

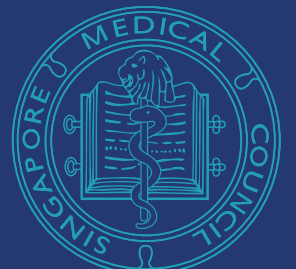


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# Singapore Medical Council Annual Report 2010



# Singapore Medical Council Annual Report 2010

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# President's Foreword

*"When I took over the helm of the Singapore Medical Council (SMC) from Prof Ong Yong Yau on 19 October 2010, SMC was at the tail end of operationalising amendments to the Medical Registration Act (MRA) which were passed in Parliament in January that year."*

The amendments to the MRA were a major achievement of the SMC in 2010. Minister had raised some significant amendments to the MRA, including changes to the constitution of the Council as well as disciplinary processes, which had been proposed after consulting the medical profession. Such changes were timely and necessary as SMC saw itself increasingly in the limelight and public eye as the profession's watchdog and gateway to entering the medical profession as a doctor in Singapore. More about the amendments to the MRA will be touched on later in this foreword.

It is this responsibility of being the medical profession's watchdog and gatekeeper that I hope the council can continue with fervour. This responsibility is increasingly significant as Singapore's population ages and more doctors are needed to see to the healthcare needs of its people.

## Medical Registration

A total of 496 new doctors entered the system in 2010, which brings the ratio of doctor-to-population to 1:562. This means there is 1 doctor for every 500 residents in Singapore. With the new Lee Kong Chian School of Medicine coming up, as well as new graduates from the Duke-NUS Graduate Medical School expected to enter the system in 2011, this is a ratio which we hope will continue to improve.

2010 1:562

*The doctor-to-population ratio in 2010 now stands at 1:562 with the entry of 496 new doctors.*

## Enhancements to the Supervisory Framework

The Supervisory Framework has been in operation for some years now, providing a structured framework for the supervision of foreign-trained doctors and helping them to acclimatise to the local healthcare system. With various changes in the healthcare industry since it was first implemented, the Medical Council felt it was timely to look into enhancing the framework to make it more relevant to the prevailing needs and conditions on the ground.

A committee was formed in the second half of 2009 to review the existing framework. Following its review, enhancements were implemented from September 2010 onwards, such as increasing the number of doctors a supervisor may take under his wing, as well as shortening the timeframe for progression from one level of supervision to the next. A new level of supervision was also introduced, known as L3 (Level 3) supervision for Conditionally Registered doctors who are assessed to be ready for independent work with minimal supervision required. The enhancements also enable Conditionally Registered doctors who have satisfactorily completed housemanship in Singapore to be directly placed on a less intense level of supervision (L2 or Level 2). In addition, Conditionally Registered doctors placed under the most intense level of supervision (L1 or Level 1) need only to undergo Multi-rater assessments in the 6th month of their first year of conditional registration, instead of having to do it in their 6th and 12th months.

These enhancements will be monitored to ensure that the standard and quality of supervision for foreign-trained doctors serve to further improve and to protect patient and public interests. SMC will also continue to fine-tune the supervisory framework in response to the evolving needs of the healthcare system.

## Amendments to the Medical Registration Act and Medical Registration Regulations

Various amendments were made to the Medical Registration Act and Medical Registration Regulations. Those highlighted here are changes which fellow doctors may find useful to know about.

### Disciplinary Processes

Various changes were made with the intention of improving processes related to disciplinary proceedings. These include increasing the number of members sitting on the Complaints Panel, who can look into complaints received. Disciplinary Tribunals will also replace previous Disciplinary Committees, and such tribunals may consist of legally-trained members such as ex-judges or Judicial Commissioners of the Supreme Court or senior legal professionals who can either sit as members of the tribunal, or as its Chairman. Such changes, far from seeking to replace the medical profession's self-regulation, were made with the intention of improving efficiency in the disciplinary processes, and ensuring fair outcomes and decisions which will be upheld in any court of law. Changes were also made to give Complaints Committees more options with regard to the orders they can mete out to doctors, including sending the matter for mediation. We believe that these changes will help to augment the processes and improve public confidence.

### Voluntary Insight

Doctors who have insight of their own professional competency issues, or who acknowledge that they have medical problems that make them unfit to practise medicine, can voluntarily inform SMC and constructively discuss these issues to find appropriate ways of restricting their practice. This provision will serve as a way to strengthen professional self-regulation, and, it is hoped, go towards prevention of any unintentional negligent act which may necessitate disciplinary action, or worse, endanger patients.

### Removal of Names from Registrar

Doctors who are under Conditional Registration may face removal from the Register if they do not

comply with any of the conditions or restrictions of their registration, or if the SMC, after reviewing reports from the doctors' supervisors or any other healthcare or medical professional, is of the opinion that the doctor is not able to satisfactorily perform the duties of a medical practitioner.

It is also important for those who wish to remain on SMC's Register to ensure that they remain contactable by providing updated contact details, as those who do not renew their practising certificates for a continuous period of 2 years, and who are not contactable will be removed from the Register as well. Restoration fees will apply if the doctor wishes to restore his or her name to the Register.

### Compulsory Pledge-Affirmation As A Pre-Requisite to Full Registration

Another amendment to the Act related to medical registration is that all doctors who wish to obtain Full Registration are now required to affirm the Physician's Pledge at a ceremony organised by the SMC. This is a necessary and important step in one's career as a medical doctor, as each individual doctor is called upon to affirm his or her commitment to the significant responsibilities he or she has to shoulder as a doctor. It is our hope that new doctors will take this pledge affirmation seriously and make an effort to ensure their attendance at one of such ceremonies, which are usually held twice yearly.

I trust the profession will take it upon itself to be familiar with the provisions of, and amendments to, the Medical Registration Act, which have been drawn up with the intention of ensuring fair and efficient self-regulation for the medical profession and with the ultimate goal of providing safe, competent and high-quality medical care in Singapore.

*Professor Tan Ser Kiat  
President  
Singapore Medical Council*

# Members of the Singapore Medical Council 2010







# Medical Registration / Specialist Registration

## Medical Registration

As at 31 Dec 2010, a total of 9030<sup>1</sup> medical practitioners were registered in Singapore, resulting in a doctor-to-population ratio of 1:562<sup>1,2</sup>.

In 2010, 2669 applications for registration were considered by the Singapore Medical Council. 1527 medical practitioners were registered, of whom 144 were previously on conditional registration and 37 on temporary registration. The breakdown of types of medical registration granted is shown in Table 1.

Of the 314 doctors on provisional registration, 221 were NUS medical graduates and 93 were graduates from foreign universities who were granted medical registration to undergo housemanship training in public hospitals and institutions for one year.

Among the 396 foreign-trained medical practitioners granted temporary registration, 51 were employed to work under supervision on short-term basis in public hospitals or institutions. 189 were foreign practitioners accepted for postgraduate training in Singapore, and they comprised 163 Clinical Fellows and 26 Clinical Observers. Another 38 were visiting experts who were invited by the hospitals and medical organisations to provide short-term training and consultancy. The remaining 118 medical doctors were part of the medical teams accompanying their national athletic teams for the Youth Olympic Games, and were granted temporary registration to treat and manage their own country's athletes.

As at end of December 2010, 179 medical practitioners were not in active practice due to various reasons such as retirement and overseas employment or studies. These included doctors who did not renew their practising certificates in 2010. 30 medical practitioners were restored to the Medical Register when they resumed clinical practice

in Singapore when they returned from overseas or for various other reasons.

There was a net increase of 496 doctors on the register in 2010, compared to 2009.

## Specialist Registration

There were 3374 doctors registered as specialists on the Register of Specialists when the year came to a close on 31 December 2010. The number of specialists had increased by 194 (6.1%), compared to 2009. They also represented 37.4% of the 9030 medical practitioners registered in Singapore. The breakdown of registered specialists in the various specialities is in Table 5-1. Table 6-1 shows the trends in specialist registration. The numbers from Year 2001 to Year 2010 were the cumulative total as at 31 December of each year.

<sup>1</sup> This number and/or ratio includes all doctors on full, conditional and temporary (service) registration only.

<sup>2</sup> As at 31 Dec 2010, a total of 8819 medical practitioners were fully and conditionally registered in Singapore, resulting in a doctor to population ratio of 1:576

Table 1 New Medical Registration by Registration Type as at 31 December 2010

Registration Type	Full	Conditional	Provisional	Temporary	Total
New Applications for Registration in 2010	-	310	314	396	1020
Doctors from Full Register	-	2	-	-	2
Doctors from Conditional Register	142	-	-	2	144
Doctors from Provisional Register	221	103	-	-	324
Doctors from Temporary Register	-	37	-	-	37
<b>Total</b>	<b>363</b>	<b>452</b>	<b>314</b>	<b>398</b>	<b>1527</b>

Table 2 New Medical Registration by Citizenship and Training# in 2010

Registration Type	Local - Trained		Foreign - Trained		Sub-Total		Total
	Local	Foreigner	Local	Foreigner	Local	Foreigner	
Full (from P to F)	211	10	-	-	211	10	221
Full (from C to F)	-	1	54	87	54	88	142
Conditional (New)	-	-	24	286	24	286	310
Conditional (from P to C)	2	-	38	63	40	63	103
Conditional (from T to C)	-	-	1	36	1	36	37
Conditional (from F to C)	1	1	-	-	1	1	2
Provisional (New)	208	13	44	49	252	62	314
Temporary (New)	-	-	-	396	0	396	396
Temporary (from C to T)	-	-	-	2	0	2	2
<b>Total</b>	<b>422</b>	<b>25</b>	<b>161</b>	<b>919</b>	<b>583</b>	<b>944</b>	<b>1527</b>

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

Registration Types	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<b>Full Registration</b>	215	156	182	201	203	220	232	222	233	221 <sup>a</sup>
NUS Degree	153	146	175	193	195	206	230	222	233	221
Foreign Degree	62	10	7	8	8	14	2	-	-	-
<b>Conditional Registration</b>	<b>146</b>	<b>121</b>	<b>128</b>	<b>114</b>	<b>112</b>	<b>158</b>	<b>275</b>	<b>357</b>	<b>320</b>	<b>413<sup>a,b</sup></b>
NUS Degree	1	-	1	-	1	-	1	3	0	2
Foreign Degree	145	121	127	114	111	158	274	354	320	411
<b>Provisional Registration</b>	<b>173</b>	<b>187</b>	<b>213</b>	<b>239</b>	<b>265</b>	<b>280</b>	<b>303</b>	<b>300</b>	<b>339</b>	<b>314<sup>c</sup></b>
NUS Degree	144	175	195	197	210	229	226	232	226	221
Foreign Degree	29	12	18	42	55	51	77	68	113	93
<b>Temporary Registration</b>	<b>193</b>	<b>334</b>	<b>256</b>	<b>345</b>	<b>342</b>	<b>355</b>	<b>352</b>	<b>215</b>	<b>294</b>	<b>396<sup>d</sup></b>
Foreign Degree	193	334	256	345	342	355	352	215	294	396
<b>Grand Total</b>	<b>727</b>	<b>798</b>	<b>779</b>	<b>899</b>	<b>922</b>	<b>1013</b>	<b>1162</b>	<b>1094</b>	<b>1186</b>	<b>1344</b>

<sup>a</sup> From 2001 to 2009, numbers reflected in table include doctors who were new conditional registrants and converted provisional registrants. From 2010, the numbers converted from temporary registrants have been added to the total.

Table 4 New Conditional Registrants by Place of Training# in 2010

	Local - Trained		Foreign - Trained		Sub-Total		Total
	Local	Foreigner	Local	Foreigner	Local	Foreigner	
Non Specialist	-	-	19	244	19	244	263
Specialist	-	-	5	42	5	42	47
<b>Total</b>	<b>-</b>	<b>-</b>	<b>24</b>	<b>286</b>	<b>24</b>	<b>286</b>	<b>310</b>

### Note:

F = Full Registration

P = Provisional Registration

C = Conditional Registration

T = Temporary Registration

# Training categorised by country where basic qualification is obtained.

### Explanatory Note:

a = Only P to F

b = Only New C, P to C and T to C

c = Only New P

d = Only New T

Employment Sector	Public	Private	Total (as at 31 Dec)
2001	1075	855	1930
2002	1184	904	2088
2003	1275	949	2224
2004	1353	1014	2367
2005	1435	1076	2511
2006	1557	1097	2654
2007	1617	1164	2781
2008	1772	1190	2962
2009	1927	1253	3180
2010	2060	1314	3374

	Public	Private	Total (as at 31 Dec)
2009 & 2010	6.9	4.9	6.1
2001 & 2010	91.6	53.7	74.8

No.	Specialties	Public Sector	Private Sector	Total	Ratio in % - Public	Ratio in % - Private
1	Anaesthesiology	184	131	315	58	42
	Cardiology	83	58(1)	141	59	41
3	Cardiothoracic Surgery	24	12	36	67	33
	Dermatology	42	38	80	53	47
5	Diagnostic Radiology	145	66	211	69	31
	Emergency Medicine	86	7	93	92	8
7	Endocrinology	49	21(1)	70	70	30
	Gastroenterology	54(1)	33	87	62	38
9	General Surgery	133	99	232	57	43
	Geriatric Medicine	47	7	54	87	13
11	Haematology	31	9	40	78	22
	Hand Surgery	17	5	22	77	23
13	Infectious Diseases	32(1)	7	39	82	18
	Internal Medicine	49	31	80	61	39
15	Medical Oncology	45	29(1)	74	61	39
	Neurology	47	16	63	75	25
17	Neurosurgery	19	13	32	59	41
	Nuclear Medicine	11	6	17	65	35
19	Obstetrics & Gynaecology	92	192	284	32	68
	Occupational Medicine	17	18	35	49	51
21	Ophthalmology	103	68	171	60	40
	Orthopaedic Surgery	98	58	156	63	37
23	Otorhinolaryngology / ENT Surgery	39	42	81	48	52
	Paediatric Medicine	131	130	261	50	50
25	Paediatric Surgery	11	5	16	69	31
	Pathology	100	20	120	83	17
27	Plastic Surgery	20	23	43	47	53
	Psychiatry	99	48	147	67	33
29	Public Health	61	35	96	64	36
	Radiation Oncology	29	5	34	85	15
31	Rehabilitation Medicine	20	5	25	80	20
	Renal Medicine	32	16	48	67	33
33	Respiratory Medicine	53	23	76	70	30
	Rheumatology	25(3)	8(1)	33	76	24
35	Urology	32	30	62	52	48
	<b>Total</b>	<b>2060</b>	<b>1314</b>	<b>3374</b>	<b>61</b>	<b>39</b>

( ) denotes number of doctors with dual specialties

Year	Specialist	Non-Specialist	Total (as at December of the Year)
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
2010	3374	5656	9030

# Only Full & Conditional registrants are included for 2001 to 2009. From 2010, full, conditional and temporary (service) are included.

**Table 6-I** Total Number of Specialists By Specialties By Year (as at December)

No.	Specialty/Year											Comparison (Net Increase %)	
		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2010	2010 & 2009
1	Emergency Medicine	24	30	34	41	52	56	58	68	81	93	14.8	287.5
2	Hand Surgery	7	8	9	10	12	15	17	19	20	22	10.0	214.3
3	Infectious Disease	13	14	16	18	25	27	28	33	34	39	14.7	200.0
4	Nuclear Medicine	6	9	10	10	14	15	15	13	14	17	21.4	183.3
5	Medical Oncology	27	31	37	43	47	52	54	62	67	74	10.4	174.1
6	Geriatric Medicine	22	23	32	35	38	43	43	47	48	54	12.5	145.5
7	Rheumatology	14	19	19	22	25	25	28	28	30	33	10.0	135.7
8	Rehabilitation Medicine	11	12	13	15	16	20	22	24	25	25	0.0	127.3
9	Diagnostic Radiology	97	111	118	128	135	142	152	169	192	211	9.9	117.5
10	Endocrinology	34	37	41	46	47	52	56	60	65	70	7.7	105.9
11	Radiation Oncology	17	17	18	20	21	25	29	30	30	34	13.3	100.0
12	Renal Medicine	24	29	33	34	34	37	40	42	43	48	11.6	100.0
13	Cardiology	72	77	83	89	98	108	111	120	130	141	8.5	95.8
14	Ophthalmology	90	96	108	117	125	130	137	152	164	171	4.3	90.0
15	Gastroenterology	46	52	54	58	58	61	66	74	85	87	2.4	89.1
16	Urology	33	37	38	43	48	51	53	57	59	62	5.1	87.9
17	Anaesthesiology	173	196	203	211	224	250	262	277	300	315	5.0	82.1
18	General Surgery	128	133	150	156	165	179	192	203	215	232	7.9	81.3
19	Internal Medicine	46	52	55	58	60	58	66	72	76	80	5.3	73.9
20	Pathology	69	74	84	88	93	98	98	106	111	120	8.1	73.9
21	Neurology	37	45	47	47	50	53	58	59	63	63	0.0	70.3
22	Dermatology	47	48	48	55	60	63	66	70	74	80	8.1	70.2
23	Orthopaedic Surgery	92	98	103	111	119	127	134	140	148	156	5.4	69.6
24	Haematology	24	25	30	30	30	31	31	33	38	40	5.3	66.7
25	Plastic Surgery	26	30	30	31	32	32	34	39	41	43	4.9	65.4
26	Respiratory Medicine	46	49	53	58	63	66	67	70	73	76	4.1	65.2
27	Psychiatry	92	95	97	105	108	111	114	122	137	147	7.3	59.8
28	Cardiothoracic Surgery	23	25	26	26	27	30	30	29	34	36	5.9	56.5
29	Paediatric Medicine	169	181	184	193	207	212	224	232	249	261	4.8	54.4
30	Paediatric Surgery	11	12	13	13	13	12	13	15	16	16	0.0	45.5
31	Public Health Medicine	67	67	67	71	74	76	81	89	94	96	2.1	43.3
32	Otorhinolaryngology / ENT Surgery	58	63	65	66	68	70	73	75	80	81	1.3	39.7
33	Neurosurgery	23	23	23	25	26	28	28	27	29	32	10.3	39.1
34	Obstetrics & Gynaecology	233	241	253	262	265	267	268	274	281	284	1.1	21.9
35	Occupational Medicine	29	29	30	32	32	32	33	32	34	35	2.9	20.7

**Total No. of Registered Specialists as at 31 December each year:** 1930 2088 2224 2367 2511 2654 2781 2962 3180 3374 6.1 74.8

# Continuing Medical Education

## 2009 / 2010 – 2010 Qualifying Periods

It has been 7 years since compulsory CME was introduced in 2003, and since then, the majority of doctors have fulfilled their CME requirements in the last 6 CME cycles. In 2010, out of a total of 6148 doctors, 6084 or 99% met the CME requirement for the CME Qualifying Periods (QPs) which ended on 31 December 2010 i.e. for practising certificates (PC) expiring anytime in 2011. (See Table 1.)

CME Qualifying Period (QP)	Number of doctors who met CME Requirements	Number of doctors who did not meet CME Requirements
2-Year QP (2009-2010)	6039	61
1-Year QP (2010)	45	3
<b>Total</b>	<b>6084</b>	<b>64</b>

Out of the 64 doctors who did not meet the CME requirements, 17 have informed the Council that they intend to make up their CME shortfall after their PCs expire and they will apply for a new PC thereafter, while 20 of these doctors do not intend to make up the shortfall (see Table 2). The remaining 27 have not responded to Council as at time of Report.

CME Qualifying Period (QP)	Types of Doctors			Total
	Intend to renew	Do not intend to renew	No response	
2-Year QP (2009-2010)	16	19	26	61
1-Year QP (2010)	1	1	1	3
<b>Total</b>	<b>17</b>	<b>20</b>	<b>27</b>	<b>64</b>

## Number of Processed Applications and Credit Claims for 2010

In 2010, SMC processed a total of 32679 accreditation applications and credit claims from Categories 1A, 1B, 1C, 2, 3A and 3B, out of which 31986 were approved (see Table 3).

Category	Approved	Rejected	Total
1A	976	56	1032
1B	2071	168	2239
1C	2119	179	2298
2	940	36	976
3A	11855	159	12014
3B	14025	95	14120
<b>Total</b>	<b>31986 approved</b>	<b>693 rejected</b>	<b>32679</b>

- 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 152 complaints against 184 doctors in 2010 compared to 96 complaints in year 2009 and 138 complaints in 2008 (see Table 1). There was a 58% increase in the number of complaints compared to 2009.

Of the 216\* complaints considered during the year, 14 cases were referred for disciplinary inquiries.

11 cases were issued letters of warning and 51 were issued letters of advice. 52 complaints were dismissed and 88 complaints were adjourned to 2011.

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

**Table 1** Complaints Received by the Singapore Medical Council 1997-2010

Year	Total No. of Doctors on Register	Total No. of Complaints Received	Complaints / 1000 Doctors
1997	4912	57	11.6
1998	5148	55	10.7
1999	5325	45	8.5
2000	5577	60	10.7
2001	5922	84	14.2
2002	6029	69	11.4
2003	6292	66	10.5
2004	6492	84	12.9
2005	6748	83	12.3
2006	6931	81	11.7
2007	7384	115	15.6
2008**	8510	138	16.2
2009**	9033	96	10.6
2010**	9506	152	16.0

Note:  
 \* 64 complaints were carried forward from 2009 and 152 complaints were received in 2010  
 2007 and before: Figures based on F and C-reg doctors  
 \*\* 2008 to 2010: Figures based on F, C, P & I-reg doctors

**Table 2** Complaints Considered by Complaints Committees in 2010

Nature of Complaint / Allegation	Complaints carried over from 2009	Complaints received in 2010	Outcome						Adjourned to 2011
			Withdrawn	No further action	Letter of Advice	Letter of Warning	Referred to Disciplinary Committee (DC)	Referred to a Health Committee (HC)	
<b>Breach of SMC Code of Ethics:</b>	<b>53</b>	<b>131</b>	<b>-</b>	<b>43</b>	<b>40</b>	<b>11</b>	<b>11</b>	<b>-</b>	<b>79</b>
a) Delay in treatment	3	2	-	2	2	-	-	-	1
b) Excessive / Inappropriate prescription of drugs	6	12	-	5	1	1	5	-	6
c) False / Misleading Certification	-	2	-	2	-	-	-	-	-
d) Misdiagnosis	2	7	-	4	1	-	-	-	4
e) No informed consent	-	1	-	-	-	-	-	-	1
f) Outrage of Modesty / Sexual relationship with patient	4	3	-	3	1	1	1	-	1
g) Over / Unnecessary / Inappropriate Treatment	8	13	-	7	9	-	-	-	5
h) Overcharging	1	2	-	1	-	-	-	-	2
i) Professional Negligence/ Incompetence	13	44	-	8	12	4	3	-	30
j) Providing false information	-	2	-	1	-	-	-	-	1
k) Refusal to provide emergency attention	-	-	-	-	-	-	-	-	-
l) Rudeness / Attitude/ Communication Issues	4	23	-	3	6	-	-	-	18
m) Other breaches	12	20	-	7	8	5	2	-	10
<b>Conviction in Court</b>	<b>-</b>	<b>2</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>-</b>	<b>1</b>
<b>Other complaints</b>	<b>11</b>	<b>19</b>	<b>-</b>	<b>9</b>	<b>11</b>	<b>-</b>	<b>2</b>	<b>-</b>	<b>8</b>
<b>Total</b>	<b>64</b>	<b>152</b>	<b>-</b>	<b>52</b>	<b>51</b>	<b>11</b>	<b>14</b>	<b>-</b>	<b>88</b>
<b>Percentage</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>24.1%</b>	<b>23.6%</b>	<b>5.1%</b>	<b>6.5%</b>	<b>-</b>	<b>40.7%</b>

# Disciplinary Inquiries



16 disciplinary inquiries were heard by the Disciplinary Committees (DCs) in 2010 and 1 appeal was heard in the High Court (see Table 1). A high court judgment on a practitioner's appeal against a DC's decision, which was heard in 2009, was delivered in 2010. A summary of the Court's decision on the appeal is provided in this section.

Table 1		Inquiries concluded by the Disciplinary Committee in 2010					
Nature of Complaint	Inquiries heard in 2010	Acquittal	Censure	Outcome			
				Censure & Fine	Censure & Suspension	Censure, Suspension & Fine	Erasure
<b>Breach of SMC's Code of Ethics</b>							
A) Professional Misconduct In Patient Management	3	-	-	1	2	-	-
B) Non-Medically Proven Remedies	3	-	-	3	-	-	-
C) Excessive/ Inappropriate Prescription of Drugs:							
i) Benzodiazepines, Codeine-containing Medication and Subutex	1	-	-	-	-	1	-
ii) Benzodiazepines and Codeine-containing Medication	3	-	-	-	-	3	-
iii) Subutex and Benzodiazepines	3	-	-	1	-	2	-
iv) Subutex	2	-	-	2	-	-	-
v) Hypnotics	1	-	-	1	-	-	-
<b>Total</b>	16	-	-	8	2	6	-
<b>Percentage (%)</b>	-	-	-	<b>50%</b>	<b>12.5%</b>	<b>37.5%</b>	-

## High Court Judgment on a Practitioner's appeal against a Disciplinary Committee's decision

The following summary refers to Case 5 published in SMC's 2009 Annual Report, in which a neurologist faced two charges in relation to the treatment of one of his patients with repetitive transcranial magnetic stimulation (rTMS) and Therapeutic Ultrasound. In 2009, the practitioner was acquitted by the DC of the first charge relating to rTMS and convicted on the second charge related to Therapeutic Ultrasound. The practitioner appealed to the High Court against the Disciplinary Committee's (DC) decision. The High Court's ruling on the appeal, announced in 2010, was as follows:

The Court ruled that the DC's decision in convicting the practitioner was lawfully wrong. The Second Charge was not proved beyond reasonable doubt, and the Court made no finding as to whether Therapeutic Ultrasound was efficacious or safe or scientifically established. Its role as an appellate court was to ensure that the DC's finding was not "unsafe, unreasonable or contrary to the evidence". Unfortunately, given the way in which the charge was framed, the manner in which the proceedings were conducted (including the fact that neither the Patient nor the Complainants testified during the DC hearing and showed no further interest in pursuing the matter against the practitioner beyond the lodgement of the Complaint) and the diffused reasoning of the DC, the Court found that the practitioner's conviction on the Second Charge was unsafe, unreasonable and contrary to the evidence and therefore set it aside.

With regard to the costs for the proceedings before the DC and the Court, the Court decided that in all the circumstances, it would not order the SMC to pay the costs of the proceedings as it was prepared to give the DC the benefit of the doubt that it had acted in good faith and in the public interest in trying to stop what it believed to be an inappropriate treatment for a particular medical condition. The parties were ordered to bear their own costs, and the usual consequential orders were to apply.

A brief account of each inquiry concluded in 2010 is given below.

## (A) PROFESSIONAL MISCONDUCT IN PATIENT MANAGEMENT

### CASE 1 | DR GAN KENG SENG ERIC

The general surgeon faced two charges of professional misconduct in relation to the management of one of his patients ("the Patient"). At the conclusion of the disciplinary inquiry, the DC acquitted the practitioner on the first charge and convicted him on the second charge.

The first charge involved the issue of whether the practitioner was competent to perform pre-cut sphincterotomy ("the Procedure"), a surgical procedure, on the Patient for the purpose of removing a stone in the common bile duct. The second charge involved the issue of whether the practitioner was in wilful neglect of his duties and had grossly mismanaged the post-operative treatment of the Patient. The practitioner contested both charges at the SMC's disciplinary inquiry.

In relation to the first charge, the DC noted that whilst the practitioner had been accredited to perform endoscopic retrograde cholangiopancreatograms ("ERCP"), no clear guidelines existed as to what constituted "competency" in performing the Procedure. The practitioner had been trained, and his technique had been supervised, by senior accomplished endoscopists familiar with the Procedure, and they had testified that he was competent to perform the Procedure. Prior to performing the Procedure on the Patient, the practitioner had performed 17 such procedures at the hospital. On this basis, the DC was unable to conclude beyond a reasonable doubt, that the practitioner was not competent to perform the Procedure on the Patient.

However, the DC emphasised that in the review of the first charge, they had some concerns about the high number of procedures (27%) out of the total number of ERCPs the practitioner performed in order to gain access to the common bile duct. Given

the risks associated with the Procedure, and that other more experienced endoscopists reported a much lower incidence of using the Procedure, the DC advised the practitioner to review his practice, and the frequency of use of the Procedure in order to gain access to the common bile duct.

The second charge alleged that the practitioner failed to carry out the appropriate clinical investigation by way of a CT scan on the Patient's abdomen and pelvis within reasonable time in order to ascertain whether there was perforation of the duodenum, which was a known risk of the Procedure. This is despite the Patient's medical history of the failed Procedure, and his clinical conditions of persistent and severe epigastric pain, bilious vomiting and abdominal distension and tenderness, which started in the first few hours after the Procedure.

The evidence showed that the practitioner first saw the Patient post-surgery nearly 16 hours after the onset of symptoms, even though he was informed that the Patient was unwell 2 hours after the Procedure. The DC noted that during this period, the most senior doctor who attended to the Patient was the Registrar on-call.

The DC was of the view that the practitioner should have personally attended to the Patient and evaluated his condition when notified that the Patient was unwell following the Procedure the practitioner performed, especially as results of initial tests were available. Being the consultant-in-charge, and by virtue of his accreditation by the hospital to perform the Procedure, he would have been in the best position to holistically evaluate all available information and adapt management decisions according to the clinical picture, especially as the Patient's condition evolved. The DC emphasised that relying solely on the assessment of junior doctors, including one still in specialty training, was not in the best interests of the Patient, and found that the practitioner's conduct fell short of his professional duty to the Patient.

In the DC's opinion, a reasonably responsible doctor who had performed a procedure which was unsuccessful, and associated with known risks

of significant complications, had the responsibility to see the Patient in a timely fashion when the Patient had symptoms, signs and tests consistent with such a complication.

Further, the DC was of the opinion that had the practitioner, as a responsible, competent consultant surgeon, seen the Patient earlier (the same night after the surgery), he would have considered ordering a CT scan earlier when the Patient's condition did not improve the following day. The CT scan was the appropriate definitive diagnostic test to be carried out as it would have revealed perforation of the duodenum. However, the practitioner did not see the Patient until 16 hours after the surgery. Although the Patient exhibited symptoms consistent with perforation (which the practitioner did not rule out), he remained with his diagnosis of pancreatitis. He did not order a CT scan until 25 hours after the Procedure. The DC was of the view that a more timely CT scan would have been crucial in the management of the Patient.

Having considered the totality of the matters, the DC was of the opinion that the practitioner's failure to personally assess the Patient on the night of the surgery when he was aware that the Patient was unwell after the unsuccessful Procedure, and manage the situation appropriately between the onset of symptoms and signs post-ERCP and the diagnosis of perforation, amounted to wilful neglect of the practitioner's professional duties. As a result, the DC found, beyond reasonable doubt, that the practitioner had grossly mismanaged the post-operative treatment of the Patient.

The practitioner was suspended from medical practice for 6 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 70% of the costs and expenses arising from the disciplinary inquiry incurred by the Council, including the costs of solicitors and the Legal Assessor.

The practitioner appealed to the Court of Three Judges in respect of the conviction on the second charge and against the sentence ordered against him. The appeal was heard on 29 April 2010 and

the Court of Three Judges delivered its decision on 1 November 2010.

## Decision of the Court of Appeal

On appeal, the practitioner's counsel raised several grounds, including:

- a) That the DC went beyond the scope of the second charge;
- b) The DC's findings that had the practitioner personally seen the Patient on the evening of 6 December 2005, he would have considered ordering a CT scan earlier is flawed and not supported by evidence; and
- c) The DC's criticism of the fact that the practitioner did not personally attend to the patient on the night of 6 December 2005 is misplaced.

The Court disagreed with the various grounds raised by the practitioner in his appeal. In particular, the Court held that even though the practitioner's failure to attend to the Patient on the night of 6 December 2005 was not specifically set out in the Charge nor in the particulars furnished, the practitioner's entire conduct in relation to the care of the Patient was necessarily put in issue when he was charged with wilful neglect of his duties and gross mismanagement in the post-operative treatment of the Patient. The Court found that the Charge, as amplified by the particulars, clearly required the DC to consider the entire conduct of the practitioner from the time the failed Procedures ceased until he performed the operation in the wee hours of 8 December 2005 to mend the duodenal perforation discovered through the CT scan which was eventually ordered. The practitioner's failure to attend to the patient on the evening of 6 December 2005 was certainly a circumstance which the DC was entitled to take into account in its overall assessment as to whether there was gross neglect or mismanagement on the practitioner's part.

In trying to justify his failure to attend to the patient during the evening of 6 December 2005, the practitioner sought to rely on the fact that he

was in communication with an on-call Registrar. In its decision, the DC did not think that this was an appropriate case for the practitioner to arrive at a clinical assessment based merely on the input of the on-call Registrar. The Court agreed entirely with the DC's finding on this point. The Court recognised that under Guideline 4.1.1.4 of the SMC's Ethical Code and Ethical Guidelines ("SMC's ECEG"), the doctor in charge could delegate to another doctor or nurse, the task of providing treatment or care to a patient. However, in this case, the issue was the clinical assessment of the condition of a patient. In order to make the right assessment, much would necessarily depend on the skill and experience of the doctor. Indeed, the Court highlighted Guideline 4.1.1.5 of SMC's ECEG, where it is stated that a doctor should make necessary and timely visits. He should also make timely investigations.

The Court further held that in view of this grave consequence if a duodenal perforation is not attended to with due dispatch, a consequence which the practitioner said he well knew, the Court affirmed the DC's decision to have found the practitioner guilty of gross neglect or mismanagement in failing to see the Patient in a more timely fashion, which would have led to a more timely CT scan and the discovery of the duodenal perforation in the Patient.

On the appeal against sentence, the Court found that the suspension of 6 months was not out of line with the previous cases and it was not manifestly excessive. As such, the sentence ordered by the DC was to stand. The Court dismissed the practitioner's appeal on both conviction and sentence, with costs.

#### **CASE 2 | DR ANG WEI LENG BERTRAND**

The DC convicted the radiologist on one charge of professional misconduct for departing from standards observed or approved by members of the medical profession in that he had failed to diagnose serious orbital and/or facial fracture(s) of a patient.

In arriving at its decision, the DC considered the expert evidence provided. The DC also had the opportunity to examine the radiology image in question. Upon considering the evidence, the DC was of the view that:

- a) Even taking into account the possibility of hindsight bias, the DC would have concluded that the right superior orbital fracture was indeed an obvious fracture.
- b) Taking into account the practitioner's own evidence that he had viewed the radiograph digitally (whereby using the digital image he could manipulate the digital image for a clearer and sharper view), the practitioner should have clearly noted the fracture.
- c) Even if the practitioner was misled by wrong clinical notes, the acceptable standard of a radiologist would be for a reasonable radiologist to look at a radiograph systematically rather than just relying on the notes given to him.
- d) If what a radiologist has observed does not gel with the clinical notes, a reasonable radiologist should then call the requesting doctor for further clarification.

The DC concluded that the practitioner had departed from the accepted medical practice. In deciding whether the practitioner's departure from the accepted medical practice amounted to professional misconduct, the DC was of the view that if the negligence was of the type that suggests that the departure was caused by indifference on the part of the doctor (or in other words, a lack of concern for accepted standards), this would be sufficient to make out a charge for professional misconduct.

Having concluded that the practitioner did not do a systematic review and heavily relied on the clinical notes, the DC was of the view that the practitioner had committed a fundamental error in his duty as a radiologist. The failure to carry out a systematic review by the practitioner also portrayed indifference as he could have done a systematic review, he could have (if he had any doubts) asked for the assistance of someone senior or sought clarification from the A & E doctor; he could have asked for additional views or for a CT scan, but he chose to do none of those. The DC was of the view that the practitioner's mistake was one committed out of indifference and of such a fundamental nature and thus fell grossly short of the standard observed or approved by members of this profession. Accordingly, the DC found that the practitioner was guilty of the charge preferred against him.

In making its decision with regard to sentencing, the DC considered several mitigating factors including:

- a) The error was made in the earlier part of the practitioner's career for which he has expressed remorse;
- b) The practitioner had no previous record in his otherwise blemish-free career of 12 years; and
- c) The error was committed 5 years ago and he has since proven himself to be a competent radiologist and has received professional accolades from his colleagues and peers.

The practitioner was fined \$3,000; censured; and ordered to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.

#### **CASE 3 | A/PROF EU KONG WENG**

The colorectal surgeon faced three charges of professional misconduct in relation to the management of one of his patients ("the Patient"):

- (a) whether the practitioner had performed staple haemorrhoidectomy ("the Surgery"), a surgical procedure, on the Patient to treat his haemorrhoids without informing him of any alternative treatment options or sufficiently explaining to him the possible risks and complications involved, and thereby failed to obtain the Patient's informed consent for the Surgery that was carried out on him;
- (b) whether the practitioner was in wilful neglect of his duties and had grossly mismanaged the post-operative care of the Patient; and
- (c) whether the practitioner had made or caused to be made laudatory and/or misleading statements concerning a procedure for the treatment of haemorrhoids and his experience in two articles which were published in the Straits Times on 26 April 2006.

The practitioner contested all three charges.

At the conclusion of the disciplinary inquiry, the Disciplinary Committee (DC) convicted the practitioner on the first charge and acquitted him on the second and third charges. In respect of the first charge, on a totality of the evidence, the DC found that the omission by the practitioner to obtain informed consent from the Patient was of sufficient severity to constitute serious professional misconduct.

In relation to the second charge, the DC was not satisfied that the practitioner had carried out good practice in the post-operative care of the Patient in the few weeks after the Surgery. The DC found that the practitioner's post-operative conduct was unsatisfactory. As a senior specialist, he ought to have kept his mind open and be prepared to depart from his initial diagnosis and conduct further investigations if circumstances warranted that. However, notwithstanding the DC's concerns with the practitioner's conduct and management, they



felt that there were reasonable doubts in respect of the evidence and they were unable to find that the charge of gross misconduct had been proved beyond a reasonable doubt.

The third charge concerned the articles "A pain-free way to treat piles" and "A pain in the rear" that were published in an edition of "Mind Your Body", a supplement of The Straits Times newspaper on 26 April 2006. These articles were based on an interview conducted by the Straits Times with the practitioner. The DC accepted that these articles contained laudatory and misleading statements. However, as the practitioner had not seen a draft of these articles before they were published and had no inkling of the contents of the articles, the DC found that there was no nexus between the practitioner and the offending contents of the newspaper articles. Thus, the DC also found that the third charge was not proven. Notwithstanding this, the DC noted their disappointment that the practitioner, though having notice of errors of the articles, failed to take steps to correct it.

In relation to the sentence to be meted out to the practitioner on the first charge, the DC expressed their concern at the serious nature of the practitioner's misconduct. The DC also noted that the practitioner, as the head of a department, leads the way in setting the standard, for his department and the hospital. The DC took the view that the circumstances of this case warrant a strong signal to members of the profession that their patients' consent must be obtained properly, both in spirit as well as procedurally.

The DC exhorted doctors to view their duty to obtain such consent as a serious duty, as it concerns the education and involvement of the patient in the treatment process. The process of taking informed consent is a fundamental pillar of the doctor-patient relationship, where the patient trusts and turns to the physician for his treatment. The DC felt that this case was a timely reminder to the medical profession that obtaining informed consent is not a process to be taken lightly. It ultimately concerns the protection of the lay public at large.

The DC was of the view that a deterrent sentence is necessary so that standards of the medical profession are upheld. A punishment involving only a fine will not achieve justice in the process. As such, the DC ordered that the practitioner be suspended from practice for a period of 3 months and that he be censured and that he give a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct. He was also ordered to pay part of the costs and expenses arising from the disciplinary inquiry incurred by the Medical Council, including the costs of solicitors and the Legal Assessor to the Medical Council.

### **Appeal before the Court of 3 Judges**

The practitioner filed an appeal to the High Court in respect of the conviction and sentence imposed on the first charge. The appeal was heard on 17 March 2011 and was dismissed by the High Court.

The High Court upheld the DC's decision that the practitioner had failed to obtain informed consent from the Patient. The High Court noted that the practitioner's case-notes did not record any discussion of treatment options or the risk and complications involved in the Surgery, and that other contemporaneous documents did not support the practitioner's claim that there was a discussion being conducted based on pamphlets. The High Court also noted that the DC had taken into account the inconsistencies in the practitioner's evidence with respect to the taking of informed consent in the SGH Day Surgery Centre, which he claimed to be a standard operating procedure in SGH. The High Court was unable to agree that the DC's findings of fact were wrong as the relevant documents supported the DC's findings of fact.

The High Court also upheld the DC's order to impose a suspension of 3 months on the practitioner. The High Court noted that the DC had considered a failure to obtain informed consent for an invasive surgery to be a serious form of professional misconduct and had wanted to send a signal to medical practitioners that the interest and welfare of the patient should be their overriding concern.

Having regard to the importance of obtaining informed consent from a patient before performing invasive surgery on him, and the mission of the SMC to raise the standard of medical treatment of patients in Singapore, the High Court agreed that a suspension was called for. Given that a 3-month period is the minimum period of suspension that is mandated under the Medical Registration Act, the High Court upheld the sentence imposed by the DC. The High Court also affirmed the DC's order on costs.



## (B) NON-MEDICALLY PROVEN REMEDIES

### CASE 4 | DR WONG YOKE MENG

The obstetrician and gynaecologist faced one charge of professional misconduct for offering, by way of an advertisement titled “Anti-Aging & Aesthetic Medicine” found on a poster panel displayed in the clinic where he practised (the “Advertisement”), stem cell for skin therapy and/or facial and body rejuvenation, a treatment that was not medically proven. This was in breach of the SMC’s Ethical Code and Ethical Guidelines (ECEG). The practitioner contested the charge against him.

The DC noted that current research on stem cells for treatment of skin conditions was mainly directed at the treatment of burns, scars and for wound healing. There was no published evidence in peer-reviewed scientific or medical journals on the usefulness of stem cells for skin regeneration “to generate new skin cells for a fresher, younger look” as claimed by the Advertisement. As such, the treatments offered in the Advertisement were not medically accepted and not evidence-based.

The practitioner claimed that the offered services described as “stem cell for skin therapy” were merely the topical application of stem cell creams. As such, he was not providing any medical treatment but was merely selling cosmetics to patients.

The Advertisement offered “escorted tours” to overseas locations for stem cell for skin therapy and/or facial and body rejuvenation. The practitioner stated that this meant that his clinic would arrange for patients to be escorted to other countries where the foreign parties provided such services and he did not get paid for services performed overseas. However, the practitioner conceded that he did have indirect benefit from referring patients for such facial and body rejuvenation treatment as he conducted the pre- and post-treatment follow-up and would attend to any side effects that patients might have after such treatment. The practitioner said that he would explain the risks involved in such stem cell treatment, and would advise patients on what to

expect. His patients would only go for the overseas treatment on his advice. He said that he had no idea that stem cell therapy was not legal in Singapore and believed that he was not doing any harm.

The DC was satisfied that the medical services offered by the practitioner, namely stem cell skin therapy and stem cell therapy for facial and body rejuvenation, were not medically proven. As such, the evidentiary burden lay on the practitioner to prove that the treatment was done in the context of an approved clinical trial, which the practitioner had not done.

The DC did not accept the practitioner’s position that he was not guilty of any misconduct because he was merely providing topical creams for skin and that such products were merely cosmetics. The DC noted that in the Advertisement, the practitioner held himself out to his patients that he was providing “Aesthetic Medicine” and “Stem Cell Therapy” and that such words would have led members of the public to believe that they would be receiving medical treatment from the practitioner, and that such treatment would be medically proven and accepted. The public’s trust in the medical profession would therefore be violated if a doctor sold cosmetic products instead of providing a medically proven treatment. On this point, the DC also noted that there was nothing in the practitioner’s advertisement, website or in the documents made available by the practitioner to his patients, that would have indicated to patients that the treatment was in the nature of cosmetics only. A patient has a reasonable expectation that when he sees a doctor for aesthetic reasons, he will be offered a form of medical treatment and/or medical management plan that is medically proven.

Accordingly, the DC convicted the practitioner of the charge of professional misconduct for the reasons below. With regard to the facial and body rejuvenation treatment, the fact that the stem cell treatment was carried out overseas did not absolve the practitioner from misconduct. The practitioner knew or ought to have known that the services offered by the entities overseas were not medically proven. The DC noted that the ECEG embodied the

standards of the medical profession in respect of untested practices and clinical trials. The gravamen of the charge was one of offering to carry out a treatment that was not medically proven. It was irrelevant where the objectionable treatment was carried out as doctors should not be offering any medical treatment to any patient that was not medically proven. In fact, the DC noted that patients would have looked to the practitioner as the primary doctor as he was providing them a holistic program for facial and body rejuvenation by offering them advice as to their suitability for the stem cell treatment (which would have led his patients to reasonably expect the practitioner to endorse such treatment) and by offering to follow up with them after they received the stem cell treatment overseas.

In determining sentence, the DC considered the fact that there was no evidence of any actual harm suffered by any of the practitioner’s patients.

The practitioner was fined \$10,000; censured; ordered to give a written undertaking that he will not offer or continue to offer to patients, management plans or remedies that are not generally accepted by the medical profession, except in the context of a formal and approved clinical trial and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.

### CASE 5 | DR WONG YOKE MENG

The obstetrician and gynaecologist faced one charge of professional misconduct for making laudatory and/or misleading statements in an advertisement published in “The Guide to Singapore’s Private Medical & Dental Specialist Care” in 2007, in breach of the SMC’s Ethical Code and Ethical Guidelines (ECEG). The practitioner pleaded guilty to the charge.

The DC found the statements made by the practitioner in the advertisement to be laudatory and/or misleading in that they gave the impression that (a) the practitioner is one of the pioneers of stem cell treatment; and/or (b) the practitioner’s clinic is part of an internationally established medical group which practises innovative and advanced techniques and treatment, including stem cell treatment; and/or (c) stem cell treatment is a medically accepted and effective therapy both for the treatment and prevention of degenerative diseases of ageing such as “arthritis, hypertension, diabetes, Parkinson’s degeneration and cancer”. Accordingly, the DC convicted the practitioner of the charge of professional misconduct.

The DC noted that the ECEG embodied the standards of the medical profession in respect of information furnished by medical practitioners to the public and their patients. The DC considered the fact that the statements relate to stem cell treatment which is largely unproven. In that context, where there is potential for harm to patients, a punishment involving a suspension of the medical practitioner may be appropriate. However, as there was no evidence on that aspect in the practitioner’s case, the DC was mindful not to include that consideration in determining the appropriate sentence. The DC also noted that there was no evidence that any actual harm had resulted to any patient because of the laudatory and/or misleading statements made in the advertisement.

The DC noted that the practitioner, in his mitigation, had stated that he did not contest the charge against him, that he had sincerely apologised for the advertisement containing the laudatory and/or

misleading statements and that he had undertaken to remove similar laudatory and/or misleading statements elsewhere, apart from the advertisement.

The practitioner was fined \$7,000; censured; ordered to give a written undertaking that he will abstain from the conduct complained of or any similar conduct and that he will remove similar laudatory and/or misleading statements elsewhere, apart from the advertisement and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.

#### CASE 6 | DR KAY AIH BOON ERWIN

The general practitioner was charged with professional misconduct for failing to treat his patients according to generally accepted methods of treatment, in breach of the SMC's Ethical Code and Ethical Guidelines ("ECEG"). The particulars of the charge related to the practitioner's use of the Bioresonance Machine to treat his patients' smoking habits, allergies and behavioural issues as a result of autism. The practitioner pleaded guilty to the charge.

The DC found that the SMC's ECEG mandates that members of the medical profession shall not offer to patients, remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial. Accordingly, the DC held that any practitioner who wants to introduce a new method of treatment must, for the protection of the public from harm, and in the public's best interests, undergo the requisite clinical trial in accordance with the Bioethics Advisory Committee's Guidelines for Institutional Review Boards for such treatment. Unless that was done, a medical practitioner should not introduce or attempt novel treatments on patients. In this context, such misconduct by a medical practitioner was not a trivial one.

In mitigation, the DC noted that the use of the Bioresonance Machine was not invasive in nature and that there was no evidence to-date of any actual harm or adverse effect to any of the practitioner's patients arising from its use.

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; and pending the provision of the written undertaking, the practitioner was directed to immediately cease the use of the Bioresonance Machine for the treatment of his patients. The practitioner was ordered to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.



#### (C) EXCESSIVE/ INAPPROPRIATE PRESCRIPTION OF DRUGS (i) BENZODIAZEPINES, CODEINE-CONTAINING MEDICATION AND SUBUTEX

#### CASE 7 | DR TAN GEK YOUNG

The general practitioner pleaded guilty to 22 charges of professional misconduct of failing to exercise due care in the management of his patients. Of the 22 charges, 21 charges related to the inappropriate prescription of benzodiazepines as hypnotic medication, out of which 2 charges related to both prescription of benzodiazepines and Subutex, and 5 charges related to the prescription of both benzodiazepines and cough mixture containing codeine. The remaining 1 charge related to the inappropriate prescription of Subutex.

In the course of its deliberations, the DC found the practitioner's mismanagement of patients relating to Subutex to be:

*"particularly troubling and given the rising incidences of undesirable conduct of medical practitioners either in indiscriminately prescribing opiates, hypnotics or cough mixtures containing codeine, [was] of the view that public policy requires [the DC] to treat these misconduct seriously and to deter [the practitioner] and any other like-minded medical practitioners from committing similar acts."*

The DC also found the practitioner's 5 charges relating to cough mixtures containing codeine to have contravened the MOH guidelines. In relation to these 5 instances, the DC was of the opinion that in the "whole scheme of things, this further pointed out the systematic failure on [his] part to conduct [himself] in a professional manner as a doctor."

The DC further found the practitioner's recording of patient information only at the initial stage to be poor and unacceptable record keeping. The DC emphasized the duty to keep accurate and precise records and case notes.

The practitioner was suspended from medical practice for 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 solicitors to the Council and the Legal Assessor.





### (C) EXCESSIVE/ INAPPROPRIATE PRESCRIPTION OF DRUGS

#### (ii) BENZODIAZEPINES AND CODEINE-CONTAINING MEDICATION

##### CASE 8 | DR CHUA BOON LING

The general practitioner faced 14 charges of professional misconduct for failing to exercise due care in the management of the patients with benzodiazepines, and/or medication containing codeine.

The charges were that the practitioner had (a) inappropriately prescribed benzodiazepines, and/or medication containing codeine, (b) failed to properly record or document in the patients' Patient Medical Records, sufficient details of the patients' diagnosis, symptoms, condition, advice given and/or any management plan to enable him to properly assess the patients' medical condition during the period of treatment, and (c) failed to refer the patients to a medical specialist and/or to a psychiatrist for further management.

The practitioner contested all 14 charges. At the conclusion of the inquiry, the practitioner was convicted on 9 charges. The DC found that the practitioner had inappropriately prescribed benzodiazepines on an indefinite basis to his patients and that this was not an accepted medical practice and cannot be in the interests of the patients. The DC noted that benzodiazepines were highly addictive and it was incumbent on the prescribing physician to exercise great care and control to ensure that his patients did not develop an addiction to the medication.

The DC also found that the practitioner had failed to properly maintain the relevant patients' records for the management of his patients' treatment. The practitioner's failure to do so amounted to professional misconduct. Given the extent of the patients' dependence and addiction to the medications prescribed, the DC did not accept that the practitioner was in a position to continue with his management of the patients and that he had failed to refer the patients for specialist treatment, or for

co-management with a specialist. The DC noted that such a failure was inappropriate and unprofessional in that the dependency of the patients was left unchecked.

In making its decision, the DC also considered several mitigating factors, including the practitioner's personal mitigating factors.

The practitioner was suspended from medical practice for 4 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 solicitors to the Council and the Legal Assessor.

The practitioner filed an appeal to the High Court which was subsequently withdrawn.

##### CASE 9 | DR NG WEI SENG

The general practitioner pleaded guilty to 17 charges of professional misconduct in failing to exercise due care in the management of his patients. The charges relate to (a) inappropriately prescribing benzodiazepines and/or cough mixtures over varying periods of treatment; (b) failing to record or document details or sufficient details of the patients' diagnosis, symptoms, condition, advice given and/or management plan in the respective patient's Patient Medical Records; and (c) failing to refer patients to a medical specialist for further management.

The DC came to the following conclusions:

(a) Hypnotic medication is prescribed for patients who have insomnia or as anxiolytics for the short term relief of anxiety. However, long-term consumption of hypnotics may lead to drug dependence and tolerance and it is incumbent on all medical practitioners to be apprised of the current medical standards and prescribing practice in the interests of their patients;

(b) The practitioner had acted in disregard of his professional duties since the prolonged prescription of benzodiazepines and cough medication without specialist referral or proper medical records is inappropriate and unprofessional. There is also a lack of management plan, a requirement stipulated by the relevant medical guidelines;

(c) It is important and in the interest of physicians to maintain proper patients' records, as ultimately these records will form the primary evidence of the work and treatment by them. Further, these records also contain the patients' medical history, and failure in this respect will affect the well-being of the patients. The practitioner's failure to maintain proper medical records amounted to professional misconduct;

(d) The professional misconduct of improper prescription of hypnotics attracts substantial punishment, which usually involves a period of suspension for a medical practitioner.

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 solicitors to the Council and the Legal Assessor.



## CASE 10 | DR LEONG YEW KIN

The DC convicted the general practitioner on 15 charges of professional misconduct for failing to exercise due care in the management of his patients, in that he had inappropriately prescribed codeine-containing medication and / or benzodiazepines to his patients over periods of time.

In arriving at its decision, the DC considered the SMC's Ethical Code and Ethical Guidelines ("ECEG") as well as the guidelines issued by MOH in relation to the prescription of benzodiazepines and codeine-containing medication. The DC was of the view that the evidence disclosed that the practitioner had failed to:

- a) Adequately assess his patients' conditions;
- b) Arrange appropriate and timely investigations, such as X-rays or blood investigations for his patients;
- c) Refer his patients to specialists but instead persisted in practising areas of medicine where he has little or insufficient experience or knowledge;
- d) Keep clear, accurate, legible and sufficient records of his attendances, advice and management of his patients' illnesses;
- e) Prescribe, dispense or supply medicine on clear medical grounds and in reasonable quantities as appropriate to his patients' needs; and
- f) Inform his patients about the prescribed medicines or their side effects.

It was noted by the DC that it was common knowledge amongst doctors that codeine-containing medication ought to be prescribed with great care. The DC was of the view that the practitioner's practice of frequently prescribing codeine containing medication was unacceptable professional conduct. With regard to benzodiazepines, the DC noted that the MOH Guidelines for Prescribing Benzodiazepines ("Guidelines") warned that "Benzodiazepines are potentially addictive drugs which should be prescribed under specific circumstances when the

benefit of the treatment outweighs the risks of adverse effect. Doctors should therefore carefully assess the indications for benzodiazepine use before prescribing the drugs". The DC found that the practitioner ignored MOH's advice on prescribing benzodiazepines and was in breach of the provisions of the Guidelines.

The DC was of the view that the conduct of the practitioner with regard to his prescription practice and patient management indicated a pattern of intentional and deliberate departure from standards observed or approved by members of the medical profession who were of good repute and competency. Accordingly, the DC found that the practitioner was guilty of the charges preferred against him.

The practitioner was suspended from medical practice for 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 solicitors to the Council and the Legal Assessor.



## (C) EXCESSIVE / INAPPROPRIATE PRESCRIPTION OF DRUGS (iii) SUBUTEX AND BENZODIAZEPINES

### CASE 11 | DR MAH MUN MO MALCOLM

The general practitioner pleaded guilty to 9 charges of professional misconduct for failing to exercise due care in the management of his patients in the prescription of Subutex and benzodiazepines. Of the 9 charges, 8 charges related to the dispensation of the drug Subutex (Buprenorphine) and 1 charge related to the dispensing of benzodiazepines.

The charges relating to Subutex against the practitioner were that he had failed to exercise due care in the management of his patients in that:

- a) He failed to formulate any long term treatment plan for the treatment of the patient's medical condition;
- b) He failed to record or document in the patient's Patient Medical Records ("PMR"), details or sufficient details of the patient's diagnosis, symptoms and condition throughout the period of treatment save for the initial consultation;
- c) He failed to carry out an adequate assessment of the patient's medical condition;
- d) He failed to refer the patient to a medical specialist and/or psychiatrist for further assessment and management;
- e) He prescribed take-home dosages of Subutex more than the allowed 1-week dosage stipulated in the MOH Guidelines dated 26 October 2005 for the Treatment of Opiate Dependence ("MOH Subutex Guidelines") for 1 patient;
- f) He prescribed Subutex in combination with benzodiazepine for 2 of the patients; and
- g) He prescribed take-home doses of Subutex to 1 patient on one occasion even though the patient's urinary test showed that the patient was using illicit opiates, in breach of the MOH Subutex Guidelines.

The charge relating to benzodiazepines against the practitioner was that he failed to exercise due care in the management of his patients in the prescription of benzodiazepines in that:

- a) He failed to formulate any long term treatment plan for the treatment of the patient's medical condition;
- b) He failed to record or document in the said patient's PMR sufficient details of the patient's diagnosis, symptoms and condition; and
- c) He failed to carry out an adequate assessment of the patient's medical condition.

The DC emphasized that blatant disregard of the standards of the profession, or of guidelines prescribed to the profession will not be taken lightly. The DC noted that the long term prescription of Subutex, benzodiazepines and hypnotics may lead to drug dependence and tolerance and cause harm to patients; this is the reason why in such cases, a period of suspension and a fine will invariably be imposed on the defaulting practitioner. The DC also noted the sentencing precedents in previous cases involving the prescription of Subutex and/or benzodiazepines.

The DC noted the mitigating circumstances. In deciding not to impose a suspension, the DC took into consideration the following mitigating facts and circumstances:

- a) There was a relatively low number of charges involving the prescription of Subutex and benzodiazepines;
- b) The practitioner had voluntarily ceased medical practice since August 2007;
- c) The practitioner had demonstrated a desire to help his patients by consulting with the doctors of the Institute of Mental Health ("IMH") on the management of his difficult patients, attended Community Addictions Management Programme counselling sessions, workshops and conferences in connection with addiction management; and

d) Testimonials provided by his patients, fellow medical practitioners and person associated with his voluntary work.

In conclusion, the DC reiterated that though in cases of misconduct involving prescription of Subutex and/or benzodiazepines, a period of suspension and a fine will invariably be imposed, the practitioner's case ought not to be cited as a precedent as the decision not to impose a suspension in this case was justified on the mitigating factors as set out above.

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 and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.

#### CASE 12 | DR NG KWEI TEO

The general practitioner pleaded guilty to 47 charges of failure to exercise due care in the management of his patients amounting to professional misconduct. The charges relate to the prescription of Subutex and / or benzodiazepines.

The DC took note that the charges on Subutex concerned professional misconduct that was predominantly committed prior to the issuance of the 2005 Guidelines by the MOH. However, the DC took the view that even where there were no guidelines, such prescription ought to be made in accordance with the standards of the medical profession and good practice.

The DC also observed that long-term consumption of hypnotics may lead to drug dependence and that the formulation of a long term management plan is crucial if these patients are to be treated without dependency on such medication. The DC emphasised that it was incumbent on all medical practitioners to be apprised of current medical standards and prescribing practice, in the interests of their patients.

The DC found that the practitioner had acted in disregard of his professional duties as he had continued to prescribe Subutex and / or benzodiazepines without appropriate specialist referral even after the issuance of the MOH Guidelines in 2005. This lack of referral was both inappropriate and unprofessional.

In respect of the lack of proper documentation, the DC was of the view that it is important and in the interest of physicians to maintain patients' records, as ultimately these will form the primary evidence of the work and treatment by them. The DC also found that the record keeping in the practitioner's case was exceptionally poor as there was little, if any, detail of the clinical conditions of the patients and the management plan. The failure to maintain proper records amounted to professional misconduct.

The DC was of the view that such professional misconduct of the improper prescription of Subutex and / or benzodiazepines attracted substantial punishment, given the serious consequences for the patients if the proper prescription practice was not carried out.

The practitioner was suspended from medical practice for 6 months; fined \$6,000; 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 solicitors to the Council and the Legal Assessor.

#### CASE 13 | DR SENG TEE KIAT THOMAS

The general practitioner initially faced 28 charges of professional misconduct for failing to exercise due care in the management and/or treatment of 28 of his patients, in that he had:

- (a) Inappropriately prescribed Subutex and benzodiazepines;
- (b) Contravened the MOH's Guidelines for the Treatment of Opiate Dependence;
- (c) Failed to refer his patients to a medical specialist for further assessment and management in the course of the patients' period of treatment;
- (d) Failed to record or document in the patients' Patient Medical Records sufficient details of the patients' diagnosis, symptoms and conditions in the course of the period of treatment save for the initial consultation; and
- (e) Failed to formulate any long term management plan for treatment of the patients' medical conditions.

SMC proceeded with 25 of the 28 charges against the practitioner, and he pleaded guilty to these 25 charges.

Having regard to all the mitigating factors, including the fact that the practitioner was a first time offender and that he had pleaded guilty, the DC suspended the practitioner from medical practice for 3 months. He was also fined \$3,000; 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 solicitors to the Council and the Legal Assessor.



### (C) EXCESSIVE / INAPPROPRIATE PRESCRIPTION OF DRUGS

#### (iv) SUBUTEX

##### CASE 14 | DR CHAI CHWAN

The proceedings arose from 2 complaints (received in 2003 and 2004) against the general practitioner which related to the practitioner's prescription of Subutex and his management of patients who were prescribed with Subutex. These 2 complaints were also previously the subject of the practitioner's application to the High Court for leave to commence judicial review proceedings. The practitioner's application was denied and the High Court's written judgement was then released in May 2009.

The 2 complaints were heard together in a joint inquiry as the nature of the charges was substantially similar. The practitioner pleaded guilty to 122 charges set out as follows:

- (a) 115 charges in respect of the 1st Complaint; and
- (b) 7 charges in respect of the 2nd Complaint.

These charges were similar in that they alleged that the practitioner:

- (a) Inappropriately prescribed Subutex to a number of patients;
- (b) Did not formulate and/or adhere to any management plan for the treatment of the patients' medical condition by the prescription of Subutex; and
- (c) Did not record or document in the patients' Patient Medical Records details or sufficient details of the patients' diagnosis, 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 DC convicted the practitioner on all the Charges that he pleaded guilty to. The DC was disappointed that the practitioner failed to demonstrate that he had a proper management

plan in treating his large number of patients. The DC noted that there were scant details in the clinical records with respect to clinical history, physical examination and management plan of the patients. There were no follow-up progress reports on the patients for their treatment. The DC was of the opinion that the general standard of clinical notes was far below what was expected.

However, the following mitigating factors were taken into consideration:

- (a) The practitioner had pleaded guilty to the 122 charges;
- (b) The charges related to periods prior to the Ministry of Health introducing the Clinical Practice Guidelines on "Treatment of Opiate Dependence" in November 2005;
- (c) The numerous courses and training the practitioner had undergone and received in his quest to gain more knowledge about drug abuse, addiction, treatment, supervision and counselling of drug addicts throughout the years of his practice, demonstrating his interest in this;
- (d) The practitioner had also notified the Central Narcotics Bureau and the Ministry of Health that he was treating drug addicts; and
- (e) Good character references from fellow doctors and testimonials from grateful former drug addicts whom he had treated.

While the practitioner had mitigating factors in his favour, the DC emphasised that it was important to have a high standard of professionalism in his practice. It was a doctor's duty to comply with the rules and practice as drawn out by the profession to ensure that standards were not compromised.

The practitioner was fined \$7,000; 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 solicitors to the Council and the Legal Assessor.

##### CASE 15 | DR SOO ING CHOONG

The general practitioner faced 32 charges of professional misconduct for failing to exercise due care in the management of the patients with Subutex. The charges included:

- (a) Failure to formulate and/or adhere to a management plan for the treatment of the patient's medical condition;
- (b) Inappropriate prescribing practice by regularly prescribing Subutex to his patients without exercising an acceptable standard of diligence and care;
- (c) Failure to properly record or document in the patients' medical records, sufficient details of the patients' diagnosis, symptoms, condition and/or any management plan to enable a proper assessment of the patient's medical condition during the period of treatment; and
- (d) Inappropriately prescribing other medication with Subutex on various occasions.

The DC found that the practitioner had inappropriately prescribed Subutex on an indefinite basis to his patients and that this was not an accepted medical practice. The practitioner also did not exercise an acceptable standard of diligence and care in relation to these patients who were prescribed Subutex on an indefinite basis. The practitioner had also failed to properly maintain the relevant patients' records as required of registered medical practitioners. The failure to maintain such proper medical records amounted to professional misconduct. In relation to the practitioner's co-prescription of Subutex with other medications, the DC noted that there was a relatively low incidence of such co-prescription and therefore was not of sufficient gravity to amount to professional misconduct.

In making its decision, the DC also considered several mitigating factors, including the absence of a breach of the Ministry of Health's Guidelines dated 26 October 2005 which was a basis for the non-imposition of a sentence involving suspension, that

there was no persistent practice by the practitioner to co-prescribe Subutex with other potentially addictive medicines, and that he had practised as a physician for about 15 years without any antecedents.

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 and to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Council and the Legal Assessor.

**(C) EXCESSIVE / INAPPROPRIATE  
PRESCRIPTION OF DRUGS  
v) HYPNOTICS**

**CASE 16 | DR THAM PAK ONN**

The general practitioner pleaded guilty to 7 charges of professional misconduct for failing to exercise due care in the management and/or treatment of his patients with hypnotics.

The charges included:

- (a) Inappropriate prescription of hypnotics to the patients;
- (b) Failure to refer the patients to a medical specialist for further assessment and treatment;
- (c) Failure to record or document in the patients' Patient Medical Records details or sufficient details of the patients' diagnosis, symptoms and/or condition except for the initial consultation; and/or
- (d) Failure to formulate any long term management plan for the treatment of the patients' respective medical conditions.

In arriving at its decision, the DC considered the fact that long term consumption of hypnotics may lead to drug dependence. Hence the DC stated that it was the duty of all doctors to be familiar with and to understand current medical standards and prescribing practices in the interests of their patients, and that it was crucial for doctors to formulate a long term management plan to minimize the possibility of creating dependency on such medication in these patients.

The DC stated that the practitioner had acted in disregard of his professional duties since the prolonged prescription of hypnotics without specialist referral or proper medical records was inappropriate and unprofessional. The DC also pointed out that it was important and in the interests of doctors to maintain patients' records, as ultimately these will form the primary evidence of the work and treatment by these doctors. The practitioner's failure to maintain proper records in this case amounted to professional misconduct.

In making its decision, the DC also considered several mitigating factors, including the fact that (a)

the practitioner faced relatively few charges; (b) he had pleaded guilty at the earliest opportunity and had cooperated with the authorities; (c) he had voluntarily ceased practice in February 2008; and (d) he is a senior member of the medical profession and had a long standing good record until these proceedings.

The practitioner was fined \$4,000; 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 solicitors to the Council and the Legal Assessor.

The DC also specifically mentioned that the sentence did not include a term of suspension which is the usual sentence for misconduct of improper prescription of hypnotics because of the strong mitigating factors in this case. As such, it should not be viewed that doctors convicted of improper prescription of hypnotics will only incur a fine.