香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr TSUI Hing Sing Robert (徐興盛醫生) (Reg. No.: M05533)

Date of hearing: 29 September 2025 (Monday) (Day 1);
30 September 2025 (Tuesday) (Day 2);
15 November 2025 (Saturday) (Day 3); and
10 January 2026 (Saturday) (Day 4)

Present at the hearing

Council Members/Assessors: Prof. TANG Wai-king, Grace, SBS, JP
(Chairperson of the Inquiry Panel)
Dr Pierre CHAN
Dr WONG Mo-lin, Maureen
Mr LAM Chi-yau
Miss LAU Wan-ching

Legal Adviser: Mr Edward SHUM

Defence Counsel representing the Defendant: Ms Deanna LAW as instructed by
Messrs. Johnson Stokes & Master

Legal Officer representing the Secretary: Miss Vivian KAO,
Senior Government Counsel

The Charges

1. The charges against the Defendant, Dr TSUI Hing Sing Robert, are:

"That between 29 February 2016 and 16 March 2016, both dates inclusive, he, being a registered medical practitioner, disregarded his professional responsibility to his patient [redacted] ("the Patient"), in that he:

(a) when encountering the Patient with blistering conditions, failed to timely take detailed medical history of the Patient;

(b) failed to take timely and appropriate diagnostic steps to consider / confirm / review possible diagnoses;

(c) inappropriately managed the Patient's infection, such as lack of reassessment in view of worsening condition, prescribing high dose of steroids, not prescribing enough antibiotics to the Patient;

(d) failed to timely pursue more rigorous clinical assessment and investigations when the general condition of the Patient was deteriorating; and/or

(e) failed to timely refer the Patient to appropriate specialist(s) / healthcare professional(s) / in-patient care when the skin condition of the Patient was worsening.

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 1 November 1984 to the present. His name has never been included in the Specialist Register.

3. For the purpose of this inquiry, the Secretary and the Defendant have agreed on the following facts:-

"... [redacted] deceased ("**Patient**"), aged 61 at the material times, consulted the Defendant at the clinic of Dr Tsui Hing Sing Robert & Associates Ltd ("**Clinic**") for a total of five times on 29 February 2016, 1 March 2016, 5 March 2016, 10 March 2016 and

14 March 2016. In addition to the above, the Defendant prescribed medication to the Patient in the morning of 15 March 2016 and also had a phone call with the Patient's relative that evening.

...A complete set of medical clinical records made by the Defendant concerning the Patient during the material period is in the Secretary's Bundle at pages 64-71 ("**Medical Records**").

...On 29 February 2016 (**First Consultation**), the Patient first consulted the Defendant for a complaint of left leg blister below the knee for 2 days.

...The Medical Records documented (among others) findings of "*14x8cm blister; cellulitis+*". The Patient was prescribed the following:

	Medication	Dosage (3 days)
1.	Curam 625mg	1 tablet, twice daily
2.	Clarithromycin 250mg	1 tablet, twice daily
3.	Pantoprazole 40mg	1 tablet, twice daily
4.	Zegavit	1 tablet, once daily

...On 1 March 2016 (**Second Consultation**), the Patient attended a follow-up consultation with the Defendant.

...The Medical Records documented (among others) findings of "*oozing from wound; cellulitis+/-*".

...On 5 March 2016 (**Third Consultation**), the Patient attended a follow-up consultation with the Defendant.

...The Medical Records documented (among others) findings of "*epithelisation+; cellulitis+/-*". The Patient was prescribed the following:

	Medication	Dosage (5 days)
1.	Curam 625mg	1 tablet, twice daily
2.	Clarithromycin 250mg	1 tablet, twice daily
3.	Raktolyn	1 tablet, twice daily
4.	Pantoprazole 40mg	1 tablet, twice daily
5.	Folic acid 5mg	2 tablets, twice daily

...On 10 March 2016 (**Fourth Consultation**), the Patient attended a follow-up consultation with the Defendant.

...The Medical Records documented (among others) findings of "*12x6cm blisters right thigh just above knee cellulitis+/-; left leg wound healing; cellulitis:0;*". The Patient was prescribed with the following:

	Medication	Dosage (3 or 5 days)
1.	Clarithromycin 250mg	1 tablet, twice daily (5 days)
2.	Xorimax 250mg	1 tablet, twice daily (5 days)
3.	Loperamide 2mg	1 tablet, 4 times daily (3 days)
4.	Raktolyn	1 tablet, twice daily (5 days)
5.	Pantoprazole 20mg	1 tablet, twice daily (5 days)
6.	Folic acid 5mg	2 tablets, twice daily (5 days)
7.	Hycephen	1 tablet, 3 times daily

	(Paracetamol 325mg and Tramadol HCl 37.5mg)	(5 days)

…On 14 March 2016 (**Fifth Consultation**), the Patient attended a follow-up consultation with the Defendant.

…The Medical Records documented (among others) findings of "*14x6cm blister upper* [sic] *right thigh; cellulitis:0; pain:0;*". The Patient was prescribed with the following:

	Medication	Dosage (3 days)
1.	Prednisolone 25mg	1 tablet every morning

…In the morning of 15 March 2016, the Defendant's Clinic received a call from the Patient or his relative. The Defendant was informed that the Patient complained of thigh and leg pain, and requested analgesics. The Patient could not return for follow-up immediately due to the pain. The Patient was prescribed with the following and advised to return to the Clinic for a follow-up as soon as he could:

	Medication	Dosage (3 days)
1.	Hycephen (Paracetamol 325mg and Tramadol HCl 37.5mg)	1 tablet, 3 times a day

…That evening, the Defendant spoke to a male relative by phone. The Defendant did not speak with the Patient, who was asleep at the time.

…On 16 March 2016, the Patient passed away."

4. The report on autopsy of the Patient performed on 18 March 2016 read, *inter alia*, as follows:-

"…
Two ruptured blisters, each about 7cm in maximal dimension, on outer right thigh.
A ruptured blister, 3cm in maximal dimension, on inner right thigh.
A ruptured blister, 10cm in maximal dimension, on inner left thigh.
A ruptured blister, 2cm in maximal dimension, on inner left knee.
A dressed ruptured blister, 9cm in maximal dimension, on inner left calf.
…
…Liver (865g) showed advanced cirrhotic changes with fibrosis, nodular appearance and contraction in size. Histology confirmed gross findings.
…
Swab of ruptured blisters on right and left legs for bacterial culture…
Mixed growth of gram negative bacilli (2 morphotypes) and gram positive cocci (1 morphotype)
Abundant epithelial cells present, suggestive of contamination.

Right and left pleural fluid for bacterial culture…
Mixed growth of gram negative bacilli (2 morphotypes) and gram positive cocci (1 morphotype)

Splenic swab for bacterial growth culture…
Gram negative bacillic (scanty growth)

Blood for bacterial culture…
Mixed growth of gram negative bacilli (4 morphotyopes) and gram positive cocci (1 morphotype)
…
Alcohol was detected in the urine at a level of less than 10mg/100mL; it was not detected in the blood or vitreous humour.

Tramadol was detected in the blood at a level of 2.9 ug/mL (reference therapeutic level 0.01-1 ug/mL).
Pantoprazole was detected in the blood at its therapeutic level (reference therapeutic level 4.6 ug/mL).
Paracetamol was detected in the blood at its therapeutic level (reference therapeutic level 2.5 – 30 ug/mL).
No significant finding was obtained for the blood and urine by a general screening procedure for other common drugs and poisons.
...

The cause of death as shown by the autopsy appears to be:

I (a) Adverse effects of tramadol...
...
II Cirrhosis of liver...

Remarks: 1. Tramadol is an opioid analgesic. The blood level of 2.9 ug/mL was grossly above the usual therapeutic range. When overdosed it may cause respiratory depression and coma, therefore contributing to the death.

2. Autopsy revealed presence of advanced liver cirrhosis. Biochemical analysis of the blood showed evidence of renal impairment (a complication of liver cirrhosis) with raised urea and creatinine level. As tramadol is eliminated primarily through metabolism by the liver and the metabolites are excreted by the kidneys, the rates of metabolism and excretion of the drug were expected to be reduced and might contribute to a raised blood level.

3. Pantoprazole is a proton pump inhibitor that inhibits gastric acid secretion.

4. Paracetamol is a painkiller.

5. Microbiological investigations showed mixed growth of bacteria in specimens from different anatomical sites. The culture result could be affected by contamination and hence it is inconclusive.

6. The low level of alcohol in the urine could be caused by decomposition during the post-mortem period, and did not necessarily indicate consumption of alcohol before death."

5. The Patient's daughter subsequently lodged this complaint against the Defendant with the Secretary of the Medical Council (the "Council").

Burden and Standard of Proof

6. 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.

7. There is no doubt that each of the allegations made 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

8. We appreciate that there is no direct evidence from the Patient as to what happened during his consultations with the Defendant. Indeed, the Complainant and the Patient's elder sister also accepted that they did not have firsthand knowledge of what happened during either the Patient's consultations with the Defendant or the telephone conversation between the Patient's father and the Defendant. However, we disagree with the submission of defence Counsel that their testimonies "*cannot be treated as reliable*".

9. In our view, the truthfulness or otherwise of any part of a witness' testimony is essentially a question of fact to be decided by looking at the whole evidence. It is open to us, as a tribunal of fact, to decide in respect of any witness whether we can accept all the evidence of that witness, none of it or only some of it.

10. In assessing credibility of witnesses, we gratefully adopted the following approach set out by Deputy High Court Judge Eugene Fung SC (as he then was) in his Judgment in *Hoh Han Keyet v Artimax Investment Limited & Others*; HCA 1163/2013; 30 June 2016:-

> "*36. In making my findings of fact in this case, I adopt the following general principles as to fact finding and assessment of credibility I set out in Hui Cheung Fai v Daiwa Development Ltd...*
>
> > "*77. Generally speaking, contemporaneous written documents and documents which came into existence before the problems in question emerged are of the greatest importance in assessing*

credibility...

78. In deciding whether to accept a witness's account, importance should also be attached to the inherent likelihood or unlikelihood of an event having happened, or the apparent logic of events...

79. In determining a witness's credibility, I have also attached importance to the consistency of the witness's evidence with undisputed or indisputable evidence, and the internal consistency of the witness evidence. The latter type of consistency is often tested by a comparison between the witness' oral testimony and his or her witness statement.

80. I have cautioned myself against the dangers of too readily drawing conclusions about truthfulness and reliability solely or mainly from the appearance of witnesses...

81. The practical approach to assessing credibility of witnesses in a case such as the present may have best been summarized by the words of Robert Goff LJ, as he then was, in The Ocean Frost [1985] 1 Lloyd's Rep 1 at 57:

> *"Speaking from my experience, I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a Judge in ascertaining the truth."*

82. Whilst these words were spoken in the context of fraud case, I believe they are applicable to any case where a witness' credibility features prominently in the court's determination..."

37. As mentioned earlier, contemporaneous documents are generally of the greatest importance in assessing credibility. However, where some evidence indicates that part of a contemporaneous document might not be completely accurate, the court may need to accordingly adjust the evidential weight to be put on the document in question."

11. The Secretary's case in respect of disciplinary charge (a) is that when encountering the Patient with blistering conditions, the Defendant failed to timely take detailed medical history of the Patient.

12. By a letter dated 15 July 2025, the Secretary also informed the Defendant through his solicitors that "*detailed medical history*" included "*details of evolution of signs and symptoms of complaint; past experience of any similar condition to present complaint; general health condition; ongoing illness and/or disease; past illness and/or disease; family history; history on medication, herbal medicine and/or supplement; past allergic reaction to any food, medication etc.*"

13. The Legal Officer further explained in her oral Opening Submission that disciplinary charge (a) relates to the 1st, 4th and 5th Consultations; and the telephone conversation between the Patient and the Defendant in the morning of 15 March 2016.

14. When being cross-examined, the Defendant accepted that the only medical records that he had kept on the Patient were the clinical records that he provided to the Preliminary Investigation Committee ("PIC") of the Council under the cover of his solicitors' letter dated 8 November 2022 ("1st PIC Submission").

15. According to the Defendant, his clinical records on the Patient were stored in a computer at his clinic. The clinical records on the Patient were divided into different sections, namely, "*Medical Record*"; "*Allergy*"; "*Glucose & BP*"; "*Other Medical Data*"; "*Immunization*"; "*Health Data*"; and "*Medical History*".

16. In his Statement to the PIC dated 26 October 2022 (the "1st Statement"), the Defendant claimed that "*[w]hile these pages bear the print date of "26*

September 2022", I confirm that the contents therein were made by me at the consultation on 29 February 2016". However, only the section on "*Other Medical Data*" bore the "*Print Date*" of "*26 September 2022*". All the other sections bore the "*Date*" and not the "*Print Date*". It is hard to believe that a clinical record keeping computer programme would use "*Print Date*" and "*Date*" interchangeably for the date when the clinical records were printed out.

17. Be that as it may, we agree with the Secretary's expert witness, Professor LEE, that in the clinical records on the Patient "*[o]nly spot observation was recorded... with no specific history and examination to explore possible underlying causes and related health conditions*". We also agree with Professor LEE that "*[w]ith acute presentation of leg blister, [the Defendant] is expected to obtain further history and examination to try to identify the possible underlying causes.*"

18. In response to the allegation that he failed, when encountering the Patient with blistering conditions, to timely take detailed medical history of the Patient, the Defendant explained, *inter alia*, to the PIC in his Statement dated 26 October 2022 ("1st Statement") that "*[p]ursuant to [his] routine practice, [he] would have asked the Patient about his... history of drug allergy, drinking and smoking... family history... ongoing medical conditions and treatments; and... current complaint and related symptoms*". The Defendant also claimed in the 1st Statement that the Patient "*did not volunteer any history of ongoing medical illness or treatment*".

19. The Defendant further explained in his Supplemental Statement dated 17 September 2025 ("2nd Statement") that "*in accordance with my routine practice, I documented the Patient had no known allergy (including drug allergy) so that I could refer to this when prescribing in future. Other than this, I did not document all the negative histories given.*"

20. We appreciate that the Defendant is not charged with failure to keep proper and adequate medical records of the Patient. We also agree with defence Counsel that the absence of documentation of negative histories in the clinical records on

the Patient did not necessarily mean that the Defendant had never asked the Patient about his medical history. But one thing is for sure and that is the Defendant's claim that he had in accordance with his routine practice taken a full medical history of the Patient is not supported by any written documents before us.

21. We wish to point out that the necessity for taking a detailed medical history of the Patient is not confined to the 1st Consultation on 29 February 2016 when the Patient presented with blistering conditions for which he was seeking treatment. We agree with the Legal Officer that if the Patient's conditions evolved, particularly when the Patient's conditions deteriorated, there was a need to take a detailed medical history of the Patient again.

22. We also agree with the Legal Officer that when the Patient complained during the 4th Consultation on 10 March 2016 of inability to stand due to pain in his left leg, the Defendant ought in our view take a detailed medical history of the Patient again. This is particularly true when, according to the Defendant, the Patient's "*left leg blister [was] healing [with] no cellulitis*". The same is true in respect of the 5th Consultation on 14 March 2016, when there was "*new eruption [of blisters on the Patient's] right thigh*" despite the Patient was, according to the Defendant, asked to stop using the Chinese herbal plasters. Indeed, the Defendant also accepted in his oral evidence that by the time of the 4th Consultation, the Patient's "*condition could potentially be serious and even life-threatening*". And yet, the Defendant did not timely take relevant detailed medical history of the Patient in the light of these changes in medical condition.

23. For these reasons, in failing to timely take a detailed medical history of the Patient when encountering the Patient with blistering conditions during the 4th Consultation on 10 March 2016 and 5th Consultation on 14 March 2016, the Defendant had in our view by his conduct in this case 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 per the disciplinary charge (a).

24. It is unchallenged evidence of the Complainant and the Patient's elder sister that before the onset of the blistering condition, the Patient was a generally healthy individual albeit with a lean statute. Although his walking was impaired by muscular dystrophy, the Patient was able to move around independently with the aid of a walking stick.

25. However, the defence witness, Madam HO, who was and still is a clinic assistant for the Defendant, told us in her witness statement that the Patient was pushed by a male person in a wheelchair to the Defendant's clinic every time when he consulted the Defendant from 29 February 2016 to 14 March 2016. Madam HO supplemented in her oral evidence that she clearly remembered that the Patient came in a wheelchair. This was because some time before 29 February 2016, she saw the Patient accompanying a child to consult the Defendant. At that time, the Patient was able to walk with the aid of a stick.

26. There is no dispute that the Patient consulted the Defendant during the period from May to November 1998 for gastrointestinal symptoms. There was a gap of almost 18 years before the Patient consulted the Defendant again on 29 February 2016. When being cross-examined, the Defendant admitted that he saw around 400 patients per week in 2016. We find it implausible that Madam HO could have such a vivid recollection of his mobility when according to her evidence the Patient merely accompanied a child to consult the Defendant. We do not accept the evidence of Madam HO in this respect.

27. The Defendant claimed in his 1st Statement that he had explained to the Patient that his "*right thigh condition could possibly be an allergic reaction to the herbal ointment*" or alternatively that "*his condition could be associated with a serious bacterial infection or an autoimmune disease*". But then again, none of these hypotheses could apply to the Patient's complaint during the 4th Consultation on 10 March 2016 of inability to stand due to pain in his left leg when, according to the Defendant, the Patient's "*left leg blister [was] healing [with] no cellulitis*". And yet, the Defendant did nothing to review and find out possible diagnoses in the light of the Patient's new complaint. The same is true when there was "*new eruption [of blisters on the Patient's] right thigh*".

28. As Professor M A Jones aptly pointed out in *Medical Negligence* (6th ed):-

> "*4-034 ... Where a practitioner has diagnostic aids available it may be*

negligent not to use them...

4-035 In some cases, although the practitioner cannot be faulted for failing to identify the specific illness or disease from which the patient is suffering, the patient's condition is so serious that he ought to have realized that either further tests were required for a more accurate diagnosis, or the patient should have been referred to a specialist who was capable of making the diagnosis. The difficulty of making a diagnosis may in itself suggest that the doctor take additional precautions such as admitting the patient to hospital for observation..."

29. In our view, the fact that the Patient's blistering conditions did not totally resolve despite treatment with antibiotics for some 10 days called for the Defendant to take during the 4th Consultation on 10 March 2016 swab for culture and see if the bacteria causing the Patient's infection were resistant to the types of antibiotic.

30. Defence Counsel submitted that expert witnesses for both sides agreed that "*skin biopsies for Pemphigus*" was beyond the expertise of a general practitioner like the Defendant. This is however beside the point. It was open for the Defendant to refer the Patient to another registered medical practitioner with the necessary expertise.

31. In our view, skin biopsy should have been arranged for confirmation of the diagnosis of Pemphigus. It is no excuse to say that the Defendant only gave the Patient a small dose of steroids for 3 days. It is a fundamental principle in medical practice that a doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate. Inappropriate use of steroids may sometimes mask the symptoms of the underlying disease and thus resulting in a missed diagnosis.

32. For these reasons, in failing to take timely and appropriate diagnostic steps to consider or review possible diagnoses, the Defendant had in our view by his conduct in this case 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 per the disciplinary charge (b).

33. Defence Counsel submitted that the scope of enquiry on disciplinary charge (c) "*focuses on the management of the Patient's infection*"; and "*should only cover the conduct of the Defendant from the [1st to 4th] Consultations*". This presupposes that the Patient's blistering conditions after the 4th Consultation were unrelated to infection. Given the results of microbiological investigation done in the Autopsy of the Patient, we are not convinced on the evidence that this was not the case.

34. We agree with the Legal Officer that the use of the words "*such as*" after the general phase of "*inappropriately managed the Patient's infection*" connotes that the scope of disciplinary charge (c) is not confined to "*lack of reassessment in view of worsening condition, prescribing high dose of steroids, [and] not prescribing enough antibiotics to the Patient.*"

35. As mentioned above, the management of the Patient's infection was inappropriate in that the Defendant should take during the 4th Consultation swab for culture and see if the bacteria causing the Patient's infection were resistant to antibiotics.

36. We do not agree with defence Counsel that the Patient's infection did not worsen after the 4th Consultation.

37. Whilst contemporaneous documents are generally of the greatest importance in assessing credibility, where some evidence indicates that part of a contemporaneous document might not be completely accurate, we shall need to adjust the evidential weight to be put on the document in question. It does not follow in our view therefore from reading the entry of "*left leg blister [was] healing [with] no cellulitis*" in the medical record for the 4th Consultation on 10 March 2016 that the Patient's infection did not worsen after that day.

38. Indeed, the Defendant also accepted under cross-examination, he did not examine the Patient's left leg again after the 4th Consultation. And this was clearly a "*lack of reassessment in view of worsening condition*" as particularized under disciplinary charge (c).

39. For these reasons, in managing the Patient's infection inappropriately, the Defendant had in our view by his conduct in this case 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 per disciplinary charge (c).

40. The Patient's general condition was running downhill on or after the 4th Consultation on 10 March 2016. By the time of the 5th Consultation on 14 March 2016, the Patient was so frail that his brother-in-law had to push him to the Defendant's clinic by a wheelchair borrowed from the church.

41. Given our findings in respect of disciplinary charges (a), (b) and (c), we are also satisfied on the evidence that in failing to timely pursue more rigorous clinical assessment and investigations when the general condition of the Patient was deteriorating, the Defendant had 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 per disciplinary charge (d).

42. The Secretary confirmed with the Defendant through a letter to his solicitors dated 15 July 2025 that disciplinary charge (e) "*alleges that the Defendant failed to timely refer the Patient to appropriate specialist(s), healthcare professional(s) and/or in-patient care when the skin (i.e. blistering) condition of the Patient was worsening. Appropriate specialist(s) and healthcare professional(s) includes those in dermatology. In-patient care includes through A&E.*"

43. There is no direct evidence from the Patient on what advice the Defendant had given to him in this respect. But there is no dispute that the Defendant did not refer the Patient to consult a specialist in Dermatology.

44. Both Professor LEE and Dr CHAN, defence expert witness, agreed that the Patient should be referred to the Accident & Emergency ("A&E") Department of a public hospital when the skin condition of the Patient was worsening. They also agreed that such advice for referral and the Patient's refusal should be documented in the clinical records. But we can find nothing about this in the clinical records.

45. The Defendant's case is that he had advised the Patient to attend the A&E Department of a public hospital on 3 occasions viz. the 4th Consultation on 10 March 2016; the 5th Consultation on 14 March 2016; and through the male

relative of the Patient during a phone call to his home number.

46. The Defendant also told us in his oral evidence that by the time of the 4th Consultation on 10 March 2016, the Patient's "*condition could potentially be serious and even life-threatening.*" He reiterated during the 5th Consultation on 14 March 2016 that the Patient's "*condition could potentially be serious and even life-threatening*". And yet, the Patient did not listen to his advice to attend the A&E Department of a public hospital.

47. The Defendant also called Madam HO to testify and corroborate with his claim that he did advise the Patient to attend the A&E Department of a public hospital as soon as possible. Interesting enough, according to Madam HO, she left the consultation room right after the Defendant had given the advice to the Patient and she did not know how the Patient responded.

48. There is no doubt in our minds that the Patient was concerned about his worsening blistering conditions. Or else, the Patient would not consult the Defendant so many times.

49. In our view, the Defendant's testimony is self-contradicting. On the one hand, the Defendant tried to convince us that there was a need for the Patient to attend the A&E Department of a public hospital as soon as possible because his "*condition could potentially be serious and even life-threatening*". But on the other hand, the Defendant was prepared to accede to the Patient's "*request [for] analgesics*" on 15 March 2016 by giving Hycephen for 3 days and without seeing him.

50. When being cross-examined as to why he prescribed on 14 March 2016 steroid to the Patient for 3 days, the Defendant told us that the purpose was "*to give him time to reflect that even if I give him this steroid, it doesn't work*".

51. When being further cross-examined as to why he needed to prescribe Hycephen for 3 days, the Defendant told us that "*I'm not specific about how many days I give him as long as he come[s] back immediately... but I'm not asking [him] to finish the 3 days before he come[s] back. I... expect him to come back the same day.*"

52. But instead of expecting the Patient to return to his clinic on the same day, the Defendant ought to have reiterated to the Patient that he needed to attend the A&E

Department as soon as possible because his medical condition had worsened to such an extent that he was unable to come to his clinic to collect the analgesics.

53. In our view, the Defendant was making up his story as he went along. And we do not find Madam HO an honest and reliable witness in this respect.

54. In failing to timely refer the Patient to appropriate specialist(s) / healthcare professional(s) / in-patient care when the skin condition of the Patient was worsening, the Defendant had in our view by his conduct in this case fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, we find him guilty of misconduct in a professional respect as per disciplinary charge (e).

Sentencing

55. 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.

56. The Defendant has two disciplinary records back in 2020 and 2021. The first disciplinary record related to the prescription of Synbetamine tablets on divers dates from August 2012 to November 2013 without advising his patient of the nature and possible side effects of the said tablets. The second disciplinary record related to his failure to take appropriate follow-up action(s) and/or arrange further investigation(s) sometime in or around 2009 when his patient suffered from persistent ear and/or nose symptom(s), and timely refer his patient to the specialist for further investigation(s) and/or treatment(s) when the circumstances so warranted.

57. We agree with the Legal Officer that the shortcomings which underlay the Defendant's misconduct in this case are similar in nature to what the Defendant did in or around 2009 when his patient suffered from persistent ear and/or nose symptoms.

58. In this connection, we note from the Judgment of the Inquiry Panel relating to the second disciplinary record that despite the patient's new complaint of "blocked nose", which was not present in any of the previous consultations for upper

respiratory tract infection or rhinitis, the Defendant still failed to review the diagnosis and make further investigations to exclude nasopharyngeal carcinoma.

59. Taking into consideration the nature and gravity of this case and what we have heard in mitigation, we shall make a global order in respect of all the disciplinary charges that the name of the Defendant be removed from the General Register for a period of 12 months.

60. We have seriously considered whether our removal order may be suspended. We are particularly concerned that the Defendant did not examine the Patient's left leg again after the 4th Consultation. Worse still, the Defendant failed to make a timely A&E referral when the circumstances so warranted. This illustrates in our view not only the Defendant's irresponsible attitude but also lack of insight into his limitation as a general practitioner. For the protection of the public, we do not find it an appropriate case for suspension of removal order.

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