SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR AAS HELD ON 1, 2, 4 JUNE 2009 AND 24 AUGUST 2009

Disciplinary Committee:
Prof Ong Yong Yau (Chairman)
Dr Wong Yue Sie (Member)
Dr Wong Evelyn (Member)
Ms Mabel Ong (Lay Member)

Legal Assessor: (M/s Straits Law Practice LLC)
Mr N. Sreenivasan

Prosecution Counsel (M/s WongPartnership):
Ms Melanie Ho;
Ms Chang Man Phing; and
Mr Liew Kuang Ping

Defence Counsel (M/s Donaldson & Burkinshaw):
Mr Eric Tin Keng Seng
Mr Haryadi Hadi
Ms Kang Yi Yixian

DECISION OF THE DISCIPLINARY COMMITTEE

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

BACKGROUND

1. These proceedings arose out of a letter of complaint made against the Respondent, Dr AAS**,** dated 22 February 2008 (the "letter of complaint"), by Ms. C to the Singapore Medical Council (the "SMC").

2. The sole witness called by the Prosecution was:-
   (a) The Complainant - C

3. The witnesses called by the Respondent were :-
   (a) The Respondent - Dr AAS;
   (b) Enrolled Nurse - DW1

(c) Principal Consultant at Institution A - DW2

(d) Expert Witness (Anaesthetist) - Dr. DE

4. The following documents were admitted into evidence by the parties:-

(a) Prosecution's Inquiry Bundle, marked "IB-1" to "IB-96";

(b) Defence Bundle of Documents, marked as "DB-1" to "DB-58";

(c) Prosecution Opening Statement, marked as "P1';

(d) E-mail chain with CASE, marked as "P2";

(e) MOH Guidelines for prescribing benzodiazepines, marked as "P3";

(f) Defence Opening Statement, marked as "D1";

(g) Photographs of Complainant, marked as "D2A" and "D2B";

(h) Documents relating to the subpoena to DW3, marked as "D3"; and

(i) Expert report of Dr. DE, marked as "D4".

CHARGES

5. The following charges were preferred against the Respondent:-

1st Charge

That you Dr AAS are charged that on 14 January 2008, whilst a registered medical practitioner practising at Institution A ("the Clinic"), you proceeded with a body contouring procedure by laser lipolysis known as SmartLipo ("Surgery") on your patient, namely, one C, ("the Complainant"), even when you knew that informed consent for the Surgery had not been obtained from the Patient, given that the Patient had consumed diazepam, which has sedative effects, prior to her first consultation with you

Particulars

(a) On 14 January 2008 at around 4.15pm, you met the Patient for the first consultation to discuss the Surgery.

(b) You knew that the Patient had consumed 2 tablets of diazepam, a medication which has sedative effects, at around 3.30pm on 14 January 2008, prior to her consultation with you.

(c) You proceeded with the Surgery at around 4.40pm on 14 January 2008.

(d) You did not ensure that the Patient was adequately informed about the treatment procedure prior to the Surgery.

(e) Paragraph 4.2.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines states that:-

*"**4.2.2 Informed Consent***

It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him. If the patient is a minor, or of diminished ability to give consent, this information shall be explained to his parent, guardian or person responsible for him for the purpose of his consent on behalf of the patient."

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Rev. Ed.)

.**2nd Charge**

That you DR AAS are charged that on 14 January 2008, whilst a registered medical practitioner practising at Institution A ("the Clinic"), you prescribed and supplied 2 tablets of diazepam to your patient, namely, one C ("the Complainant"), and allowed her to consume such medication prior to a personal consultation with you

Particulars

(a) The Patient's first consultation with you to discuss a body contouring procedure by laser lipolysis known as SmartLipo ("Surgery") was on 14 January 2008.

(b) Prior to the Patient's consultation with you, one DW3, a staff in the Clinic who is not a medical practitioner or a pharmacist, provided 2 tablets of diazepam to the Patient and instructed her to consume the same for the purposes of undergoing the Surgery.

(c) Diazepam is a medication listed under the Poisons List in the Schedule of the Poisons Act (Cap.234) and can only be supplied by a medical practitioner or a pharmacist in accordance with the Poisons Act (Cap. 234).

(d) Paragraph 4.1.3 of the Singapore Medical Council Ethical Code and Ethical Guidelines states that:-

A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs…Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects. A doctor shall prescribe medicines only following an adequate personal consultation and relevant investigations…"

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Rev. Ed.)

6. Parties were given the opportunity to file written submissions and to thereafter exchange reply submissions. Parties did so. The written submissions were supported by extracts from the evidence as well as by authorities. These submissions were fully considered by the Committee, which then proceeded to consider the following factual and legal issues:

(i) <u>In relation to the 1st Charge:-</u>

(a) Did the Respondent know, at the time of consultation, that the Complainant had consumed diazepam?;

(b) On the facts, were all relevant information, risks and expectations sufficiently explained by the Respondent and understood by the Complainant?; and

(c) Even if all relevant information, risks and expectations were sufficiently explained by the Respondent and understood by the Complainant, was consent vitiated only by the fact that that the diazepam was given, or does the prosecution also have to show that consent was in fact vitiated by the effects of diazepam?

(ii) In relation to the 2nd Charge:-

(a) Is there sufficient evidence to infer that the Respondent gave actual instructions for the supply of diazepam?;

(b) If actual instructions were not given by the Respondent, is the charge made out by any legal or professional rule that there was "constructive" (sufficient to form the basis of a charge of professional misconduct) prescription and supply?; and

(c) If actual instructions were not given by the Respondent, is the charge made out by any legal or professional rule that there was vicarious liability (sufficient to form the basis of a charge of professional misconduct) for the supply?

7. In considering the evidence, the Committee applied the following principles:-

(a) Burden of proof for each ingredient rests on the prosecution;

(b) Standard of proof to be applied is proof beyond reasonable doubt;

(c) Adverse inferences may be drawn in accordance with the principles set out in the Evidence Act;

(d) That findings should be restricted to the ingredients of the charges as formulated, in the absence of any application to amend the charges; and

(e) The general principles of evidence law apply.

FINDINGS OF THE DISCIPLINARY COMMITTEE

8. The key points made in the submissions of counsel for the prosecution are summarised as follows:

(a) That the Respondent knew that the Complainant had consumed diazepam, when he saw her at 4.15 p.m., relying on the Respondent's explanation to the Complaints Committee.

(b) That if it shown that diazepam was consumed, given the fact that diazepam was a sedative, it would follow that informed consent of the Complainant was not taken; and that it entirely irrelevant whether, factually, the Complainant suffered or exhibited the effects of the sedation.

(c) That the above submission was supported by the Respondent's expert, who had confirmed that informed consent should be taken before prescribing any sedative.

(d) That it is not acceptable standards of practice to take consent from a sedated patient, no matter what the time lag and whether the sedation has taken effect.

(e) That the sedative effect of diazepam is indisputable and that it was therefore untenable for the Respondent to give evidence that the Complainant was lucid or alert.

(f) That the duty to obtain informed consent is a non-delegable duty of the doctor and that the Respondent had not ensured that the Complainant was adequately informed about the procedure.

(g) In respect of the 2nd charge, that the Respondent had prescribed the diazepam before seeing the Complainant.

(h) That allowing the nurse to hold the keys to the dispensary cabinet was sufficient to prove the element of supply.

(i) That IB page 26 (the handwritten note) contained instructions by the Respondent for the diazepam to be given to the Complainant and that these instructions were given before seeing the Complainant. In this regard, it was also submitted the evidence of Nurse DW1 that the lower part of IB page 26 was not written at the material time was to be disregarded.

(j) That, as the only doctor in the clinic, the Respondent is responsible for the treatment of the patient and remains accountable and responsible for the prescription and supply of the diazepam. In support of this proposition, paragraph 4.1.1.4 of the SMC Ethical Code and Ethical Guidelines were cited. Other than this reference, counsel for the Prosecution did not refer to any authorities.

(k) That it was not believable that Nurse D gave the Complainant the Diazepam without instructions;

(l) That the Respondent should be found liable, as it would otherwise allow doctors to escape liability for supplying scheduled drugs, by blaming their nurses.

(m) That the Respondent's inconsistencies in evidence and "deliberate lies" arose from and reveal a consciousness of guilt. The main argument was that the Respondent was lying when he stated in evidence that he did not know that the diazepam had already been given, especially as this was inconsistent with his written explanation and with the correspondence between Institution A and CASE.

(n) That the Committee should accept the Respondent's explanation to the Complaints Committee instead of his evidence at the hearing, in relation to whether he knew that the Complainant had already consumed the diazepam.

(o) That Nurse D's statement was inadmissible and should not be relied upon.

(p) That an adverse inference be drawn against the Respondent for failing to call Nurse D as a witness.

(q) That the SMC Ethical Code and Ethical Guidelines served to provide the medical profession with an ethical compass on acceptable standards, from which a departure may constitute professional misconduct.

9. The key points made in the submissions of counsel for the Respondent are summarised as follows:

(a) That it is clear from the evidence of the Complainant herself that she had not mentioned consuming diazepam to the Respondent;

(b) That the Complainant's statement that she did not feel very sleepy could not lead to the irresistible inference that the Respondent knew that she had consumed diazepam.

(c) That the Respondent's words in his explanation to the Complaints Committee must be taken in the context of the complaint made and the allegations in the complaint, which were not about the issue of informed consent at all, and that the explanation was based on knowledge acquired after the day in question.

(d) That the Respondent did not have personal knowledge of what transpired between the nurses and the Complainant, before she came in to see him.

(e) That the Complainant made up the allegation of having a "floating feeling", as this was not mentioned to the Respondent or in her written complaint.

(f) That the Respondent's evidence, that IB page 26 was written after the event and was not a prescription written before seeing the Complainant, was not contradicted by any other evidence.

(g) That, by the Complainant's own evidence, substantial information was provided to her.

(h) That the Complainant, in giving evidence, showed herself to be a cautious and prudent person, and took pains to rebut counsel in cross examination, and that such a person would not have gone ahead with the procedure if she felt ill-informed.

(i) That the prosecution had to show that the consumption of the diazepam had in fact affected the Complainant to the point that she could not give informed consent, and that it was not sufficient to merely show that the Complainant had consumed diazepam.

(j) That, applying ***Low Cze Hong v Singapore Medical Council***, informed consent was obtained when the patient was informed of all options and that the Respondent had sufficiently explained the risks, side-effects and nature of the procedure, and that the patient understood these two elements.

(k) That, on the facts of the present case, informed consent was obtained, as evidenced by IB pages 28-29.

(l) That it would be going too far and would be a dangerous precedent to take the blanket position that any prior consumption of sedatives would vitiate consent; and that such a position would lead to defensive medical practices.

(m) That informed consent is based on whether the patient lacks or does not lack medical decision making capability. It was submitted that the question is whether the patient had such capacity as was commensurate with the gravity of the decision he purported to make.

(n) That Dr DE's evidence showed that the medical decision making ability of the Complainant would not have been impaired, given the dosage in this case.

(o) That the Complainant had complained that she had “no proper consultation” and that “procedure was done poorly”, and had not complained that it was done without informed consent.

(p) That, on the totality of the evidence, the Complainant did not have diminished ability to give informed consent.

(q) On the 2nd charge, that there is insufficient evidence to draw the inference that the Respondent gave instructions, before seeing the Complainant, for her to be given diazepam.

(r) That DB 52 (also referred to as IB page 26) was written after the event and was not evidence of such instructions.

(s) That, if the Respondent did not actually give instructions for the supply of the diazepam before seeing the Complainant, he would not be liable unless the facts and circumstances give rise to the reasonable inference that what he did amounted to prescription and supply. In this regard, it is noted that the Respondent’s counsel could not assist by reference to any authorities on point.

(t) That the documents relied upon by the prosecution only show that there was a standard operating procedure to supply diazepam prior to the procedure, but do not support the inference that the Respondent was responsible for the supply and consumption of diazepam before consultation.

(u) That for the Respondent to be said to allow the supply of the diazepam, he must have had actual knowledge that it would happen or connivance or have so extensively have delegated his power that he could no longer prevent the act from being carried out.

(v) That professional misconduct cannot be founded upon vicarious liability.

(w) That, however tenuous the defence or unsatisfactory the conduct of the Respondent, the burden of proof lies at all times with the prosecution, and that it is simply insufficient for the prosecution to point out to inadequacies

in the Respondent's testimony, citing ***Yeo See Koon Jimmy v PP***, a decision of the Singapore High Court.

(x) That there were credible reasons for not calling Nurse D, and an adverse inference should not be drawn in respect of the failure to do so.

(y) That the applicable elements of professional misconduct, namely an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, or such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner were not present in this case.

10. The counsel for the prosecution, in reply submissions, made the following additional points:

(a) That the issue of informed consent rested on professional standards of practice, and not the diminished ability or capacity of the patient.

(b) That the gap in the Respondent's case, as to when he intended to prescribe the diazepam, shows that his defence is without substance, and that the reason why he did not address this issue was that he knew that the diazepam had already been given.

(c) That the Respondent's defence raises clever loopholes but has no substance.

(d) That while the concept of vicarious liability did not apply, the Respondent was in breach of his direct responsibility for the overall management of the patient in relation to the prescription and supply of diazepam, even when he delegated care to the nurses.

11. The counsel for the Respondent, in reply submissions, made the following additional points:

(a) That the Respondent was not privy to the documents prepared by Institution A in response to CASE, and that the inconsistency between the contents thereof and the Respondent's evidence cannot be held against him.

(b) That the prosecution's assertion that the mere consumption of diazepam vitiates consent is not borne out by any caselaw or expert evidence.

(c) That while the Respondent accepts the general proposition that consent should not be obtained after sedatives consumed, the test must remain whether the patient's decision making capacity is impaired; it would therefore be relevant to consider the dosage etc.

(d) That clause 4.2.2 of the SMC Ethical Code and Ethical Guidelines makes it clear that the focus should be on the patient's ability to participate on the decision making process, when the question of informed consent is considered.

(e) That there is no evidence that the Respondent allowed Nurse D to supply the diazepam before consultation.

(f) That the inconsistencies do not show a guilty mind.

12. The Committee wishes to thank both counsel for their detailed and extensive submissions. The Committee carefully considered the evidence of the witnesses, the documents tendered and the submissions of counsel for the prosecution and counsel for the Respondent, and made its findings on the issues as follows :-

1st Charge

A. Did the Respondent know, at the time of consultation, that the Complainant had consumed diazepam?

13. The evidence on this issue was contradictory. The Complainant's evidence was that she had informed the Respondent at the consultation that she was not sleepy despite taking a sedative. This would clearly show that the Complainant had taken a sedative prior to the consultation. In addition, the prosecution relied on the

handwritten note at IB page 26. It was also submitted that the Respondent's explanation to the Complaints Committee shows that he knew of the prior consumption.

14. The Respondent's version is that he did not know of the Complainant's prior consumption of the diazepam. He stated that the explanation to the Complaints Committee was based on his knowledge of the facts acquired after the event.

15. The Committee is very conscious of the fact that factual ingredients of the charge must be proven beyond a reasonable doubt. The Committee is of the view that, on all the evidence considered in totality, it cannot conclude beyond a reasonable doubt that the Respondent knew that the Complainant had consumed diazepam prior to the consultation and the taking of consent.

16. While the above finding would dispose of the first charge, the Committee had considered the question of whether the consumption of diazepam would vitiate informed consent, and sets out its views below; both on the facts of this case and in terms of general application.

B. On the facts, was all relevant information, risks and expectations sufficiently explained by the Respondent and understood by the Complainant?

17. The Committee considered the evidence in totality. It is clear to the Committee that all relevant information, risks and expectations relating to the procedure were, as a matter of fact, sufficiently explained by the Respondent and understood by the Complainant.

C. Even if all relevant information, risks and expectations were sufficiently explained by the Respondent and understood by the Complainant, is consent vitiated only by the fact that that the diazepam was given, or does the prosecution also have to show that consent was in fact vitiated by the effects of diazepam?

18. The Committee has carefully considered this difficult issue. The Committee accepts the Respondent's submissions, based on the decision in ***Low Cze Hong v Singapore Medical Council*** that 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. The Committee also accepts that a blanket position, that the prior consumption of sedatives would vitiate consent, is not tenable.

19. On the facts of this case, the Committee is satisfied that the prior consumption of diazepam did not vitiate the Complainant's consent in that her medical decision making ability was not impaired. In the premises, the Respondent is acquitted on the first charge.

20. However, the Committee wishes to emphasise the inherent risks of obtaining informed consent after the consumption of sedatives. Taking of consent involves more than just signing the consent form. As stated earlier, it involves the explanation of the benefits, risks and complications of the procedure, and the availability of other options.

21. It must be emphasised that 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. It must be borne in mind that medication may adversely affect such capacity. Valid consent must meet three criteria; it must be informed, it must be voluntary and the patient must be competent.

22. Sedation is a potential barrier to consent. It is difficult to determine at what point a patient who is on a sedative may still be able to provide consent. The presence of sedation diminishes the likelihood that a patient can provide informed consent; though it may not entirely preclude it. The divergent and sometimes inconsistent views found in studies[1] highlight the need for further clarification of the issue of informed consent for procedures where the patient is under sedation.

[1] Ward B, Shah S, Kirwan P, Mayberry JF. Issues of consent in colonoscopy; if a patient says 'stop' should we continue? J Royal College of Medicine 1999 (99) 132-3

2nd Charge

A. Is there sufficient evidence to infer that the Respondent gave actual instructions for the supply of diazepam?

23. The nurse (Nurse D) who administered the diazepam did not give evidence. The Respondent denied giving instructions for the administration of the diazepam. There was no oral evidence contradicting his evidence. While, the handwritten notes at IB page 26 suggest that the Respondent had knowledge of the prescription and supply of the diazepam, this note was explained by the Respondent. While the Committee finds the explanation less than satisfactory, the Committee is of the view that, on the totality of the evidence, it has not been shown that the Respondent gave actual instructions for the Complainant to be supplied diazepam.

24. However, it is clear that the clinic had protocols and standing instructions in place for the diazepam to be given to Smart Lipo patients as a standard pre-procedure medication. This and related issues are considered in the section below.

B. If actual instructions were not given by the Respondent, is the charge made out by any legal or professional rule that there is "constructive" prescription and supply?;

25. The Committee notes the contents of paragraph 4.1.3 of the SMC Ethical Code and Ethical Guidelines, which emphasises the importance of adequate personal consultation before the supply of medicines. This would be of particular importance in considering the supply of diazepam, which is listed in the Schedule to the Poisons Act.

26. The Committee also notes the following:

(a) The Respondent was the only medical practitioner involved in the running of the clinic, even though he was not the holder of the licence.
(b) The Respondent was aware of the protocols and standing instructions in the clinic.
(c) The keys to the dispensary cabinet were held by the nurses.

27. The Committee notes the terms of paragraph 4.1.1.4 of the SMC Ethical Code and Ethical Guidelines, 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 does not delegate his responsibilities. This general proposition is accepted by the Respondent, albeit in different terms, in paragraph 69 of the Defence Closing Submission. However he denies allowing such supply because, in his mind, the diazepam would be given only after the consultation (paragraph 70 of the Defence Closing Submission).

28. In considering this matter, it was clear to the Committee that there was an absence of accountability and control measures which are normally expected in a medical clinic, particularly, with regard to the control of, access to and prescription and administration of medicines. The Committee is of the view that neither the Clinic Manager nor the Respondent held themselves accountable or responsible for the administration of the clinic and to ensure proper control of clinic practices. In particular, it appeared 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.

29. In addition, the Respondent did not demonstrate the clinical responsibility, supervision and leadership expected of him, as the only doctor in the clinic. As the clinic doctor, he had the responsibility of ensuring the design and implementation of good clinical practices, protocols and standing instructions that will safeguard the safety and health of his patients.

30. On the facts of this case, the diazepam was supplied under the general terms of the protocol and standing instructions. The Committee accepts that the Respondent had presumed that the nurses would supply the diazepam only after the Complainant had seen him. However, the Respondent took no steps to check whether the Complainant had been given diazepam. After seeing the Complainant, the Respondent did not give instructions for the diazepam to be administered; assuming that it would be done. In such circumstances, the Committee is satisfied beyond a reasonable doubt that the Respondent had extensively delegated his power and duty to prescribe and supply diazepam and, as a matter of fact, had failed to exercise the necessary supervision in relation to the prescription and supply of the diazepam. In the premises, the Committee is of the view that the

second charge has been made out beyond a reasonable doubt and the Respondent is accordingly convicted.

C. If actual instructions were not given by the Respondent, is the charge made out by any legal or professional rule that there is vicarious liability for the supply?

31. Both counsel agree that vicarious liability cannot give rise to professional misconduct. A breach by the doctor himself of a duty or standard must be shown. Insofar as this breach is a breach of a duty to supervise or exercise control, this has been dealt with earlier.

CONCLUSION

32. The Committee finds the Respondent not guilty on the 1st charge and guilty on the 2nd charge.

MITIGATION

33. Counsel for the Respondent tendered a written plea in mitigation, which is attached and marked as "A". Given the acquittal on the 1st charge, Counsel did not go through the portions relating to informed consent.

34. Counsel for the Respondent submitted that only half costs should be awarded against the Respondent as the Respondent was acquitted on the first charge.

35. Counsel for the prosecution responded by referring the Committee to ***R (on the application of Eden) v General Medical Council***, and went through the case.

36. On the question of costs, Counsel for the Prosecution submitted that the prosecution had only called one witness and the Respondent's Witnesses' evidence covered both charges. Counsel submitted that costs in the proportion of 70% to 80% be awarded.

SENTENCE:

37. The Committee carefully considered the submissions in mitigation. The Committee found that the facts of the case cited by the Prosecution were quite different from the present case and of little assistance to the Committee. On the issue of costs, the Committee was of the view that both charges were closely linked and that there would have been little savings in time or costs had only the second charge been proceeded with.

38. Having regard to all the circumstances, the Committee makes the following orders pursuant to section 45(2) of the Medical Registration Act:

(a) That the Respondent be fined $2,000;
(b) That the Respondent be censured;
(c) That the Respondent give a written undertaking to the Medical Council to abstain in future from the conduct complained of in the second charge or any similar conduct; and
(d) That the Respondent pays 80% of the costs and expenses of and incidental to these proceedings in respect of the costs of the solicitor to the Medical Council, and pays the full costs of the Legal Assessor.

39. The hearing is hereby concluded.

Dated this 24th day of August 2009.