SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR ABJ HELD ON 29, 30, 31 MARCH, 1 APRIL AND 1 JULY 2010

Disciplinary Committee:
Dr Tan Kok Soo (Chairman)
A/Prof Chin Jing Jih
Dr Tham Tat Yean
Mdm Suwarin Chaturapit (Lay Member)

Legal Assessor:
Mr Andy Chiok
(M/s Michael Khoo & Partners)

Prosecution Counsel:
Ms Chang Man Phing
Mr Liew Kuang Ping
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Defence Counsel:
Mr Eric Tin
Mr Haryadi Hadi
Ms Kang Yixian
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DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent Dr. ABJ is a general practitioner having his practice at the Simon Road Family Clinic at the material time.

2. An audit of the Respondent's clinic was conducted by the Clinic Assurance & Audit Branch, Ministry of Health on 2 July 2008. These proceedings arose out of a letter of complaint made against the Respondent on 20 October 2008 by Dr C of the Health Regulation Division of the Ministry of Health to the Singapore Medical Council (the "SMC").

3. Following the complaint, a written response dated 19 February 2009 by the Respondent was submitted to the Complaints Committee, which then referred the matter to this Committee for inquiry.

The Charges

4. In the Amended Notice of Inquiry dated 1 February 2010, 14 charges ("the Charges") were framed against the Respondent. It is alleged that by reason of the conduct as set out in these Charges, the Respondent failed to exercise due care in the management of the patients referred to in the Charges, in particular (and as the case may be in respect of the relevant charge), that

   (a) he inappropriately prescribed benzodiazepines, and/or medication containing codeine,

   (b) he 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 patient's medical condition during the period of treatment,

   (c) he failed to refer the patients to a medical specialist and/or to a psychiatrist for further management.

   The Respondent contested all Charges.

<u>A preliminary point on the Charges</u>

5. We would at this juncture deal with a point raised by the SMC and the Respondent in submissions. In essence, the SMC had stated that even if one or more particulars were not proved against the Respondent, this Committee is entitled to find the charge of misconduct is proved if it is satisfied that the remaining particulars are sufficient to find misconduct.

6. It is not essential for this Committee to make any finding with this point because we note that counsel for the SMC had stated during the hearing and in her submissions that the particulars are to be taken conjunctively. Nonetheless, we would state that any dispute on this issue could have been avoided from the onset if the SMC, in framing the charges, had expressly stated therein whether

the particulars are to be taken on a conjunctive basis and as elements necessary for the charges to be proved. Counsel for the SMC should bear this in mind when framing charges for future proceedings.

The Proceedings

7. In the course of the hearing, the SMC relied on the expert evidence and testimony of Dr. PE as part of its case. An expert witness Dr. DE testified on behalf of the Respondent. Parties tendered written submissions.

8. We now turn to the specific elements of the Charges against the Respondent.

A. The inappropriate prescription of benzodiazepines / codeine medication

9. The first particular that is common to all of the 14 Charges against the Respondent is that of inappropriate prescription of benzodiazepines and (for Charge Nos. 1, 5, 10, 11, 12 and 14) with a co-prescription of codeine medication. The relevant prescriptions of the medication are contained in the Schedules annexed to the Amended Notice of Inquiry.

The parties' cases

10. The SMC's case is that based on the medical records, there is no formulation by the Respondent and/or adherence to any management plan. Broadly, it is the Respondent's defence that he had in place a management plan "to gradually reduce the dosage"[1] for these benzodiazepine-dependent patients. In its closing submissions the SMC's case is by the 2002 Guidelines, a physician has to refer a patient to a psychiatrist if the patient's insomnia is not treated after two weeks. The 2008 Guidelines are more stringent.

11. The Respondent did not dispute his knowledge about the Guidelines but he sought to justify any departure from it in that the Guidelines do not impose

[1] See paragraph 10, Defence Opening Statement.

obligations on him for the prescription of benzodiazepines. The Respondent's case is that a long duration of treatment involving benzodiazepine *per se* is not inappropriate prescription. He justified the prescription on the patients' individual needs (in particular chronic insomnia) and the necessity to provide them with medication to enable them to continue functioning in their everyday lives. In his submissions, the Respondent also relied on the point that there was no escalation in the dosages for the patients.

The views of both experts

12. The evidence relating to the maintenance treatment plan is incomplete without reference to the following:

a. In their evidence on the long-term use of benzodiazepines, Dr. PE and Dr. DE provided their views that this class of medication is highly addictive.

b. This is a point that is also accepted by the Respondent, both under cross-examination and in his submissions.[2]

c. This Committee is impressed by the fact that Dr. DE, in his answers to the Committee, had regarded Erimin, the benzodiazepine prescribed by the Respondent with much caution. He testified that if a patient developed dependency on the medication, then the physician would have to treat the dependency as an issue in itself. He would have to recommend the patient to specialist care, and if the patient refused, the physician has to advise the patient of the consequences, including the discontinuance of treatment. Notably, even as a specialist Dr. DE testified that he would find it difficult to manage the administration of Erimin.

d. Dr. DE also testified that chronic insomnia cannot be treated with medication[3]. He testified that a general practitioner can turn to non-pharmacological alternatives.

[2] See paragraph 77, Defence's Closing Submissions

Our findings on particular (a)

13. It is this Committee's view that the medication dispensed to any patient must be in accordance with good clinical practice and/or with adherence to any guidelines issued by the Ministry of Health in force at the relevant time. On the evidence adduced before it, this Committee finds it is not an accepted medical practice that benzodiazepines be prescribed by a general practitioner to patients on a long-term basis, without any end-point.

14. Notably, the relevant Guidelines in force as well as well as good clinical practice demands that as part of a treatment plan, patients be referred to specialist care or the discontinuance of treatment if patients develops a dependency or is not cooperative. Co-management of such patients with a specialist can also be explored. On a related note, this Committee took care during its deliberations not to view the Respondent's pre-2008 conduct though the lens of the 2008 Guidelines, nor the standards imposed by it. The Guidelines and the practices advocated therein cannot be retrospectively applied to a physician's practice.

15. We note the Respondent's position on the Guidelines i.e. that it does not have the force of law and do not impose any obligation on him in his management of patients[4]. This is an untenable position. The relevant Guidelines are issued by the Ministry of Health after consultation with specialists and practitioners, and in our view, it sets a standard or practice for medical practitioners to adhere to, and any departure from the Guidelines must be justified by the practitioner. This is a view shared by the Defence's own expert Dr. DE. To this end, we also disagree with the Respondent's position that the Guidelines do not impose any obligation.

16. Reverting to the instant case, we do not see any documentation of such a maintenance treatment plan, for a fixed period or with an intended cessation date. A perusal of the periods of treatment for the 14 patients shows that these patients were prescribed benzodiazepines for periods ranging from 4 months to 59 months.

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[3] See page 140E, Notes of Evidence recorded by the Defence

17. While the Respondent had relied on the point that there was no *escalation* of dosages[5], conversely this Committee do not see any significant *reduction* of the dosages over the periods of treatment. Patients began their need on benzodiazepines as a means to address an underlying medical problem e.g. stress or insomnia. However, with long-term prescription of benzodiazepines, another medical problem now manifests i.e. that of dependency and addiction to the benzodiazepines themselves. This concern was clearly shared by Dr. DE when he testified that he did not think that Erimin is "*a useful drug to take" and that "GP who prescribe it run risk of letting it become like wild fire.*"[6] Dr. DE also testified that from his experience, he "never able to succeed with using replacement" for Erimin."[7]

18. Given the highly addictive nature of this benzodiazepine, it is incumbent on the prescribing physician like the Respondent to exercise great care and control to ensure that his patients do not develop an addiction to the medication. In the present case, this Committee takes the view that for many of the patients in the Charges, the patients are dependent on benzodiazepines to the extent of an addiction.

19. This Committee also noted that there is little if any documentation in the patients' records of any plan or attempt by the Respondent to reduce or wean the patients off the medication. As stated above, this Committee's view is that on the evidence, the prescription of benzodiazepines on an indefinite basis is not an accepted medical practice and cannot be in the interests of the patients. On that basis, we cannot accept that the prescription of benzodiazepines by the Respondent was appropriate as claimed by him.

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[4] See paragraphs 22 to 31, Defence's Closing Submissions
[5] See paragraph 78, Defence's Closing Submissions
[6] See page 139H, Notes of Evidence recorded by the Defence
[7] See page 123E, Notes of Evidence recorded by the Defence

20. In this regard, for Charge Nos. 2, 4, 6, 8, 9, 11, 12, 13 and 14 (totalling 9 Charges) where the periods of prescription exceeded 9 months or more, this Committee finds that the SMC has successfully proved particular (a) therein.

B. Adequate or proper documentation of patients' records

21. This is a particular that is common to all 14 Charges.

22. The SMC's case is that the Respondent did not record or document in his patients' medical records details or sufficient details of the patients' diagnosis, symptoms and/or condition and/or advice given and/or any management plan such as to enable a proper assessment of the patients' medical condition over the period of treatment.

23. It is the Respondent's case[8] that

    a. whether the patients' record was of sufficient detail to enable the Respondent to properly assess the patients is a matter for him, and

    b. that paragraph 4.1.2 of the Ethical Guide does not stipulate that the details documented must be such as to enable proper assessment of the patients' medical condition over the period of treatment.

24. In the course of the proceedings, the Committee had been referred by both counsel to the patients' medical records in respect of the Charges. The Committee notes the following aspect of the evidence relating to these medical records:

    a. Both expert witnesses agree that for benzodiazepine-dependent patients as those seen by the Respondent, a comprehensive history taking is necessary for proper treatment by a physician.

[8] See paragraph 62, Defence Closing Submissions

b. Dr. PE testified that if the patient is dependent on a drug, then the physician ought to keep better records, especially a physician who knew that the patient had been turning to the black market as a source for drugs.

c. Dr. DE testified that where there is a variation from the Guidelines, then the justification for such variations ought to be documented by the physician.[9]

25. This Committee notes that in paragraph 4.1.2 of the Ethical Code and Guidelines, it is stated that:

> "*Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented*"

26. This Committee takes the view that in considering whether this particular of the Charges is made out, paragraph 4.1.2 is the yardstick for the standard of record keeping required of physicians. In that regard, the Ethical Guidelines are not irrelevant to these proceedings. On the contrary (and this is also accepted by the Defence[10]), the introduction to the SMC's Ethical Code and Guidelines states:

> "This Ethical Code represents the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore. The Ethical Guidelines elaborate on the application of the Code and are intended as a guide to all practitioners as to what SMC regards as the *minimum standards* required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore. It is the

[9] See page 143F, Notes of Evidence recorded by the Defence

view of the SMC that serious disregard or persistent failure to meet these standards can potentially lead to harm to patients or bring disrepute to the profession and consequently may lead to disciplinary proceedings."

27. On this point, this Committee disagrees with the Respondent's case (relying on Dr. DW's views) that the paragraph 4.1.2 of the Ethical Guidelines serves as "an aspirational statement and advice on good minimum practice"[11]. The Ethical Guidelines contains more than an aspirational statement and advice on good minimum practice. It sets the minimum standards for medical practitioners.

The patients' testimonials

28. One point of contention during the hearing and in submissions is the preparation of testimonials by certain patients (Charge Nos. 1, 3, 4, 6, 7, 9, 10, 12 and 14). The SMC's objection is that such testimonials, not being contemporaneous and specifically prepared for the hearing, cannot be relied upon. The Defence's case is that the testimonials are part of the medical records and weight should be given by this Committee to them.

29. This Committee does not accept that these testimonials form part of the medical records of the relevant patients as it was not created in the course of their medical treatment. While these testimonials may form part of the evidence in support of the Respondent's case, only two of these patients testified at the hearing. While we do not draw any adverse inference against the Respondent for failing to call the other patients who provided testimonials, we are cautious of the weight to be placed on these testimonials in the light of the unavailability of the patients who purportedly provided them, especially when the Respondent testified that for a few of the testimonials, he wrote the testimonials on the patients' behalf and read it to them.

Our findings on particular (b)

[10] See paragraph 183, Defence Closing Submissions

30. In the present case, the Committee has no doubt that on the evidence, the Respondent had failed to properly maintain the relevant patients' records for the management of his patients' treatment:

a. Notably, while there was some documentation of treatment, the standard practised by the Respondent fell short of what was required, as stated by the expert witnesses. The test, as stated in paragraph 4.1.2 is an objective one i.e. that the "*Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case.*"

b. Dr. DE had testified that Erimin is a medication that is "*difficult to manage*"[12]. Given its nature, the onus is on the prescribing physician like the Respondent to ensure that the medical records are comprehensive, even as a tool for tracking the patient's progress[13].

c. It is not in dispute that the Respondent had departed from the relevant Guidelines; he sought to justify the departures. However, contrary to the views of his own expert, the Respondent did not document the reasons that justified his departure from the Guidelines.

d. In the course of the Respondent's evidence, we observed that reliance was placed by him on his recollection of the consultations with the patients. For example, he testified that he could recall from memory that he had advised patient No. 2 to see a specialist even thought here is no such entry in the relevant patient's medical records. He attributed it to his "general practice" to ask the patients. If the records were properly documented in the first place, there would be no such necessity to rely on recollection. We would also add that during the cross-examination of the Respondent, he was drawn to various inconsistencies between the medical records, his explanation and the Extra Notes he prepared for the

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[11] See paragraph 43, Defence's Reply to the Prosecution Closing Submissions
[12] See page 140C, Notes of Evidence recorded by the Defence
[13] See page 142A, Notes of Evidence recorded by the Defence

inquiry. This aspect of the inquiry also eroded the veracity of the Respondent's evidence.

e. We also note that there was no recording of discussions with the patients of the basis for specialist treatment, alternatives as well as the patients' rejection of such recommendations.

f. We would also add that although consultations were recorded, the lack of details of each consultation and the results of any review conducted by the Respondent points towards a conclusion that these records were not properly maintained to enable the Respondent, let alone another physician to rely on them to manage the patients.

g. This Committee also cannot accept that it is good clinical practice for a physician to not expressly document a treatment or management plan that he had in mind, and then to justify this failure to document on the basis that such a plan can be inferred from the history of the previous consultations or the subsequent pattern of prescriptions of medication.

31. Finally, this Committee would add that it is in the interest of physicians to maintain patients' records, as ultimately these will form the primary evidence of the work and treatment carried out by them. Given the codification of the obligation of proper record keeping in the Ethical Guidelines, and for the reasons set out above, this Committee takes the view that failure to maintain proper records by the Respondent amounts to professional misconduct.

32. On the above basis, this Committee finds that particular (b) of all Charges has been proved.

C. Referral of patients to specialist and/or psychiatrist

33. This is a particular common to all Charges. The SMC's case is that patients should be referred to a specialist for treatment if 2 weeks of treatment of insomnia with benzodiazepine did not work. Dr. PE testified that if a general practitioner

cannot reduce the prescription of benzodiazepines for the patients, then he would have to refer the patient to specialist treatment. Dr. DE concurred with this view.

34. The Respondent's testimony is that referral to a specialist is only appropriate if there is a need where the primary doctor cannot handle the complexity of the case and that the patient himself has agreed[14].

35. Dr. DE confirmed that patients Nos. 3, 7, 10, 11, 13 and 14 are benzodiazepine-dependent. Dr. DE also testified that he would recommend that benzodiazepine-dependent be referred to a psychiatrist to deal with the dependence[15]. The Respondent confirmed under examination that patients 2, 4, 7, 10 and are benzodiazepine-dependent.

36. The Respondent testified that he knew about the 2002 Guidelines but he sought to justify his departure from it. In his evidence, the Respondent testified that he would refer a patient to see a specialist if he feels that he cannot manage the patient, e.g. if the dosages increases. He also claimed that he has a general practice of advising patients to see a specialist. However, for patient 4 he testified that he did not suggest to the patient to see a specialist.

37. Having reviewed the evidence presented and received the arguments of the SMC and the Defence, this Committee does not accept that the Respondent was in a position to continue with his management of the patients, given the extent of their dependence and addiction to the medication. He ought to have referred the patients for specialist treatment, or at least co-management with a specialist. This was not done, save for the patients set out below.

38. In this regard, as patients Mr. P1 and Mr. P2 testified that they were advised by the Respondent to see a specialist, there are sufficient reasonable doubts whether the Respondent had referred them to see a specialist. While we do not condone the prescription practice as well as record keeping for these patients,

[14] For an example, see the patient summary D4 for patient 5.
[15] See page 120H going on to page 121A, Notes of Evidence recorded by the Defence

this Committee is compelled to find that this last particular is not proved by the SMC in respect of these two patients. As stated above, this Committee does not rely on the other patients' testimonials in view of the fact that the said patients were not called to give oral testimony of the facts asserted therein.

39. This Committee therefore finds that particular (c) is proved for all Charges except for Charges 1 and 3.

Findings of the Committee

40. Having heard the evidence and on the totality of the evidence and arguments before it, this Committee finds that a total of 9 charges have been proved by the SMC against the Respondent. In summary,

    a. particular (a) has been proved in respect of 9 charges i.e. Charges Nos. 2, 4, 6, 8, 9, 11, 12, 13 and 14.

    b. Particular (b) of all Charges has been proved i.e. misconduct on the ground of the failure to maintain good and proper medical records.

    c. In respect of the particular (c) relating to the failure to refer the patients to a specialist for further management, it has been proved for all Charges except for Charges 1 and 3.

41. The Committee therefore finds the Respondent guilty of professional misconduct in respect of Charge Nos. 2, 4, 6, 8, 9, 11, 12, 13 and 14 and calls for his counsel to address us in mitigation.

Sentencing

42. In his address on mitigation, counsel for the Respondent urged this Committee to impose only a censure, relying on *inter alia* the following:

    (1) The Respondent had good intentions towards treating his patients,

(2) the various mitigating factors highlighted by Dr. PE,

(3) the Respondent's patients had benefitted from the treatment administered, and that there was no harm to them,

(4) there was no escalation of dosages; and there was in fact reduction of dosages,

(5) although the Respondent is a member of the Medical Council, he did not commit the misconduct during his term of office,

(6) references to various testimonials by the Respondent's patients,

(7) the personal mitigating factors relating to the financial impact of any sentence of suspension and the Respondent's personal illness, and

(8) that the fact that the Respondent did not plead guilty is not an aggravating factor.

43. Counsel for the SMC in addressing the points raised on mitigation stated:

(1) There is a finding by this Committee that there was no significant reduction in dosages,

(2) the misconduct complained of involved inappropriate prescription of benzodiazepines and/or codeine medication,

(3) the Committee should take into account the Respondent's conduct in respect all charges, even those where the entire charge is not made out and

(4) citing precedents, that a punishment of suspension is the norm for such misconduct.

44. The Disciplinary Committee had considered all the points raised in the plea in mitigation including the above, and had come to the following conclusions:

(a) Benzodiazepines and codeine medication are prescribed for patients who have insomnia or as anxiolytics for the short term relief of anxiety. However, the long-term consumption of benzodiazepines, especially a highly addictive drug like Erimin is likely to lead to drug dependence and tolerance, which will cause harm to patients. This is clear from the evidence of all expert witnesses. Indeed in the present case this Committee has taken the view that the relevant patients had developed dependency and came to harm.

(b) With regard to the Respondent's failure to refer the patients to specialists, such a failure is inappropriate and unprofessional in that the dependency of the patients is left unchecked.

(c) This Committee also takes the view that it is important and in the interests of physicians to maintain proper patients' records as stipulated in the Ethical Guidelines. The failure to maintain proper records amounts to misconduct as highlighted in our decision.

(d) The misconduct of the inappropriate prescription of benzodiazepines and codeine medication attracts substantial punishment, and will involve a period of suspension for a medical practitioner.

45. However, we are mindful of the mitigating factors presented to us, especially the personal mitigating factors submitted by counsel for the Respondent. We would emphasise that the fact that the Respondent is now a member of the Medical Council is irrelevant, and also that for the purpose of sentencing this Committee will restrict itself to the misconduct in respect of the 9 Charges. While we are aware of the potential hardship that a period of suspension entails, this Committee will impose that sentence because it is the appropriate punishment for the misconduct. The length of the suspension will be a reflection of the gravity of the misconduct, taking into account the mitigating circumstances.

46. Having regard to the representations made by both counsel and the nature of the misconduct, it is this Committee's decision that the appropriate sentence is as follows:-

    a. that the Respondent's registration in the Register of Medical Practitioners shall be suspended for a period of 4 months,

    b. that the Respondent shall be fined the sum of $5,000,

    c. that the Respondent be censured;

    d. that the Respondent shall give a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct; and

    e. that the Respondent pays the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the SMC and the Legal Assessor.

47. The hearing is hereby concluded.

Dated this 1st day of July 2010.