香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 27 November 2008, 19 January 2009, 23 February 2009, 16 March 2009 and 1 May 2009

Defendant: Dr WIN Yu (羅文友醫生)

1. The charges alleged against Dr WIN Yu are that:

"That he, being a registered medical practitioner:-

(a) on 13 October 2005, accessed electronic patient record of a female psychiatric patient ("Patient A") not under his care without any authorization and/or proper grounds;

(b) on 15 October 2005, accessed electronic patient record of Patient A who was not under his care without any authorization and/or proper grounds;

(c) on 24 April 2006, accessed electronic patient record of Patient A who was not under his care without any authorization and/or proper grounds;

(d) in or about May 2006, had inappropriate personal contacts with Patient A;

(e) between 1997 and 2007, had an inappropriate personal relationship with Patient A;

(f) on 6 October 2005, accessed and printed electronic patient record of a male psychiatric patient ("Patient B") not under his care without any authorization and/or proper grounds;

(g) on 16 March 2006, accessed electronic patient record of Patient B who was not under his care without any authorization and/or proper grounds;

(h) in or about April 2006, offered financial help to a female psychiatric patient ("Patient C") to create a relationship beyond that of a doctor and a patient;

(i) in or about April 2006, had inappropriate personal contacts with a female psychiatric patient ("Patient D");

(j) in or about April 2006, had inappropriate personal contacts with a female psychiatric patient ("Patient E);

(k) between 2005 and 2006, had inappropriate personal contacts with a female psychiatric patient ("Patient F");

(l) on or about 3 December 2001, failed to keep proper handwritten prescription records in respect of prescribing dangerous drugs to a patient ("Patient G");

(m) on or about 2 July 2002, failed to keep proper handwritten prescription records in respect of prescribing dangerous drugs to a patient ("Patient H");

(n) in or about April 2006, improperly retained personal particulars of the psychiatric patients by keeping their patient labels and some of their telephone numbers in his personal diary; and/or

(o) in or about April 2006, failed to send within a reasonable time all the unused drugs returned by patients to the pharmacy of United Christian Hospital for proper handling and disposal."

In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of case

2. The Defendant was at all material times a Medical Officer of the Hospital Authority. He worked in the Psychiatry Department of United Christian Hospital ("UCH") from 1/1/1994 to 6/7/1997. Between 7/7/1997 and 31/7/2000, he was posted to 4 other hospitals. On 1/8/2000 he was posted back to the Psychiatry Department of UCH, where he worked until 30/6/2006. He resigned from the Hospital Authority on 1/7/2006.

3. As a Medical Officer in the Psychiatry Department of UCH, he was responsible for treatment of psychiatric patients assigned to his care.

4. A female, Patient A, was first admitted to UCH on 19/3/1997, after she attempted suicide because of her broken marriage. The Defendant diagnosed her with Major Depressive Disorder.

5. According to the medical records, the Defendant was the case doctor of Patient A while she was an in-patient in UCH from 19/3/1997 to 17/4/1997. He followed up Patient A as an out-patient in UCH on 6/5/1997, 5/7/1997. On 13/12/2000, he attended to Patient A again. He made a diagnosis and prescribed medications for her.

6. Although the Defendant was working in Kwai Chung Hospital in September 1998, he issued a memorandum (Exhibit T) dated 29/9/1998 for Patient A certifying that she needed to take 8 types of medicines for her Dysthymic Disorder with Panic Episode. In other words, the Defendant maintained a doctor-patient relationship with Patient A even away from UCH.

7. In 1997, the Defendant and Patient A were aged 47 and 27 respectively.

8. Patient A came to Hong Kong after she got married. She grew up in Taiwan and had no other connection in Hong Kong. Because of the broken marriage she had nowhere to go upon discharge from UCH. According to Patient A, the Defendant took her home on 17/4/1997 when she was discharged from UCH. They then cohabited and had sex at various places until 2006.

9. The Defendant admitted to have a sexual relationship with Patient A and cohabited with her until 2006. However, he disputed the time when the relationship commenced. In his explanation to the Preliminary Investigation Committee, he said that the sexual relationship started after he had been transferred out of UCH and therefore after the doctor-patient relationship had ceased. His case initially was that cohabitation began in 1999. At the inquiry after Patient A produced photographs showing their close relationship as early as 30/8/1997, his case changed to cohabitation beginning on 30/8/1997.

10. According to Patient A, sex started soon after her discharge from UCH. She initially refused the sexual approaches of the Defendant, but was unable to resist after the Defendant gave her some drugs which made her weak and powerless. Throughout all the years of cohabitation she was controlled by the Defendant by various means including drugs, force and threats. To her it was a tortuous relationship, but she failed in breaking away from the Defendant's control despite her attempts every now and then. In April 2006 she secretly complained to UCH about the Defendant accessing her medical record. The complaint sparked off investigation by UCH, and a number of other improper practices were also revealed. Before a Committee of Inquiry for Gross Misconduct was convened, the Defendant resigned on 30/6/2006 with immediate effect.

11. The Defendant admitted 8 charges, i.e. charges (a), (b), (c), (f), (g), (l), (m) and (o). Nevertheless, we have to decide whether the allegations constituted professional misconduct.

Charges (a), (b), (c), (f) and (g)

12. Charges (a), (b), (c), (f) and (g) are concerned with unauthorized access to the patient records of 2 psychiatric patients, i.e. Patient A and Patient B. At the time of the unauthorized access, the patients were not under the Defendant's care.

13. Access to patient records was strictly controlled by the Hospital Authority. According to the Clinical Data Policy Manual, access could only be made under 2 conditions, i.e. 'patient-under-care' or 'organizational-need-to-know'. Neither of these conditions applied to the Defendant's access to the medical records of Patient A and Patient B.

14. The Defendant's explanation to the investigation panel of UCH was that he met Patient A in the street and she asked him to look at her medical records. He also looked at her records because of his interest in cases of borderline personality disorder. Patient B was the husband of another patient of the Defendant. The Defendant checked Patient B's medical records in order to verify the claims of Patient B's wife.

15. The explanation by the Defendant in respect of Patient A was rebutted by Patient A. Her evidence was supported by her complaint (Exhibit J) on 28/12/2007 to UCH and the Medical Council that the Defendant had on 27/12/2007 forced her to write a letter (enclosure P1 of Exhibit J) to indicate her consent to the unauthorized access and covert audio recordings (Exhibit K) showing that the letter was dictated by the Defendant.

16. In respect to Patient B, the Defendant doctor was not the case doctor and therefore had no basis to access his data. This is based on the Clinical Data Policy Manual that access could only be made under 2 conditions, i.e. 'patient-under-care' or 'organizational-need-to-know'.

17. It is the duty of every doctor to protect patients' confidentiality and to prevent unauthorized access to patients' records. This is clearly set out in both the International Code of Medical Ethics and paragraph 1.1 of the Professional code and Conduct. This duty is particularly important in public hospitals, given the large number of patients involved. Otherwise, there will be no data security for patients.

18. The Defendant had abused his position by exploiting his password to the computerized record system. This is conduct clearly below the standard expected amongst registered medical practitioners. We are satisfied that it constituted professional misconduct. We find him guilty of charges (a), (b), (c), (f) and (g).

Charges (l) and (m)

19. Charges (l) and (m) are concerned with prescribing dangerous drugs to 2 patients (i.e. Patient G and Patient H) without proper record.

20. The prescriptions of dangerous drugs to the 2 patients were discovered from the dispensing records of the pharmacy. However, such prescriptions were not recorded in the patients' medical records.

21. It is a strict requirement to keep proper record of prescription of dangerous drugs, particularly psychiatric drugs. The Defendant recognized the importance of recording prescriptions in the patient's medical record, in particular dangerous drugs. The Defendant's failure to do so is conduct falling below the standard expected. We are satisfied that it constituted professional misconduct. We find him guilty of charges (l) and (m).

Charge (o)

22. Charge (o) concerns the Defendant's failure to send the unused drugs returned by patients to the pharmacy for disposal.

23. In a public hospital drugs are not kept by doctors. Instead, all drugs are kept and dispensed by the pharmacy. If unused drugs are returned by patients, the doctor is required to either tell the patient to return the drugs to the pharmacy directly or return the drugs to the pharmacy on behalf of the patients as soon as practicable. It is improper for a doctor to keep the drugs himself for an extended period of time, particularly in respect of dangerous drugs. It is also a criminal offence for the doctor to keep the dangerous drugs without keeping a record in the statutory form.

24. The Defendant kept the unused drugs returned by patients. There were many drugs for which the dispensing date could not be traced. For those traceable drugs, some were dispensed as early as 2002 and 2003. The majority were dispensed in 2004.

25. The drugs were returned to the pharmacy on 28/4/2006, after UCH had started investigation. There were large quantities of such unused drugs, including significant quantities of dangerous drugs. From the Defendant's description of the circumstances in which he kept the drugs, no record was kept of the drugs including the dangerous drugs. However, it is for the police, not the Council, to investigate whether any offence under the Dangerous Drugs Ordinance had been committed.

26. No acceptable explanation had been provided by the Defendant for keeping large quantities of unused drugs for such a long time. If there had not been an investigation by UCH, in all likelihood the drugs would have been kept for a much longer time.

27. The main concern about keeping dangerous drugs without record is the potential for abuse. This is particularly worrying in the present case, in view of Patient A's evidence of being given drugs by the Defendant without prescription. By keeping an unrecorded pool of the drugs in the manner the Defendant described, the drugs were open to be abused by the Defendant or anyone who happened to stumble upon them as they were not kept in locked receptacles.

28. The Defendant's conduct has fallen below the standard expected amongst registered medical practitioners. We are satisfied that this constituted professional misconduct. We find him guilty of charge (o).

Charge (d)

29. This involved contact with Patient A after the Defendant was instructed by the Investigation Panel of UCH not to do so. The instructions were very specific: "not to contact any of the named patients during the investigation process through whatever means including face-to-face contact, telephone, in writing or e-mail etc." This was because the Defendant was under investigation from a complaint lodged by Patient A.

30. We do not accept the Defendant's explanation that there was an existing relationship with Patient A and therefore the Investigation Panel made the specific instruction on the wrong basis.

31. The Defendant's conduct has fallen below the standard expected amongst registered medical practitioners. We are satisfied that this constituted professional misconduct. We find him guilty of charge (d).

Charge (e)

32. Charge (e) is concerned with the Defendant's improper relationship with Patient A. The Legal Officer made it clear that the charge was in respect of

the sexual relationship only, and did not include any allegations of bribery, force or threat.

33. In our view, this is the most important charge. In the case *McCoan v. General Medical Council* cited by the Legal Officer, the Privy Council said:-

> "*One of the most fundamental duties of a medical adviser, recognised for as long as the profession has been in existence, is that a doctor must never permit his professional relationship with a patient to deteriorate into an association which would be described by responsible medical opinion as improper….Sexual intercourse with a patient has always been regarded as a most serious breach of the proper relationship between doctor and patient*".

34. The Defendant admitted to have a sexual relationship with Patient A from 30/8/1997 to 2007. Patient A said that sex started soon after her discharge from UCH on 17/4/1997.

35. Having considered all the evidence carefully, we accept Patient A's version. While there were discrepancies in her evidence, we consider them to be insignificant. She was cross-examined by Defence Solicitor at length for almost 2 days. It is unrealistic to expect a witness who had been in psychological turmoil for a long time to remember accurately what happened on which date more than 10 years ago. There was solid corroboration of her evidence by the covert audio recordings, photographs and documents.

36. Even if we were to accept the Defendant's version that sex started on 30/8/1997 , given that the doctor-patient relationship lasted up to 13/12/2000, there was no change in the position that he pursued a sexual relationship with Patient A when there was an existing doctor-patient relationship.

37. We wish to make it clear that a doctor is not always at liberty to pursue a sexual relationship shortly after the termination of the doctor-patient relationship. A key factor is whether there has been any abuse of the doctor's position of trust. It also depends on whether the circumstances will undermine the public trust in the profession. Paragraph 23 of the Professional Code and Conduct makes this clear.

38. Patient A was a psychiatric patient. She was particularly vulnerable, having just been through a broken marriage and a suicide attempt. Having regard to the development of the relationship, all along it was a grossly improper relationship. The relationship went on for 9 years during which Patient A remained unwell due to her psychiatric illness. It was an extremely serious breach of his position of trust, and a blatant abuse of his position as a doctor.

39. The Defendant's conduct was seriously below the standard expected amongst registered medical practitioners. It was disgraceful. It constituted very serious professional misconduct. We find him guilty of charge (e).

Charge (h)

40. This involved offering financial help to female psychiatric patient C. In regard to this charge, there was no evidence of ulterior motive.

41. It is always risky to enter into personal financial relationship with patients unless there is proper justification. This is especially germane in patients with psychiatric disorders.

42. Doctor should take special care and prudence in situation which could leave them open to allegation of improper conduct.

43. We find the Defendant not guilty of charge (h).

Charge (i)

44. This involved female psychiatric Patient D with whom the Defendant had a meal.

45. This by itself was a neutral act and did not constitute inappropriate personal relationship.

46. We find the Defendant not guilty of charge (i).

Charge (j)

47. This involved female psychiatric Patient E with whom the Defendant had a meal.

48. This by itself was a neutral act and did not constitute inappropriate personal relationship.

49. We find the Defendant not guilty of charge (j).

Charge (k)

50. This involved attending dancing lessons with female psychiatric Patient F over an extended period.

51. This kind of personal contact outside hospitals was bordering on professional misconduct. It may lead to the development of emotional dependency especially in cases of patients suffering from psychiatric disorders. However, there is no evidence of any inappropriate conduct.

52. We find the Defendant not guilty of charge (k).

Charge (n)

53. This involved keeping patients' labels and some of their telephone numbers in the Defendant's personal diary.

54. There is no evidence as to the contents of the labels.

55. Although this is improper conduct, it does not amount to professional misconduct.

56. We find the Defendant not guilty of charge (n).

Sentencing

57. The Defendant has a clear record. Apart from this, there is no other mitigating factor of weight.

58. It is the duty of every doctor to protect patients' confidentiality and to prevent unauthorised access to patients' medical record.

59. Registered medical practitioners are authorised to supply dangerous drugs for the purpose of medical treatment, and there is a corresponding responsibility to keep proper records in the prescribed form. The purpose of such record keeping is to ensure that the dangerous drugs are traceable and to prevent abuse.

60. Medical Council has all along taken a serious view of failure to keep proper records of dangerous drugs. The Council also takes a serious view of any failure to ensure safe custody of dangerous drugs.

61. A doctor, like any other citizen, should not have any contact with a complainant where he is the subject of the complaint. This is to prevent undue influence on the complainant and interference with the investigation.

62. It is clearly stated in 23.1 of the Professional Code and Conduct that: "*Any form of sexual advance to a patient with whom there exists a professional relationship is professional misconduct*". The practice of medicine puts the doctor in a close personal relationship with the patient who may sometimes become emotionally dependent on the doctor. To take any advantage of this dependency is an abuse of responsibility and trust.

63. With regard to the gravity of the charges, we make the following orders:

    (i) in respect of charges (a), (b), (c), (f) and (g), the Defendant be reprimanded;

    (ii) on charge (d), the Defendant be reprimanded;

    (iii) on charges (l) and (m), the Defendant's name be removed from the General Register for a period of 1 month;

    (iv) on charge (o), the Defendant's name be removed from the General Register for a period of 3 months;

    (v) on charge (e), the Defendant's name be removed from the General

Register indefinitely, and the order shall take effect upon its publication in the Gazette;

(vi) the orders in respect of charges (e), (l), (m) and (o) shall run concurrently.

64. The reason for the exceptionally severe sentence on charge (e) is that this offence, given the extensive duration and the blatant abuse of trust, is at the high end of gravity. The fact that the offence was committed on a particularly vulnerable psychiatric patient further aggravates the offence.

65. We have also made an order under section 21(1)(iva) of the Medical Registration Ordinance in respect of the order on charge (e). This means that the removal shall take effect immediately upon publication of the order in the Gazette, which shall take place as soon as possible. This will prevent delay of the removal by further legal procedures of appeal. We have taken this unprecedented move as we are satisfied that the Defendant poses a danger to the public and the immediate removal is necessary for the protection of the public.

66. Although any application for restoration to the General Register is a matter to be decided when the application is made, we recommend that the Defendant's name should not be restored earlier than 10 years after the removal of the Defendant's name from the General Register.

Prof. Felice Lieh-Mak, CBE, JP
Chairman, Medical Council