香 港 醫 務 委 員 會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr YUEN Fu Lam (Reg. No.: M13568)

Dates of hearing: 20 and 21 March 2023 (Monday and Tuesday)

Present at the hearing

Council Members/Assessors: Prof. LAU Wan-yee, Joseph, SBS
(Chairperson of the Inquiry Panel)
Prof. CHOW Yat-ngok, York, GBS, MBE
Prof. LAU Yu-lung, BBS, JP
Mr CHAN Wing-kai
Mr NG Ting-shan

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Mr Chris HOWSE of
Messrs. Howse Williams

Outside Counsel representing the Secretary: Mr Ernest NG as instructed by
Department of Justice

1. The amended charge against the Defendant, Dr YUEN Fu Lam, is:

> "That on or about 30 July 2015, he, being a registered medical practitioner, without proper care and/or assessment, issued a medical certificate in respect of Madam xxx ("the Patient"), which certified that the Patient was mentally fit for making judgement of her own finance.
>
> 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 2 July 2002 to the present and his name has been included in the Specialist Register under the Specialty of Family Medicine since 2 March 2011.

3. Briefly stated, the Secretary of the Medical Council (the "Council") received a complaint from one of the Patient's daughters, (the "Complainant") alleging the Defendant of professional misconduct when certifying on 30 July 2015 the Patient's ability to manage her financial affairs.

4. The material parts of the medical certificate issued by the Defendant read as follows:

"*... Re:* xxx *... Female / 86Y*

This is to certify that Madam xxx attended our clinic today.

She got heart disease, and claimed no history of cognitive or psychiatric dysfunction.

She understood the reason of attendance here, for financial management authorization, involving the transfer of property ownership, and the follow up plan of finance by herself and her son afterwards, and fully know that she could not get back the money after the legal procedure.

She is orientated to time, place and person, and the cognitive assessment was matching her educational level.

Impression: She is mentally fit for making judgment of her own finance…"

5. In support of her complaint, the Complainant also provided the Council with a copy of the medical report prepared by one Dr KWOK, Associate Consultant, Department of Psychiatry of the Pamela Youde Nethersole Eastern Hospital ("PYNEH") on the Patient dated 14 December 2016. The material parts of that medical report read as follows:

"*...Re: xxx ..., Female,... DOB: 1929*

Madam xxx was born in China. She reported no family history of mental illness. She attended primary school for a few years. She came to Hong Kong at young age. She was married at her 20's with son and daughters. Her husband passed away years ago. She reported no illicit drug abuse. She lived with a daughter and maid.

Madam xxx was first assessed by consultation liaison psychiatrist on 10/4/2014 for memory decline for 1 year. No depressive symptoms, no abnormal perceptions were reported. CT brain performed in 2/2014 showed periventricular hypodensities. Mini-mental state examination in 1/2014 showed score 12/30. She was diagnosed to have Alzheimer's disease. She was treated with Aricept. She was referred to psychogeriatric clinic of day hospital for training in 7/2014. When last seen with daughter at psychiatric clinic of this hospital on 4th November 2016. She reported stable mood and fair memory…

In summary, Madam xxx was suffering from Alzheimer's disease with treatment of medications from our department since 10/4/2014. Further psychiatric treatment is required…"

6. In response to the allegation of the Complainant, the Defendant first submitted to the Preliminary Investigation Committee ("PIC") of the Council on 20 December 2018 *inter alia* that:

"…

6. Madam xxx ("the patient") only attended my clinic once. On 30-7-2015, she attended my clinic, together with her son and a staff from law firm.

7. According to her son, the patient had no history of cognitive disorder, or psychiatric illness or dementia. The purpose of this consultation was for documentation of ability for legal procedure of name transfer of property, with aid of legal firm.

8. The patient reported that she had heart disease. She claimed no history of cognitive or psychiatric dysfunction.

9. I had no knowledge about the patient's psychiatric history at the Psychiatry Department of… PYNEH… I did not have access to the patient's medical record at the Hospital Authority.

10. Upon my assessment, the patient was oriented to time, place and person. She understood the reason of attendance here, which was for financial management authorization, involving transfer of property ownership, and the follow up plan of finance by herself and her son afterwards. She fully knew that she could not get back the money after the legal procedure.

11. She gave her rationale that she was old, the remaining money being no use to her, and that her life would be supported by her son.

12. I conducted Mini Mental State Examination (MMSE), an instrument for cognitive function assessment. It yielded a score of 18 out of 30 (uneducated at all).

13. In the medical certificate, I commented that she is mentally fit for making judgement on her own finance…

14. I only met this patient, and her son and the staff of the law firm in this clinical encounter at my clinic on 30-7-2015. I did not know the patient, any of her relatives, or any financial or legal agency concerned, before this consultation on 30-7-2015. I did not see this patient again after 30-7-2015.

15. In 2017, I received letters from LAU & CHAN Solicitors which was acting on behalf of patient's daughter, and H.Y. LEUNG & Co., Solicitors which was acting on behalf of GAIN HERO FINANCE LIMITED. Despite their request, I did not release the patient's clinical information to these 2 parties, because I did not have the patient's consent…"

7. In his witness statement dated 14 March 2023, the Defendant supplemented *inter alia* that:

"*41. In a letter dated 24th February 2017, Messrs Lau & Chan wrote to me to state that they were acting in a civil claim for the Patient on the instructions of her daughter. According to the heading of the letter, a company called Gain Hero Finance Limited had sued the Patient and [the Complainant's brother] in a civil action…*

42. Messrs Lau & Chan asked me to provide them with the basis of my opinion for the medical certificate which I had issued to the Patient on 30th July 2015 with supporting evidence, and also a copy of my medical notes and records for the consultation on that day. They wrote to me again on 26th April 2017, restating their request…"

8. According to the Complainant, the civil action brought by Gain Hero Finance Limited was for an order for sale of a residential property jointly owned by the Patient and her brother. The Defendant's solicitor also told us that the order for sale was sought on the basis of a default judgment of $1,400,000 plus interest owed by the Patient and the Complainant's brother under a Loan Agreement made with Gain Hero Finance Limited on 30 July 2015.

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.

Preliminary Issues

11. At the beginning of this Inquiry, the Defendant objected through his solicitor the admissibility and relevance of certain documents in the Secretary's Bundle of Documents, namely, the Statutory Declaration of the Complainant and medical records kept on the Patient by the Hospital Authority.

12. In gist, the Defendant contended that the Statutory Declaration of the Complainant contained double hearsay and he had no knowledge of medical records kept on the Patient by the Hospital Authority when he saw her on 30 July 2015.

13. Having considered the legal submissions from the Defendant's solicitor and the Legal Officer, we ruled that the Statutory Declaration of the Complainant is admissible subject to redaction of the double hearsay contents. We wish to emphasize that strict rule of evidence does not apply to disciplinary proceedings under the Medical Registration Ordinance. The ultimate test of admissibility of evidence is relevance. Subject to the issue of fairness, hearsay may be admitted into evidence.

14. But then again, we agreed with the Defendant's solicitor that admission of the double hearsay contents of the Statutory Declaration would be unfair to the Defendant because the prejudicial effect outweighed its probative value.

15. We also ruled that the medical records kept on the Patient by the Hospital Authority on or before 30 July 2015 should be admitted into the evidence. We disagreed with the Defendant's solicitor that those medical records are irrelevant because the Defendant had no knowledge of the same when he saw the Patient on 30 July 2015. In our view, those medical records are highly relevant to the mental condition of the Patient at the time when the Defendant saw her on 30 July 2015.

Findings of the Inquiry Panel

16. After the Secretary's case has closed, the Defendant admitted through his solicitor the factual particulars of the amended disciplinary charge against him. It remains for us to consider and determine on all the evidence whether the Defendant has been guilty of misconduct in professional respect.

17. We wish to emphasize at the outset that MMSE is only a screening test for cognitive function. It is however not definitive. The validity of the results of the MMSE depends on the circumstances under which it is administered, the patient's rapport with the interviewing healthcare professionals, the age and education background of the patient & etc.

18. Hence, one has in our view to approach the results of the MMSE with caution, which are not conclusive as to the mental capacity of the subject patient at the material time. This is particularly true when the score is within a low range of 18-20/30.

19. In this connection, our attention was drawn by Dr CHUNG, the Secretary's expert witness and a specialist in psychiatry, to the local study by Professor Helen CHIU and her colleagues that "*The optimal cutoff points were 18 or below for illiterate subjects, 20 or below for those with 1 to 2 years of schooling, and 22 or below for those with more than 2 years of schooling.*" Dr CHUNG also told us and we accept patients with the score of 18/30 in MMSE have an 80% probability of suffering from dementia.

20. And we agree with Dr TSOI, the Secretary's expert witness and a specialist in Family Medicine, that "*The score of MMSE alone cannot confirm presence of satisfactory capacity or lacking of it.*"

21. We also agree with Dr CHUNG that although "*Madam xxx denied having any illness affecting her memory… a reasonable doctor should know that the [medical] history from Madam xxx would be unreliable because her memory was impaired as suggested by the low score in the memory test" during the MMSE*; and "*A reasonable doctor should also know that such memory impairment cannot be explained by "uneducated at all"."*

22. And we agree with Dr TSOI that "*This [was] the first ever consultation by the patient to Dr Yuen... Dr Yuen should not rush into signing a certificate before full and proper medical information was obtained.*"

23. Worse still, as Dr CHUNG rightly pointed out, the Defendant had "*not obtained information about [the Patient's] contemporaneous financial situation and her ability in managing her finance*."

24. We agree with Dr CHUNG that the particular poor results relating to subtraction and recent memory coupled with the borderline score of 18/30 in MMSE called for further medical and social information from the Patient and/or her family before the Defendant would be in a position to certify that she was mentally fit for making judgment of her own finance.

25. For these reasons, we are firmly of the view that the Defendant had issued the said medical certificate in respect of the Patient's mental fitness for making judgment of her own finance without proper care and assessment.

26. In doing so, the Defendant has in our view by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find the Defendant guilty of misconduct in a professional respect as charged.

Sentencing

27. The Defendant has a clear disciplinary record.

28. In line with our published policy, we shall give the Defendant credit in sentencing for admitting the amended disciplinary charge and not contesting the issue of professional misconduct. However, given the fact that the Defendant only admits the amended disciplinary charge after the close of the Secretary's case, the credit to be given to the Defendant must be of a lesser extent than the case of a defendant doctor who admits to the disciplinary charge at the beginning of the inquiry.

29. We appreciate that there is no evidence to suggest that the present case involved fabrication of untrue matters.

30. However, given the Defendant's claim in his PIC submission about his training and experience in mental capacity assessments, we find the lack of proper care and assessment in the present case quite appalling.

31. We are told in mitigation that the Defendant no longer conducted medical capacity assessments after 2017. But then again, we need to ensure that the Defendant would not commit the same or similar breach in the future.

32. Taking into consideration the nature and gravity of this case and what we have read and heard in mitigation, we order that the name of the Defendant be removed from the General Register for a period of 6 months. We further order the removal order be suspended for a period of 24 months.

Remarks

33. The name of the Defendant is included in the Specialist Register under the Specialty of Family Medicine. We shall leave it to the Education and Accreditation Committee to decide on whether anything may need to be done to his specialist registration.

34. Although this is not the disciplinary charge that the Defendant is facing, we wish to remind the Defendant that medical record reflects on the quality of patient care. The medical record that he kept for the Patient was surely below the standards expected of registered medical practitioners of Hong Kong.

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