the word "eczema".

7. There is in any event no dispute that the Defendant prescribed various medicines to Patient B. One of them was Tridewel cream. When being asked by Madam A, the Defendant also acknowledged that Tridewel cream contained steroid. According to Madam A, she raised this enquiry with the Defendant because he had mentioned to her earlier during the first consultation that, unlike other doctors, he liked to use steroids on his patients. However, the Defendant denied having told Madam A that he liked to use steroids on his patients.

8. On 3 January 2011, Madam A brought Patient B to see the Defendant at his clinic. There is again conflicting evidence on what happened during the second consultation. According to the Defendant's PIC statement, Madam A complained to him during the second consultation that Patient B was in poor

general condition. Patient B was coughing persistently and had presented with a fever for 2 days. Patient B also had poor feeding and poor sleep.

9. Madam A told us that she could only remember that Patient B's general condition did not improve after the first consultation. Whilst Madam A accepted that Patient B still had a cough but it was not bad enough to cause him to wake up in the night. Moreover, Madam A denied that Patient B had any difficulty in breathing, wheezing or rapid respiration.

10. However, the Defendant told us in his PIC statement that he examined Patient B and found him to be in poor general condition. Patient B had a distressful cough with expiratory wheezing and he also had dyspnoea. Moreover, he found Patient B to have had atopic tendency based on his eczema and his father's history of allergic airways. Considering Patient B's clinical presentation, the Defendant diagnosed him to suffer from acute bronchiolitis caused by a virus with probable allergic elements. The Defendant also considered the acute bronchiolitis to be severe because of the rapid deterioration of his general condition since the first consultation and which resulted in poor appetite and poor sleep.

11. The Defendant also told us in his PIC statement that he clearly advised Madam A that Patient B's diagnosis had both infective and allergic elements and any further deterioration could lead to hospitalization. He told Madam A that Patient B's acute bronchiolitis and allergic elements could benefit from nebulized steroids. He further explained to Madam A that the short course and low dosage of nebulized steroid (i.e. Flixotide) he was going to prescribe would be minimally absorbed into Patient B's bloodstream and hence was safe.

12. Madam A denied that the Defendant had ever discussed with her about the treatment plan during the second consultation. Nor was she given to know that Flixotide contained steroid. As far as Madam A could remember, all the medications were dispensed to her by the Defendant's clinic nurse, who also explained to her how the medications were to be used.

13. There is conflicting evidence on how frequent nebulized Flixotide was to be given to Patient B. The Defendant told us in his PIC statement that he prescribed 10 nebules of 0.25 mg Flixotide diluted with normal saline to be inhaled on the average 3 times a day for 3 days. The Defendant also told us that he advised Madam A to give Patient B nebulized Flixotide initially every 2 hours

but she should monitor Patient B's general condition and adjust the frequency to every 4, 6 or 8 hours when there was improvement in his cough.

14. However, according to Madam A, her understanding (the same as what had been written on the printed label of the plastic bag containing the medicine) was that nebulized Flixotide had to be given to Patient B every 2 hours.

15. But then again, there is no dispute that the Defendant also prescribed Pholcodine 2.5 ml 4 times daily, Zyrtec 5 ml daily, Pro-Bio Gold 1 capsule daily and Diflucan 2 ml daily to Patient B after the second consultation.

16. According to the Defendant's PIC statement, Madam A was contacted by phone by his clinic nurse on 4 January 2011. According to usual practice, his clinic nurse would enquire the progress of Patient B's use of the nebulized Flixotide and whether there was any improvement from using the same. However, Madam A denied having talked to the Defendant's clinic nurse on the phone at all.

17. On 5 January 2011, Madam A brought Patient B to see the Defendant again. There is conflicting evidence on whether that was a scheduled follow-up consultation. There is also conflicting evidence on what happened during the third consultation.

18. Madam A agreed that Patient B's general condition did not improve after taking the prescribed medications and that was why she brought Patient B to see the Defendant on 5 January 2011. However, Madam A denied that she was frustrated by the lack of improvement in Patient B's general condition. She also denied having told the Defendant that Patient B had a history of disturbed sleep due to his blocked nose and breathing difficulties. Moreover, Madam A told us that she had no recollection of the Defendant telling her that Patient B's condition had deteriorated as a result of the allergic elements and an escalation of his treatment was necessary. She was adamant that the Defendant never talked to her about the possibility that Patient B might have a bacterial infection.

19. And yet, the Defendant told us in his PIC statement that when he examined Patient B during the third consultation, he found Patient B to have dyspnoea and respiratory distress. In addition, Patient B had a distressful cough and a runny blocked nose. He also learnt from Madam A that Patient B had a history of disturbed sleep due to his blocked nose and breathing difficulties. Moreover, Patient B constantly moved about in his sleep to relieve himself of breathing difficulties and he preferred to sleep in a prone position. The frequent turning also caused excessive sweating.

20. Considering Patient B's clinical picture in the light of his history of allergic rhinitis, the Defendant explained to Madam A that Patient B's general condition had probably been aggravated by allergic elements. The Defendant also decided that an escalation of treatment was necessary. He therefore prescribed to Patient B amongst other medications, further nebulized Flixotide; Allersan (containing systemic steroid) 3.75 ml 4 times a day for 3 days; and 3.3 ml Zimax (an antibiotic) once daily for 3 days.

21. According to the Defendant's PIC statement, Madam A telephoned his clinic and talked to his clinic nurse on 6 January 2011. Madam A told his clinic nurse that Patient B's condition worsened on 5 January 2011 after the third consultation. Patient B had cried and had a runny nose. In the course of washing his nose with nasal puff spray, his movement slowed down, his face was pale and his lips turned blue. He appeared sleepy but remained conscious. Although his movement still remained slightly slow, Patient B's condition at the time of the telephone call was alert and playful.

22. However, Madam A denied having talked to the Defendant's clinic nurse on 6 January 2011 at all. According to Madam A, she immediately brought Patient B to see his usual paediatrician, one Dr LAU, for check-up. After examination, Dr LAU found Patient B to be well and prescribed to him the usual medications for treating cold or influenza. But when Dr LAU told her that some of the medications prescribed by the Defendant contained steroids and/or antibiotics, Madam A was shocked and disappointed. She subsequently lodged this complaint with the Medical Council.

Burden and Standard of Proof

23. 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.

24. There is no doubt that the allegations made against the Defendant here are serious ones. 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 each of the amended disciplinary charges against him separately.

Findings of the Council

25. We bear in mind that the Defendant had nothing to prove but we must at the same time remind ourselves that he claimed to have "zero memory" of what happened during the 3 consultations. His evidence on what happened is based on "inferences" that he drew from the clinical notes.

26. In our view, primary facts must be proven on the evidence before reasonable inferences can be drawn. However, the Defendant's medical expert, Dr TAM, accepted that none of the symptoms and physical findings recorded in the clinical notes kept by the Defendant on Patient B are specific for acute bronchiolitis. Dr TAM also agreed that even if Patient B had a disturbed sleep in between the second and third consultations, it does not by itself mean that his illness had deteriorated. His sleep might have been affected by his blocked nose and/or having a nebulizer or nose wash every now and then. Therefore, only based on the clinical notes, Dr TAM would not be able to make a diagnosis of acute bronchiolitis.

27. The first question to be asked in this case is whether Patient B was suffering from acute bronchiolitis. In our view, he was not.

28. We gratefully adopt the following test for assessing witness credibility (set out by Chung J in *Hua Tyan Development Ltd v Zurich Insurance Co. Ltd*. [2012] 4 HKLRD 827 at 835-6]:-

"The assessment of a witness's credibility and/or reliability is a task frequently undertaken by the court in litigation (in fact, very often an essential task). I consider the following to be the appropriate test to adopt:
There are two objective tests for assessing a witness's credibility regarding a matter to which he has testified:

(a) whether that part of his testimony is inherently plausible or implausible;

(b) whether that part of his testimony is, in a material way, contradicted by other evidence which is undisputed or indisputable (an example often given of such evidence is contemporaneous documents).
Further, where it is shown that a witness has been discredited over one or more matters to which he has testified (using the above tests), this fact is relevant to the assessment of his overall credibility. Likewise, regard may be had to a witness's motive for deliberately not giving truthful testimony. For example, telling the truth may prejudice his interest, or a just determination of the litigation may affect his interest".

29. The Defendant admitted that he had "zero memory" of what happened. He could only reason out from the clinical notes that he kept as to what happened during the 3 consultations with Patient B. In this connection, there was no mention of the diagnosis of "acute bronchiolitis" in the Defendant's clinical notes. Nor were there records of such specific clinical features of acute bronchiolitis as rapid respiration, insucking of the chest, prolonged expiration and expiratory wheeze. To the contrary, the diagnosis stated in both the receipts issued and signed by the Defendant after the second and third consultations was "bronchitis".

30. We have no hesitation in accepting Madam A's evidence on Patient B's general condition during the 3 consultations. Although Patient B's general condition did not improve, there was no deterioration and let alone rapid deterioration in between 3 to 5 January 2011. Indeed, Dr TAM also accepted that he could not tell from the clinical notes whether Patient B was getting worse. Had Patient B been suffering from acute bronchiolitis of such severity as claimed by the

Defendant and was on the verge of hospitalization, Madam A could hardly be convinced by Dr LAU's assurance that Patient B was well after examination.

31. Initially, the Defendant sought to convince us that escalation of treatment on 5 January 2011 was justified because of "rapid deterioration" after the second consultation and he considered nebulized Flixotide alone to be clinically ineffective. Indeed, he went so far as to saying that Patient B was on the verge of hospitalization on 3 January 2011. However, the Defendant was constrained to accept under cross-examination that apart from dyspnoea, which he claimed to have lasted for 3 days, he was unable to pinpoint from the clinical notes record of any specific clinical features in support of his diagnosis of acute bronchiolitis.

32. The Defendant sought to explain that there was no mention of wheezing in his clinical notes because the dyspnea had become so severe that wheezing could not be heard at all. However, as Dr TAM said, if this was the case, Patient B should have been sent to hospital. And yet, the Defendant never advised Madam A of the necessity to do so on 5 January 2011. Nor had Dr LAU, who examined Patient B on the following day.

33. It is clearly stated in the Code of Professional Conduct (2009 edition) that a doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate. Although it was controversial whether steroids might be of use in treating acute bronchiolitis for young patients under the age of 24 months, Dr TAM agreed that there was no basis to prescribe steroids if Patient B was not suffering from acute bronchiolitis; and if there was no indication for steroids, whatever dosage would be considered to be high.

34. Given our finding that Patient B was not suffering from acute bronchiolitis, it must follow that the Defendant's prescription of Allersan and Flixotide, either alone or in combination, was inappropriate and without proper justification. As a corollary, prescription of steroids to Patient B in whatever quantity would be high and excessive. We therefore find the Defendant guilty of the amended charges (a), (d), (e) and (h).

35. We also accept Madam A's evidence that the Defendant had never discussed with her about the treatment plan during the second consultation. Nor had the Defendant told Madam A that Allersan and Flixotide contained steroids and their possible side effects. Moreover, since there was no indication for using steroids, any dosage would be high. Accordingly, we are satisfied on the evidence that

the Defendant had failed to properly and adequately explained to Madam A on the use (let alone combined use) of high dosage of steroids. Therefore, we also find the Defendant guilty of the amended charge (b).

36. With regard to the amended charge (c), it is stated in the Clinical Guidelines on the Management of Acute Bronchiolitis issued by the Hong Kong College of Paediatricians that "there is no evidence to support use of antibiotics in uncomplicated bronchiolitis". We are unable to find anything in the clinical notes to support the Defendant's claim that Patient B suffered from bacterial infection. Accordingly, we also find the Defendant guilty of the amended charge (c).

37. With regard to the amended charge (f), the Defendant sought to convince us that his clinic nurse had talked to Madam A on the phone on 4 and 6 January 2011. The Defendant also told us that according to usual practice, his clinic nurse would enquire the progress of Patient B's use of the nebulized Flixotide and whether there was any improvement from using the same.

38. We do not have the benefit of hearing from the Defendant's clinic nurse. But then again, the real point is that there was no mention in the clinical notes on 4 and 6 January 2011 about the progress of Patient B's use of the nebulized Flixotide at all. Even if there were telephone conversations between Madam A and the Defendant's clinic nurse, we are still unable to infer from the clinical notes alone that the Defendant's clinic nurse had closely monitored the Patient in relation to the nebulization therapy.

39. We accept Madam A's evidence that the Defendant left it to his clinic nurse to tell her how the nebulized Flixotide would be used. Indeed, we find the Defendant's evidence that he advised Madam A to adjust the frequency by monitoring Patient B's general condition difficult to comprehend. Had it been the case, the drug label for the nebulized Flixotide should read "inhale mist when necessary" instead of "inhale mist once every 2 hours". But then again, the real point is that the Defendant never told Madam A to look for possible adverse signs after inhaling Flixotide and when to seek further help or treatment. We accept Madam A's evidence that the Defendant never advised her to closely monitor Patient B in relation to the nebulization therapy. Therefore, we also find the Defendant guilty of the amended charge (f).

40. With regard to the amended charge (g), the Legal Officer's case is that when faced with the hypoxia episode, Madam A was clearly in panic going around for Dr LAU. Had Madam A been given proper advice by the Defendant, she would not be in such a helpless state. However, the incident relates to nose washing with nasal puff spray and not the use of inhaled steroid. Accordingly, we are not satisfied on the evidence that the Defendant failed to properly and adequately explain to Madam A on the necessary follow-up arrangements for the use of inhaled steroid. Therefore, we find him not guilty of the amended charge (g).

41. With regard to the amended charge (i), we accept that the Defendant used Pro Bio Gold which was not a registered drug in Hong Kong. However, mere provision of a probiotic mixture to Patient B does not by itself constitute misconduct in a professional respect. Therefore, we find him not guilty of the amended charge (i).

<u>Sentencing</u>

42. We accept that this is not a case of long term use of steroids. However, we are particularly concerned with the Defendant's indiscriminate prescription of steroids to a 10-month old baby. Babies are not miniature adults. How they may react to combined use of steroids is difficult to foresee. It is only fortunate that Patient B suffered no harm as a result of taking steroids.

43. Taking into consideration the nature and gravity of the disciplinary offences which we found the Defendant guilty and what we have heard and read in mitigation, we order that:-

(1) in respect of the amended charge (a), the name of the Defendant be removed from the General Register for a period of 3 months;

(2) in respect of the amended charge (b), the name of the Defendant be removed from the General Register for a period of 3 months;

(3) in respect of the amended charge (c), the name of the Defendant be removed from the General Register for a period of 2 months;

(4) in respect of the amended charge (d), the name of the Defendant be removed from the General Register for a period of 2 months;

(5) in respect of the amended charge (e), the name of the Defendant be removed from the General Register for a period of 2 months;

(6) in respect of the amended charge (f), the name of the Defendant be removed from the General Register for a period of 1 month;

(7) in respect of the amended charge (h), the name of the Defendant be removed from the General Register for a period of 2 months; and

(8) the above removal orders to run concurrently, making a total of 3 months.

44. We have considered whether the operation of the removal orders may be suspended. We do not agree with the Defendant's solicitor's submission in mitigation that this is a case of wrong diagnosis. Although the Defendant admitted that he had "zero memory" of what happened during the 3 consultations and none of the specific clinical features for acute bronchiolitis could be found in the clinical notes, he still insisted that his prescriptions of steroids were justified. In our view, the Defendant shows no insight into his wrongdoings. We do not find this to be a suitable case for suspension of the removal orders.

Remark

45. The Defendant is included in the Specialist Register under the specialty of Paediatrics. We shall leave it to the Education and Accreditation Committee to decide on whether anything may have to be done to his specialist registration.

Prof. Felice LIEH-MAK GBS CBE JP
Temporary Chairman, Medical Council