SINGAPORE MEDICAL COUNCIL

Annual Report 2006

SINGAPORE MEDICAL COUNCIL
ANNUAL REPORT 2006

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President's Foreword

2006 was an eventful year during which the Council deliberated several important issues. Notable among these were the support of the national initiative to increase the number of medical doctors for the expanding medical service and bio-medical research programmes, fine-tuning of the criteria of supervisory requirements for conditional registration, disciplinary cases from continued poor management of patients on Subutex and the highly publicised Shorvon case that was referred to U.K. courts for judicial review.

Medical Manpower

The continuing advances in medicine and expansion of services coupled with the ageing population will require regular increase in medical manpower. As the input from local medical school is not sufficient to meet the demand, doctors and specialists have been recruited from other countries. There is also a future need to have more clinician scientists to support the biomedical research.

During the year, a number of foreign medical schools have been added to the schedule of the MRA. The increase from 71 to 120 in 2006 included top medical schools from Europe in addition to those from USA, Canada and Australia. As more doctors who have graduated from recognised medical schools are recruited to work in Singapore, the recruitment of doctors graduated from medical schools not listed can be gradually phased out.

Conditional Registration of Doctors

The SMC has revised the time frame and supervision for conditional registrants before they become eligible for full registration. At the end of the year there were 525 doctors on

conditional registration. They were mainly graduates of recognised medical schools in the Schedule of the Medical Registration Act (MRA) or whose postgraduate qualifications are recognised by SMC.

Supervision enables the doctors' performance to be assessed to ensure that they are competent and safe and meet the standard to practice in Singapore. The supervisors' regular reports to the Council help determine that a doctor has the required knowledge, skills and attitudes to practice safely. The period of supervision of which the first year is mandated in approved institutional practice is longer for non-Singaporeans so that they can become familiar with the local culture, languages, disease patterns and health service system.

CECA - Mutual Recognition Agreement

In accordance with the Comprehensive Economic Cooperation Agreement (CECA) between the governments of India and Singapore, SMC negotiated and signed an agreement with the Medical Council of India in September 2006. The agreement mutually allows temporary or limited registration for medical graduates of one country to engage in areas of teaching, training, research and work in charitable organisations in the other country. SMC unilaterally also recognised two top medical schools in India which was added on to our Schedule of recognised foreign medical schools in 2006.

Ethical Conduct in Research

Singapore is well known to have a high standard of health care. In order to preserve this reputation doctors must strive to maintain high standards of moral and ethical conduct not only in their clinical practice but also in medical research. The high profile Simon Shorvon case* is an example of a serious breach in ethical standards in research. Accessing patient information, recruiting patients into the trial without patient consent and

altering medication without consent of patients and their primary physicians are serious lapses with regard to patient confidentiality and standard of practice. The SMC takes a serious view of such professional misconduct in conducting research.

The cancellation of the formal inquiry by the General Medical Council (GMC) had undermined the integrity of the SMC's findings and cast doubts on the fairness of its procedures. SMC's research ethics standards are in accordance with international standards and the basic principles stated in GMC's 'guidance on good practice' (2002). It is important for SMC to continue to apply high ethical standards based on internationally agreed tenets of patient rights, safety and confidentiality. While the dismissal of SMC's application by the administrative court was a disappointment, SMC has done what it should to ensure proper closure in this case of a high profile researcher who has now left to practice in a different jurisdiction. If the same ethical problems are to occur in the next host country, it would not be because SMC had not done due diligence to deal with the case to its proper conclusion procedurally.

Ethical Conduct in Practice

The number of complaints against medical practitioners received by the Council has remained much the same as in the previous years. There were 7 cases of disciplinary inquiries held for different types of professional misconduct.

Excessive and inappropriate prescription of hypnotics and sedatives without proper management plan and medical records of clinical assessment fall way below accepted medical standard of practice. Conviction in courts for offences involving fraud or dishonesty such as falsification of documents or forging of payment vouchers are indeed dishonorable acts that bring disrepute to the medical profession.

As medical practitioners, we are duty bound to practice in the best interest of our patients and to uphold the honour and noble values of our profession.

Council Members

During the year, the Council noted the completion of membership terms of Prof Lee Eng Hin, Prof Low Poh Sim, A/Prof Chan Yew Weng and Dr Ho Nai Kiong. The Council remains grateful to all of them for their valuable services. Prof Lee Eng Hin, besides other contributions, had played a key role in implementing SMC's Continuing Medical Education Programme for many years. The Council is pleased that he has agreed to continue to lead the programme into its next phase.

The Council welcomed A/Prof Gilbert Chiang and Prof Tay Boon Keng who were re-elected and A/Prof Siow Jin Keat and Dr Wong Sin Yew who were newly elected to Council.

Foreign Visitors

The Council received the following visitors in 2006:-

- 21 Feb - Malaysian delegates from the Academy of Medicine Malaysia and MOH, Malaysia;
- 21 Jun - Indonesian Disciplinary Commission;
- 26-30 Jun - Attachment to SMC for Brunei (MOH) delegates; and
- 3-9 Dec - Study visit by the Mongolian MOH Ethics Committee Members.

I would like to thank the members of the Council for their invaluable contribution and the staff of the SMC for their dedicated services.

PROF RAJ NAMBIAR
PRESIDENT

* Summary Of The Disciplinary Action Against Simon Shorvon

In February 2004, the Disciplinary Committee (DC) after a 10 day hearing found Professor Simon Shorvon guilty of professional misconduct over the manner in which a major research project was carried out in Singapore (Professor Shorvon was the Director of the National Neuroscience Institute and had left Singapore in 2003). The DC ordered Professor Shorvon to, inter alia, pay a fine and for his name to be removed from the Medical Register.

The General Medical Council (GMC) of UK informed the Singapore Medical Council (SMC) that GMC was keen to know the outcome of SMC inquiry. At that time, Shorvon was practising in the UK. In March 2004, the SMC informed GMC of the verdict of the DC and forwarded all the relevant documents to GMC. About 6 months later, in October 2004, SMC was informed that GMC's Preliminary Proceedings Committee (PPC) considered Shorvon's case and determined that there was a real prospect of the facts of the case being proved which could amount to serious professional misconduct. The PPC ordered that a charge should be formulated against Shorvon and that the Professional Conduct Committee should hold a public inquiry into that charge.

However, on 23 September 2005, close to a year later, GMC informed SMC that the chairman of GMC's Investigating Committee had cancelled the referral to the Professional Conduct Committee (PPC) for formal inquiry and closed its case against Professor Shorvon.

The SMC was surprised by the change in GMC's position. The solicitors who studied the case advised SMC that GMC had committed serious procedural and substantative errors in cancelling the referral to the PPC and advised SMC to request GMC to review the cancellation decision. GMC rejected the request for any reconsideration.

After due consideration and following expert legal advice from the appointed solicitors in UK, SMC decided to bring the matter up for judicial review. The decision was supported by the Ministry of Health. However, in December 2006, the administrative court in UK dismissed SMC's application and upheld the GMC's decision to cancel the formal inquiry.

Members Of The Singapore Medical Council 2006

President	Clinical Prof R Nambiar
Registrar	Prof K Satku
NUS Nominees	Prof John Wong Eu Li Prof Robert Pho Wan Heng
Elected Members	Assoc Prof Chan Yew Weng *(until 20 Nov 2006)* Clinical Assoc Prof Gilbert Chiang Shih Chuin Dr Richard Guan Dr Ho Nai Keong *(until 20 Nov 2006)* Prof Ng Han Seong Assoc Prof Siow Jin Keat *(from 21 Nov 2006)* Dr Tan Chi Chiu Dr Tan Kok Soo Clinical Assoc Prof Tay Boon Keng Dr T Thirumoorthy Dr Wong Sin Yew *(from 21 Nov 2006)*
Appointed Members	Clinical Assoc Prof Ho Lai Yun Prof Lee Eng Hin *(until 31 May 2006)* Dr Lim Cheok Peng Prof Low Poh Sim *(until 31 May 2006)* Assoc Prof Ong Biauw Chi *(from 1 June 2006)* Assoc Prof Benjamin Ong *(from 1 June 2006)* Adjunct Prof Walter Tan Tiang Lee Dr Yap Lip Kee

Names of Council members

Back (L – R): Dr Richard Guan, Dr Wong Sin Yew, Dr Lim Cheok Peng, Prof Walter Tan, A/Prof Siow Jin Keat, A/Prof Benjamin Ong, Prof Tay Boon Keng, Dr T Thirumoorthy, Prof Ng Han Seong

Front (L – R): A/Prof Gilbert Chiang, Dr Tan Kok Soo, Prof Ho Lai Yun, Prof R Nambiar, Prof K Satku, Prof Robert Pho, Dr Yap Lip Kee, A/Prof Ong Biauw Chi

Absent: Prof John Wong, Dr Tan Chi Chiu

Other Members Of The Singapore Medical Council 2006

Prof John Wong

Dr Tan Chi Chiu

Physician's Pledge Ceremony

Medical Registration / Specialist Registration

Medical Registration

As at 31 Dec 2006, a total of 6931 medical practitioners were fully or conditionally registered in Singapore, resulting in a doctor to population ratio of 1:650.

In 2006, the Credentials Committee considered 1183 applications for registration. 1079 medical practitioners were registered of which 51 were previously on conditional registration and 15 on temporary registration. The breakdown of the registration granted is given in Table 1.

Of the 280 on provisional registration, 229 were NUS medical graduates and 51 were graduates from foreign universities. They were granted medical registration to do housemanship training in restructured hospitals and institutions for one year.

Among the 355 foreign-trained medical practitioners granted temporary registration, 89 were employed to work under supervision on short-term basis in restructured hospitals or institutions. Another 155 were foreign practitioners accepted for postgraduate training in Singapore. 111* visiting experts were invited by the hospitals and medical organisations to provide short-term training and consultancy.

There were 212 medical practitioners not in active practice due to various reasons such as retirement, working or studying overseas. These are doctors who had not renewed their practising certificates in 2006. 8 medical practitioners were restored to the Medical Register when they returned to resume practice in Singapore.

As compared to 2005, the total number of doctors as at 31 Dec 2006 registered a net increase of 183 doctors.

Specialist Registration

As at 31 Dec 2006, there were 2654 doctors registered as specialists on the Register of Specialists. The number of specialists had increased by 143 (5.69%) as compared to 2005. They also represented 38.3% of the 6931 medical practitioners registered in Singapore. The numbers of registered specialists in the various specialities are in Table 4. Table 5 shows the trends for specialist's registration. The numbers from Year 2001 to Year 2006 were the cumulative total as at 31 December of the year.

*: Including 40 doctors who were registered previously.

Table 1: New Medical Registration by Registration Type as at 31 December 2006

Registration Types	Registered from:				Total
	New applications	Provisional Registration	Temporary Registration	Conditional Registration	
Full	1	219	-	51	**271**
Conditional	118	40	15	-	**173**
Provisional	280	-	-	-	**280**
Temporary	315	-	40*	-	**355**
Total	**714**	**259**	**55**	**51**	**1079**

*** these were doctors who were registered previously and whose registration had lapsed**

Table 2: New Medical Registrations by Citizenship and Training in 2006

Registration Types	NUS Trained		Foreign Trained		Sub-Total		Total
	Singaporean	Non Singaporean	Singaporean	Non Singaporean	Singaporean	Non Singaporean	
Full	185	22	13 + 12*	1 + 38*	210	61	**271**
Conditional	-	-	23	135 + 15*	23	150	**173**
Provisional	205	24	14	37	219	61	**280**
Temporary	0	0	3	312 + 40~	3	352	**355**
Total	**390**	**46**	**65**	**578**	**455**	**624**	**1079**

~ doctors who were registered previously
*** doctors converted from conditional registration (for fully registered doctors) or temporary registration (for conditionally registered doctors)**

Table 3: Medical Registration by Year and Place of Medical Training

Registration Types	2000	2001	2002	2003	2004	2005	2006
Full Registration	**170**	**215**	**156**	**182**	**201**	**203**	**220**
NUS Degree	146	153	146	175	193	195	206
Foreign Degree	24	62	10	7	8	8	14
Conditional Registration	**114**	**146**	**121**	**128**	**114**	**112**	**158**
NUS Degree	-	1	-	1	-	1	-
Foreign Degree	114	145	121	127	114	111	158
Provisional Registration	**173**	**173**	**187**	**213**	**239**	**265**	**280**
NUS Degree	156	144	175	195	197	210	229
Foreign Degree	17	29	12	18	42	55	51
Temporary Registration	**252**	**193**	**334**	**256**	**345**	**342**	**355**
Foreign Degree	252	193	334	256	345	342	355

Note: This table does not include conversion cases.

Table 4: Specialist Registration as at 31 Dec 2006

No.	Specialities	Public Sector	Private Sector	Total	Ratio in %	
					Public	Private
1	Anaesthesiology	146	104	250	*58*	*42*
2	Cardiology	64	44	108	*59*	*41*
3	Cardiothoracic Surgery	17	13	30	*57*	*43*
4	Dermatology	30	33	63	*48*	*52*
5	Diagnostic Radiology	93(1)	49	142(1)	*65*	*35*
6	Emergency Medicine	50	6	56	*89*	*11*
7	Endocrinology	36(1)	16	52(1)	*69*	*31*
8	Gastroenterology	34(1)	27	61(1)	*56*	*44*
9	General Surgery	98	81	179	*55*	*45*
10	Geriatric Medicine	36	7	43	*84*	*16*
11	Haematology	23	8	31	*74*	*26*
12	Hand Surgery	12	3	15	*80*	*20*
13	Infectious Disease	22(1)	5	27(1)	*81*	*19*
14	Internal Medicine	29(1)	29	58(1)	*50*	*50*
15	Medical Oncology	36	16	52	*69*	*31*
16	Neurology	41	12	53	*77*	*23*
17	Neurosurgery	16	12	28	*57*	*43*
18	Nuclear Medicine	9	6	15	*60*	*40*
19	Obstetrics & Gynaecology	76	191	267	*28*	*72*
20	Occupational Medicine	11	21	32	*34*	*66*
21	Ophthalmology	87	43	130	*67*	*33*
22	Orthopaedic Surgery	81	46	127	*64*	*36*
23	Otorhinolaryngology / ENT Surgery	37	33	70	*53*	*47*
24	Paediatric Medicine	92	120	212	*43*	*57*
25	Paediatric Surgery	8	4	12	*67*	*33*
26	Pathology	78	20	98	*80*	*20*
27	Plastic Surgery	11	21	32	*34*	*66*
28	Psychiatry	69	42	111	*62*	*38*
29	Public Health Medicine	55	21	76	*72*	*28*
30	Rehabilitation Medicine	18	2	20	*90*	*10*
31	Renal Medicine	24	13	37	*65*	*35*
32	Respiratory Medicine	46	20	66	*70*	*30*
33	Rheumatology	19(1)	6	25	*76*	*24*
34	Therapeutic Radiology/ Radiation Oncology	21	4	25	*84*	*16*
35	Urology	32	19	51	*63*	*37*
	Total	**1557**	**1097**	**2654**	*59*	*41*

( ) denotes number of doctors with dual specialties.

Table 5: Total Number of Specialists as at 31 December in Year 2002 to 2006

No.	Specialty / Year	2002	2003	2004	2005	2006	% Increase Between	
							2005 & 2006	2002 & 2006
1	Anaesthesiology	196	203	211	224	250	11.6	27.6
2	Cardiology	77	83	89	98	108	1.0	40.3
3	Cardiothoracic Surgery	25	26	26	27	30	11.1	20.0
4	Dermatology	48	48	55	60	63	5.0	31.3
5	Diagnostic Radiology	111	118	128	135	142	5.2	27.9
6	Emergency Medicine	30	34	41	52	56	7.7	86.7
7	Endocrinology	37	41	46	47	52	10.6	40.5
8	Gastroenterology	52	54	58	58	61	5.2	17.3
9	General Surgery	133	150	156	165	179	8.5	34.6
10	Geriatric Medicine	23	32	35	38	43	13.2	87.0
11	Haematology	25	30	30	30	31	3.3	24.0
12	Hand Surgery	8	9	10	12	15	25.0	87.5
13	Infectious Disease	14	16	18	25	27	8.0	92.9
14	Internal Medicine	52	55	58	60	58	-3.3	11.5
15	Medical Oncology	31	37	43	47	52	10.6	67.7
16	Neurology	45	47	47	50	53	6.0	17.8
17	Neurosurgery	23	23	25	26	28	7.7	21.7
18	Nuclear Medicine	9	10	10	14	15	7.1	66.7
19	Obstetrics & Gynaecology	241	253	262	265	267	0.8	10.8
20	Occupational Medicine	29	30	32	32	32	0	10.3
21	Ophthalmology	96	108	117	125	130	4.0	35.4
22	Orthopaedic Surgery	98	103	111	119	127	6.7	29.6
23	Otorhinolaryngology / ENT Surgery	63	65	66	68	70	2.9	11.1
24	Paediatric Medicine	181	184	193	207	212	2.4	17.1
25	Paediatric Surgery	12	13	13	13	12	-7.7	0
26	Pathology	74	84	88	93	98	5.4	32.4
27	Plastic Surgery	30	30	31	32	32	0	6.7
28	Psychiatry	95	97	105	108	111	2.8	16.8
29	Public Health Medicine	67	67	71	74	76	2.7	13.4
30	Rehabilitation Medicine	12	13	15	16	20	25.0	66.7
31	Renal Medicine	29	33	34	34	37	8.8	27.6
32	Respiratory Medicine	49	53	58	63	66	4.8	34.7
33	Rheumatology	19	19	22	25	25	0	31.6
34	Therapeutic Radiology/ Radiation Oncology	17	18	20	21	25	19.0	47.0
35	Urology	37	38	43	48	51	6.25	37.8
Total No. of Registered Specialists as at 31 December each year:		2088	2224	2367	2511	2654	5.69	27.1

2006 / 2005-2006 CME Qualifying Periods

Since compulsory CME was introduced in 2003, the majority of doctors have fulfilled their CME requirements in the last 3 CME cycles. This year, out of a total of **5405** doctors whose CME qualifying periods (QPs) ended on 31 December 2006 (i.e. for practising certificates expiring anytime in 2007), **5353** or **99%** of doctors met the CME requirement (see Table 1).

Out of the 52 doctors who did not meet the CME requirements, **25** doctors had informed the Council that they did not intend to renew their practising certificates (see Table 2).

Mean and Median CME Points

The mean (i.e. average) CME points obtained by doctors with 2 and 1-year CME QPs are 109 points and 87 points respectively (uncapped points for various categories). In contrast, the median CME points obtained by doctors are 84 points and 85 points for 2 and 1-year CME QPs respectively (see Table 3).

Average Number of Points Obtained by Doctors for the various CME Categories (Without Category Cap)

Doctors practising in the public sector had obtained their CME points mainly from Categories 1A and 1B activities while those in the private sector attended more Category 1B activities and participated in more Categories 3A and 3B self-learning and self-studying educational activities (see Table 4).

Total Number of CME Providers and Accredited CME Activities

425 CME providers from the restructured and private hospitals / institutions, medical associations and professional bodies organised a total of **780** Category 1A and **1557** Category 1B activities in 2006 (see Table 5).

Table 1: Number of Doctors who met CME requirements at the end of the qualifying period

CME Qualifying Period (QP)	Number of Doctors Who Met Requirements
2-Year QP (2005-2006)	5281
1-Year QP (2006)	72
Total	5353

Table 2: Number of Doctors who did not meet CME requirements at the end of the qualifying period

CME Qualifying Period (QP)	Type of Doctors	Number of Doctors who did not meet requirements
*2-Year QP (2005-2006)	Intends to Renew	27
	Do not Intend to Renew	25
Total		**52**

*There were no doctors who did not meet the CME requirements for the 1-year QP.

Table 3: Mean and Median CME points

CME Qualifying Period (QP)	Mean	Median
2-Year QP (2005-2006)	109	84
1-Year QP (2006)	87	85

Table 4: Average Number of CME Points Obtained by Doctors in the Public / Private Sectors

CME Qualifying Period (QP)	Average Points	Cat 1A	Cat 1B	Cat 1C	Cat 2	Cat 3A	Cat 3B
2-Year QP (2005-2006)	Public Sector	97.5	42.8	3.3	0.8	1.6	1.4
	Private Sector	9.6	51.0	4.2	0.3	7.1	7.8
1-Year QP (2006)	Public Sector	68.8	20.2	0.8	0.1	0.4	0.4
	Private Sector	11.0	21.5	0.0	0.7	5.2	2.0

Cat 1A : Pre-approved established programmes such as teaching and tutorial sessions

Cat 1B : Locally held events such as scientific meetings, conferences, seminars and workshops

Cat 1C : Overseas events such as scientific meetings, conferences, seminars and workshops

Cat 2 : Publication/editorial work/presentation of original paper or poster

Cat 3A : Self study from refereed journals, audio-visual tapes and online education programmes

Cat 3B : Distance learning through interactive structured CME programme with verifiable self-assessment

Table 5: Number of CME Providers in 2006

*Number of CME Providers for 2006	Restructured Hospitals / Specialty Centres / Private Hospitals	Medical/ Associations / Societies / PBs	Others	Total
	313	48	64	425

Complaints Lodged With The Council

The Council received a total of 81 complaints during the year compared to 83 complaints in year 2005 and 84 complaints in 2004 (see Table 1). There was no significant increase in complaints for the past 5 years.

Out of the 106 cases considered during the year, including the 25 complaints carried forward from 2005, 1 was withdrawn and 39 were dismissed, 24 medical practitioners were issued letters of advice and 3 were issued letters of warning. 10 cases were referred to a Disciplinary inquiry. 29 cases were adjourned to 2007.

The complaints mainly concerned professional negligence/ incompetence (28%), inappropriate treatment (7%), and excessive/ inappropriate prescription of drugs (11%).

Table 1 : Complaints Received by the Singapore Medical Council 1995 - 2006

Year	Total No. of Complaints Received	Total No. of Doctors on Register	Complaints Per 1000 Doctors
1995	36	4495	8.0
1996	66	4661	14.2
1997	57	4912	11.6
1998	55	5148	10.7
1999	45	5325	8.5
2000	60	5577	10.7
2001	84	5922	14.2
2002	69	6029	11.4
2003	66	6292	10.5
2004	84	6492	12.9
2005	83	6748	12.3
2006	**81**	**6931**	**11.7**

Table 2: Complaints Considered by Complaints Committees in 2006

Nature of Complaint	Complaints carried over from 2004	Complaints received in 2005	OUTCOME						
			No Formal Inquiry				Referred to a Disciplinary Committee (DC)	Referred to a Health Committee (HC)	Adjourned to 2006
			Withdrawn	No further action	Letter of Advice	Letter of Warning			
Professional Negligence /Incompetence	3	23		9	8		1		8
Misdiagnosis	4	11		10	1		1		3
Over/Unnecessary/ Inappropriate Treatment	1	6		3	1				3
Excessive/Inappropriate prescription of drugs	3	9		3		1			5
No informed consent	1	3			3		3		1
Improper Delegation of duties									
Failure to perform appropriate tests	1	1		2					
False/Misleading Certification	1								
Refusal to provide emergency attention	1	2		1	1		1		
Providing false information	2				1	1			
Delay in treatment	1	2		2					1
Fitness to practise									
Breach of SMC Code of Ethnics	4	8		5	2	1	1		3
Abusive Behaviour		1	1						
Conviction in Court		3					3		
Other Complaints	4	11		4	7				4
Total	**25**	**81**	**1**	**39**	**24**	**3**	**10**		**29**

Disciplinary Inquiries Held In 2006

There were 7 disciplinary inquiries completed in 2006 under the Medical Registration Act (Cap 174). A brief account of each case is given below:

Excessive / Inappropriate Prescription of Drugs

Case 1:

1. A medical practitioner was convicted of 9 out of the 11 charges against him for failure to exercise an acceptable standard of care for 11 patients while practicing as a locum doctor in a clinic in Jurong. The charges were for inappropriate prescribing of various benzodiazepines i.e., Dormicum, Valium or Nitrazepam, to 11 of his patients.

2. The Disciplinary Committee (DC) found the practitioner guilty of excessive prescribing of benzodiazepines and for failing to provide counselling for his patients, and to refer them for psychiatric evaluation in cases of chronic insomnia.

3. The DC held that the practitioner had breached professional responsibility by not discharging his professional duties appropriately. Proper prescribing by doctors was a statutory privilege and carried with it a heavy responsibility. This responsibility must be safeguarded for the public interest. As the charges against the practitioner were serious, the DC suspended him for 6 months and imposed a fine of $6000. He was also censured and ordered to give an undertaking to the Medical Council to abstain from such conduct or any similar conduct in future and to pay the costs of the disciplinary proceedings.

Case 2:

1. A medical practitioner faced 6 charges for failure to exercise an acceptable standard of care for 6 of his patients. The charges were for inappropriate prescribing of Dormicum and Nitrazepam.

2. In addition, the practitioner faced a 7th charge that as licensee and manager of the clinic, he failed to exercise adequate supervision over the prescribing practices of the doctors in the clinic by allowing benzodiazepines to be regularly prescribed to patients of the clinic and not making arrangements for these benzodiazepine-dependent patients to receive specialist treatment

for their insomnia or dependency on benzodiazepines.

3. The DC found the practitioner guilty of 4 charges of excessive prescribing of benzodiazepines and for failing to provide counselling for his patients, and to refer them for psychiatric evaluation in cases of chronic insomnia or benzodiazepine-dependency. They held that given the patients' case histories and their prolonged use of benzodiazepines, the practitioner should not have prescribed the further use of these dependency forming drugs. The DC did not accept the practitioner's explanation that he did counsel them and advise them to seek psychiatric help, or that he did not wish to dispense the medicine to them but did so because the patients were adamant. This was because his explanations were not supported by the medical records and notes he kept.

4. In convicting the practitioner of the 7th charge, the DC held that he had a duty as a doctor, who is also a licensee of the clinic under Regulation 4 of the PHMC Regulations, to ensure that the MOH's Guidelines were complied with. As manager/licensee of the Clinic, the practitioner was obliged to supervise the work of the doctors employed. However, he left the running of the clinic and the ordering of these drugs to his locum doctor, did not review the medical and dispensing records of the clinic and the patients and delegated his responsibility via private agreements with his doctors.

5. The DC was of the view that the practitioner could not delegate such serious statutory responsibility to other doctors, whether by private agreement of otherwise, or for whatever reason. If he had carried out this responsibility as licensee/manager of the clinic, he would have obviously noticed much earlier that the excessive prescription of benzodiazepines to various repeat patients of the clinic over a period of about 5 years.

6. After considering all the circumstances and the practitioner's mitigation plea, the DC suspended him for 3 months and imposed a fine of $2000. He was also censured and ordered to give an undertaking to the Medical Council to abstain from such conduct or any similar conduct in future and to pay the costs of the disciplinary proceedings.

Conviction in Court

Case 3:

1. A medical practitioner pleaded guilty to a charge that on 1 December 2004, whilst still a regular medical officer of HQ Medical Corps and subject to military law, he was convicted of an offence of falsification

of an official document under Section 50(b) of the Singapore Armed Forces Act (Cap. 295), an offence involving fraud or dishonesty. He was sentenced to be discharged with ignominy from the Singapore Armed Forces.

2. At the disciplinary hearing, the practitioner was accordingly convicted. The DC accepted that he had co-operated with the Military authorities in their investigation and that he was genuinely contrite for this offence. However, the offence that he had committed was a serious one that breached the high level of trust that the public places in the profession.

3. Taking all the circumstances into consideration, including his mitigation plea, the DC ordered that his medical registration be suspended for a period of 3 months and censured him. He was also ordered to give a written undertaking to the SMC that he will not engage in the conduct which gave rise to the charge against him, or any similar conduct and to pay the costs and expenses of the disciplinary proceedings.

Case 4:

1. A medical practitioner had pleaded guilty to a charge in the Subordinate Courts of forging a payment voucher under Section 465 of the Penal Code, Chapter 224. He was sentenced to a fine of S$10,000, in default 2 months' imprisonment.

2. As his offence had involved fraud or dishonesty, the practitioner was referred to SMC's Disciplinary Committee (DC). The practitioner pleaded guilty to the charge against him before the DC. The DC ordered that his medical registration be suspended for a period of 6 months and censured his misconduct. He was also ordered to give a written undertaking to the SMC that he will not engage in such or any similar misconduct in future.

Case 5:

1. A medical practitioner forged a payment voucher and appended a signature purported to belong to another doctor, making it appear that the doctor was the locum for him and had received a locum fee of S$9,765.

2. The practitioner then submitted the forged payment voucher to the NSmen Payment Centre, MINDEF for reimbursement for the loss of income for his reservist period. MINDEF later found out that the practitioner had submitted a false claim. The matter was reported to the police.

3. The practitioner pleaded guilty to an offence under Section 465 of

the Penal Code, Chapter 224, in the Subordinate Courts and was convicted. He was sentenced to a fine of S$9,000, in default 2 months' imprisonment on 10 Apr 2006.

4. Since the practitioner was convicted of an offence involving fraud or dishonesty, he was referred to a disciplinary inquiry by SMC's DC.

5. The DC heard and considered the practitioner's mitigation plea submitted by his Counsel and the fact that he had already been dealt with in the Subordinate Courts.

6. The DC ordered that he be censured and his medical registration suspended for a period of 5 months. He was also ordered to give a written undertaking to the SMC that he will not engage in such or any similar misconduct in future and to pay the costs of the disciplinary proceedings.

Alleged Professional Misconduct

Case 6:

1. A medical practitioner was acquitted by the DC of 2 charges of professional misconduct. The 1st charge alleged that she failed to provide good clinical care to her patient by making a diagnosis of genital herpes without performing adequate clinical evaluation, and/or failing to provide a course of treatment that was appropriate to the patient, in all the circumstances of the case.

2. The 2nd charge alleged that she had practised outside her area of competence in the management of the Patient in that she failed to refer him to a competent specialist for treatment when she should have done so.

3. On the first charge, the DC found some inadequacy in the practitioner's clinical evaluation. In diagnosing genital herpes, there were insufficient records in her case notes to show that she had taken an adequate history from the Patient. The DC doubted that she could make a diagnosis of genital herpes based on her description of the Patient's lesion. The practitioner had also not appreciated the fact that the serological test ordered would not confirm whether the Patient had active and/or recurrent genital herpes infection. The DC felt that she should have taken a culture of the lesion and/or performed a Tzanck test because it was an atypical presentation.

4. The DC held that the course of treatment/medicine given to the Patient was not inappropriate for the diagnosis. The dosages of 800mg Acyclovir per day for the first week and 400mg Acyclovir per day for the

second week were not excessive.

5. Notwithstanding the DC's finding of the inadequacy of the clinical evaluation, they were of the opinion that such inadequacy on the practitioner's part was not tantamount to professional misconduct under the Medical Registration Act.

6. The DC held that the Prosecution had not proven the 2nd charge beyond a reasonable doubt. They held that the practitioner was practising within the area of her competence and in particular in this case, her treatment of the Patient was done in connection with the treatment of the Patient's wife for infertility.

Management of Patients on Subutex

Case 7:

1. A medical practitioner faced 19 charges of failing to formulate and/or adhere to any management plan for the treatment of the patient's medical condition by the prescription of Subutex. The charges also stated that the practitioner did not record or document in the patient's record details or sufficient details of the patient's diagnosis, symptoms and/or condition and/or any management plan such as to enable him to properly assess the medical condition of the patient.

2. On the first limb of the 19 charges, the DC by a majority found that with reference to each of the patients, the practitioner did not formulate and/or adhere to any management plan for the treatment of the patient's medical condition by the prescription of Subutex.

3. On the second limb of the 19 charges, the DC unanimously found that the medical record of each of the patients concerned was very scanty and in the opinion of the DC did not contain sufficient details of the patient's diagnosis, symptoms and conditions or any management plan such as to enable the practitioner to assess properly the medical condition of the patient.

4. The DC found the practitioner guilty as charged and ordered that he be fined $2,500, censured, give a written undertaking to the SMC that he will not engage in such or similar conduct in future, be supervised by a mentor to improve his clinical case recording practice and to pay the costs of the proceedings.

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