香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Defendant: Dr WONG Kwok Ho Joseph (黃國豪醫生) (Reg. No. M07038)
Dates of hearing: 9 July 2014 (Day 1), 19 October 2014 (Day 2) &
10 January 2015 (Day 3)

1. The amended charges against the defendant, Dr WONG Kwok Ho Joseph, are:

> "That between November and December 2009 he, being a registered medical practitioner, had disregarded his professional responsibility to his patient Madam [redacted] ("the Patient") in that –
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> (i) he inappropriately or without proper indication prescribed Thyroxine to the Patient; and
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> (ii) he failed to further investigate the Patient and/or arrange another urine test for the Patient when her urine test showed the presence of red blood cell.
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> 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 and still is a registered medical practitioner. His name has been included in the General Register from 19 August 1988 to present. The Defendant's name has also been included in the Specialist Register under the specialty of "Family Medicine" since 4 March 1998.

3. It is not in dispute that the Patient first consulted the Defendant on 16 November 2009 for amongst others, her gastro-intestinal problems and poor appetite. According to the Defendant, the Patient also complained of constipation, left sided abdominal pain, feeling depressed and tired all the times. The Defendant then referred the Patient to undergo various laboratory tests and in particular, tests on her thyroid function.

4. By a laboratory test report dated 19 November 2009 issued by Pathology & Clinical Laboratory (HK) Pte. Limited 香港百樂醫務化驗室 ("the Laboratory"), the Defendant was informed, amongst other things, that the Patient's TSH level was 3.08 uIU/ml (or mIU/L) (which fell within the Laboratory's reference range of 0.35-5.50 mIU/L) and there was trace of blood in the Patient's urine sample.

5. The Patient returned to see the Defendant on 23 November 2009 and was prescribed amongst other drugs with half a Thyroxine 100 microgram (mcg) tablet to be taken daily for 30 days and the Patient was asked to come back for follow up in one month's time.

6. According to the Defendant, when the Patient returned for follow up on 29 December 2009, she reported better sleep, decreased abdominal pain, better bowel movement and improved energy and mood. Again, the Defendant prescribed the Patient with half a Thyroxine 100 mcg tablet to be taken daily for 30 days.

7. There is no dispute that the Defendant never told the Patient that this was a trial of Thyroxine therapy; nor had the Defendant advised the Patient that he planned to recheck her thyroid function and urine when she returned for follow up next time.

8. The Patient did not return for follow up. Instead, she consulted another doctor and was told that her TSH level as shown in the laboratory tests was within the normal range. The Patient then lodged the subject complaint with the Medical Council.

Burden and Standard of Proof

9. 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.

10. There is no doubt that each of the allegations made against the Defendant here is serious. 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 charges separately.

Findings of the Council

11. The Defendant did not dispute that he had never told the Patient that his prescription of Thyroxine was intended to be a trial therapy. This is however not the charge that the Defendant is facing. For charge (i), we are only concerned with whether his prescription of Thyroxine was inappropriate and/or without proper indication.

12. We appreciate that differences of opinion and practice exist in the medical profession and there is seldom any one answer exclusive of all others to problems of professional judgment. A doctor cannot be faulted for preferring one respectable (or responsible) body of opinion to another.

13. We fully accept that the decision to initiate thyroid therapy should be based on both clinical and laboratory findings, and not solely on the results of a single laboratory test.

14. We also accept that different populations and ethnic groups may have different normal range of TSH levels. Different laboratories may use

different instruments and/or assay methods and therefore their reference ranges of normal TSH levels also differ.

15. We also agree with the Legal Officer's expert, Dr TSANG, that the interpretation of TSH levels had a lot of pitfalls and test results of blood sample taken in the morning might differ from that taken in the afternoon. Accordingly, slight deviation from the reference range of normal TSH level in a single laboratory test does not necessarily reflect a change of thyroid status.

16. There is no dispute that the Defendant wrote down in his medical record for the Patient's consultation on 23 November 2009 the clinical impression of "[s]ubclinical hypothyroidism" and the plan "to try thyroxine supplementation". In his written statement dated 27 June 2014, the Defendant also explained that the clinical impression was based on the TSH reading of 3.08 mIU/L and the Patient's presenting complaints of constipation, depressed mood and lethargy.

17. The Defendant further told us at this inquiry that he adopted a published study by another laboratory, PATHLAB Medical Laboratories Ltd 栢立醫學化驗所 ("PATHLAB"), in 2007 which stated that the upper reference range for TSH was 2.82 mIU/L. The Defendant considered the Patient's TSH level of 3.08 mIU/L to be over what he claimed to be the upper normal range of 3 mIU/L as recommended by the American Association of Clinical Endocrinologists ("AACE"). We are however unable to find anything in the evidence before us to support the Defendant's claim. As a matter of fact, the Defendant conceded in answer to Members' question that he did not have any documentary proof of AACE stating that the normal range of TSH levels should be 0.3 to 3 mIU/L.

18. We fully agree with Dr TSANG that since different laboratories might use different instruments, it would be inappropriate to substitute the reference range of one laboratory for another. As a matter of fact, PATHLAB, the laboratory which published the study in 2007 had actually produced two

different upper reference ranges for TSH (i.e. 2.82 and 3.64 mIU/L respectively) by using two different instruments.

19. We need to bear in mind that the Defendant has no burden of proof and it is up to the Legal Officer to prove his case on evidence. Although there is general agreement in the medical profession around the world that patients with primary hypothyroidism with TSH levels above 10 mIU/L should be treated, there are virtually no clinical outcome data to support treating patients (other than pregnant women) with TSH levels between 2.5 and 4.5 mIU/L.

20. Moreover, whilst some patients with TSH levels between 2.5 and 4.5 mIU/L may have early hypothyroidism, many do not. Data to support treating patients in this range are lacking, with the exception of data in pregnancy.

21. Our attention was drawn to a Consensus Statement from AACE, ATA (American Thyroid Association) and TES (The Endocrine Society) on management of subclinical hypothyroidism ("the Consensus Statement") which advocated for an aggressive approach to case-finding in patients with symptoms and/or signs that suggest the possibility of thyroid dysfunction. It is however clear to us from reading the Consensus Statement that early intervention by drug treatment might be considered only for patients having persistent serum TSH elevations and of TSH levels of 4.5-10 mIU/L. In our view, the Consensus Statement could not be relied upon to support early drug treatment for a patient with a TSH level of 3.08 mIU/L from a single laboratory test.

22. We appreciate the Defendant's case is that he made the provisional diagnosis of subclinical hypothyroidism on basis of both the results of the laboratory test and his clinical findings. However, subclinical hypothyroidism can be asymptomatic and non-specific symptoms like constipation, depressed mood and lethargy may also be present in patients without subclinical hypothyroidism. Even if we were to accept that the Defendant's evidence that the upper reference range of the Laboratory should be 2.82 mIU/L, the

Patient's TSH level of 3.08 mIU/L was marginally above the upper reference range.

23. But then again, the real point is that given the non-specific symptoms of the Patient (which might or might not be thyroid-related) and bearing in mind that there are virtually no clinical outcome data to support treating patients (other than pregnant women) with subclinical hypothyroidism with TSH levels between 2.5 and 4.5 mIU/L, the Defendant ought to have arranged for repeated laboratory tests in order to rule out other pathologies before prescribing Thyroxine to the Patient. There was simply nothing in the Patient's medical conditions which justified immediate drug treatment.

24. The Defendant sought to argue that by giving the Patient a safe dose of Thyroxine and if she came back and told him that she had improved, that would be the best confirmation of his provisional diagnosis of subclinical hypothyroidism. The fallacy of his argument is that the pharmaceutical effect of Thyroxine might result in the lowering of TSH regardless of whether she was actually suffering from subclinical hypothyroidism. Moreover, improvement on non-specific symptoms does not necessarily mean that they were resulting from drug treatment of subclinical hypothyroidism.

25. In our view, it was inappropriate for the Defendant to prescribe Thyroxine to the Patient without first seeking confirmation of his provisional diagnosis. We also find on the evidence that his prescription of Thyroxine to the Patient was without proper indication because the Patient's TSH level of 3.08 mIU/L was nowhere near the ranges stated in the Consensus Statement.

26. It is clearly stated in the Code of Professional Conduct ("the Code") that a doctor may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate. We therefore find the Defendant guilty of amended charge (i).

27. As to amended charge (ii), the Legal Officer fairly conceded that the charge is not proven on the evidence before us.

28. Dr TSANG fairly accepted that finding of small number of red blood cells in urine in asymptomatic young lady like the Patient was common; and risk of underlying sinister disease in such a case would be very low.

29. In his written statement dated 27 June 2014, the Defendant further explained that he planned to recheck the Patient's urine after 2 months. This is corroborated by what the Defendant wrote down in his medical record for the Patient's consultation on 29 December 2009.

30. We agree with Dr TSANG that in order to prevent unwarranted investigations and worries, the general approach was to confirm the result by repeating the laboratory test 6 to 8 weeks later. This was precisely what the Defendant planned to do. We therefore find the Defendant not guilty of amended charge (ii).

Sentencing

31. The Defendant has a clear record.

32. Having considered the nature and gravity of the disciplinary offence for which the Plaintiff is found guilty and what we have heard in mitigation, we order that a warning letter be issued to him in respect of charge (i).

Other remarks

33. We note that the Defendant's name is included in the Specialist Register for family medicine and we shall leave it to the Education and Accreditation Committee to consider whether anything needs to be done in respect of the Defendant's specialist registration.

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