香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr WONG Wai Chung (黃偉忠醫生) (Reg. No. M05518)
Date of hearing: 19 February 2014

1. The charges against the Defendant, Dr WONG Wai Chung, are that:

> "In or about 2009 to 2012, he, being a registered medical practitioner, disregarded his professional responsibility to his patients in that:-
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> (1) in respect of Patient H, he inappropriately or without proper justification prescribed Rohypnol to Patient H without proper examination and/or proper cause;
>
> (2) in respect of Patient K, he inappropriately or without proper justification prescribed Rohypnol to Patient K without proper examination and/or proper cause;
>
> (3) in respect of Patient C, he inappropriately or without proper justification prescribed Rohypnol to Patient C without proper examination and/or proper cause.
>
> In relation to the facts alleged, either singularly or cumulatively, he has been guilty of misconduct in a professional respect."

Ruling on preliminary issues

2. The Defendant is neither present nor represented at the hearing before us today. We first consider whether or not to proceed in the absence of the Defendant and the relevant legal principles were neatly summarized in the English High Court decision of **Yusuf v The Royal Pharmaceutical Society of Great Britain** [2009]

EWHC 867 (Admin). We remind ourselves that the discretion to proceed with a disciplinary hearing in a defendant's absence should be exercised with the utmost care and caution. If the absence of the defendant is attributable to involuntary illness or incapacity it would very rarely, if ever, be right to exercise the discretion in favour of commencing the disciplinary hearing, particularly if he is unrepresented. However, where a defendant, fully informed of a forthcoming disciplinary hearing, has deliberately chosen not to attend, there is no reason in principle why his decision to absent himself should have the automatic effect of suspending the disciplinary hearing against him until such time, if ever, as he chooses to attend or appear by counsel.

3. In our opinion, the real question here is whether in all the circumstances the Defendant can get a fair hearing at the end of the day despite his absence. We bear in mind that the nature and gravity of the allegations against the Defendant are very serious. We recognize that the discretion to proceed in the absence of the Defendant is one which must be exercised with the utmost care and caution.

4. We are satisfied on the evidence adduced by the Legal Officer that the Assistant Secretary of the Medical Council Secretariat has used her best endeavours to contact the Defendant and to inform him of the scheduled date of hearing. We verily believe that the Defendant deliberately chooses not to attend the hearing before us today. Having considered all the circumstances, we think it is proper for us to proceed in the Defendant's absence.

Facts of the case

5. There is no dispute that the Defendant had prescribed Rohypnol for Patients H, K & C for a few years (i.e. since 2009, 2007 and 2009 respectively). The indication for his prescriptions of Rohypnol for all 3 patients was "severe insomnia".

6. On 7 March 2012, the Secretariat of the Medical Council first received a letter of complaint from the father of Patient H relating to the Defendant's inappropriate prescriptions of Rohypnol to a group of young people with drug abuse and his son was one of the victims. This was followed by the receipt on 25 April 2012 of letters of complaint written by Patients H, K & C, which accused the Defendant of selling Rohypnol for profit rather than for genuine treatment of insomnia.

7. In his written response to the complaints, the Defendant did not accept that he had not made any proper inquiry into the insomnia of the 3 patients. He also denied that he did not ask about the therapeutic response of their insomnia to Rohypnol. Moreover, the Defendant maintained that he always told the 3 patients to take Rohypnol on a as required basis and he had also advised them to reduce the dosage gradually.

Burden and Standard of Proof

8. 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.

9. There is no doubt that each of the allegations made against the Defendant here is very serious. We need to look at all the evidence and to consider and determine each of the charges separately.

Findings of Council

10. Rohypnol is a hypnosedative which is currently classified as a dangerous drug because of its abuse and dependence potential. Utmost caution should be exercised in its prescription. The patient needs to have individualized and comprehensive medical, sleep and psychiatric assessment before prescription. In the management of insomnia, especially severe insomnia, comprehensive and appropriate biopsychosocial approach should be adopted.

11. Although we have no reason to doubt the truthfulness of Patient H's father, where the core issue is a stark one of credibility and the allegations made against the Defendant are serious, fairness requires that we should insist on hearing the oral evidence from Patient H. And we are not persuaded on the evidence before us that good and cogent reasons have been shown for the non-attendance of Patient H. Accordingly, we are unable to rely on the complaint letter from Patient H to the Medical Council dated 25 April 2012 as evidence of proof against the Defendant. Since Patient H's father was never present at any of the consultations,

we are unable to rely purely on his account to substantiate the allegations against the Defendant. We therefore find the Defendant not guilty of Charge (1).

12. Patient K frankly admitted that he approached the Defendant for prescription of Rohypnol for abuse under the false pretext that he had insomnia for 4 years before the first consultation on 6 July 2007. Although this was the first time that Patient K was seen by the Defendant, we do not find anything in the clinical notes or indeed his written explanation to PIC which indicated that the Defendant had adequately assessed Patient K through history taking and clinical examination before establishing the diagnosis of "severe insomnia".

13. Although in his written explanation to PIC, the Defendant alleged that Patient K did not have any depressive mood, depression, hallucination or suicidal tendency at the time of the first consultation, this was not recorded in the corresponding clinical notes.

14. In his written explanation to PIC, the Defendant also alleged that the dosage of Rohypnol that Patient K had been taking for many years was already the highest recommended dosage and his treatment plan was aimed at reducing the dosage step by step, hoping for total withdrawal in the near future. But contrary to what the Defendant said, prescription for Rohypnol was actually increased from "1 mg tab. 1 to 2 Nocte" from 13 September 2007 to 16 March 2012.

15. Although we find numerous references in the clinical notes about "Advise to decrease gradually", we do not find anything in the clinical notes and his written

explanation to PIC which indicated that the Defendant had actually put his treatment plan in practice.

16. If the Defendant believed that Patient K's "severe insomnia" did not improve despite prolonged prescription of the recommended maximum dose of Rohypnol for over 5 years, he should have reassessed Patient K or referred him to specialist treatment much earlier.

17. Throughout the course of over 5 years after the first consultation, the Defendant had made no record in the clinical notes of development of adverse effects. Patient K gave a detailed account of symptoms compatible with the adverse effects after taking Rohypnol. If the Defendant had properly reviewed with Patient K his medical condition during the subsequent consultations, there should be reference in the clinical notes about these adverse effects. From this we can only conclude that the Defendant did not assess Patient K or monitor treatment progress of Patient K before repeatedly prescribing Rohypnol to him.

18. After careful consideration of all the evidence, we accept that the first consultation lasted about 2 minutes and the Defendant did not make any proper assessment of the alleged insomnia. Again, in each of the subsequent consultations, the Defendant did not ask Patient K anything about his therapeutic response of the alleged insomnia and/or adverse effects of Rohypnol. In our view, the Defendant's prescription for Rohypnol to Patient K was inappropriate and without proper justification. We also find as a fact that such prescription was made without proper examination of Patient K.

19. We therefore find the Defendant guilty of Charge (2).

20. Patient C frankly admitted that he developed insomnia after abusing Ketamine. He told the Defendant at the first consultation that he had insomnia for 2 years and requested for prescription of Rohypnol. Again, we do not find anything in the clinical notes or indeed his written explanation to PIC which indicated that the Defendant had adequately assessed Patient C through history taking and clinical examination before establishing the diagnosis of "severe insomnia" and continued the prescription of Rohypnol.

21. In his written explanation to PIC, the Defendant alleged that he had explained to Patient C that "Rohypnol is a long acting hypnotic agent in the dangerous drug category. It can cause habituation. The dosage he had been taking was already the maximum recommended dosage. Over dose would cause dangerous consequence such as inability to breath, coma or even death. The treatment plan should be decreasing the dosage step by step and aiming at total withdrawal from drug treatment gradually but positively progressively." We are however unable to find anything in the clinical notes which documented this advice.

22. In our view, the Defendant had clearly failed to take any adequate steps to review Patient C's medical condition during the subsequent consultations. He should have been more assertive and proactive in putting the treatment plan in practice, especially when the Defendant was aware of the potential abuse and adverse effects of the drug. As a matter of fact, throughout the course of over 3 years, the Defendant never reduced the dosage of Rohypnol prescribed to Patient C. If the Defendant believed that Patient C's "severe insomnia" did not improve

despite prolonged prescription of Rohypnol for over 3 years, he should have reassessed Patient C or referred him to specialist treatment much earlier.

23. Having considered all the evidence carefully, we accept that the first consultation lasted about 2 minutes and the Defendant did not make any proper inquiry into the alleged insomnia. Again, in each of the subsequent consultations, the Defendant did not ask Patient C anything about his therapeutic response of the alleged insomnia and/or side effects of Rohypnol. In our view, the Defendant's prescription for Rohypnol to Patient C was inappropriate and without proper justification. We also find as a fact that such prescription was made without proper examination of Patient C.

24. We therefore find the Defendant guilty of Charge (3).

Sentencing

25. The Defendant has a clear disciplinary record.

26. It is clearly stated in the Code of Professional Conduct that a doctor should not prescribe or supply drugs of addiction or dependence otherwise than in the course of bona fide and proper treatment. And a doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate. The Defendant had clearly failed to comply with these basic requirements for prescription of a drug of dependence.

27. A doctor has to be particularly cautious in prescribing drugs of potential abuse and Rohypnol is one of such drugs.

28. We are satisfied that the Defendant's professional misconduct is not the result of ignorance. He was well aware of the potential abuse and adverse effects of Rohypnol. However, in circumstances where he should have been assertive and proactive in preventing abuse, he prescribed Rohypnol to Patients K & C indiscriminately over a long period of time. In our view, it is necessary for the protection of the public to stop the Defendant from practising medicine immediately.

29. Having considered all the circumstances here, in respect of Charge (2), we order that the Defendant's name be removed from the General Register immediately upon its publication in the Gazette for a period of 18 months. We further order in respect of Charge (3) that the Defendant's name be removed from the General Register immediately upon its publication in the Gazette for a period of 12 months, of which 6 months will be concurrent with the sentence imposed under Charge (2), making a total of 24 months.

Prof. LAU Wan Yee, Joseph, SBS
Chairman, Medical Council