**G.N. 1509**

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF
THE MEDICAL COUNCIL OF HONG KONG

DR CHOW HEUNG WING STEPHEN (REGISTRATION NO.: M03960)

It is hereby notified that after due inquiry held on 15 February 2023 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong found Dr CHOW Heung Wing Stephen (Registration No.: M03960) guilty of the following amended disciplinary charges:—

"That he, being a registered medical practitioner:—

(a) was convicted at the High Court on 12 December 2017 of the offence of manslaughter, which is an offence punishable with imprisonment, contrary to Common Law and punishable under section 7 of the Offences against the Person Ordinance, Chapter 212, Laws of Hong Kong; and

(b) has been guilty of misconduct in a professional respect in that he failed to report to the Medical Council the conviction mentioned in paragraph (a) above within 28 days of the conviction, contrary to section 29.1 of the Code of Professional Conduct published in January 2016."

Dr CHOW's name has been included in the General Register from 10 July 1980 to the present. His name has never been included in the Specialist Register.

Dr CHOW was originally tried together with 2 other defendants, namely, CHAN Kwun-chung ("CHAN") and MAK Wan Ling ("MAK"), each facing one count of manslaughter, contrary to the Common Law and punishable under section 7 of the Offences Against the Person Ordinance, Chapter 212 of the Laws of Hong Kong. After a trial which took 100 days in 2017, the jury found Dr CHOW and CHAN guilty of manslaughter on 11 December 2017. On 18 December 2017, Dr CHOW was sentenced to imprisonment for 12 years.

Dr CHOW lodged an appeal against his said conviction and sentence. On 4 November 2021, the Court of Appeal unanimously dismissed Dr CHOW's appeal against conviction. However, Dr CHOW's appeal against sentence was allowed to the extent of reducing his sentence from imprisonment of 12 years to 10 years.

Dr CHOW later applied to the Court of Appeal for leave to appeal to the Court of Final Appeal but was refused on 23 February 2022. His application to the Court of Final Appeal for leave to appeal was also refused.

By his application form for Annual Practising Certificate for 2018 dated 16 January 2018, Dr CHOW first informed the Registrar of Medical Practitioners of his said conviction. He also indicated on his application form that "*the conviction has not been reported to the Medical Council*".

In support of the Secretary's case, the Legal Officer also relies on the following court documents relating to Dr CHOW, copies of which are placed before the Inquiry Panel for its consideration:—

(1) Extracts from the transcript of proceedings at the trial of Dr CHOW, CHAN and MAK;

(2) Reasons for Sentence by Mrs Justice BARNES dated 18 December 2017;

(3) Judgment of the Court of Appeal in *HKSAR v Chow Heung Wing Stephen & Another* [2021] HKCA 1655 dated 4 November 2021; and

(4) Judgment of the Court of Appeal in *HKSAR v Chow Heung Wing Stephen & Another* [2022] HKCA 313 dated 23 February 2022.

The factual background of the offence of manslaughter, for which Dr CHOW was found guilty by the jury, was neatly summarized by the Court of Appeal in its Judgment dated 4 November 2021:—

*"4. In February 2012, the "DR Group" launched a cellular therapy treatment, known as "CIK" or "AI" or "CIK/AI" treatment, whereby blood was to be extracted from a human body and taken to a laboratory, Asia Pacific Stem Cell Science Ltd ("APSC"), to undergo a particular process of culturing, after which it would be transfused back into the same human body…*

5. *The CIK treatment was received by various customers, including Madam Chan Yuen-lam ("the deceased"), who had her blood drawn on 12 September 2012 at a clinic of the DR Group known as the Mesotherapy Clinic ("Mesotherapy"), which was then processed at APSC. Unfortunately, her blood became contaminated during the processing stage before it was infused back into her body on 3 October 2012, as a result of which bacteria were introduced into her bloodstream. She was subsequently admitted to the Intensive Care Unit of Ruttonjee Hospital on 4 October 2012 for emergency treatment, but tragically died on 10 October 2012; the cause of death being "multi-organ failure", caused by mycobacterium abscessus septicaemia.*

6. *The prosecution alleged that CIK treatment was experimental in nature (for trial in cancer patients only) and, accordingly, wholly inappropriate and unnecessary for administration to a healthy human being such as the deceased. The treatment was tantamount to a trial of a new medical procedure which, if conducted as such, should have been compliant with ethical medical principles and the medical Code of Professional Conduct. The medical procedures involved fell short of the standards prescribed by Good Manufacturing Practice ("GMP") and the requirements for cellular treatment under the American Association of Blood Banks protocol ("AABB"). Despite its nature and risks involved, CIK treatment was nevertheless marketed by the DR Group through DR Esthetic, the blood was cultured at APSC and the resulting blood product administered to its customers at Mesotherapy, for commercial gain. Accordingly, the prosecution alleged that D1, as the person in charge of the DR Group (who also happened to be a medical practitioner himself) which offered the treatment… [was]… criminally liable for the offence of manslaughter by gross negligence."*

There was no dispute that Dr CHOW was convicted after trial by a jury in Hong Kong of manslaughter, which was at all material times and still is an offence punishable with imprisonment. By virtue of section 21(1)(a) of the Medical Registration Ordinance ("MRO"), Chapter 161, Laws of Hong Kong, the Inquiry Panel's disciplinary powers against Dr CHOW were engaged.

The Inquiry Panel noted from reading the Reasons for Sentence by Mrs Justice BARNES that:—

*"3. Judging from the jury's verdict, the jury must have found that D1 was a "hands-on-boss", someone in effective control of the DR Group of companies including either all or some of the three limited companies: DR Esthetic Centre (Causeway Bay) Limited, Hong Kong Mesotherapy Centre Limited and Asia Pacific Stem Cell Science Limited, and as such a person in effect control, he was in breach of his duty of care to the deceased Chan Yuen Lam.*

4. *The particulars of breach of duty of care cited against D1 in the indictment were that D1, in the knowledge that the CIK Therapy was based on experimental process for the treatment of cancer and which involved the extraction, manipulation in a laboratory and reintroduction of blood taken from Chan Yuen Lam, (a) failed to ensure a properly qualified person was responsible for the preparation of the CIK blood product; (b) failed to ensure properly validated protocol was in use for the CIK processing, which included the process of sterility test; (c) failed to ensure that sterility test was in fact carried out and documented; (d) failed to have a safe system to ensure that the doctor who administered the blood product to Chan Yuen Lam had checked that sterility test had been conducted and documented; and lastly, (e) failed to fully inform Chan Yuen Lam the risks involved in the administration of the CIK Therapy.*

5. *In finding D1 guilty, the jury must have been satisfied that the breach of duty which they found proved was the cause, or the substantial cause, of the death of Chan Yuen Lam. The evidence showed that Chan Yuen Lam was admitted into the Ruttonjee Hospital on 4 October 2012, the day after she received the CIK infusion. Upon admission Chan Yuen Lam was diagnosed to be suffering from septic shock. The bacteria Mycobacterium Abscessus was found in her blood. The number of bacteria was so abundant that Dr Raymond Liu, the doctor in charge of the ICU at Ruttonjee, described it as "catastrophic". Professor Yuen Kwok Yung, an eminent microbiologist invited by Dr Liu to look at the situation of Chan Yuen Lam, told this court that he had only ever seen one case of such severity: that was in a case of a terminally ill AIDS patient.*

6. *The bacteria in Chan Yuen Lam's blood were so numerous that they could be detected even before any bacterial culturing was performed.*

7. *Bearing in mind that from the evidence, the culturing of the CIK cells involved the manipulation of the blood in the laboratory of APSC and being kept in incubation at a temperature of 37 degree Celsius for around 15 days, any bacterial contamination, if unchecked or undetected, would result in the bacteria being multiplied to a vast number.*

8. *The evidence before this court, which the jury clearly accepted, was that the contamination of Chan Yuen Lam's blood product must have occurred at APSC during the culturing process… The breach of duty on the part of D1 resulted in the bacterial contamination not being checked and the heavily contaminated blood product was directly infused into the blood stream of Chan Yuen Lam, causing her to suffer from Mycobacterium Abscessus septicaemia, from which she died due to multi-organ failure.*

9. *The jury's findings also indicated that they were sure that at the time of the breach they found proved, D1 was aware of a serious and obvious risk of death to Chan Yuen Lam.*

10. *Lastly, the jury must have also found that the breach, in all circumstances, were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction. Put differently, the negligence of D1 went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of Chan Yuen Lam as to amount to a crime and deserves punishment."*

In dismissing Dr CHOW's application for leave to appeal against conviction, the Court of Appeal also had this to say of Dr CHOW in its Judgment dated 4 November 2021:—

*"134. …when we examine the part D1 played in the companies concerned, which marketed, prepared and administered the CIK treatment, it becomes obvious that he was involved intimately and personally with them at almost every level of their functions. He was, on the evidence, truly a "hands-on" boss in every aspect; and, moreover, on a persistent, regular basis…*

*…*

*137. It was D1's case that he assumed everything was being carried out correctly. But any educated or moderately intelligent person would know, let alone one who is a registered medical practitioner, that one must be exceedingly careful with a blood product so as to ensure it is not contaminated, and to set in place a system designed to ensure its integrity and sterility. Yet APSC had no records, it had no system of checking and cross-checking, there was no SOP designed for the culturing of the CIK blood product in circumstances where D1 acknowledged that the treatment was still experimental: in short, there was no safe system in operation at all. And D1, who was intimately concerned with the marketing, preparation and administration of CIK treatment must have known that. Assumptions that everything is in order are of little relevance where a blood product is concerned; and they are wholly beside the point where there is no safe system employed to deal with it.*

*138. It was the evidence of Professor Yuen…[that]:*

*"(c) It should also be a very basic and elementary understanding of every medical doctor that any material (such as blood cells) injected or infused into patients must be free of microbes and toxins.*

*(d) The medical doctors involved in this incident should know well that the processed blood cells had been taken out from patients for many days or even weeks for laboratory manipulation before the infusion back into patients. They should be well aware of the obvious risk of microbial (including any bacterial, fungal or mycobacterial) contamination to the processed blood cells which could lead to serious injury or death of a patient receiving infusion. They should therefore only have accepted processed blood cells generated from accredited haematology laboratory supervised by qualified specialist (clinical haematologist). They should also have ensured that the blood cells were free of contaminating microbes by requesting for laboratory reports of microbial culture test done just a few days before the infusion and preferably the report of the gram stain test of the product just before the infusion. Unfortunately, there is no record or indication that they had done the above."*

*…*

*160. However, the background was surely relevant to an assessment of the element of grossness: for example, the fact that the treatment was experimental and unproven, yet was very expensive; the ways in which it was marketed and developed, focusing on particular customers: the "indecent haste" with which it was launched in order to beat a well-known*

*hospital, which was believed to be about to launch CIK treatment itself; and the fact that APSC was being used commercially to generate enormous sums of money for D1 when the government's initiative and true intention behind the use of Science Park was scientific research, were all matters that were part of the background against which to judge whether D1's negligence (which by this stage the jury must have found) was gross. Most evidence called by the prosecution is by its nature prejudicial to an accused person: that does not make it inadmissible. In our judgment, the background was relevant, notwithstanding that the incidents of failure to take reasonable care for the safety of the deceased were in themselves quite appalling, and certainly bad enough to satisfy the test of grossness."*

Since Dr CHOW's application for leave to appeal had already been summarily dismissed by the Court of Final Appeal, the Inquiry Panel was entitled to take his conviction as conclusively proven against him. Accordingly, the Inquiry Panel found Dr CHOW guilty of the amended disciplinary charge (a).

Given the nature and gravity of the criminal offence to which his conviction relates, the Inquiry Panel found it inexcusable for Dr CHOW not to report it to the Council within the prescribed time limit.

In the Inquiry Panel's view, Dr CHOW's conduct in this regard had fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, the Inquiry Panel also found Dr CHOW guilty of the amended disciplinary charge (b).

Dr CHOW had one previous disciplinary record back in 2002 for not disclosing the relationship with the relevant company or institution when recommending in his column in the Apple Daily certain esthetical products.

It was in the view of the Inquiry Panel beside the point that Dr CHOW did not commit the criminal offence in his capacity as a medical practitioner. As a registered medical practitioner, Dr CHOW ought to know better than any educated or moderately intelligent person that he had introduced an experimental and intrinsically dangerous treatment to the market where there was no safe system in existence.

When considering the appropriate sanction to be imposed on Dr CHOW, it was essential in the view of the Inquiry Panel to bear in mind that the extent to which his conviction for the offence of manslaughter would undermine public confidence in the medical profession; and the sanction had to reflect the ethos and expectations of the community at large.

Taking into consideration the nature and gravity of this case and Dr CHOW's plea of mitigation, the Inquiry Panel made a global order in respect of the amended disciplinary charges (a) and (b) that the Dr CHOW's name be removed from the General Register indefinitely and the operation of the removal order would take immediate effect upon publication in the *Gazette* pursuant to section 21(1)(iva) of the Medical Registration Ordinance.

Pursuant to the Inquiry Panel's orders, Dr CHOW's name has been removed from the General Register on 10 March 2023.

The orders are published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Inquiry Panel is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman*, *The Medical Council of Hong Kong*