香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr CHAN Wai Ip (陳偉業醫生) (Reg. No.: M06470)

Date of hearing: 11 November 2020 (Wednesday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS
(Chairperson of the Inquiry Panel)
Dr IP Wing-yuk
Dr FUNG Tak-kwan, James
Ms HUI Mei-sheung, Tennessy, MH, JP
Ms CHOW Anna M W

Legal Adviser: Mr Stanley NG

Defence Solicitor representing the Defendant: Mr Warren SE-TO of
Messrs. Mayer Brown

Senior Government Counsel representing the Secretary: Ms Rachel LI

1. The charge against the Defendant, Dr CHAN Wai Ip, is:

"That on 31 January 2018, he, being a registered medical practitioner, disregarded his professional responsibility to his patient ("the Patient") in that he, without reasonable justifications, issued an attendance record for insurance claim ("attendance record") with diagnosis of Upper Respiratory Tract Infection ("URTI") and consultation date of 1 February 2018 when the Patient did not consult him on 1 February 2018.

In relation to the facts alleged, 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 30 April 1987 to present. His name had been included in the Specialist Register under the Specialty of Paediatrics from 7 July 1999 to 1 July 2009.

3. On 31 January 2018, the Patient consulted the Defendant with complaints of, among others, right wrist pain. The Patient was covered by a group medical insurance policy, under which she could only have one medical consultation per day. The Patient requested for referral letters. The Defendant issued to her two referral letters, one to physiotherapy specialist dated 31 January 2018, and another to orthopaedic specialist dated 1 February 2018. In both letters, the Defendant wrote there was no known injury.

4. At the end of the consultation, the Patient was asked to sign on two attendance record for insurance claim. She settled her co-payment of the consultation fee and left the clinic.

5. A few months later, the Patient called the Defendant to assist to clarify on the words "no known injury" used in the referral letters as her insurance claim for physiotherapy was unsuccessful. The Defendant declined her request.

6. Later, the Patient sought from her insurance company the consultation record with the Defendant. The Patient discovered that she had signed on an attendance record for insurance claim with diagnosis of URTI and consultation date of 1 February 2018. The Patient said she had no URTI and she had not consulted the Defendant on 1 February 2018.

7. On 4 May 2018, the Patient and her husband went to the Defendant's clinic and requested the Defendant to assist in clarifying the words "no known injury", and on why the attendance record showed the diagnosis as URTI. The Defendant asked the Patient and her husband to leave. The Patient and her husband refused to leave and police were called. According to a memo from the Commissioner of Police to the Secretary of the Medical Council dated 13 July 2019, the police had investigated and classified the case as "Dispute" without settlement.

8. On 16 May 2018, the Patient lodged a complaint to the Medical Council.

Burden and Standard of Proof

9. We bear in mind that the burden of proof is always on the Secretary 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.

10. There is no doubt that the allegation 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 the disciplinary charge against him carefully.

Findings of the Inquiry Panel

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

12. It is clearly stated in paragraph 26 of the Code of Professional Conduct (the "Code") (January 2016 edition) that:

> "*26.1 Doctors are required to issue reports and certificates for a variety of purposes (e.g. insurance claim forms, payment receipts, medical reports, vaccination certificates, sick leave certificates) on the basis that the truth of the contents can be accepted without question…*
>
> *26.2 A sick leave certificate can only be issued after proper medical consultation of the patient by the doctor. The date of consultation and the date of issue must be truly stated in the certificate, including a certificate recommending retrospective sick leave.*
>
> *26.3 Any doctor who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper renders himself liable to disciplinary proceedings…*"

13. There is no dispute that the Defendant had issued an attendance record for insurance claim with diagnosis of URTI and consultation date of 1 February 2018, when in fact there was no such consultation on 1 February 2018.

14. The Defendant explained in his submission dated 11 March 2020 that on 31 January 2018 his diagnosis of the Patient was myositis related to URTI. The Patient requested him for referral to physiotherapy without a reason, and he told the Patient that he could only arrange an orthopedic referral before ordering physiotherapy. Since the Patient had already had one consultation she would have to pay cash as the referral to physiotherapy was not related to her problem. The Defendant said the Patient refused to pay cash, and could not provide him with all the information that was related to hand injury. At the end, the Patient agreed to sign on another consultation voucher on next days for 2 referral letters to orthopedic and physiotherapy.

15. Even if we accept what the Defendant wrote in his submission as true, what the Defendant should have done, if he honestly held the view that referral to physiotherapy was not justified, was to explain to the Patient and refuse to issue the letter of referral to physiotherapy specialist. However, not only the Defendant had not done so, instead he asked the Patient to pay cash for the issuance of a referral letter which he believed in the first place there was no reason to issue at all. When the Patient refused to pay cash, the Defendant then allowed the Patient to sign on a consultation voucher or attendance record for the next day (i.e. 1 February 2018). There was no consultation on the next day. The attendance record with the date of consultation of 1 February 2018 was untrue. Even if what the Defendant said that he had the Patient's agreement to sign on the attendance record for the next day was the case, the fact remains that the said attendance record was untrue, and it would be used to claim payment from the insurance company. We do not see there is any reasonable justification for issuing the said attendance record.

16. In our view, the Defendant's conduct had fallen below the standards expected of registered medical practitioners in Hong Kong. We therefore find him guilty of misconduct in a professional respect as charged.

Sentencing

17. The Defendant has a clear disciplinary record.

18. In line with published policy, we shall give credit to the Defendant for his frank admission and full cooperation throughout these disciplinary proceedings.

19. 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 its high standards and good reputation.

20. This is not the type of cases in which there was no consultation. There was a consultation on 31 January 2018.

21. The Defendant's solicitor told us that the reason the Defendant issued the attendance record with consultation date of 1 February 2018 was because the Patient demanded a referral letter and he therefore accommodated the Patient's demand. The Defendant's solicitor also said there was no financial gain. This we disagree. It is clear that there was financial gain as the consultation fee would be claimed from the Patient's insurance company. The nature and gravity of the case was serious.

22. Taking into consideration the nature and gravity of the Defendant's case and what we have heard in mitigation, we order that the Defendant be removed from the General Register for a period of 1 month. We further order that the removal order be suspended for a period of 12 months.

23. We note from the Defendant's clinical record that there was an entry which reads "phone call claim physio over $10000". There was no date of when the entry was made. As a matter of good practice, we would wish to remind the Defendant to ensure all entries in his medical record are properly dated.

Prof. LAU Wan-yee, Joseph, SBS
Chairperson of the Inquiry Panel
The Medical Council of Hong Kong