SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR ABM HELD ON 4, 6 & 16 AUGUST 2010

Disciplinary Committee:-
Dr Lim Cheok Peng (Chairman)
Dr Tan Kok Soo
A/Prof Quak Seng Hock
Mr Ong Ser Huan (Lay Member)

Legal Assessor:-
Mr Ravinran Kumaran
(M/s Ravi, Lim & Partners)

Prosecution Counsel:-
Mr Francis Goh / Ms Cassandra Ow
(M/s Harry Elias LLP)

Respondent-in-Person:-
Dr ABM

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent, Dr ABM, is a registered medical practitioner. During the material time he was employed as a general practitioner at the Clinic A at **[address of clinic redacted]** ('Clinic').

2. On 6th April 2010, 16 charges were preferred against the Respondent by Singapore Medical Council ('SMC') for failing to exercise due care in the management of 16 patients of the Clinic between various dates. All 16 charges stated that the Respondent was guilty of professional misconduct under Section 45(1)(d) of the Medical Registration Act (Cap. 174) as follows:-

   (a) His management of his patients was inappropriate in that they were prescribed, over periods of time, codeine containing cough mixtures or benzodiazepines or both on all or on almost all their consultations, many for long periods;

   (b) He did not record or document in his patients' Patient Medical Records the need to continue such regular prescriptions of codeine containing cough mixtures and benzodiazepines;

   (c) He failed to carry out adequate assessments of his patients' medical conditions over the periods of treatment;

(d) He failed to refer his patients to specialists for treatment of his patients' conditions;

(e) He failed to arrange for chest X-rays or blood investigations for his patients suffering from chronic respiratory conditions that required frequent codeine containing cough mixtures;

(f) He did not record or document in his patients' Patient Medical Records warnings of potential addiction to the medications he was prescribing to them; and

(g) He had breached the Ministry of Health's Guidelines for Prescribing Benzodiazepines, dated 17th August 2002 ('the Guidelines').

3. The Respondent claimed trial to all 16 charges. At the beginning of the proceedings, Counsel for the SMC tendered to the Disciplinary Committee ('DC') two agreed bundles of documents. They were marked AB-1 and AB-2. They contained the relevant correspondence and documents in these proceedings and the DC was informed that both parties are agreed on their authenticity..

4. The material facts of the Prosecution's case are that, sometime in the early part of 2008 the Ministry of Health ('MOH') received information that the Respondent was prescribing large quantities of codeine containing cough mixtures. The Clinical Assurance & Audit ('CAA') branch of the MOH conducted an inspection at the Clinic. They obtained the medical records of 16 patients, seen at the Clinic, and also extracts of the Clinic's Drug Dispensing Register ('DDR') for the period 1st March 2008 to 31st March 2008. On 25th July 2008, the MOH then made a complaint to the SMC about the prescribing practice of the Respondent with respect to benzodiazepines and/or codeine containing cough mixtures. Based on the above the 16 charges were preferred against the Respondent.

5. The Prosecution called 2 witnesses. The first, Ms PW1 ('Ms PW1'), is an Assistant Manager in the Compliance, Surveillance & Audit Branch in MOH. She testified that, together with a colleague, one Dr PW2, from CAA, they attended at the Clinic on 2nd May 2008. They obtained the medical records of the 16 patients and the DDR referred to above. The Respondent's cross-examination of Ms PW1 was brief. He established that the complaint against him emanated from a member of the public.

6. The second prosecution witness, Dr PW3 ('Dr PW3'), was called as an expert to give evidence on the prescribing practice of the Respondent. Dr PW3 is a Consultant Psychiatrist in private practice. He qualified as a medical doctor in 1987 and eventually

specialized in psychiatry. He is a member of the National Opiate Treatment Guidelines Committee of the MOH, an advisor to the Committee on Clinical Guidelines for the use of Buprenorphine in the Treatment of Heroin Dependence in Malaysia of the Malaysian Psychiatric Association and a member of the National Mental Health Sub-Committee on Provision and Co-ordination of Services for Children & Adolescents, MOH. He has given expert evidence in disciplinary proceedings in the SMC and in courts in Singapore and, on one occasion, in the United Kingdom. He has several other important related credentials and awards. The DC accepts that he is qualified to give evidence as an expert in these proceedings.

7. Dr PW3 confirmed that he had been requested to give his expert opinion on the prescribing practice of the Respondent based on the evidence obtained by the CAA and the Respondent's written explanation to the SMC dated 20th October 2008, amongst other documents the 2 agreed bundles of documents. He noted the following concerns in relation to the 16 patients referred to in the charges:-

   (a) They were prescribed, over periods of time, a codeine containing cough mixture or benzodiazepines, or both, on all or most of their visits for long periods;
   (b) There was no regular documentation in their case notes about the need to continue regular prescriptions of the codeine containing cough mixture and benzodiazepines;
   (c) They ought to have been referred for specialist reviews as is required under the Guidelines for Prescribing Benzodiazepines 2002 ('Guidelines');
   (d) Those who were suffering from chronic respiratory conditions that require the codeine containing cough mixture ought to have chest X-rays or blood investigations arranged for, but this was not done;
   (e) There was sparse documentation in the case notes (Patient Medical Records) about warnings of potential addiction to the prescribed medications;
   (f) There were many instances where the Guidelines were breached in that the 2 week prescription limit for benzodiazepines was exceeded, and benzodiazepines were prescribed together with the codeine containing cough mixture;
   (g) There were instances where 2 benzodiazepines were prescribed, some together with the codeine containing cough mixture;
   (h) There were many instances where the sole entry is *'Buy Dhasedyl'* followed by the quantity of the codeine containing cough mixture, thus raising the question of whether the Respondent sold Dhasedyl without seeing the patients; and

(i) In the case of one patient, there were entries indicating only *'Dormicum'* and the numbers of tablets prescribed, thus raising the question of whether the Respondent sold Dormicum without seeing the patient.

8. Dr PW3 stated that benzodiazepines and codeine are potentially addictive compounds and that their continued prescription needed to be monitored and curtailed.

9. The Respondent cross examined Dr PW3 on 2 points. First, to show that there were occasions, listed in the schedules to the charges, when he did not necessarily attend to the patients in question – he pointed out the different handwritings in the Patient Medical Records exhibited in AB-2 as proof. Dr PW3, understandably, was not able to comment on the handwritings. He had proceeded on the basis that the Respondent was responsible for all the entries. The Respondent's second point was that Dhasedyl (a codeine containing cough mixture) could be obtained without a doctor's prescription. This was not disputed by Dr PW3 except that he added that pharmacies selling Dhasedyl would have to record the particulars of the purchasers. The Respondent had no further questions for Dr PW3 and the prosecution closed its case.

10. The Respondent was invited to state his defence. He started with opening remarks of the evidence he intended to give. In the course of it, he referred to Charge No. 15 and stated that he had only attended to this patient once. On the only other occasion, referred to in the schedule, he stated that the patient was attended to by a locum of the Clinic. Upon inquiry by the DC, it appeared that it was the Respondent's case that there were other instances, stated in the schedules to the charges, in which he did not attend to the patients. The DC then stood the hearing down for the Respondent to identify these occasions.

11. The hearing was later adjourned to the 6th of August 2010 as the Respondent required more time. The DC also directed the Prosecution to go through the Respondent's list carefully and, if need be, make the necessary applications.

12. At the resumed hearing the Prosecution tendered to the DC the Respondent's letter of 5th August 2010 to the SMC which included a list of the occasions the Respondent said he did not attend to the patients in the charges. In the same list the Respondent also sought to clarify the dosage of Valium prescribed by him to some of the patients. The Prosecution also tendered a fresh set of schedules attached to the 16 charges which incorporated the Respondent's list and the Prosecution's position on the Respondent's

list. Essentially, the Prosecution and the Respondent had come to an agreement that the dates of attendances disputed by the Respondent ought to be deleted from the schedules.

13. Notwithstanding these changes the Prosecution's stand was that the points raised by the Respondent did not materially change the factual matrix and/or the Prosecution's case against the Respondent. The Prosecution was also prepared to address the DC in respect of Charge 15 (in which case the Respondent had attended and prescribed a benzodiazepine to the patient only on the first of the two occasions listed in the schedule).

14. The DC however ruled that, in view of the agreement between the parties (on the amendment to the schedules), the Prosecution ought to amend most of the charges and in the case of Charge 15 rethink its position. The proceedings were stood down for this purpose.

15. When the hearing resumed, the Prosecution informed the DC that it was amending Charges 1 to 8, 11 to 14 and 16 to reflect the deletions in their respective schedules. The Prosecution also sought leave to withdraw Charge 15 which the DC granted. The amended charges were then read out to the Respondent. The Respondent pleaded not guilty to them.

16. The Prosecution called Dr PW3 back to the stand. He was invited to give his opinion based on the amended and unamended charges. Dr PW3 clarified that his report was divided into issues concerning the prescribing of codeine containing cough mixtures and benzodiazepines by the Respondent. He noted that there were no guidelines for prescribing codeine containing cough mixtures but that the MOH has set a prescription limit. It was his view that the Respondent did not exceed the prescribed limit but the greater concern was that of long term prescriptions of codeine containing cough mixtures without referrals to specialists and/or for investigations.

17. Dr PW3 went through each of the schedules to the amended and unamended charges. He maintained, in respect of each of these charges, his opinion that the Respondent's prescribing practice was inappropriate and in breach of MOH's prescription limits and/or the Guidelines.

18. The Respondent was then invited to cross examine Dr PW3. He had no questions for him.

19. The Respondent next took the stand. He opened his evidence with the remark that he did not intend to challenge the amended schedules. Instead he wanted to make a *'summary statement'* to the DC. The Respondent tendered a written statement to the DC which he read. Essentially, the Respondent's testimony was that he admitted to the amended and unamended charges in that he:-

    (a) *'… prescribed Benzodiazepines and/or Codeine containing compounds over a prolonged duration which is contrary to the standard practice as stipulated by the available guidelines'*;
    (b) did not make *'adequate documentation with regards to the medical grounds of* (sic) *prescribing and continuing* (sic) *dispensing of Benzodiazepines and/or Codeine-containing compounds*';
    (c) *'… inadequately informed'* his *'patients of the purpose of the prescribed medicines, contraindications and possible side-effects'*;
    (d) *'… failed to arrange appropriate investigations'* for his *'patients who have been on prolonged prescriptions for Benzodiazepines and/or Codeine containing compounds'*;
    (e) *'… inadequately referred patients on prolonged Benzodiazepines and/or Codeine containing compounds to specialists for further management of their illness'*;
    (f) he has, since the investigations, been made aware of the seriousness of *'his inadequacies as a medical practitioner especially with respect to the management of patients with drug dependency/addiction'*;
    (g) he was *'misguided'* by his *'own subjective views in the management'* of the patients;
    (h) his *'deviation from the standards observed or approved'* by the medical profession *'was neither intentional nor deliberate'*; and
    (i) he would *'familiarize'* himself *'with the SMC Ethical Code and Ethical guidelines and the various management guidelines made available by MOH/SMC from time to time'*.

20. The Prosecution's cross-examination of the Respondent was understandably short. The Respondent confirmed that he was not challenging any of the schedules in the amended and unamended charges. Neither was he challenging the expert's report or evidence nor was he contradicting or challenging the information in AB-1 (save for the

amendments) and AB-2. The Respondent went on to state that he only realised that there was a quota for prescribing benzodiazepines when he heard Dr PW3's evidence. He stated that he had prescribed 15 tablets of benzodiazepines on a *'calendar basis'* i.e. on a half monthly basis.

21. The Respondent was invited, but chose not to make a closing statement. The Prosecution, on the other hand, in making its closing statement, submitted two tables which were summaries of the Respondent's prescription patterns in respect of benzodiazepines and codeine containing cough mixtures respectively, and submitted that the Respondent was guilty of the amended and unamended charges.

22. In view of the agreed facts, the Respondent's admissions and the evidence at this hearing, the DC has no difficulty in coming to a decision that the Respondent was guilty of the amended and unamended charges. We state our reasons below in coming to this conclusion.

23. The manner in which a doctor ought to conduct himself in relation to his patients is broadly prescribed in the SMC's Ethical Code & Ethical Guidelines ('ECEG'). In ***Low Cze Hong v. Singapore Medical Council (2008) 3 SLR at page 628*****,** the High Court stated that the ECEG *'represents the fundamental tenets of conduct and behaviour expected of doctors practicing in Singapore and are intended as a guide to all practitioners as to what the SMC regards as the minimum standards required of all practitioners. It is the view of the SMC that 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'*.

24. The Court went on to describe the circumstances in which professional misconduct can be found:-

    "… professional misconduct can be made out in at least two situations: first, where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and second, where there has been such serious negligence that it objectively portrays an abuse of privileges which accompany registration as a medical practitioner…"

25. We next summarise, in our opinion, the relevant provisions of the ECEG to these proceedings. Guideline 3, amongst other things, states that a doctor is expected to:-

    (a) provide competent, compassionate and appropriate medical care to patients;

(b) endeavour to ensure that patients suffer no harm;
(c) abide by the code of ethics of the profession; and
(d) uphold patients' right to be adequately informed.

26. Guideline 4, in setting out what is the standard of good medical practice, states, amongst other things, that:-

(a) *A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination* (4.1.1.1);
(b) *A doctor shall provide competent, compassionate and appropriate care to his patient. This includes … arranging appropriate and timely investigations… and the most appropriate management is expeditiously provided* (4.1.1.5);
(c) *A doctor should practice within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise. A doctor shall not persist in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having the required experience* (4.1.1.6);
(d) *Medical records kept by a doctor shall be clear, accurate, legible … of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigations, informed consents and treatment by drugs or procedures should be documented* (4.1.2); and
(e) *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* (4.1.3).

27. The DC is of the view that the evidence discloses that the Respondent 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 abut the prescribed medicines or their side effects.

28. In respect of paragraph 27(e) above, the DC makes two points. First, in 1996 the MOH raised, to clinics and pharmacies, concerns about the dangers of making preparations containing codeine easily available to customers. The MOH advised that customers be restricted to 240 ml (2 x 120 ml) per customer and no sale to the same customer within four days, wherever possible. This concern was again raised to clinics and pharmacists in MOH's letter of 9th October 2000 as the National Pharmaceutical Association reported that cough mixtures containing codeine could easily be obtained from clinics and pharmacies. The MOH sought the cooperation of these agencies to exercise greater control of the sale and supply of codeine preparations to patients. It was and has been common knowledge amongst doctors that codeine containing cough mixtures ought to be prescribed with great care.

29. Whilst the Respondent did not, on any occasion that he attended to the 15 patients, exceed the limit advised by MOH, the DC is of the view that his practice of frequently prescribing codeine containing cough mixtures is unacceptable conduct.

30. Second, on 17th August 2002, the MOH issued to all doctors the Guidelines. MOH's covering letter to the Guidelines warns 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'*. We summarise below the relevant provisions of the Guidelines:-

(a) *The need for a benzodiazepine must be assessed and justified before it is prescribed* (1.(1));
(b) *Drug tolerance and dependency can occur with the use of any of the benzodiazepines, even with regular use for only two weeks* (1.(2));
(c) *The type of benzodiazepine, the duration of use and other treatment options must be considered before a decision to prescribe is made* (1.(3));
(d) *Patients being prescribed benzodiazepines must be advised to follow strictly the prescribed dosage. They should be asked about the manner in which they are taking the medicines. This should clearly be documented in the patient medical record* (1.(4));
(e) *The need for a repeat prescription should be assessed and the following clearly documented in the case notes:-*

(i) *Justification for a repeat prescription*

(ii) *Comprehensive assessment of the patient*

(iii) *Diagnosis*

(iv) *Psychosocial history of the patient*

(v) *Evidence that the psychosocial aspects have been attended to* (1.(4));

(g) *Benzodiazepines should be used to treat insomnia only when the insomnia is severe, disabling, or subjects the individual to extreme distress… Treat primary cause first. Intermittent treatment if possible. Not more than 2 weeks (course may be repeated after an interval)* (4.(1));

(h) *The concurrent prescription of two or more benzodiazepines should be avoided* (5(5));

(i) *Repeat prescriptions for benzodiazepines should not be provided without a clinical review* (5(6)); and

(j) *Consult a psychiatrist if there are doubts about dosage prescription or reduction* (5(7)).

31. The DC finds that, based on the undisputed facts, the Respondent has ignored MOH's advice on prescribing codeine containing cough mixtures and is in breach of the above stated provisions of the Guidelines. The DC notes the Respondent had stated that he *'did not intentionally or deliberately'* deviate from the standards of the medical profession. The DC is of the view that the undisputed evidence indicates otherwise. The DC makes the following observations of the Respondent's prescription practice of the 15 patients (who are referred below according to the number of the charge concerned):-

(a) With the exception of patients 4, 9 and 11, the Respondent prescribed Dhasedyl over prolonged periods to the patients without requiring further investigations or referring the patients to a specialist for their persistent complaints;

(b) With the exception of patients 1, 2 and 11, the Respondent prescribed Dhasedyl in combination with a benzodiazepine on many occasions to the patients, a practice which we find is not acceptable;

(c) In the case of patients 7 and 10, the Respondent prescribed 2 benzodiazepines together, twice and once respectively which is prohibited under the Guidelines;

(d) In the case of patients 3, 4, 5, 7, 8, 9, 11, 12, 13, 14 and 15, there were several instances where more than the allowed 2 week prescription limit for benzodiazepines was prescribed by the Respondent which is prohibited under the Guidelines. In the case of patient 10 he exceeded it on one occasion;

(e) The Respondent did not document or record in the 15 patients' Patient Medical Records details or sufficient details of the patients' diagnoses, symptoms and/or conditions;

(f) The Respondent did not take into account the prescription history in respect of each of the 15 patients when prescribing codeine containing cough mixtures or benzodiazepines;

(g) The Respondent did not refer the patients to specialists for reviews in cases of repeat complaints of the same symptoms;

(h) The Respondent had even exceeded his *'own guideline'* of half monthly prescriptions of benzodiazepines in the case patients 4, 5, 8, 9, 10, 12, 13 and 16.

32. The DC is of the view that the conduct of the Respondent with regard to his prescription practice and patient management indicates a pattern of intentional, deliberate departure from standards observed or approved by members of the medical profession of good repute and competency. Accordingly, we find the Respondent guilty of the 15 amended and unamended charges preferred against him.

<u>Mitigation</u>

33. We invited the Respondent to make his mitigation plea. In mitigation, the Respondent had nothing further to add and urged the DC to consider what he had already stated in his testimony.

34. As the Respondent was unrepresented we also took into account the following points in his Explanation Letter dated 20th October 2008 to the SMC and his Summary Statement tendered to the DC when he gave evidence:-

(a) The Respondent did not at any time seek to deny the allegations made against him. Instead he sought to explain them;

(b) He did not waste the DC's time or prolonged the process unnecessarily. The only issue he took up was in respect of attendances to the patients for which he was not responsible and it was resolved in his favour eventually;

(c) Notwithstanding that he claimed trial he effectively admitted to the charges against him in his evidence;

(d) He was a fixed income employee and did not gain from his excessive prescriptions of codeine containing medicine and/or benzodiazepines; and

(e) He indicated that he would familiarize himself with the ECEG and MOH's directives.

Sentence

35. In the circumstances of this case the decision of the DC is that the Respondent:-

    (a) be suspended for a period of **6 months**;

    (b) be fined a sum of **$5,000**;

    (c) be censured;

    (d) give a written undertaking to the Singapore Medical Council that he will not engage in the conduct complained of and any similar conduct; and

    (e) pays the cost and expenses of and incidental to these proceedings, including the costs of the solicitors to the Singapore Medical Council and the Legal Assessor.

36. The hearing is hereby concluded.

Dated this 16th day of August 2010.