HCMP 2745 & 2747/2016
[2018] HKCFI 843

IN THE HIGH COURT OF THE

HONG KONG SPECIAL ADMINISTRATIVE REGION

COURT OF FIRST INSTANCE

MISCELLANEOUS PROCEEDINGS NO 2745 OF 2016

———————

BETWEEN

CHAIRMAN AND DEPUTY CHAIRMAN
OF THE PRELIMINARY INVESTIGATION
COMMITTEE OF THE MEDICAL COUNCIL
OF HONG KONG Plaintiffs

and

HOSPITAL AUTHORITY Defendant

———————

AND

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BETWEEN

CHAIRMAN AND DEPUTY CHAIRMAN
OF THE PRELIMINARY INVESTIGATION
COMMITTEE OF THE MEDICAL COUNCIL
OF HONG KONG Plaintiffs

and

HOSPITAL AUTHORITY Defendant

———————

(Heard Together)

Before: Hon Au-Yeung J in Court

Date of Hearing: 23 November 2017

Date of Judgment: 20 April 2018

J U D G M E N T

A. INTRODUCTION

1. In these 2 actions, the Plaintiffs are the Chairman and Deputy Chairman (both as "**the Chairman**") of the Preliminary Investigation Committee (the "**PIC**") of the Hong Kong Medical Council (the "**Council**"). The Chairman is seeking (a) documents from the Defendant (the "**HA**") in connection with complaints made against doctors in their treatment of patients in hospitals managed by the HA ("**the Requested Documents**"); and (b) a mandatory injunction ordering HA to produce the Requested Documents for the Chairman's inspection.

2. The Chairman claims that:

(1) The Requested Documents are necessary to enable him to perform his statutory duties in handling complaints against registered medical practitioners under the Medical Registration Ordinance (Cap 161) ("**MRO**") and the Medical Practitioners (Registration and Disciplinary Procedure) Regulation (Cap 161E) ("**MPR**"). ("**the necessity ground**")

(2) There is strong public interest in the proper administration of professional disciplinary proceedings, particularly in the field of medicine, to investigate and eradicate medical misconduct or improper practice. The public interest will invariably outweigh the confidentiality of the patients save in exceptional cases. ("**the public interest ground**")

(3) The Chairman has power at common law to compel the HA to provide the Requested Documents in the absence of patients' consent. ("**the common law power ground")**

(4) The Chairman has power under section 40(1) of the Interpretation and General Clauses Ordinance, **Cap 1** to compel the HA to provide, despite the absence of patients' consent, documents which are "*reasonably necessary"* to enable the Chairman to carry out his statutory functions. ("**the Cap 1 ground**")

(5) The HA's disclosure of the documents would not be a breach of patient confidentiality and privacy because the exemption under s.58(2) of the Personal Data (Privacy) Ordinance, Cap 486 ("**PDPO**") applies to the use of personal data for the Council's disciplinary proceedings. ("**the PDPO ground**")

3. The HA resists production of the documents on the following principled grounds:

(1) The right to privacy is guaranteed by the Hong Kong Bill of Rights Ordinance, Cap 383 ("**BORO**"). The HA cannot provide the documents without the patient's consent in breach of this constitutional right;

(2) On a proper construction of the MRO and MPR, prior to an inquiry under the MRO, even the full Council has no power to compel the production of documents by any person to the Council; and

(3) Even if the exemptions under s.58(2) PDPO were to apply, that would not give rise to a legal obligation on the part of the HA to provide the documents to the Chairman.

4. In the analyses below, I shall consider the constitutional right to privacy and the statutory powers in which the Chairman operate before analyzing the 5 grounds relied on by the Chairman.

B. BACKGROUND

B1. The Disciplinary Scheme

5. The MRO implements a three-tier disciplinary scheme to handle complaints about, amongst others, professional misconduct of registered practitioners. The decision makers for each tier are the Chairman, the PIC and the Council respectively. The 3 tiers operate as follows:

(a) Initial consideration by the Chairman in consultation with a Council member of the PIC to decide whether the complaint is groundless or frivolous, and should not proceed further or that it should be referred to the PIC for full consideration;

(b) Examination of the complaint as well as explanation of the medical practitioner concerned at the PIC meetings, and the forming of a decision on whether or not there is a *prima facie*

case to refer the complaint to the Council for holding of an inquiry; and

(c) Inquiry by the Council to hear the evidence from the complainant and the registered medical practitioner concerned.

6. If, after due inquiry, the Council is satisfied that any registered medical practitioner has been guilty of a disciplinary offence, the Council may impose disciplinary sanctions which may include removing the name of the registered medical practitioner from the General Register.

7. See sections 20T and 21 of the MRO; sections 6, 8, 9, 11 and 13 of the MPR; and the further analyses in Section D below.

*B2. Factual background in HCA 2745 of 2016 ("**Case A**")*

8. On 1 February 2010, the Secretary of the Council (the "**Secretary**") received an anonymous complaint from an anonymous group of healthcare workers alleging that **Doctor A** had prescribed a dangerous drug, valium, in 10 times higher than normal dosage(s) to **Patient A** on about 13 June 2007 ("**Incident A**"). Doctor A was then working with Hospital A, which was and is managed by the HA.

9. The Council also noted from a report in the media on 2 February 2010 that Hospital A had investigated the matter, that the complaint was substantiated, that an apology was given to Patient A and that follow-up action had been taken against Doctor A.

10. On 8 February 2010, the complaint came before the first-tier screener, ie the Chairman. The Chairman instructed the Secretary to seek further information and documents from the HA. The Secretary's letter to Hospital A stated that the personal information of Patient A, if mentioned in the report, could be masked or anonymized for confidentiality considerations.

11. This request was rejected by the HA on the basis of doctor/patient confidentiality and because of the Chairman's lack of power to require access to such information and documents. The Council repeated its requests and the HA maintained its stance in the years that followed.

12. Meanwhile, with a view to facilitate the Council, the HA met with Patient A and his adult son on 26 July 2013 to provide them with the Council's contact details, so that Patient A could consent to disclosure should he wish to do so.

13. Patient A passed away on 1 August 2013 for reasons wholly unrelated to Incident A.

14. By 18 March 2014, the Secretary had lost contact with the complainants.

15. By a letter dated 19 January 2015, the HA informed the Council of the full name of Patient A and the fact that he had passed away. The letter also mentioned that the original hard copies of Patient A's medical records in Hospital A had been disposed of in August 2014 in accordance with the HA's standard disposal practice given the lapse of time;

that after the handling of an anonymous staff complaint letter in 2009, Hospital A kept a copy of several pages of Patient A's medical records; and that some clinical information of Patient A had been recorded in the HA's computer system.

16. The disposal of the original hard copies was without warning to the Chairman. As things stand, there had been no consent for disclosure from Patient A (or his personal representative) for disclosure by the HA to the Chairman. Complaint A which relates to Incident A that happened over 10 years ago has never reached the PIC or the Council.

*B3. Factual Background in HCA 2747 of 2016 ("**Case B**")*

17. The incident happened in December 2012 and January 2013. On 15 February 2013, the Council received a complaint from a laboratory employee in Hospital B managed by the HA. On 27 February 2013, the complaint was brought to the attention of the Chairman of the PIC. Upon direction of the Chairman, the Secretary wrote to the HA on 18 March 2014 requesting for information now sought. The request similarly suggested anonymizing Patient B's identity for confidentiality reason.

18. The HA contacted the wife of Patient B on 23 December 2014 and delivered to Patient B a letter under seal from the Chairman, to invite Patient B to contact the Council. There has been no consent from Patient B for disclosure by the HA to the Chairman. Accordingly, the HA has declined to produce Patient B's records.

19. The information in the Chairman's hands, including an email from Doctor B dated 5 February 2013, is insufficient for the Chairman to pursue further.

20. The Chairman now seeks medical records and investigation reports relating to both Patients and any other available information and documents.

C. THE CONSTITUTIONAL RIGHT TO PRIVACY

C1. The constitutional provisions

21. Article 14 of the Hong Kong Bill of Rights Ordinance ("**BORO14**"), same as Article 17 of the ICCPR, provides as follows:

> "(1) No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
>
> (2) Everyone has the right to the protection of the law against such interference or attacks." (underline added)

22. BORO14 has different wording to Article 8 of the European Convention on Human Rights ("**ECHR8**") which provides as follows:

> "1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others." (underline added)

23. Despite the difference in wording, it has been held that the concept of privacy in BORO14 is indistinguishable from "private life" in

ECHR8: *Democratic Party v Secretary for Justice* [2007] 2 HKLRD 804**,** Hartmann J (as he then was) at §58.

24. "Privacy" is the state or condition of being withdrawn from the society of others or from public attention; freedom from disturbance or intrusion; seclusion. A right to privacy will generally exist where the person in question has a reasonable expectation of privacy. See *HKSAR v Chan Kau Tai* [2006] 1 HKLRD 400, Ma CJHC (as he then was), §102.

25. Under BORO14, a person has the right to determine for himself or herself when, how, and to what extent he or she will release personal information about himself or herself or his private life. *R v Symbalisty* (2004) 119 CRR (2d) 311 at 319; *Campbell v MGN Ltd* [2004] 2 AC 457 at §51, Lord Hoffmann.

26. There should be no unlawful or arbitrary interference with a person's privacy. "Unlawful" means that there could be no interference unless envisaged by law. "Arbitrary" might extend to an interference which is envisaged by law but is nevertheless capricious: *Democratic Party v Secretary for Justice*, §§61-63.

27. When applying BORO14, court must do a balancing exercise and the verbal differences from ECHR8 should not be heavily stressed. In deciding whether there is arbitrary or unlawful interference, it may be appropriate to consider, amongst others, democratic necessities as are listed in ECHR8(2): *Fok Lai Ying v Governor in Council* [1997] HKLRD 810, p 819C-E, Lord Cooke.

C2. BORO14 in the context of disclosure of medical data

28. The protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private life as guaranteed by ECHR8: *Z v Finland* (1997) 25 EHRR 371 at 405. The European Court of Human Rights stated the rationale thus:

> "95. … Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.
>
> Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health, and in the case of transmissible diseases, that of the community.
>
> The domestic law must therefore afford appropriate safeguards to prevent any such communication or disclosure of personal health data as may be inconsistent with the guarantees in Article 8 of the Convention."

29. The right to full protection of information about a person's health and treatment for ill health under the law of confidence and now under BORO14 stems not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself: *Campbell v MGN Ltd*, Lord Hoffmann, at §51; Baroness Hale, at §145.

30. However, that right is not absolute. A tension exists between, on the one hand, the right of patients to enjoy privacy and, on the other hand,

(a) The need to protect the public from the risk of practice by practitioners who for any reason (whether competence, integrity or health) are incompetent or unfit to practice and to maintain the reputation of, and public confidence in, the medical profession: *Dr Li Wang Pong Franklin v Medical Council of HK* [2009] 1 HKC 352, at §§41 and 42; and

(b) A high public interest, analogous to that in the due administration of criminal justice, in the proper administration of professional disciplinary hearings, particularly in the field of medicine, and effective disciplinary procedures for the investigation and eradication of medical malpractice: *A Health Authority v X (No.1)* [2002] 2 All ER 780, §19, Thorpe LJ.

31. The court has to strike a balance between those competing interests to see if there is a compelling public interest for disclosure, and which would satisfy the criteria of necessity and proportionality: *A Health Authority v X,* §20, Thorpe LJ; and *General Dental Council v Rimmer* [2010] EWHC 1049 (Admin), §12, Lloyd-Jones J.

32. Thorpe LJ at §24 of his judgment was careful to state that he did not want the judgment to be construed or used as laying down any general propositions beyond the context of Children Act proceedings. Nevertheless, his decision has been extended to a dental disciplinary case where the court granted disclosure as there was no less intrusive means of achieving the desired result: *GDC v Rimmer*, §15. However, *Rimmer* emphasized that disclosure must be in accordance with the law: §§13 & 14.

33. Confidentiality does not apply to anonymized records that cannot identify the patient. The court will, if it orders disclosure, impose safeguards to prevent abuse and preserve confidentiality: *GDC v Rimmer*, §§10-12.

34. Mr Ismail (counsel for the Chairman) relies on (a) *Royal Women's Hospital v Medical Practitioners Board of Victoria* (2006) 15 VR 22; (b) *The General Dental Council v Savery* [2011] EWHC 3011 (Admin) Sales J, §§58 and 62; (c) *W v Egdell* [1990] 1 Ch 359, Bingham LJ, at p 419E-G; and (d) *Re A (disclosure of medical records to the General Medical Council)* (1998) 47 BMLR 84 as examples where the courts had ordered disclosure of medical records, despite absence of patients' consent and in view of the strong public interest aforesaid.

35. With respect, those authorities must be read with care because they either did not discuss ECHR8 or there was express legislation to govern disclosure.

36. In *Royal Women's Hospital*, the Court of Appeal in Victoria held that there was no "arbitrary or unlawful interference" under *ICCPR Art. 17* in an application to the court for a search warrant to obtain medical records after non-coercive attempts to obtain the documents had been exhausted. The Medical Practitioners Board (applicant) had similar functions of investigation and imposing punishment as the Council (not PIC) in the present case (§§83, 86, 136, 142). Further, whilst medical confidentiality was protected by statute, the statute did not prevent the disclosure of medical information if the person was expressly authorized, permitted or required to give such information under that or any other Act;

or the use of health records was authorized or permitted whether expressly or implicitly by or under law (other than a prescribed law) (§132). Parliament had considered the question of protection necessary for medical confidentiality in great detail in various pieces of legislation, and the fact that such legislation permitted the disclosure of medical records when a different public interest (such as a requirement for disclosure under other legislation) was considered to require it (§134). The search warrant which caused the medical records to be seized was issued pursuant to legislation (§136).

37. Similarly, in *GDC v Savery*, there was express legislation under section 33B(2) of the Dentists Act 1984 which allowed the GDC to impose a requirement on "any person (except the person in respect of whom the information or document is sought)" to supply information or "any document in his custody or under his control which appears to the Council relevant to the discharge of those functions." This provision plainly gave power to the GDC to require HSA (an insurance company) to provide further information and patient records as it did (§34 of the judgment). Note that that power was similar to the disclosure power given to the Council under section 22(1) MRO.

38. *W v Egdell* and *Re A (disclosure of medical records to the General Medical Council)* did not discuss a doctor's duty of confidence in the light of ECHR8.

39. In *Re A*, the General Medical Council had a duty to investigate serious professional misconduct (just like the Council in the present case). There was power granted to the professional Conduct Committee of the

General Medical Council to administer oath, issue writs of subpoena. Disclosure of court records was permitted under the Family Proceedings Rules 1991.

C3. Application of BORO14 to Patients A and B

40. The documents sought contain the personal particulars and medical details of Patients A and B. They are documents that the individual patient can reasonably expect to keep to himself or withhold from others. The rights over the documents belong to the Patients whilst the Chairman does not assert any exercise of a right.

41. The Chairman's requests had been brought to the attention of Patients A and B but no consent had been given.

C4. Application of BORO14 to the HA

42. A patient's records are confidential as between him and his doctor. They are equally confidential as between the patients and the HA: *A Health Authority v X* [2001] 2 FCR 634 at §31.

43. Accordingly, the HA owes a positive duty of confidentiality to protect a patient's personal details, health information and treatment from disclosure to third parties.

44. The obligation of confidentiality arguably survives the death of a patient. That obligation is one of conscience, not of property: *Lewis v Secretary of State for Health* [2008] EWHC 2196 (QB) at §§18-30 per Foskett J.

45. Article 7 of BORO provides that BORO is binding upon all public authorities and any person acting on behalf of the Government or a public authority, of which HA is one. Infringement of the right may give rise to remedies against HA under Article 6 of BORO.

46. There is no question that the Requested Documents are necessary to enable the Chairman to discharge his statutory functions. The public interests of the kind in paragraph 30 above exist. The Chairman has suggested safeguards to protect the patients' privacy rights if an order for disclosure is made.

47. The question is whether the Chairman has power to compel disclosure.

D. STATUTORY POWERS OF THE CHAIRMAN TO COMPEL DISCLOSURE

48. It is quite clear from the analyses in this section that the Chairman does not have statutory power to seek the disclosure now sought.

49. The Chairman, PIC and the Council are creatures of statute. Their functions and powers are limited to those expressly or implied conferred by statute, ie MRO and MPR.

50. In terms of *functions*, PIC is required by section 20T(1) MRO:

> "(a) to make preliminary investigations into complaints or information touching any matter that may be inquired into by the Council…
>
> (b) to make recommendations to the Council for the holding of an inquiry under section 21…"

51. The Council is required by section 21 of the MRO to make "due inquiry" of a case referred to it by, amongst others, the PIC, and to make, if appropriate, disciplinary orders as set out in s.21(1) MRO.

52. Under section 21(2), "due inquiry" is defined as "an inquiry by the Council conducted substantially in accordance with procedure prescribed by regulations made under section 33".

53. Accordingly, the MRO clearly distinguishes the 3 tiers of functions as set out in paragraph 5 above.

54. The PIC is put in as a screening body to ensure that medical practitioners are not vexed with complaints which might turn out, after inquiry, to be groundless. It aims to strike a balance between the legitimate expectation of the complainant that a complaint of serious professional misconduct will be fully investigated and the need for legitimate safeguards for the practitioner who, as a professional person, may be considered particularly vulnerable to and damaged by unwarranted charges against him. See *Dr Li Wang Pong Franklin* at §§37, 38.

55. Aside from inquiry, the Council is empowered by section 33(4) to, by regulations, provide for the procedure to be followed in relation to, amongst others:

> "(iii) the receipt of complaints or information touching any matter that may be inquired into by the Council;
>
> (iv) the submission of complaints and information to the PIC;
>
> (v) the preliminary investigation of any complaint or information by the PIC;

(vi) the formulation of charges arising out of complaints and information;

(vii) the reference to the Council by the PIC of cases arising out of complaints and information;

(viii) the procedure to be followed in relation to inquiries held by the Council…"

56. The MPR is the subsidiary legislation that governs the procedure in each of the 3 tiers. Part III of the MPR governs the procedure in relation to the PIC's preliminary investigation:

(a) If the Chairman and Deputy Chairman consider that the case is frivolous or groundless and should not proceed further, they may dismiss the case (s.6(2) and (3) of the MPR);

(b) If the Chairman or Deputy Chairman considers that the allegation made "gives rise to a question as to whether a defendant has been guilty of misconduct in any professional respect" he may (i) require the complainant to set out the specific allegations in writing and the grounds thereof; (ii) require the complainant to make clarifications about the complaint or information; or (iii) require that any matter alleged in the complaint or information be supported by one or more statutory declarations (s.8 MPR);

(c) If a case has not been dismissed under s.6 MPR, the Chairman or Deputy Chairman shall direct that the case be referred to the PIC for its consideration, and to direct the Secretary to fix a date upon which the PIC is to meet to consider the case (s.9(1) MPR). The Secretary must carry out specific procedures under s.9(2) MPR, including to notify the medical practitioner concerned of the complaint, information or

referral (s.9(2)(b) MPR), and invite him or her to submit written explanations of conduct relevant to the complaint, information or referral (s.9(2)(f) MPR);

(d) the PIC may "cause to be made such further investigations or further clarification from the defendant with regard to the case being considered by the Committee and with regard to his written explanation, and may obtain such additional advice or assistance as it considers necessary." (s.11(7) MPR);

(e) the PIC shall make a decision "having regard to any written explanation submitted by the defendant and all the materials put before it by the Secretary under subsection (2), consider the case, and, subject to subsections (5) and (7), may decide, amongst others, that no inquiry shall be held or refer the case in whole or in part to the Council for inquiry" (s.11(8) MPR).

57. In the light of the above provisions, Zervos J summarized the functions of the Chairman in the first-tier in *Law Yiu Wai Ray v Medical Council of Hong Kong* at §127:

> "127. The salient tasks and functions of first stage screeners can be summarised as follows:
>
> (1) The first stage screeners consider whether the case is frivolous, or groundless, and should not proceed further. It can only be dismissed if they are both satisfied that is the case.
>
> (2) The role of the first stage screeners is a narrow one which requires them to filter out complaints that should not proceed further. Wider questions as to the prospects of success of the complaint, or whether the complainant is acting oppressively, or the justice of the investigation proceeding further, do not lie within the first stage screener's remit.

> (3) The first stage screeners must be satisfied of a negative in that the normal course of the complaint to the PIC should not be followed because it is frivolous or groundless.
>
> (4) The first stage screeners may carry out investigations to supplement the materials which are reasonably necessary to enable the first stage screeners to carry out their task.
>
> (5) The first stage screeners should not assume the role assigned to the PIC and carry out any of its investigative functions, in particular, should not seek to resolve conflicts of evidence. (underline added)
>
> (6) The first stage screeners, if of the opinion that there is an allegation that gives rise to a question as to whether the medical practitioner has been guilty of misconduct in any professional respect, may require the complainant to make clarification about the complaint or set out the specific allegations in writing and the grounds to it or require that the allegation be supported by a statutory declaration. Failure to comply with any of these requirements, it is open to the first stage screeners to decline to proceed with the investigation of the case.
>
> (7) If the case is not dismissed by the first stage screeners, it is referred to the PIC."

58. It is thus clear that the PIC's investigatory powers are quite limited (and still less for the Chairman). It may seek further clarification from the complainant under s.8 MPR, or invite the defendant to give written explanation under s.11(8), or seek any advice or assistance it considers necessary under s.11(7) to assist its preliminary investigations.

59. Having regard to section 11(7) MPR and the true intent and purpose of MRO and MPR, those powers can even be exercised before the PIC stage: *Dr Li Wang Pong Franklin*, §§27, 35, 41-43, 66.

60. In contrast, under section 22(1) MRO, the Council has more extensive powers, amongst others:

> "(a) to hear, receive and examine evidence on oath;
>
> (b) to summon any person to attend the inquiry to give evidence or produce any document or other thing in his possession and to examine him as a witness or require him to produce any document or other thing in his possession, subject to all just exceptions." ("**Council's Disclosure Power**")

61. The Council also has broad powers to determine its own procedures in the course of the inquiry, and to admit or take into account any document or information: section 31 MPR.

62. The plain legislative intention is to allow such powers to summon witnesses and compel disclosure only *after* a case is referred by PIC to the Council for due inquiry.

63. Conferring the Council's Disclosure Power on the Council necessarily implies that no one else below the Council's tier will have such powers. Section 33(4)(a) MRO does not even empower the Council to make regulations giving power to compel disclosure to PIC/the Chairman. If the legislature has intended otherwise, it would have said so: *Craies on Legislation* (11th Ed, 2017), at §20.1.28.

64. I am fortified in my view in that powers similar to those under paragraph 60 are given to the Health Committee under section 22(1A) MRO, but none have been given to PIC, also a committee.

65. That being the case, giving the Chairman the power to compel HA is not only inconsistent with the purpose of having the first 2 tiers but

is also not envisaged by the primary legislation. It constituted unlawful interference within the meaning of BORO14: paragraph 26 above.

E. THE NECESSITY GROUND

66. As admitted by the Chairman, the documents now in his possession are not sufficient to enable the investigation to go forward. The documents are thus necessary for him to discharge his duty under the first tier.

67. However, the mere need for the documents, without more, cannot justify the orders for disclosure and inspection now sought if the governing statute does not authorize the Chairman to seek such orders.

F. THE PUBLIC INTEREST GROUND

68. Mr Ismail submits that there is strong public interest in the proper administration of professional disciplinary proceedings which will invariably outweigh the confidentiality of the patients save in except cases. He cites *W v Egdell* and *Re A* in support.

69. He submits that a court order is not even required before medical records can be disclosed without the consent of a patient for the purpose of investigation by official regulatory bodies (such as PIC) of allegations of professional misconduct or improper practice: *GDC v Savery*.

70. I do not dispute the existence of such public interest though I repeat paragraphs 38 and 39 above. It was in the light of express legislation that *GDC v Savery* (at §§58 & 62) held that patient's consent

was not required. Nor was a court order required where it was proposed to use the patient records for regulatory proceedings *by appropriate regulatory bodies*. However, compelling HA to make disclosure to *the Chairman* (as opposed to the Council) is unlawful interference within the meaning of BORO14.

71. The public interest ground does not assist the Chairman.

G. THE COMMON LAW POWER GROUND

72. Mr Ismail relies on the following rationale in *Dr Li Wang Pong Frankin:*

> "64. With the rapid advancement of medical science almost on a daily basis, and with so many specialties and sub-specialties in the medical field nowadays, it is impossible and completely unrealistic to expect the Chairman of the PIC to possess by himself all necessary expert knowledge to deal with each and every case of complaint of professional misconduct. It is simply natural and in fact, in my view, part of the duty of the Chairman of the PIC to seek expert assistance, where appropriate and necessary, from an outside source, in order to determine whether a particular case is frivolous or groundless and should not proceed further, or should be referred to the PIC for consideration, provided that he does not abdicate his duty to the outside expert: see *Tam Chi Ming v The Medical Council of Hong Kong* [2008] 1 HKLRD 24 .
>
> 65. By the same token, a complaint made by a complainant or the information supplied by him to the Secretary may or may not contain all the facts, materials or other information that the Chairman may reasonably require in order to fulfil his statutory function. Some of the missing documents or information may well be obtainable from the complainant himself, and thus s 8. But it is just common sense that some of these materials or information may not be within the possession or reach of the complainant, in which case, it is simply natural that the Chairman should need to contact other sources where the materials or information may be available for access to the same…

> 67. … The wording clearly suggests that prior to the consideration of the case by the PIC, that is to say, at the stage of the Chairman's consideration of the case, there can be made or caused to be made investigations and clarification generally, and advice or assistance may be obtained from outside sources. (emphasis added)
>
> 68. In other words, based on the true intent and purpose of the provisions, as well as the wording of the provisions in the Regulation and s 40(1) of the Interpretation and General Clauses Ordinance, and interpreting the provisions in the light of what generally happens on the ground, I have no doubt that the Chairman of the PIC has the general powers given under s 40(1) of the Interpretation and General Clauses Ordinance to carry out investigations, obtain materials and seek expert assistance from outside sources, which are reasonably necessary to enable the Chairman to decide whether the case is frivolous or groundless and should not proceed further, or whether the same should be referred to the PIC for consideration, and to properly identify and formulate the issue(s) of professional conduct that may be involved." (emphasis supplied)

73. *Dr Li Wang Pong Franklin* was followed in *Law Yiu Wai, Ray*, at §§126 & 127 and *Doctor U v Preliminary Investigation Committee of the Medical Council of Hong Kong* [2016] 4 HKLRD 31, §108. Zervos J talks of this as a power and necessary to perform their statutory duty and function and in order to further the overall aim of the provisions of MRO and MPR.

74. I have no reason to question the principles in *Dr Li Wang Pong Franklin* and *Law Yiu Wai Ray.*

75. However, the disclosure in *Dr Li Wang Pong's* case is clearly distinguishable. The information involved was expert advice and papers from the Coroner's Court. The former was from an expert who advised the Chairman on a specific medical aspect. The latter was in the court's possession and the court had power under its own rules to govern

disclosure. Those 2 classes of documents were very different to the Requested Documents which are protected by BORO14.

76. Any common law power must be subject to the principles in Section C above.

77. Further, at common law, there is no independent cause of action whereby a person can ask an innocent third party to produce documents or information save where the principles in eg section 41 of the High Court Ordinance, Cap 4, or *Norwich Pharmacal* are engaged.

78. A public regulatory body stands in no different position. The court simply would not order delivery up of documents or information merely because they are sought by such a body, however reasonable it may be and whatever the claimed public interest is, if the governing legislation for that public regulatory body does not allow it. Section 41 HCO would not apply to the Chairman anyway as no court proceedings are contemplated.

79. Further, as Mr McCoy SC (counsel for HA) puts it, the powers claimed by the Chairman is even greater than what the civil court would recognize. Effectively, the Chairman is seeking a *Norwich Pharmacal* order without having to satisfy the threshold test, ie:

(a) That the applicant must show that there is already in existence cogent and compelling evidence of wrongdoing against the defendant: *A Co v B Co* [2002] 3 HKLRD 111 at §13(1), per Ma J (as the CJ then was).

(b) The applicant cannot seek a *Norwich Pharmacal* order for the purpose of a fishing exercise: *Attorney General v Wellcome Foundation Ltd* [1992] 1 HKC 158, at 169E-G, per Litton JA (as he then was).

80. On the Chairman's own case, there is not sufficient evidence to go forward without the documents. The equivalent of a *Norwich Pharmacal* order would unlikely be granted.

81. Even if, as Mr Ismail submits, there is sufficient evidence for Case A to go forward, the Chairman is not the proper applicant for disclosure under the MRO or MPR, having regard to paragraph 65 above.

82. The common law power ground is not substantiated.

H. THE CAP 1 GROUND

83. Mr Ismail submits that the general power under section 40(1) of Cap 1 is ancillary to the powers in sections 6, 8 and 9 of the MPR.

84. Section 40(1) of Cap 1 provides that *where a statute confers upon a person power* to do or enforce any act "… all such powers shall be deemed to be also conferred as are reasonably necessary to enable the person to do or enforce the doing of the act…"

85. The principles governing limits to implied powers in the disciplinary context are set out in *Man Hing Medical Suppliers (International) Ltd v Director of Health* [2015] 3 HKLRD 224 at §39:

> "(1) The common law permits authorities to undertake tasks that are "reasonably incidental" to the achievement of the purposes of a legislation, provided that they do not contradict any express statutory power.
>
> (2) The implications are only legitimate when it is "what is necessarily or properly implied" by the language used in the statute.
>
> (3) In this respect:
>
> (a) Whether a particular incidental power is to be implied must be considered in the context of the facts of each case, and that the provisions of the statute which confer and limit functions must be considered and construed.
>
> (b) A power is not incidental merely because it is convenient or desirable or profitable.
>
> (c) The implication thus needs to be "necessary" in that it is "reasonably required" for the effective exercise of the power or jurisdiction expressly conferred upon authority.
>
> (d) Further, if it is a penal enactment, the penalty will not fall to be imposed unless the implication is clear and obvious, especially considered under the principle against doubtful penalisation.
>
> (e) It may also be improper to imply a power when it imposes onerous burdens."

86. In *Dr Li Wang Pong Franklin*, A Cheung J (as he then was) held that under section 40(1) of Cap 1, the Chairman could make investigation and seek assistance from outside sources to determine whether a particular case should not proceed further or should be referred to the PIC for consideration.

87. Mr Ismail submits that the general power to obtain materials from outside sources can only be achieved by demanding or enforcing. Thus, section 40(1) of Cap 1 does not only give the power to ask but also a power to compel. Even if section 40(1) Cap 1 only permits the PIC to

ask outside sources in a general way for help, there must be a corresponding duty on the part of such outside sources to help so as not to defeat the legitimate expectation of the complainant that a complaint of serious professional misconduct will be fully investigated and the need for legitimate safeguards for the practitioner. Mr Ismail quotes the example of the Council's Disclosure Power which would be ineffectual unless there was a corresponding duty on the part of the person summoned to obey.

88. With respect, Mr Ismail overlooks the fundamental premise in section 40(1) of Cap 1, ie that statute must have already conferred upon the decision maker the power to do certain act. Where the statute has not done so (in the present case, confer the power to summons witness or compel disclosure) the ancillary power in section 40(1) cannot be elevated to a power that the legislature never intended the Chairman to have.

89. The Cap 1 Ground does not assist the Chairman.

I. THE PDPO GROUND

90. The HA accepts that section 58(2) PDPO provides an exemption from the use of data for purposes including the "prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, by persons". See section 58(1)(d) PDPO.

91. However, the exemption under section 58(2) PDPO could only be relevant to the *use* of personal data if it is in the possession of the Chairman. The exemption does not give rise to a legal obligation on the

part of HA to disclose confidential patient records, still less confer a power on the Chairman to compel disclosure: *Chan Yim Wah Wallace v New World First Ferry Services Ltd* [2015] 3 HKC 382, §85 & footnote 61, Bharwaney J.

92. *Solicitor v Law Society of Hong Kong* (2006) 9 HKCFAR 175 relied on by Mr Ismail has no application here. Statute has conferred highly intrusive and coercive power on the Law Society and its appointed inspector which cannot be found in section 11 of MPR. (§§9, 28)

93. The PDPO ground does not assist the Chairman.

J. DELAY

94. This is a decision on a matter of principle. It is not for the court to seek to evaluate or assess the strength or otherwise of the case to be investigated by a statutory tribunal to which the disclosure is being made: see *Re N (a child)*, (2009) 109 BMLR 106, at §§47 and 48, Munby J.

95. The delay in the Chairman's application to the court was appalling but it does not affect my ruling on matters of principle.

K. CONCLUSION

96. The Chairman has relied on a range of powers from BORO14, to implied powers to override the rights of Patients A and B to privacy. Notwithstanding the necessity for the Requested Documents, and the public interest to ensure proper administration of disciplinary proceedings, to compel HA to make disclosure would be to give the Chairman wider

powers than contemplated by MRO and MPR. It would be an unlawful interference with the privacy rights of Patients A and B. The application is thus dismissed.

97. I make an order *nisi* for the Plaintiffs to bear the costs of the Defendant, with certificates for 2 counsel.

98. I thank counsel for their assistance.

(Queeny Au-Yeung)
Judge of the Court of First Instance
High Court

Mr Anthony Ismail, instructed by the Department of Justice, for the plaintiffs

Mr Gerard McCoy SC leading Mr Kim J McCoy, instructed by Mayer Brown JSM, for the defendant