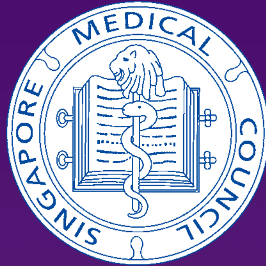

SINGAPORE MEDICAL COUNCIL

Annual Report 2009

Singapore Medical Council
Annual Report 2009

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President's Foreword

The Singapore Medical Council (SMC)'s core responsibilties, which include registration of doctors, accrediting Continuing Medical Education (CME) programmes, crediting of CME points, and regulating the professional conduct and ethics of doctors in Singapore, kept the Council fully occupied in 2009.

Medical Registration

One of SMC's roles is to ensure that there are sufficient numbers of qualified and skilled medical practitioners registered to practise in Singapore to meet the needs of the population, and to provide for qualified doctors in areas of need. To this end, in 2009, a policy was put in place to grant Temporary Registration to doctors without registrable qualifications to work in identified areas of need like Emergency Medicine, Geriatric Medicine, Internal Medicine, Rehabilitative Medicine, Renal Medicine and Neonatology. This allows for non-traditional source doctors, or doctors who do not hold qualifications from any of the institutions on the list of recognised schools, but who are skilled in these identified areas, to contribute their expertise in the public healthcare sector and in certain private institutions.

SMC also revised the requirements for doctors undergoing postgraduate training as Clinical Observers in 2009. With the revision, the training scheme for observership, which is capped at 3 months, will not require accreditation by SMC. This opens up opportunities for foreign-trained doctors to come to Singapore to participate in training for short periods.

At the end of 2009, the total number of registered doctors in Singapore saw a 6.1% increase from 2008, and a 12.7% increase from 2007. The doctor-to-population ratio in 2009 saw an improvement from 1:620 in 2007 and 2008, to 1:600 in 2009. The rising number of medical doctors is necessary, especially since Singapore faces an ageing population and with two new hospitals in the pipeline.

Surveillance

During the year, some changes were made to streamline the work done by the SMC Secretariat and to create a more efficient system. The level of importance placed by the SMC upon regulating doctors' performance to maintain high standards of medical practice is apparent with the branching out of a separate Division from the Registration Division, to have, as its main responsibility, the monitoring of doctors' performances through assessment reports. This responsibility was previously subsumed under the Registration Division.

The Surveillance Division works closely with the Supervisory Framework Audit Committee, which was formed in July 2009. The Committee reviews the guidelines of the SMC Supervisory Framework for conditionally and temporarily registered doctors, and ensures effective implementation and operations of the framework. In addition, the committee reviews the methodology for conducting inspections at healthcare institutions which employ conditionally and temporarily registered doctors to audit their compliance with the requirements of the framework, including such aspects as the institution's training environment and supervisory standards. This is done with the long-term objective of allowing both public and private sector institutions to employ conditionally-registered doctors so long as they are able to meet the new criteria under the enhanced supervisory framework and be accredited as 'learning institutions'.

The Council continually reinforces its surveillance of doctors under supervision to ensure that patient-safety and high professional standards are safeguarded and upheld. Poor performers identified through the supervisory assessment system will be exited from the register, and the school(s) from which a significant number of poor performers graduated will be delisted from the Schedule after a thorough review by the Council. With the growing increase in the number of foreign-trained doctors being registered, the Council has also stepped up its surveillance through peer review. Randomly-identified raters (colleagues, including

nursing staff) will be requested to submit multi-rater reports on the doctor under review. This provides the Council with a holistic view of the doctor's performance. Furthermore, in 2009, three audits were conducted at private and public sector healthcare institutions on their compliance with SMC's Supervisory Framework. The findings showed that the healthcare institutions met the requirements of the framework in general, although they should document more clearly the review of the supervisees' work by the supervisor for the purpose of the records and audit.

Study Visit

The Council's Schools Review Committee made its first overseas visit to 3 Chinese medical schools in April 2009. The Council has accepted, and supports, the Committee's recommendation arising from this visit that only the 7- and 8-year programmes leading to a Master of Medicine (M Med) and Doctor of Medicine (MD) qualifications, respectively, from the 8 Chinese medical schools on the Schedule should be recognised for medical registration under the Medical Registration Act (Cap 174) (MRA).

Practising Certificate

Some revisions were made to the issuance of practising certificates (PC) to doctors. Doctors whose PCs have lapsed due to non-fulfillment of CME points or other reasons, and who apply to renew their PCs within a year of its expiry, will be issued with a PC which will expire on the original expiry date, should there have been no lapse in the renewal.

Doctors can now also apply for a lower-fee PC at the new rate of $150 per year or part thereof, subject to fulfillment of certain criteria (eg. they are not in full-time practice).

Removal of Names of Medical Practitioners from the Register

In 2009, the Council found that 118 medical practitioners registered with the SMC had not renewed their PCs for a continuous period of 5 years and were not contactable. These practitioners were thus removed from the Register in accordance with Section 31(f) of the Medical Registration Act.

Elections

An election was held in November 2009 to fill 3 vacancies in the SMC which arose from 3 Council members' terms of office ending on 20 November 2009. 5 candidates stood for the elections, including the 3 Council members whose terms of office were due for expiry. At the close of the voting period, the 3 Council members, Prof Tay Boon Keng, A/Prof Siow Jin Keat and Dr Wong Sin Yew were re-elected into the Council as they had obtained the highest numbers of votes. Their new terms of office began on 21 November 2009 and will last for 3 years.

Physicians' Pledge Affirmation Ceremony

The Physicians' Pledge Affirmation Ceremony was held on 16 May 2009 at the Yong Siew Toh Conservatory of Music and was attended by over 300 doctors.

Visits by overseas delegates

SMC played host to 2 delegations in 2009, one from the Peoples' Republic of China in October, and one from the Ministry of Health, Vietnam, in November.

Complaints and Disciplinary Proceedings

Much interest has been paid to SMC's disciplinary proceedings over the past year and rightly so. The SMC has a responsibility to the public to ensure that errant doctors are duly disciplined so that patient-safety is upheld.

96 complaints were received in 2009, which is a marked fall from the 138 complaints that were received in 2008. In early 2009, MOH conducted a public consultation to obtain views on the proposed amendments to the Medical Registration Act (MRA). The proposed amendments to the Act will enable SMC's cases to be heard and resolved more expediently.

Professor Ong Yong Yau
President
Singapore Medical Council

Members Of The Singapore Medical Council 2009

President	*Prof Ong Yong Yau*
Registrar	*Prof K Satku*
NUS Nominees	*Prof Robert Pho Wan Heng* *Prof John Wong Eu Li*
Elected Members	*Dr Chua Boon Ling* *Prof Ng Han Seong* *Dr Wilmot Rasanayagam* *A/Prof Siow Jin Keat* *Dr Tan Chi Chiu* *Dr Tan Kok Soo* *Prof Tay Boon Keng* *Dr Wong Sin Yew* *Dr Wong Yue Sie*
Appointed Members	*A/Prof Chin Jing Jih* *Prof Ho Lai Yun* *Dr Lim Cheok Peng* *A/Prof Ong Biauw Chi* *A/Prof Benjamin Ong* *Prof Walter Tan Tiang Lee*

Names of Council Members (photo taken in May 2009)

Front row (L – R): A/Prof Benjamin Ong, Prof Robert Pho Wan Heng, Prof Jong Wong Eu Li, Prof Ong Yong Yau, Prof K Satku, Dr Tan Kok Soo, Prof Ho Lai Yun, Dr Lim Cheok Peng

Back row (L – R): Prof Walter Tan Tiang Lee, Dr Wong Yue Sie, Dr Wong Sin Yew, A/Prof Chin Jing Jih, Dr Tan Chi Chiu, A/Prof Siow Jin Keat

Other Members Of The Singapore Medical Council 2009

Dr Chua Boon Ling

Prof Ng Han Seong

A/Prof Ong Biauw Chi

Dr Wilmot Rasanayagam

Prof Tay Boon Keng

Medical Registration / Specialist Registration

Medical Registration

As at 31 Dec 2009, a total of 8323 medical practitioners were fully or conditionally registered in Singapore, resulting in a doctor to population ratio of 1:600.

In 2009, the Credentials Committee considered 1514 applications for registration. 1362 medical practitioners were registered, of whom 99 were previously on conditional registration and 40 on temporary registration. The breakdown of the registration granted is given in Table 1.

Of the 339 on provisional registration, 226 were NUS medical graduates and 113 were graduates from foreign universities granted medical registration to undergo housemanship training in public hospitals and institutions for one year.

Among the 331 foreign-trained medical practitioners granted temporary registration, 31 were employed to work under supervision on short-term basis in public hospitals or institutions. 202 were foreign practitioners accepted for postgraduate training in Singapore. Of these, 162 were being trained as Clinical Fellows and 40 as Clinical Observers. 76* visiting experts were invited by various hospitals and medical organisations to provide short-term training and consultancy. In addition, there were 22 team doctors brought in by the respective National Olympic Councils for the Asian Youth Games.

126 medical practitioners were not in active practice owing to various reasons such as retirement, working or studying overseas. These doctors did not renew their practising certificates in 2009. At the same time, 32 medical practitioners were restored to the Medical Register when they resumed practice in Singapore.

The total number of doctors as at 31 Dec 2009 registered a net increase of 482, compared to 2008.

Specialist Registration

As at 31 Dec 2009, there were 3180 doctors registered as specialists on the Register of Specialists. The number of specialists had increased by 218 (7.36%), compared to 2008. They also represented 38.2% of the 8323 medical practitioners registered in Singapore. The numbers of registered specialists in the various specialities are in Table 5-1. Table 6-1 shows the trends in specialist registration. The numbers from Year 2000 to Year 2009 were the cumulative total as at 31 December of each year.

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* Including 37 doctors who were registered previously.

Table 1: New Medical Registration by Registration Type as at 31 December 2009

Registration Types	New Applications for Registration in 2009:	Doctors from Provisional Register:	Doctors from Temporary Register:	Doctors from Conditional Register:	Total
Full	-	233	-	99	**332**
Conditional	258	62	40	-	**360**
Provisional	339	-	-	-	**339**
Temporary	294	-	37	-	**331**
Total	**891**	**295**	**77**	**99**	**1362**

Table 2: New Medical Registrations by Citizenship and Training# in 2009

Registration Types	Local - Trained		Foreign - Trained		Sub-Total		Total
	Local	Foreigner	Local	Foreigner	Local	Foreigner	
Full (from P to F)	210	23	-	-	210	23	233
Full (from C to F)	2	-	20	77	22	77	99
Conditional (New)	-	-	21	237	21	237	258
Conditional (from P to C)	-	-	20	42	20	42	62
Conditional (from T to C)	-	-	2	38	2	38	40
Provisional (New)	217	9	38	75	255	84	339
Temporary (New)	-	-	2	292	2	292	294
Temporary (Visiting experts-existing)	-	-	-	37	0	37	37
Total	**429**	**32**	**103**	**798**	**532**	**830**	**1362**

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

Registration Types	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Full Registration	**170**	**215**	**156**	**182**	**201**	**203**	**220**	**232**	**222**	**233**
NUS Degree	146	153	146	175	193	195	206	230	222	233
Foreign Degree	24	62	10	7	8	8	14	2	0	0
Conditional Registration	**114**	**146**	**121**	**128**	**114**	**112**	**158**	**275**	**357**	**320**
NUS Degree	-	1	-	1	-	1	-	1	3	0
Foreign Degree	114	145	121	127	114	111	158	274	354	320
Provisional Registration	**173**	**173**	**187**	**213**	**239**	**265**	**280**	**303**	**300**	**339**
NUS Degree	156	144	175	195	197	210	229	226	232	226
Foreign Degree	17	29	12	18	42	55	51	77	68	113
Temporary Registration	**252**	**193**	**334**	**256**	**345**	**342**	**355**	**352**	**215**	**294**
Foreign Degree	252	193	334	256	345	342	355	352	215	294
Total	**709**	**727**	**798**	**779**	**899**	**922**	**1013**	**1162**	**1094**	**1186**

Table 4: New Conditional Registrants by Place of Training# in 2009

Conditional Registration	Local Trained		Foreign Trained		Subtotal		Total
	Local	Foreigner	Local	Foreigner	Local	Foreigner	
Non Specialist	0	0	17	192	17	192	209
Specialist	0	0	4	45	4	45	49
Total	0	0	21	237	21	237	258

Note: F = Full Registration; P = Provisional Registration; C = Conditional Registration; T = Temporary Registration; # Training categorised by basic qualification.

Table 5: Total Number of Specialists By Year (as at December)

Employment Sector	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Comparison (Net Increase %)	
											2008 & 2009	2000 & 2009
Public	1023	1075	1184	1275	1353	1435	1557	1617	1772	1927	8.7	88.4
Private	796	855	904	949	1014	1076	1097	1164	1190	1253	5.3	57.4
Total (as at 31 December)	**1819**	**1930**	**2088**	**2224**	**2367**	**2511**	**2654**	**2781**	**2962**	**3180**	**7.4**	**74.8**

Table 5-1: Specialist Registration by Specialities as at 31 December 2009

No.	Specialities	Public Sector	Private Sector	Total	Ratio in %	
					Public	Private
1	Anaesthesiology	177	123	300	59	41
2	Cardiology	76	54 (1)	130	58	42
3	Cardiothoracic Surgery	21	13	34	62	38
4	Dermatology	38	36	74	51	49
5	Diagnostic Radiology	137	55	192	71	29
6	Emergency Medicine	71	10	81	88	12
7	Endocrinology	46	19 (1)	65	71	29
8	Gastroenterology	53 (1)	32	85	62	38
9	General Surgery	123	92	215	57	43
10	Geriatric Medicine	43	5	48	90	10
11	Haematology	30	8	38	79	21
12	Hand Surgery	15	5	20	75	25
13	Infectious Diseases	29 (1)	5	34	85	15
14	Internal Medicine	44 (1)	32	76	58	42
15	Medical Oncology	42	25 (1)	67	63	37
16	Neurology	47	16	63	75	25
17	Neurosurgery	16	13	29	55	45
18	Nuclear Medicine	8	6	14	57	43
19	Obstetrics & Gynaecology	92	189	281	33	67
20	Occupational Medicine	17	17	34	50	50
21	Ophthalmology	102	62	164	62	38
22	Orthopaedic Surgery	92	56	148	62	38
23	Otorhinolaryngology / ENT Surgery	36	44	80	45	55
24	Paediatric Medicine	124	125	249	50	50
25	Paediatric Surgery	11	5	16	69	31
26	Pathology	90	21	111	81	19
27	Plastic Surgery	19	22	41	46	54
28	Psychiatry	89	48	137	65	35
29	Public Health	60	34	94	64	36
30	Radiation Oncology	25	5	30	83	17
31	Rehabilitation Medicine	21	4	25	84	16
32	Renal Medicine	27	16	43	63	37
33	Respiratory Medicine	50	23	73	68	32
34	Rheumatology	23 (2)	7 (1)	30	77	23
35	Urology	33	26	59	56	44
	Total	**1927**	**1253**	**3180**	**61**	**39**

( ) denotes number of doctors with dual specialities

Table 6: Total Number of Doctors# on Register (by Year)

Year	Specialist	Non-Specialist	Total (as at December of the Year)
2000	1819	3758	5577
2001	1930	3992	5922
2002	2088	3941	6029
2003	2224	4068	6292
2004	2367	4125	6492
2005	2511	4237	6748
2006	2654	4277	6931
2007	2781	4603	7384
2008	2962	4879	7841
2009	3180	5143	8323

Only Full & Conditional registrants included

Table 6-1: Total Number of Specialists By Specialities By Year (as at December)

No.	Specialities / Year	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	Comparison (Net Increase %)	
												'08 & '09	'00 & '09
1	Emergency Medicine	21	24	30	34	41	52	56	58	68	81	19.1	285.7
2	Infectious Disease	11	13	14	16	18	25	27	28	33	34	3.0	209.1
3	Medical Oncology	23	27	31	37	43	47	52	54	62	67	8.1	191.3
4	Hand Surgery	7	7	8	9	10	12	15	17	19	20	5.3	185.7
5	Geriatric Medicine	17	22	23	32	35	38	43	43	47	48	2.1	182.4
6	Radiation Oncology	11	17	17	18	20	21	25	29	30	30	0.0	172.7
7	Nuclear Medicine	6	6	9	10	10	14	15	15	13	14	7.7	133.3
8	Rehabilitation Medicine	11	11	12	13	15	16	20	22	24	25	4.2	127.3
9	Diagnostic Radiology	88	97	111	118	128	135	142	152	169	192	13.6	118.2
10	Urology	29	33	37	38	43	48	51	53	57	59	3.5	103.4
11	Rheumatology	15	14	19	19	22	25	25	28	28	30	7.1	100.0
12	Gastroenterology	43	46	52	54	58	58	61	66	74	85	14.9	97.7
13	Endocrinology	33	34	37	41	46	47	52	56	60	65	8.3	97.0
14	Cardiology	68	72	77	83	89	98	108	111	120	130	8.3	91.2
15	Ophthalmology	86	90	96	108	117	125	130	137	152	164	7.9	90.7
16	Haematology	21	24	25	30	30	30	31	31	33	38	15.2	81.0
17	Anaesthesiology	166	173	196	203	211	224	250	262	277	300	8.3	80.7
18	Neurology	36	37	45	47	47	50	53	58	59	63	6.8	75.0
19	Respiratory Medicine	42	46	49	53	58	63	66	67	70	73	4.3	73.8
20	Orthopaedic Surgery	86	92	98	103	111	119	127	134	140	148	5.7	72.1
21	Renal Medicine	25	24	29	33	34	34	37	40	42	43	2.4	72.0
22	Plastic Surgery	24	26	30	30	31	32	32	34	39	41	5.1	70.8
23	General Surgery	126	128	133	150	156	165	179	192	203	215	5.9	70.6
24	Dermatology	44	47	48	48	55	60	63	66	70	74	5.7	68.2
25	Internal Medicine	45	46	52	55	58	60	58	66	72	76	5.6	68.9
26	Cardiothoracic Surgery	21	23	25	26	26	27	30	30	29	34	17.2	61.9
27	Paediatric Medicine	156	169	181	184	193	207	212	224	232	249	7.3	59.6
28	Psychiatry	86	92	95	97	105	108	111	114	122	137	12.3	59.3
29	Public Health	60	67	67	67	71	74	76	81	89	94	5.6	56.7
30	Pathology	72	69	74	84	88	93	98	98	106	111	4.7	54.2
31	Otorhinolaryngology / ENT Surgery	55	58	63	65	66	68	70	73	75	80	6.7	45.5
32	Paediatric Surgery	11	11	12	13	13	13	12	13	15	16	6.7	45.5
33	Neurosurgery	21	23	23	23	25	26	28	28	27	29	7.4	38.1
34	Obstetrics & Gynaecology	225	233	241	253	262	265	267	268	274	281	2.6	24.9
35	Occupational Medicine	28	29	29	30	32	32	32	33	32	34	6.3	21.4
Total No. of Registered Specialists as at 31 December each year:		1819	1930	2088	2224	2367	2511	2654	2781	2962	3180	7.3	74.8

Continuing Medical Education

2009 / 2008 – 2009 Qualifying Periods

Compulsory CME was introduced in 2003 and since then, the majority of doctors have fulfilled their CME requirements in the last 7 CME cycles. This year, out of a total of 2076 doctors, 2049 or 98.7% met the CME requirement for the CME Qualifying Periods (QPs) which ended on 31 December 2009 {i.e. for practising certificates (PC) expiring anytime in 2010}. (see Table 1).

Out of the 27 doctors who did not meet the CME requirements, 12 informed the Council that they intended to make up their CME shortfall after their PC lapses, and apply for a new PC thereafter, while 3 doctors did not intend to make-up the shortfall (see Table 2). The remaining 12 had not responded to Council as at time of Report.

Number of Processed Applications and Credit Claims for 2009

In 2009, SMC processed a total of 29,429 accreditation applications and credit claims for Categories 1A, 1B, 1C, 2, 3A and 3B, out of which 28,824 were approved (see Table 3).

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	Number of Doctors who did not meet Requirements
2-Year QP (2008-2009)	1939	22
1-Year QP (2009)	110	5
Total	**2049**	**27**

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 CME Requirements
2-Year QP (2008-2009)	Intend to Make-up Shortfall	11
	Do not Intend to Make-up Shortfall	2
	No Response	9
1-Year QP (2009)	Intend to Make-up Shortfall	1
	Do not Intend to Make-up Shortfall	1
	No Response	3
Total		**27**

Table 3 : Number of Processed Applications and Credit Claims for 2009

Category	Approved	Rejected	Total
1A	**954**	**28**	**982**
1B	**2037**	**203**	**2240**
1C	**2476**	**178**	**2654**
2	**709**	**27**	**736**
3A	**10372**	**122**	**10494**
3B	**12276**	**47**	**12323**
Total	**28824**	**605**	**29429**

Cat 1A : Pre-approved established programmes such as grand ward rounds and teaching/ 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.

Complaints Lodged With The Council

The Medical Council received a total of 96 complaints against 116 doctors in 2009 compared to 138 complaints in year 2008 and 115 complaints in 2007 (see Table 1). There was thus a decrease of 30% in the number of complaints from the calendar year before.

Of the complaints considered during the year, some of which were carried forward from 2008, 18 cases were referred for disciplinary inquiries. There were 11 cases in which the doctors involved were issued letters of warning and in 43 cases, the doctors involved were issued letters of advice. 35 complaints were dismissed and 1 complaint was withdrawn.

Table 2 shows the details. The complaints mainly concerned alleged professional negligence and competence issues.

Table 1: Complaints Received by the Singapore Medical Council 1997-2009

Year	Total No. of Complaints Received	Total No. of Doctors on Register	Complaints Per 1000 Doctors
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
2007	115	7384	15.6
2008*	138	8510	16.2
2009*	**96**	**9033**	**10.6**

Note:
(a) 2007 and before - Figures based on F and C-reg doctors
(b) *2008 and 2009 - Figures based on F, C, P & T-reg doctors

Table 2: Complaints Considered by Complaints Committees in 2009

Nature of Complaint / Allegation	Complaints carried over from 2008	Complaints received in 2009	OUTCOME						
			No Formal Inquiry				Referred to a Disciplinary Committee (DC)	Referred to a Health Committee (HC)	Adjourned to 2010
			Withdrawn	No further action	Letter of Advice Issued	Letter of Warning			
Professional Negligence/ Incompetence	24	28		11	20	4	4		13
Misdiagnosis	2	2		1	1				2
Over/ Unnecessary/ Inappropriate treatment	7	10		2	5	2			8
Excessive/ Inappropriate prescription of drugs	14	7		1		1	13		6
No informed consent	2	0				2			0
Providing false information	3	0		1	1		1		0
Delay in treatment	0	5		1	1				3
Breach of SMC Code of Ethics	3	12		2		1			12
Rudeness/Attitude/ Communication issues	5	7		2	6				4
Other Complaints	14	19	1	13	8				11
Outrage of Modesty/ Sexual relationship with patient	1	5		1		1			4
Overcharging	1	1			1				1
Total	**76**	**96**	**1**	**35**	**43**	**11**	**18**	**0**	**64**
Percentage (%)			**0.6**	**20.3**	**25**	**6.4**	**10.5**	**0**	**37.2**

Disciplinary Inquiries

18 disciplinary inquiries were heard by the Disciplinary Committees in 2009 and 1 appeal was heard in the High Court (see table 1).

Table 1: Inquiries concluded by the Disciplinary Committees in 2009

Nature of Complaint	Inquiries heard in 2009	OUTCOME					
		Acquittal	Censure	Censure & Fine	Censure & Suspension	Censure, Suspension & Fine	Erasure
Misrepresentation as an Accredited Specialist	1				1		
Professional Misconduct	1			1			
Professional Misconduct and Misrepresentation	1			1			
Inappropriate treatment (*Case 5)	2			1	1		
No informed consent and inappropriate treatment	1	1					
No informed consent and improper delegation of duty	1			1			
Breach of SMC's Code of Ethics	2			2			
Excessive / Inappropriate Prescription of Drugs (Benzodiazepines)	4					3	1
Excessive/ Inappropriate Prescription of Drugs (Benzodiazepines and Codeine-containing Medication)	2					2	
Excessive / Inappropriate Prescription of Drugs (Benzodiazepines and other drugs)	1					1	
Excessive / Inappropriate Prescription of Drugs (Subutex)	1					1	
Excessive / Inappropriate Prescription of Drugs (Subutex and Benzodiazepines)	1					1	
Total	**18**	**1**	**0**	**6**	**2**	**8**	**1**
Percentage (%)		**6%**		**33%**	**11%**	**44%**	**6%**

*Case 5 – The practitioner appealed to the High Court in respect of the orders made by the DC. The outcome of the appeal will be highlighted in the next annual report (i.e. 2010 Annual Report) as the above table is a summary of all the decisions made by the various Disciplinary Committees.

A brief account of each case is given below:

(A) Misrepresentation as an Accredited Specialist

Case 1:

A general practitioner pleaded guilty to 2 charges which arose from his breaches of Section 65(1)(a) and Section 65(1)(b) of the Medical Registration Act (MRA) read with Section 4.4.2 of the SMC Ethical Code and Ethical Guidelines (ECEG).

The first charge was in respect of the practitioner falsely assuming the title of specialist and/or consultant in the practice of plastic surgery or cosmetic surgery. The Disciplinary Committee (DC) took a serious view of this breach as the MRA clearly provides that a medical practitioner must obtain a certificate from the Specialists Accreditation Board ("SAB") certifying *inter alia*, that the medical practitioner has completed and obtained the requisite qualifications and training before the said medical practitioner can be registered as a specialist and assume the title of a specialist and/or practise medicine under a recognised specialty.

The DC noted that while the practitioner was registered as a medical practitioner with the SMC, he had not obtained such prescribed specialty training or qualifications. As such, he was not accredited by the SAB for the purposes of specialist registration in Singapore, nor did he obtain any specialist registration in the United Kingdom (UK), as he would like his patients to believe. However, when queried by members of the public on his training and accreditation, the practitioner did not clarify that he was not accredited as a specialist and had, instead, provided information which portrayed himself as a specialist.

Further, the practitioner had declared his area of specialty as "Cosmetic Surgery" even though cosmetic surgery was not a specialty recognised by SAB, and also claimed that his area of practice was "Private Specialist" in his membership application form submitted to the Singapore Medical Association.

The law clearly states that a registered medical practitioner should not hold himself out to be a specialist unless he has obtained the relevant accreditation from the appropriate governing body, in this case, the SAB. Further, based on the evidence, the DC was of the opinion that it was not a simple oversight on the practitioner's part but, rather, that he systematically set out to create a false impression of his qualifications and experience. The DC would not tolerate such actions where, in effect, the public were being misled.

The second charge related mainly to the practitioner causing to be published, misleading statements on the website of the clinics at which he practised. The information on the website created a false impression that he was a specialist and/or consultant in the practice of plastic surgery or cosmetic surgery. The website contained numerous misleading and unsubstantiated statements, including claims on his experience, training and qualifications.

The DC did not accept that the information posted by the practitioner could have been the result of an oversight or misunderstanding as there were numerous instances where the information provided was false or misleading. The DC further held that the offence was serious, especially since the misleading information had been disseminated through the internet where it is envisaged that the information will reach a wide audience.

The DC felt that appropriate action had to be taken bearing in mind that this was the first time a medical practitioner was charged with a breach of Section 65 of the MRA. The DC was also of the opinion that the fact that the practitioner breached the MRA before the SMC's guidelines on the Display of Titles and Designations by Medical Practitioners came into effect was not a relevant factor. Public safety should not be compromised and it was vital that the public should be protected from such false and misleading statements by registered medical practitioners.

The practitioner was suspended for a period of 6 months; censured; ordered to give a written undertaking to abstain in future from the conduct complained of or any similar conduct; remove all misleading statements contained on the said website and in any publication forthwith; and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Appeal to the High Court

Subsequently, the practitioner appealed against the 6-month suspension before the Court of 3 Judges. The Court dismissed his appeal with cost.

(B) Professional Misconduct

Case 2:

A general practitioner pleaded guilty to 1 charge of acting in serious disregard of her professional responsibilities by falsely certifying to the Controller of Work Permits in a medical report / form that she had carried out Veneral Disease Research Laboratory (VDRL) and pregnancy screenings on her foreign domestic worker when she had in fact failed or neglected to carry out the tests so stated in the medical report / form. The DC accepted that there were

extenuating circumstances at the material time which resulted in the false declaration being submitted to the Ministry of Manpower and also accepted that the practitioner was remorseful for the act or conduct complained of. The DC also noted that the practitioner had pleaded guilty to the charge at the earliest opportunity and had co-operated fully with the authorities.

However, the DC highlighted that it was a serious error which could not be condoned by the medical profession in view of the important role which medical practitioners play in screening foreign domestic workers. As such, the DC was of the view that the subject-matter of the charge was a serious professional misconduct which warranted the imposition of a penalty.

The practitioner was fined $3,000; censured; ordered to give a written undertaking to abstain in future from the conduct complained of or any similar conduct, and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(C) Professional Misconduct and Misrepresentation

Case 3:

A general practitioner faced two charges; the first charge related to his misrepresentation to a patient that he was a fully-trained and accredited specialist plastic surgeon and the second charge related to a liposuction procedure he performed on the patient.

On the first charge, which the practitioner denied, the DC found that the charge had been proven beyond reasonable doubt and that the practitioner had misrepresented to the patient, orally and through the information posted on his website, that he was a fully-trained and accredited specialist plastic surgeon. Thus, the practitioner was guilty of contravening Section 65 of the MRA.

The DC noted that the practitioner had, during a consultation with the patient, discussed the work and prices of other plastic surgeons to whom the practitioner compared himself. The DC found that the practitioner had told the patient of his overseas training and work experiences, that he was trained in "Cosmetic Surgery" and of his Consultant appointment in "Cambridge". However, at no time did he tell the patient that he was not a plastic surgeon.

In respect of the second charge, the practitioner was charged with professional misconduct under Section 45(1)(d) of the MRA in carrying out a liposuction procedure on the patient. Arising from the liposuction procedure, the patient was left with deformities and scars which required corrective procedures in the form

of both liposuction of residual fat followed by fat grafting.

The DC accepted the evidence of the Prosecution's expert witness, as well as the attending doctors for the patient, who all confirmed that the results of the surgery indicated that harm was caused as a consequence of incompetent treatment.

The DC concluded that although the result was far from satisfactory and *the manner the practitioner carried out the procedure may amount to negligence*, it did not amount to professional misconduct within the meaning of Section 45(1)(d) of the MRA. Accordingly, the DC acquitted the practitioner of the second charge.

In sentencing the practitioner, the DC took into account an earlier disciplinary inquiry against him whereby he pleaded guilty to two charges under section 65 of the MRA and was suspended from practice for 6 months. After hearing a mitigation plea from counsel for the practitioner, and taking into account all the relevant circumstances, the practitioner was censured and fined $10,000 and further ordered to provide a written undertaking to abstain in future from the conduct complained of or any similar conduct in the first charge. The DC also ordered the practitioner to pay 50% of the costs and expenses of and incidental to these proceedings in respect of the costs of the solicitor to the Council and the Legal Assessor.

(D) Inappropriate treatment

Case 4:

A haematologist pleaded guilty to (i) a charge of failing to exercise due care to his patient in that he failed to make an adequate clinical evaluation of the patient's medical condition by failing to carry out the appropriate clinical examination and/or clinical tests pertaining to the treatment of the patient's condition of Non Hodgkin's Lymphoma, and (ii) a charge of failing to exercise due care to his patient in that he failed to properly manage the Hepatitis-B infection that the patient developed during the course of treatment of Stage IVA Low-Grade Lymphoma with chemotherapy.

In February 2005, a patient suffering from lymphoma consulted the practitioner. Although it was the usual practice to test lymphoma patients for Hepatitis-B serology prior to administering chemotherapy on such patients, the practitioner failed to do so before administering chemotherapy to the patient between February and April 2005.

In May 2005, the patient was tested and diagnosed to have Hepatitis-B. The patient was hospitalised at Gleneagles Hospital. The practitioner discharged the patient although it was a serious condition that was potentially life-threatening. The patient subsequently passed away in May 2005, with the cause of death being certified

as Hepatitis-B with Non Hodgkin's Lymphoma as a contributing condition.

With respect to the first charge, the DC noted that since chemotherapy is a well-known cause for reactivation of Hepatitis-B and that we are in an area of moderate endemicity of Hepatitis-B, these 2 facts taken together should have prompted the practitioner to screen this patient for Hepatitis-B. Although the DC noted that the screening of Hepatitis-B before commencement of chemotherapy was not uniformly practised in Singapore in 2005, there was still sufficient medical literature urging testing before chemotherapy.

With respect to the second charge, the practitioner had admitted, amongst other things, that he had failed to discuss with the patient the options of consultation with a hepatologist and/or to consult a hepatologist to assist in the management of the patient's development of Hepatitis-B.

The DC then carefully considered the points made in mitigation by the practitioner's counsel and took into account his unblemished record for the past 44 years and testimonials from members of the profession.

The practitioner was suspended from medical practice for 3 months; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Case 5:

A neurologist faced 2 charges in relation to the treatment of his patient, from 15-18 August 2006. The charges concerned his application of repetitive transcranial magnetic stimulation ("rTMS") and Therapeutic Ultrasound on his patient for treatment of her medical condition.

At the hearing, a legal issue was raised by the practitioner's solicitors on the non-attendance of the complainants. The practitioner argued that the proceedings should be dismissed on this ground. The prosecution resisted this application and argued that the Agreed Statement of Facts contained sufficient factual basis to support the charges. The other issues which the DC had to investigate did not relate to the complainants' evidence. The DC agreed with the prosecution that the fact that the complainants were not called as witnesses did not nullify the proceedings. It was further noted that under the present MRA and Regulations, it was not necessary for either the patient or the complainants to testify. On this basis, the inquiry hearing proceeded.

Legal arguments were also made in relation to the patient's medical condition. In this respect, the prosecution took the position that the actual diagnosis was not relevant to the main issues as the 2 treatments, rTMS

and Therapeutic Ultrasound, were inappropriate, regardless of the patient's medical condition. The practitioner said he diagnosed the condition as Atherosclerotic Parkinson's Disease ("PD"), Diffuse Small Vessel Disease in the Brain, and an element of Psychosis, and the DC accepted this diagnosis.

At the conclusion of the Inquiry, the DC acquitted the practitioner of the first charge relating to rTMS and convicted him of the second charge relating to Ultrasound.

For the first charge relating to rTMS, the DC accepted that the treatment modality had not found general acceptance in medical practice. However, the DC was of the view that the practitioner had done a review of the experience of others in the treatment of PD with rTMS and there was evidence through the medical research papers quoted by the practitioner that rTMS did result in temporary improvement in motor function.

As such, the DC took the position that the application of rTMS as an extended indication or auxiliary treatment for a patient suffering from PD, especially one who had failed other treatment options (as in this case), can be supported. Accordingly, the DC was unable to find, beyond all reasonable doubt, that the practitioner's use of rTMS on the patient was inappropriate for the patient's medical condition, and therefore acquitted him of the first charge.

In passing, the DC did, however, make it a point to also note that it did not agree with the assertion by the practitioner that the Bioethics Advisory Committee's ("BAC's") Guidelines, in particular paragraph 3.22, sanctions all activities as therapies when they are undertaken with the sole intention of benefiting patients, thereby overriding Section 4.1.4 of the SMC Ethical Code and Ethical Guidelines which, among other things, states that "*A doctor shall treat patients according to generally accepted methods*" and that "*A doctor shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approval clinical trial*".

For the second charge relating to Ultrasound, the DC took issue with the practitioner's reasoning for use of Ultrasound on the patient. The practitioner had, through a review of the use of diagnostic ultrasound in obstetric and neurological practice, concluded that Therapeutic Ultrasound (as used by physiotherapists) could also be reasonably applied to treatment of neurological diseases of the brain.

The DC noted that, as the safety of patients or "do no harm" is a cardinal principle for doctors, it was incumbent on the practitioner to satisfy the DC that the application of Therapeutic Ultrasound on the brain was safe on

patients, a burden which he failed to discharge. The DC found that there was neither experimental evidence nor physical proof of the safety of this modality on the human brain.

Accordingly, the DC found that the practitioner's use of Therapeutic Ultrasound was not generally accepted by the medical profession and not an appropriate treatment for the medical condition of the patient.

The practitioner was fined $5,000; censured; ordered to give a written undertaking that he would not continue with the therapeutic use of Ultrasound for insonation on a patient's brain other than for indications as generally accepted by the community of neurologists; and to pay the full cost of the Legal Assessor as well as 60% of the costs of the solicitor to the Council.

In closing, the DC also cautioned the practitioner that it was not seeking to discourage his desire for innovation but any novel treatment which he contemplated should be considered in accordance with the BAC's Guidelines for Institutional Review Boards.

The practitioner appealed to the High Court in respect of the orders made by the DC.

(E) No Informed Consent and Inappropriate Treatment

Case 6:

An orthopaedic surgeon faced 2 charges in relation to his treatment of his patient; the first charge being that he performed the surgery for the excision of a fibromatous lesion of about 2 cm in diameter on the left sole of the patient, without sufficiently explaining to the patient the risk of nerve damage to the plantar nerve of the patient's left sole, and thereby failed to obtain the informed consent of the patient for the surgery. The second charge was that the practitioner performed the surgery for the excision of the fibromatous lesion under local anaesthesia ("LA"), when he knew or ought to have known that the surgery should have been performed under general anaesthesia ("GA").

The complaint was noted to be made by the patient some 7 years after the incident. The recollection of witnesses of fact and its reliability were difficult because the records of the patient's primary case notes had been destroyed by end of 2004, about 5 years after the patient's last consultation in 1999.

Given the time lapse and the destruction of medical records and after hearing the patient, the practitioner, the experts and witnesses, the Prosecution could not satisfy the DC that it had been proven beyond all reasonable doubt that the complainant

and prosecution's versions of facts were correct or that the respondent's version was wrong.

The DC decided to dismiss the case against the practitioner and acquit him of both charges.

(F) No Informed Consent and Improper Delegation of Duty

Case 7:

A hand surgeon faced 2 charges in relation to carrying out a body-contouring procedure by laser lipolysis, known as SmartLipo ("Surgery") on one of his patients. The first charge involved the issue of informed consent. The second charge involved the issue of medication given prior to a personal consultation with the patient. The practitioner contested both charges.

At the conclusion of the inquiry, the DC acquitted the practitioner of the first charge and convicted him on the second charge.

In relation to the first charge, the DC emphasised the importance of doctors ensuring that proper informed consent is obtained. The purpose of obtaining informed consent was to ensure that the patient had been informed of all options and that the doctor had sufficiently explained the risks, side-effects and nature of the procedure, and that the patient understood these two elements. Taking of consent involves more than just signing the consent form.

However, the DC emphasised that there were inherent risks of obtaining informed consent after the consumption of sedatives, as sedation is a potential barrier to consent. The presence of sedation diminishes the likelihood that a patient can provide informed consent, though it may not entirely preclude it. Doctors have a duty to ensure that information is given to the patient in the most appropriate way and that steps are taken to try to enhance the patient's capacity to give informed consent. Doctors must bear in mind the possibility that medication may adversely affect capacity.

For the second charge, the DC referred to the SMC's Ethical Code and Ethical Guidelines (ECEG) which emphasise the importance of adequate personal consultation by a medical practitioner before he supplies or prescribes medicines. This was of particular importance considering that the present medication involved the supply of diazepam, which has sedative effects.

The DC found that the Clinic had protocols and standing instructions in place for the diazepam to be given to SmartLipo patients as a standard pre-procedure medication. The DC also noted that:- (i) the practitioner was the only medical practitioner involved

in the running of the Clinic, even though he was not the holder of the clinic licence; (ii) the practitioner was aware of the protocols and standing instructions in the Clinic; and (iii) the keys to the dispensary cabinet were held by the nurses.

The DC found from the evidence that the nurses were given full autonomy, such that they were able to administer and dispense medication (including benzodiazepines) without the requirement for a medical consultation or a doctor's written instructions. It was found that the practitioner had presumed that the nurses would supply the diazepam only after the patient had seen him. However, the practitioner took no steps to check whether the patient had been given diazepam. After seeing the patient, the practitioner did not give instructions for the diazepam to be administered, assuming that it would be done. The DC was of the view that there was an absence of accountability and control measures which are normally expected in a medical clinic, in particular, with regard to the control of, access to and prescription and administration of medicines. In this regard, the DC also emphasised that the practitioner had not demonstrated the clinical responsibility, supervision and leadership expected of him, as the only doctor in the clinic.

The DC relied on the terms of SMC's ECEG, which, while permitting the delegation of duties, imposes upon the doctor the need to ensure effective supervision. In short, the doctor may delegate his duties but not his responsibilities.

In these circumstances, the DC was satisfied beyond a reasonable doubt that the practitioner had extensively delegated his power and duty to prescribe and supply diazepam, and had failed to exercise the necessary supervision in relation to the prescription and supply of the diazepam.

Accordingly, the DC was of the view that the second charge was made out beyond reasonable doubt and convicted the practitioner of the second charge.
The practitioner was fined $2,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of in the second charge or any similar conduct and to pay 80% of the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(G) Breach of SMC Ethical Code and Ethical Guidelines

Case 8:

A plastic surgeon was charged with offering to and performing on his patients, cell therapy involving the

injection of xenogenic (animal) foetal cells into humans ("Cell Therapy") for anti-ageing and rejuvenation purposes, a procedure that was not generally accepted by the medical profession, outside the context of a formal and approved clinical trial. The practitioner pleaded guilty to the charge.

The DC found that the Cell Therapy offered and performed by the practitioner was not a generally accepted method of treatment and was of the view that the only situation where Cell Therapy could be offered and performed was in the context of a formal and approved clinical trial.

The DC noted that patients primarily rely on the advice given to them by their doctors due to the imbalance in the level of knowledge and experience between doctor and patient. The DC pointed out that most patients who seek treatment from doctors who perform aesthetic procedures, do so out of a perceived sense that their appearances can be improved. Such patients will naturally seek out doctors who are known to be experienced in aesthetic procedures. Whilst such patients may have a cursory knowledge of the laudatory claims made in magazines and articles regarding aesthetic procedures, they are unlikely to have the necessary knowledge or experience to make determinations on the appropriateness of medical procedures. It is therefore important that patients can trust and rely on the advice of their doctors.

The DC referred to the SMC Ethical Code and Ethical Guidelines (ECEG) which provide, inter alia, that "*A doctor shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial*". The DC stated that strict adherence to the ECEG is necessary to uphold the trust that the public reposes in doctors. Each time a doctor fails to abide by the provisions of the ECEG, this trust is eroded. The profession, as a self-regulating body, then has to take the necessary steps to ensure that this trust is restored.

The DC emphasised that doctors must be subject to the exacting standards that the profession has set for itself. A doctor is not at liberty to perform a particular procedure without ensuring that the general body of doctors approve. The basis for requiring such exacting standards from doctors is to protect the public from harm that may be caused by methods of treatment that are not evidence-based or not generally accepted by the medical profession. Such standards are also necessary for the medical profession to maintain the trust and confidence of society. The public is entitled to believe that doctors will guarantee professional competence and integrity to society.

The DC commented that current knowledge is inadequate in determining the desired action of human or autologous cells injected into human

anti-ageing and rejuvenation, and it is even more doubtful when xenogenic cells are used for this purpose. Any such experimental procedure ought to be rigorously reviewed by an Institutional Review Board before it can be performed. The DC noted that the practitioner was aware from the outset that Cell Therapy was not a generally accepted method of treatment, and as a senior doctor, must have been aware of the requirement to obtain the approval of an Institutional Review Board to conduct a clinical trial.

The practitioner was fined $5,000; censured; ordered to give a written undertaking to abstain in future from the conduct complained of or any similar conduct; and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Case 9:

The proceedings arose out of a complaint by a patient against a general practitioner. In September 2006, one of his patients consulted the practitioner for aesthetic treatment. From October 2006 to April 2007, the practitioner administered aesthetic LASER treatment on the patient's face.

Sometime in 2007, 2 photographs of the patient, taken in the course of the patient's treatment, were published in a local magazine without the patient's consent. This resulted in a complaint by the patient against the practitioner.

The practitioner pleaded guilty to (i) a charge of having breached his responsibility to maintain medical confidentiality in respect of the patient, by disclosing or allowing the disclosure of two photographs taken by him without the patient's consent (the "First Charge"); and (ii) a second charge in that he had associated himself with persons not qualified to provide medical or medical support services (the "Second Charge").

In coming to its decision, the DC considered the mitigating factors presented by the practitioner's counsel: (i) that the practitioner had pleaded guilty and had co-operated with the authorities at all times; (ii) that, in respect of the First Charge, the offence was not committed deliberately and was due to an inadvertent error; (iii) upon discovery of the disclosure, the practitioner had taken immediate steps to ascertain the circumstances and tendered an apology to the patient; (iv) in respect of the Second Charge, that the practitioner had taken steps to ensure that the clinic complied with the relevant regulations governing the licensing of the clinic, and to disassociate the spa business from the operations of the clinic; (v) there was no act which brought the medical profession into disrepute; and (vi) that the practitioner will seek to terminate the arrangement for the supply of medical services to the clinic.

The DC concluded that the confidentiality of a patient's treatment and records is a fundamental tenet of medical practice. The DC also highlighted that the SMC Ethical Code and Ethical Guidelines had stated very clearly the obligations and duties of a medical practitioner to preserve the confidentiality of a patient.

The DC viewed that this failure to maintain the confidentiality of a patient's record is a serious breach by a medical practitioner and that in the present case, the breach was all the more disconcerting as it involved the publication of photographs of the patient from which she could be and was identified in a local magazine. While the DC noted that the disclosure might be due to an inadvertent error by the practitioner, the DC also noted that the patient was distressed by her discovery of the publication.

The DC also took the view that in respect of the Second Charge, the association by a medical practitioner with persons not qualified to provide medical or medical support services is wholly unacceptable. Notwithstanding the attempts to disassociate the clinic's operations from that of the spa's business, the practitioner should not have put himself into that difficult position in the first place by entering into the service agreement with the clinic.

The practitioner was fined $5,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct; that he will furnish to the Council within 30 days written evidence of the termination of the service agreement with the clinic; and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(H) Excessive / Inappropriate Prescription of Drugs (Benzodiazepines)

Case 10:

A general practitioner contested 21 charges related to the prescription of hypnotic medication (benzodiazepines) to 21 of his patients. The charges were that he failed to exercise due care in the management of his patients in the prescription of hypnotic medication. He did not record or document in the Patient Medical Records, details or sufficient details of his patients' diagnosis, symptoms and/or condition, and/or any management plan to justify the continued prescription of hypnotic medication over the period of treatment. The practitioner also failed to refer the patients to a medical specialist and/or psychiatrist for further assessment and/or management. The DC convicted the practitioner of 20 charges and acquitted him of the remaining charge.

The DC considered the various factors

brought to their attention including, in particular, the following:

(i) the credibility of the practitioner's testimony. The practitioner had changed his case on the use of benzodiazepines for certain patients to being treatment for anxiety, when it was his initial case that the treatment was for chronic insomnia;

(ii) the practitioner's disagreement with the report on concurrent prescription by his expert witness;

(iii) the practitioner had an antecedent conviction as he was previously convicted of 7 charges of over-prescription of hypnotic drugs and 1 charge of failing to keep proper records. For those past offences, the DC ordered that the practitioner's name be struck off the Register of Medical Practitioners ("the Register") in 1993. The practitioner was restored to the Register some 2 years later in 1995. The DC also noted that during the practitioner's application for restoration, he had assured the Council of better management and treatment of his patients. However, in spite of that assurance, the practitioner's misconduct in the present charges had the same elements as those of the charges against him in his previous antecedent. The DC noted that the present offences involved long periods of usage of benzodiazepines and hypnotics by the patients involved, with little attempt on the practitioner's part to taper off the dosage and eradicate the dependence of these patients on such medication. Accordingly, the DC was not convinced that the practitioner was remorseful for his acts; and

(iv) the DC was also of the view that a more serious punishment was warranted because of the public interest element, i.e. the necessity to keep away from the public, harm which may be caused by inappropriate prescription of hypnotic medication. Further to that, the DC was also of the view that there was a need to send a clear signal to all medical practitioners that blatant disregard of the standards of the profession or of the guidelines prescribed to the profession will not be taken lightly. Also, given the facts of the present case as well as the overwhelming evidence in support of the charges against the practitioner, the DC was of the view that it was entitled to take into consideration the fact that there was no plea of guilt by the practitioner in determining the sentence against him.

The practitioner's name was removed from the Register of Medical Practitioners and he was ordered to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Case 11:

A general practitioner pleaded guilty to 7 charges of failing to exercise due care in the management of his patients in the use of hypnotics / benzodiazepines, specifically: (i) his management of his patients was inappropriate in that he did not formulate any long-term management plan for the treatment of his patients' medical conditions; (ii) he did not record or document in his patients' Patient Medical Records, sufficient details of his patients' diagnoses, symptoms and conditions; (iii) he failed to carry out adequate assessments of his patients' medical conditions over the periods of treatment; (iv) he failed to refer his patients to specialist treatment for his patients' conditions in a timely manner; and (v) where benzodiazepines were prescribed, he had breached the MOH's Guidelines for Prescribing Benzodiazepines dated 17 August 2002.

The practitioner was suspended from medical practice for 3 months; fined $2,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Case 12:

The Complaints Committee referred a general practitioner to the Disciplinary Committee (DC) and the Interim Orders Committee (IOC). The IOC held its inquiry against the practitioner and ordered under Section 52(1)(a) of the MRA that the practitioner be suspended for a period of 1 year with immediate effect, or until the conclusion of the DC inquiry, whichever was earlier.

The practitioner faced 18 charges of professional misconduct under Section 45(1)(d) of the MRA in that he failed to exercise due care in the management of his patients. All 18 charges related to inappropriate prescription of benzodiazepines as hypnotic medication and cough mixtures containing codeine. The practitioner pleaded guilty to all 18 charges.

The DC noted that benzodiazepines are prescribed as hypnotic medication for patients who have insomnia or as anxiolytics for the short-term relief of anxiety and that long-term consumption of benzodiazepines and hypnotics may lead to drug dependence and tolerance. The DC also noted that cough mixtures containing codeine carry the potential for abuse by drug addicts and require careful practices in respect of prescription.
By the practitioner's improper prescription of benzodiazepines and cough mixtures, the DC considered

that the practitioner had acted in disregard of his professional duties and in a manner which was inappropriate, unprofessional and not in accordance with the SMC Ethical Code and Ethical Guidelines.

The DC took cognizance of the fact that the practitioner underwent similar proceedings in 2008 and that he was convicted on similar charges in 2008. The DC also noted by way of the practitioner's mitigation, that he had not renewed his clinic licence for practice since February 2009.

Whilst accepting that the previous conviction did not amount to an antecedent, the practitioner's previous conviction was nevertheless a factor taken into consideration by the DC in relation to its decision to impose a heavier sentence on him.

The practitioner was suspended from medical practice for 30 months; fined $10,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings and the Interim Orders Committee Inquiry, including the costs of the respective solicitors to the Council and the Legal Assessors.

Case 13:

A general practitioner pleaded guilty to 7 charges of failing to exercise due care in the management of his patients, inappropriate prescription of benzodiazepine and failure to record or document in the said patients' Patient Medical Records, details or sufficient details of the patients' diagnoses, symptoms and/or conditions, and/or any management plan such as to enable him to properly assess the medical condition of the patients over the period of treatment.

In considering the appropriate sentence, the DC noted that benzodiazepines are prescribed as hypnotic medication for patients who have insomnia or as anxiolytics for the short-term relief of anxiety and as long-term consumption of benzodiazepines may lead to drug dependence and tolerance, it is incumbent on all medical practitioners to be appraised of current medical standards and prescribing practice, in the interests of their practice and patients.

In the light of the above, the DC considered the practitioner to have acted in disregard of his professional duties since the prolonged prescription of benzodiazepines without specialist referral or proper medical records was inappropriate and unprofessional.

In coming to a decision on the sentence, the DC was also mindful of the mitigating factors

presented, including the fact that the benzodiazepines were of low dosages, that the practitioner had pleaded guilty and co-operated fully, that he had a long clean record and that he had ceased practice after December 2008. The DC also took into consideration the relatively low number of 7 charges.

The practitioner was suspended from medical practice for 3 months; fined $1,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(I) Excessive/ Inappropriate Prescription of Drugs (Benzodiazepines and Codeine-containing Medication)

Case 14:

A general practitioner pleaded guilty to 15 charges of failing to exercise due care in the management of his patients. Of the 15 charges, 8 related to the dispensation of hypnotic drugs (benzodiazepines) and cough mixtures containing codeine while the remaining 7 related to the dispensation of cough mixtures containing codeine.

The practitioner failed to exercise due care in the management of his patients in that he had inappropriately prescribed the various medications to his patients; failed to record or document in the Patient Medical Records, details or sufficient details of his patient's diagnosis, symptoms and/or conditions, and/or advice given and/or any management plan such as to enable him to properly assess the medical condition of his patient over the period of treatment; and he had failed to refer his patients to a medical specialist and/or psychiatrist for further management.

The DC was of the view that benzodiazepines and cough mixtures containing codeine were two types of common medication that were abused by patients. The intent of the Ministry of Health in implementing the Guidelines for Prescribing Benzodiazepines (2002) and Guidelines in relation to the Sale and Supply of Cough Mixtures containing Codeine (2000) was therefore to prevent such substance abuse. The DC expressed a need to send a strong reminder to medical practitioners to be more circumspect when prescribing such medication.

In considering the orders to be made, the DC acknowledged that the practitioner was a first time offender who indicated, at the earliest opportunity possible, that he intended to enter a plea of guilt. The DC noted that the practitioner had voluntarily closed down his practice and also took

into account the various testimonies of his character.

The practitioner was suspended from practice for a period of 6 months; fined $5,000, censured, ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

Case 15:

A general practitioner pleaded guilty to 22 charges of failing to exercise due care in the management of his patients. Of the 22 charges, 16 were related to the inappropriate prescription of benzodiazepines and codeine-containing medication, 4 were related to the inappropriate prescription of benzodiazepines and 2 were related to the inappropriate prescription of codeine-containing medication.

In considering the appropriate sentence, the DC considered the mitigating factors presented by the practitioner's counsel. In particular, the DC noted his remorse for his actions which was manifested in the fact that the practitioner had chosen to enter a plea at the earliest opportunity, the fact that he was a first-time offender and the written testimonials of his patients who had spoken well of him.

The DC had also considered the fact that the misconduct by the practitioner was of a serious nature. There was undoubtedly an issue of public interest and doctors must be reminded that the failure to exercise due care in prescribing such hypnotic medicines may lead to problems of addiction and drug abuse. In particular, the DC noted that in some instances, such medications were issued in high quantities within very short periods to his patients.

The practitioner was suspended from medical practice for 6 months; fined $10,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(J) Excessive / Inappropriate Prescription of Drugs (Benzodiazepines and other drugs)

Case 16:

A general practitioner pleaded guilty to 23 charges (ranging from as early as 1988 to 2003) of failing to exercise due care towards his patients in that he inappropriately prescribed medication to patients without consultation and/or medical examination. The medications prescribed included Dormicum, Valium,

Phensedyl, Phenobarbitone, Amoxicillin, Artane, Carbimazole and Atenolol.
In particular, the DC noted that the practitioner had engaged in inappropriate prescribing practice by regularly prescribing benzodiazepines to patients without exercising diligence and care, thereby making the patients physically and/or psychologically dependent on the drugs.

The practitioner was suspended from medical practice for 6 months; fined $3,000; censured; ordered to give a written undertaking to abstain in future from the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(K) Excessive / Inappropriate Prescription of Drugs (Subutex)

Case 17:

A general practitioner pleaded guilty to 11 charges of failing to exercise due care in the management of his patients in that: (i) he did not formulate and/or adhere to any management plan for the treatment of the patients' medical condition by the prescription of Subutex; and/or (ii) he did not record or document in the patients' Patient Medical Records, details or sufficient details of the patients' diagnoses, symptoms and/or condition and/or any management plan such as to enable him to properly assess the medical condition of the patients over the period of treatment.
The practitioner also admitted that he had failed to exercise due care in the management of his patients by not registering the patients and their prescriptions in the Central Addiction Registry of Drugs ("CARDS") after 26 October 2005.

The practitioner was suspended from medical practice for 3 months; fined $2,500; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

(L) Excessive / Inappropriate Prescription of Drugs (Subutex and Benzodiazepines)

Case 18:

A general practitioner pleaded guilty to 14 charges for failing to exercise due care in the management of his patients. Of the 14 charges, 8 charges related to inappropriate prescription of both Subutex and benzodiazepines as hypnotic medication and 6 charges related to inappropriate prescription of Subutex alone.

The practitioner had appeared before two other Disciplinary Committees

prior to the proceedings. These two other Disciplinary Committee (DC) Inquiries were concluded in 2008 and 2009, respectively. The practitioner was currently serving a 30-month suspension sentence resulting from the 2009 proceedings. This suspension will terminate in April 2012.

With regard to the prescription of Subutex and benzodiazepines, the DC, in the course of its deliberations, noted that: (i) the raid on the practitioner's clinic in March 2006 led to the 2008 proceedings relating to the prescription of Subutex and benzodiazepines to patients; (ii) the Subutex and benzodiazepines charges that the practitioner faced in the 2009 proceedings were in relation to another separate and distinct raid which took place in August 2006; (iii) the DC noted that the practitioner had continued to prescribe Subutex and benzodiazepines despite the March 2006 raid.

In general, sentences are ordered to run from the date of the order. However, in determining the appropriate period of the sentence, the DC was of the view that there were sufficient reasons for the sentence to run only after the end of the practitioner's current suspension.

The practitioner was suspended from medical practice for a further 3 months to commence at the end of his current 30-month suspension; fined $5,000; censured; ordered to give a written undertaking that he will not engage in the conduct complained of or any similar conduct and to pay the costs and expenses of and incidental to these proceedings, including the costs of the respective solicitors to the Council and the Legal Assessors.

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