SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR ERIC CHONG YU AND DR KONG KOK LEONG ON 20 TO 23 OCTOBER 2009, 17 TO 21 MAY, 24, 26 MAY 2010, 12 TO 16 JULY 2010, 18 TO 20, 25, 26 JULY 2011, 17, 19 OCTOBER 2011, 14 TO 19 NOVEMBER 2011, 13 DECEMBER 2011, 16 AND 17 AUGUST 2012

Disciplinary Committee:
Prof Ong Yong Yau - Chairman
A/Prof Siow Jin Keat
Dr Chan Wing Kwong
Ms Tan Mui Ling (Lay Member)

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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 1st Respondent (Dr Kong Kok Leong) and the 2nd Respondent (Dr Eric Chong Yu) were at all material times general practitioners at Kings Clinic.

2. This inquiry arose from a complaint made by the Ministry of Health of Singapore (MOH) on 1 June 2007 to the Singapore Medical Council (SMC), following an audit conducted by the MOH at the clinic on 13 January 2006. In particular, the complaint is made in connection with the Respondents' treatment of patients with Buprenorphine (Subutex) at the clinic.

3. On 9 October 2007, the Respondents, in response to the request of the Complaints Committee appointed, furnished an Explanation. The Complaints Committee then referred this matter for formal inquiry.

The Charges

The Notice of Inquiry

4. By a Notice of Inquiry dated 4 November 2008, both Respondents were charged with professional misconduct in their respective treatments of 19 patients at the clinic, by failing to carry out a proper assessment of the condition of these patients. For ease of reference, for both Respondents, the charge number of the charges corresponds with the patient number assigned to the relevant patient who is the subject matter of the charge.

5. On 14 July 2010, the Notice of Inquiry was amended by the SMC. The effect of the amendments is that 2 charges (Charge Nos. 2 and 4) were withdrawn against Dr Chong and particulars were omitted from various charges against both Respondents.

6. A summary of the Charges as amended on 14 July 2010 against the Respondents, with a summary of the relevant particulars of the charges are set out at Annex 1A of the SMC's closing submissions in respect of Dr Kong, and Annex 1B in respect of Dr Chong.

7. On 9 May 2012, we exercised our powers to amend various charges and the Charges were amended by the removal of the particular in respect of the failure to perform sufficient checks on the patient for inappropriate use or abuse of Subutex prescriptions by intravenous use before prescribing take-home doses of Subutex. This amendment affects:

   (1) In respect of Dr Kong, the Charges in respect of Patients 9, 11, 12, 14, 16 and 19, and

   (2) In respect of Dr Chong, the Charges in respect of Patients 9, 12 and 14.

The reasons for the amendment are set out near the end of these grounds. A summary of the Amended Charges are set out at exhibit P9A and P9B for Dr Kong and Dr Chong respectively.

The particulars of the Charges

8. On 26 October 2005, the MOH introduced a set of guidelines on the treatment of opiate dependence. The guidelines "Guidelines for the Treatment of Opiate Dependence" prescribe the clinical practice for the treatment of opiate dependent patients. Prior to these Guidelines, and in particular prior to August 2005, there were no such guidelines in Singapore, and the treatment of such patients was guided by general standards of clinical care and management that exists at all times.

9. We would add at this point that there is therefore a distinction between Patients 1 to 4 and 12 (the "Group A" patients) and the other patients (the "Group B" patients), as the Group A patients started their treatment with the Respondents after the implementation of the MOH Guidelines.

10. The Charges contain various particulars in connection with the treatment of the patients. In summary, these are:

    a. Failure to carry out direct visual supervision during the patient's initial phase of therapy; this particular is relevant to the Group A patients i.e. to Charge Nos. 1, 2, 3 and 12 in respect of Dr Kong, and Charge Nos. 1, 3 and 12 in respect of Dr Chong.

    b. Failure to carry out weekly urinary tests, or urinary tests on a monthly basis as the case may be; this particular is relevant to Charge Nos. 1 to 3, 6 to 16 and 19 in respect of Dr Kong, and Charge Nos. 1, 3, and 6 to 19 in respect of Dr Chong.

    c. Failure to check the patient for signs of intravenous use; this particular is relevant to Charge Nos. 6 to 19 in respect of both Dr Kong and Dr Chong.

d. Prescribing a dosage that exceeded the maximum take-home dose; this particular is relevant to Charge No. 9 for Dr Kong.

e. Failure to refer the patient to CAMP (acronym for "Community Addiction Management Programme") within 6 months of the Buprenorphine treatment; this particular is relevant to Charge Nos. 5 to 19 in respect of Dr Kong and Dr Chong.

f. Failure to record sufficient details in the patient's medical records; this particular is relevant for all patients of Dr Kong and Dr Chong.

11. At this juncture, while this inquiry calls into question the treatment of the patients before, and after the implementation of the MOH Guidelines, we will only examine the Respondents' conduct of the treatment of their patients post-MOH Guidelines for the following reasons:

a. We had examined the medical records and noted that the Respondents had taken some measures towards the monitoring of their patients prior to the implementation of the MOH Guidelines.

b. Prior to the MOH Guidelines, there was no definitive stipulation as to the standard of care and regime of treatment for opiate-dependant patients in Singapore. It was on a case-by-case basis depending on the approach taken by the treating physician.

On the above basis, we are prepared to allow the Respondents the benefit of the doubt and confine the measurement of their conduct to the yardstick of the MOH Guidelines.

12. It follows that in respect of the 2 charges against Dr Kong involving Patients 17 and 18, as he was not the treating physician of these patients after the MOH Guidelines were implemented, these charges against him cannot stand.

Our decision

13. We have considered the evidence as well as the arguments made by the SMC and the Respondents as set out in their respective closing submissions. Our views and decision are set out below.

Particular (1) :
Failure to carry out direct visual supervision during the initial phase of therapy

14. This particular applies to Group A patients who were treated by the Respondents after the implementation of the Guidelines in October 2005. The main issue here is whether these patients were on initial phase of their therapy. Paragraph 7.1.1 of the MOH Guidelines states:

> *"During the initial phase of therapy (first month of initiation of treatment with buprenorphine or when a maintenance dose of 8 mg per day is reached, whichever is later)* all patients on buprenorphine treatment must have their sublingual dose administered under the **direct visual supervision** of the doctor or his treatment team member or any designated pharmacist."

15. The Respondents contend that the term "*initial phase of therapy*" referred to a patient starting Subutex treatment for the first time under their care, and does not apply to a patient who had just transferred from another clinic or had taken Subutex previously.

16. In turn, this issue turns on whether the steps taken by the Respondents were adequate to ascertain that the relevant patients are not in the initial phase of therapy. To this end, the Respondents' case is that that they had clinically assessed that the relevant patients were at the maintenance phase of the Subutex treatment, taking into account their history, checks for IV marks, verification with clinics that offered the previous treatments, and their records with the Central Narcotics Bureau ("CNB").

17. In the first place, patients seeking Subutex treatment are opiate-dependent, and require strict monitoring during the treatment regime. When physicians undertake to treat this category of patients, there must be strict adherence to the prevailing Guidelines to ensure that the objective of the treatment is achieved. Secondly, in the treatment of patients generally, it is important to maintain good medical records, a principle enshrined in the SMC's Ethical Guidelines. We would add that all the more so, for patients involved in Subutex treatment, the keeping of proper medical records is all the more important given that doctor-hopping is common amongst such patients, and the MOH Guidelines impose additional obligations on physicians managing such patients.

18. We accept that the plain meaning of "*initial phase of therapy*" refers to the commencement of the Subutex treatment regime by the patients. The next point to consider is whether the relevant patients who are the subject matter of the Charges involving this particular were indeed not at the initial phase of therapy, as contended by the Respondents.

19. The Respondents' case revolves on the steps taken by them to ascertain that the patients were not at the initial phase of therapy when they first attended to these patients. Much of their evidence rests on the patients' medical records supplemented by their oral testimony. Having perused the records and heard the Respondents' evidence, we are of the view that the Respondents did not properly ascertain whether the relevant patients were at the initial or maintenance phase of the therapy:

    a. As the Respondents were starting treatment for these patients, they would be at the initial phase of therapy unless they had undergone treatment at another clinic and had completed the initial phase of therapy at the previous clinic.

    b. We note that the medical records contain scant (if any) details of the verification / investigation by the Respondents with the clinics where these patients purportedly had completed the initial phase of treatment. There was no record of the information received by the Respondents

from these clinics, especially details on the treatment received. We regard the Respondents' oral testimony with caution bearing in mind that these events took place sometime in 2005, and also bearing in mind our views on the veracity of the Respondents' testimony as set out below.

c. It is disconcerting that the source of the patients' history of taking Subutex is the patients themselves. For example, for Patient 1, she was regarded to be on the maintenance phase after taking into account her prison and DRC history, and that she was taking Subutex from the black market. There is no detailed record of any verification by the Respondents of the patient's Subutex treatment with the previous treating general practitioner, which would have been the most crucial and reliable method of establishing that the patient had already completed the initial phase of therapy if the Respondents were contemplating to assess her as being on the maintenance phase. We must bear in mind that the CARDS system was only implemented in late October 2005 and prior to that there was no independent manner of verification except for communications between treating physicians.

d. The fact that the patient may have demonstrated to the Respondents the proper manner of consuming Subutex merely shows that she had taken Subutex previously, but it does not show that the patient had completed the initial phase of therapy. A negative urine test also shows that she was opiate-free, but does not confirm the stage of her therapy. What is more alarming is that this patient (and Patient 4) had informed the Respondents that she had been taking Subutex from the black market. While the Respondents had clinically assessed her, given their diagnosis as set out in the patient's medical records, we cannot see any reasonable basis for their conclusion that this patient was already at the maintenance phase of therapy. A patient cannot possibly be at the maintenance phase while consuming Subutex obtained from the black market.

e. Similarly, for Patient 2, while Dr Kong testified that he had contacted the patient's previous clinic, this verification carried out by him is not proved by the contemporaneous evidence i.e. the entries in the patient's medical records or the patient's assessment carried out on 12 January 2006. This was also not stated in the Respondents' explanation furnished to the Complaints Committee.

f. The same inadequacies apply for Patients 3 and 12. While the previous clinics may have been mentioned, it is unclear from the records whether these were obtained from the patients or by independent verification, as there is no recording of any such communication / verification of the patients' history, even though Dr Chong testified that he had called the previous clinic. Once again, the contemporaneous evidence does not support the oral testimony that the verification with the previous clinic had indeed been carried out.

20. For the above reason, we are unable to agree with the Respondents' position that these patients were on the maintenance phase of therapy.

21. We next turn to the issue whether the relevant patients' consumption of the medication were carried out "under the **direct visual supervision** of the doctor or his treatment team member or any designated pharmacist" as stipulated by the MOH Guidelines. Having perused the medical records, while there were records of instances of direct visual supervision being carried out by the Respondents, it is clear that within the first month of these patients' treatment, direct visual supervision was not carried out in the manner stipulated in the MOH Guidelines.

22. For the above reasons, we are of the view that this particular in respect of Charges Nos. 1, 2, 3 and 12 in respect of Dr Kong, and Charge Nos. 1, 3 and 12 in respect of Dr Chong have been proved.

Particular (2):
Failure to carry out weekly urinary tests, or urinary tests on a monthly basis

23. Urine tests are an important part of monitoring a patient's abstinence from opiate consumption. While a patient may be asked, or checked by a medical practitioner for signs of intravenous use of drugs, or his physical condition observed, a urine test is a scientific and objective way to determine if a patient is free from drug abuse, or had strayed from the Subutex regime of opiate detoxification. In other words, it is the most crucial and reliable method available to a treating physician and is a valuable tool to assist him to monitor his patient.

24. The MOH Guidelines stipulates:

    a. Under paragraph 7.3.1, for patients at the initial phase of therapy, "*Weekly urinary tests must be carried out to verify the patient's abstinence from illicit opiates. The urinary test results are to be documented clearly.*", and

    b. under paragraph 8.5, for patients at the maintenance phase of therapy, "*Urinary tests should be conducted at least monthly to verify the patient's abstinence from illicit opiates. The results of the urinary tests should be clearly documented*".

25. It is our view that the MOH Guidelines contain strict regimes for the monitoring of the patients because it is recognised that such patients are at high risk of returning to drug abuse and undermining the Buprenorphine treatment. In this regard, a treating doctor must adhere to the monitoring regime or risks failure of the treatment.

26. The Respondents' case is that for the patients in Group A (i.e. the Charges involving Patients 1 to 4 and 12), these patients are not on at the initial phase of therapy. We had set out above our reasons why we did not agree with the Respondents' position and that these patients should have been treated as being on the initial phase of therapy.

The urine testing

27. We now turn to the issue regarding the urine testing and the urine test sheets. According to the Respondents, this is part of a system they implemented for monitoring of the patients' urine tests. In essence, this system entailed:

    a. The recording of urine test results on the patient's medical records i.e. the patient's cards where details of the consultations and assessments are noted. The urine tests were conducted by the clinic's staff and be sighted by the staff and/or the Respondents.

    b. Where the patient is under supervision by the Central Narcotics Bureau (CNB), the Respondent also relied on the result of the urine test conducted by the CNB, as evidenced by the CNB card that the patient would be carrying.

    c. A separate record of the outcome of urine tests conducted on patients. These are loose sheets containing a table of the relevant date and outcome of the urine tests for each patient i.e. each urine test sheet is unique to that patient.

28. For the reasons as set out below, it is our view that the patients' medical record cards are the most reliable evidence on the issue of urine testing. Even then, the fact that a urine test was recorded in the medical record cards is conclusive evidence that a urine test was done. Dr Chong testified that the entry can be from (a) a verification of the urine test dipstick by the doctor, (b) communication by the staff of the outcome of a urine test or (c) the assumption of a negative test by inference from a CNB card of the patient's.

29. We had examined the patients' medical record cards to verify whether the requisite weekly or monthly urine tests were conducted by the Respondents, and we are of the view that the requisite urine tests, as recorded in the patients' medical record cards, were not carried out.

30. On the Respondents' reliance and adoption of the CNB urine tests, we do not agree that this practice is desirable or that it satisfy the criteria of the MOH Guidelines. While the patients under CNB's supervision would undergo urine tests by CNB, to rely and adopt them as urine tests done by the Respondents in their clinic is unacceptable simply because between the time when the CNB urine tests were conducted and the time when the patient presented himself at the Respondents' clinic, there was a window of opportunity where the patient could consume opiates and not be detected. This is a serious flaw in the Respondents' system that could be exploited, with the clinic's staff and the Respondents being none the wiser.

31. We now turn to the issue of the urine test sheets relied upon by the Respondents to show that the requisite urine tests were done. The Respondents' evidence on the urine test sheets is:

    a. They allowed the clinic's nurses to conduct the urine tests and then to record the results in the urine test sheets.

    b. The urine test sheets were kept by the nurses separately from the patients' medical records cards, and were not referred to during the consultations with the patients.

    c. The urine test results were compiled from (a) actual urine tests conducted at the clinic, or (b) verification of the urine tests conducted by the CNB.

32. We do not think that there is anything wrong with entrusting the nurses to conduct the urine tests. However, we are unable to understand and cannot accept why urine testing requires separate documentation which was not recorded in the medical record cards. Even if this is acceptable, the system is flawed when the Respondents allowed this documentation to be kept separately from the medical record cards. A physician must be armed with all available information to make an informed assessment of a patient's condition (all the more so when treating patients for opiate-dependence), and this system did not allow that.

33. It is noteworthy that when the Respondents provided the explanation to the Complaints Committee, while they referred to urine testing, no reference was made by them to the system of urine test sheets that they had in place. This either demonstrates that the detrimental "out of sight, out of mind" effect of keeping separate the documents constituting medical records, or alternatively, it supports the SMC's case that the urine test records were fabricated and came into existence only after the explanation to the Complaints Committee was sent. Either interpretation does not help the Respondents' case.

Authenticity of the urine test sheets

34. We now address the issue of the authenticity of the urine test sheets. As stated above, these documents were not presented to the MOH officers who conducted the audit in January 2006 or to the Complaints Committee when the Respondents furnished their written explanation in October 2007. The Respondents contend that (a) the MOH officers only took the medical record cards and hence they did not think the urine test sheets were relevant, and (b) they did not know the thrust of the misconduct that they faced and thus it did not occur to them to produce the urine test sheets.

35. We do not accept this explanation for the following reasons:

a. In the first place, it cannot be disputed that to the Respondents, the urine test sheets must be an integral part of, and important documentation in respect of their treatment of these patients.

b. When the Complaints Committee wrote to the Respondents seeking their explanation, the letter of complaint dated 1 June 2007 from the MOH was copied to them. Paragraph 3 of the MOH's complaint states:

> "3. Based on the findings from the review of these patient medical records, the Ministry is greatly concerned at the practices of Dr Kong Kok Leong and Dr Eric Chong Yu, especially in their prescription of Subutex."

c. To the Respondents, it would have been clear that the MOH's concerns were based *only* on the medical record cards taken away by the MOH's officers, to the Respondents' detriment. Given that, it is reasonable to suppose that the Respondents would have no hesitation to immediately draw the Complaints Committee's attention to the urine test sheets which would have been relevant to the Respondents' practice of prescribing Subutex, but this was not done. We note that this was the case even though the explanation to the Complaints Committee was fairly comprehensive.

d. The Notice of Inquiry was served on the Respondents in November 2008 and it would then have been crystal clear to the Respondents that urine testing is a crucial matter relevant to the charges they faced. Even then, the urine test sheets were disclosed only about 7 months after the Notice of Inquiry was served.

36. We would add that while the SMC made the point in its closing submissions that the urine test sheets were not reviewed by the Respondents' expert Dr RE in April 2009, we are reluctant to make any finding based on this because the omission could well be explained by facts protected from disclosure by legal privilege communications.

37. Finally, we find that the urine test sheets are not reliable evidence that we can accept, for the following reasons:

a. The Respondents relied on the urine test sheets to show that urine tests had been performed for their patients as according to MOH guidelines. They contended that the urine tests were recorded separately from the patient medical records but existed contemporaneously with the patient medical records.

b. The integrity of the urine tests have been challenged by the SMC at the start of these hearings. These urine test results were produced about 7 months after the Notice of Inquiry was issued.

c. We had inspected the urine test sheets with reference to the patient medical records cards. The urine tests sheets carry a label containing the patient's name, date of birth, sex, telephone, name of the clinic, address and drug allergy status. The labels of the urine tests sheets carry a single consistent type of font in all 19 patients. The labels in the patient medical record cards for the patients seen on and before 18 August 2005 (9 patients i.e. Patients 9, 10, 13, 14, 15, 16, 17, 18 and 19) were printed with fonts that are obviously different from those affixed to the labels in the urine tests sheets. In these nine patients, the patients' labels in the urine tests indicate "Allergy : Nil" whereas the patients' labels on the patients' medical records show Allergy as a blank space. In the label of one patient (Patient 5), the patient's address was printed in CAPITALS on the urine test sheet but was printed as Title Case in the patient's medical record card. In the labels of 5 patients (Patients 2, 3, 4, 6 and 7), the difference in fonts was more subtle but could be recognized upon examination to be different in the line "Allergy:Nil". In the label of one patient (Patient 1) this subtle difference could be seen in the line "Allergy: Ampicillin".

d. In one patient (Patient 11) a new label with a later address was pasted over an older label with an older different address in the patient's medical record card when only the new label with the later address is seen on the urine test sheet (when we would expect to see the same older label with the older address be pasted over with the new label). In one patient (Patient 8) who was first seen for another condition and 3 weeks later for Subutex treatment, the labels in the patient's medical record card were obviously different from that in the urine test sheet. In one patient's case (Patient 16) the mistake of the date entry "17.06.06" when it should have been "17.06.05" was made in both the patient medical record card and the urine test sheets. As the Respondents had said that the urine test records were recorded separately by the nurse, it appears to be too much of a coincidence that the nurse who prepared the label would make the same mistake as the doctor in dating the entry one year ahead.

e. The fonts of the clinic name “Kings Medical Clinic” appear to be different between the labels in the urine test sheets and the patient medical record cards for 7 patients (Patients 6, 9, 10, 11, 12, 13 and 14).

f. Both Respondents testified that there was only one machine printing the labels in the clinic. If the urine test sheets and the patient medical record cards were contemporaneous, the labels on both documents (which were created at the same time) would be the same. As noted above the labels are not the same in many instances. It was only when we raised these concerns with the Respondents that the explanation that there was more than one printer at the clinic was offered.

g. The Respondents were made aware of these discrepancies during the hearing by the Disciplinary Committee but they were not able to give any convincing reasons for these discrepancies when asked during the hearing.

h. We also note that the clinic nurse RW is one of the persons who maintained these urine test sheets records but was not called to give evidence even though she was originally listed as a witness. She would have provided illuminating evidence on the system in place and explain the above discrepancies. However, to the detriment of the Respondents, they elected not to call her to testify even though she is still working at the clinic. We are invited to draw an adverse inference against the Respondents for their failure to call her and we agree.

38. We also note the SMC’s contention that while every urine test recorded in the patient medical records cards were charged to the patient, urine tests that were not recorded in the patient medical records cards but recorded in the urine test sheets were not. This is a telling fact with no reasonable explanation except that the urine test sheets are not contemporaneous with the patient medical records cards. We will also mention that the CARDS system entries also do not largely tally with the records of the urine test sheets, unlike the data between

the CARDS system and the patient medical records cards which tallied to a large extent.

39. For the above reasons, we therefore finds it unsafe to treat the urine test sheets as contemporaneous documents like the patient medical records cards which are the primary evidence. We thus decline to rely on the urine test sheets in considering this particular of the Charge. We also find that the SMC had succeeded in proving this particular against both Respondents.

Particular (3):
Failure to check the patient for signs of intravenous use

40. Checks for intravenous use of opiates i.e. needle marks are prescribed in the MOH Guidelines in 2 aspects (a) monitoring of patients during the initial phase of therapy and (b) monitoring of the patients during the maintenance phase, where the checks are less stringent.

41. The Respondents' case is that they have always conducted such checks when they see the patients. However, the patients' medical record cards does not show consistent and thorough recording of such checks. The oral testimony of the Respondents is that sometimes a negative sign (i.e. that there were no needle marks) was not recorded as it was not a positive finding. We are unable to accept this practice. In a situation like this, a negative finding is as important as a positive finding because it will not be apparent to one looking at the patients' medical record cards whether these checks were carried out. It is a fundamental principle of good medical practice and record keeping that "if it is not written down, it is assumed to be not done". It is also notable that there were in fact recordings of negative findings for the needle marks checks in the patient medical records as well. This brings out the point that the Respondents' practice had not been consistent, calling into question whether the checks were done as they claimed, or that the medical records were so questionable that they were unreliable.

42. We had perused the patients' medical record cards in respect of this aspect of checking for needle marks. We are satisfied that the checks for needle marks

were inadequate except for Patients 9, 11, 12, 14, 16 and 19 for Dr Kong, and Patients 9, 12, and 14 for Dr Chong.

Particular (4):
Prescribing a dosage that exceeded the maximum take-home dose

43. This particular is relevant only to the charge involving Patient 9 for Dr Kong. The relevant portion of the MOH Guidelines is:

> "8.2 The maximum duration of a take-home supply of buprenorphine at any one time is restricted to ONE week. The maintenance dose for take-home supply shall not exceed 8 mg per day.
>
> 8.3 Under exceptional circumstances where a take-home buprenorphine supply of longer than one week is required, prior written approval should he obtained from CAMP/Ministry of Health on the attached form at Annex A-2 ("Application for Extension of Take-Home Supply of Buprenorphine/Methadone"). This form can also be downloaded from the CARDS website. The reason for seeking an extended supply of buprenorphine must be clearly stated in Annex A-2."

44. On 27 October 2005, Dr Kong prescribed 10 tablets of Subutex (8 mg each). This is excess of the maximum take-home dose of 7 tablets and without the written approval from CAMP. There is a breach of the MOH Guidelines that came into effect from 26 October 2005. As for Dr Kong's defence that he had yet to receive the Guidelines, we do not accept it because there is no credible evidence proving this except for his oral assertion which we reject. However, in view of the fact that the breach occurred only a day after the implementation of the Guidelines, we are of the view that it will be unduly harsh to impute misconduct on Dr Kong in these circumstances. We therefore do not find that Dr Kong is guilty of misconduct in respect of this particular.

Particular (5):
Failure to refer to CAMP after 6 months of treatment

45. Paragraph 6.2 of the MOH Guidelines states:

> "Within 6 months of treatment with buprenorphine, patients on maintenance therapy should be referred to CAMP for psychosocial assessment and intervention."

46. It is also the SMC's case that reading paragraph 9 of the MOH Guidelines, a patient must be referred to CAMP whenever a patient is non-compliant by the use of illicit opiates or if there is suspicion of diversion of Subutex, even after one month of supervised treatment.

47. One of the main tenets of the Respondents' case on this issue is that the 6-month period is to be calculated from the date of the implementation of the MOH Guidelines in October 2005, as opposed to the date when the patient commenced treatment with the Respondents. To show an example of this contention, a patient who had, say, started treatment in May 2005 need only be reviewed by CAMP in April 2006, and not November 2005.

48. We do not accept this contention. The requirement of the 6-month review by CAMP addresses the fact that opiate-dependent patients are difficult to manage, with a high risk of abandoning the treatment program. The requirement of the Guidelines serves:

a. to achieve a degree of co-management of these difficult patients between treating physicians like the Respondents, and the addiction specialists at the institute of Mental Health, and

b. to allow CAMP to evaluate the Respondents' management of these patients.

Given these aims, we cannot envisage that when this guideline for review by CAMP was framed, it was intended that the 6-month period was to only

commence from the date of the implementation of the MOH Guidelines. Numerous ex-addicts were already on Buprenorphine treatment by then, and the MOH Guidelines were implemented to regulate their treatment.

49. Another aspect of the SMC's case is that referral to CAMP meant a referral to CAMP that resulted in a review of the patient. In contrast, the Respondent's case appears to be that referrals by way of counseling to the patients, as well as writing letters of referral to CAMP satisfy the criteria of referral under the MOH Guidelines.

50. We do not accept the Respondents' contentions. While it is good to counsel patients on the benefit of a review by CAMP, this is not the same as making an actual referral. In respect of writing referrals to CAMP, while this arguably may on the face of it satisfy the MOH Guidelines' criteria, we are of the view that to give effect to the MOH Guidelines there must be some enforcement of the referral by the treating physicians like the Respondents, as it is only too easy for the patients to settle into a maintenance phase without any eventual tapering off. The enforcement of the referral could have been by the threat of withholding of further treatment until the patient attends the review by CAMP. To take an example, for Patient 19, even though referral was made in August 2006, there was no withholding of treatment or any record of the follow-up with the patient on the CAMP review after the referral was made. Having reviewed the Respondents' practice, we find that the entire process smacks of the Respondents simply paying lip service to the MOH Guidelines without actually complying with the medical intent of these guidelines.

51. In the present case, we see from the patients' medical records that the referrals, in the form of referral letters written by the Respondents for the patients involved in the relevant charges were predominantly made in early 2006. The SMC pointed out that the referrals were only made *after* the audit by the MOH, but even if we ignore that point, when we take into account the date of the commencement of treatment of the relevant patients, the referrals were made more than 6 months later, and are breaches of paragraph 6.2 of the MOH Guidelines.

52. Finally, the SMC in its closing submissions pointed out that the referral forms were not included in the patient's medical records except in the case of Patient 3 (for 3 March 2006) and Patient 19 (for 3 April 2006). The point being made is that all the other referral forms produced were about more than 6 months after the Notice of Inquiry was issued in November 2008, and not even when the Respondents addressed the Complaints Committee with their explanation. The dates of these referrals do not tally with the references to the referrals in the patients' medical record cards. The late appearance of these documents casts suspicion on the genuineness of these records. We find there is no credible or acceptable explanation for this system being implemented by the Respondents. However, we need not comment further on this, given our decision that the referrals were not made, or properly followed up within the 6 months of treatment as set out above.

Particular (6):
Failure to record sufficient details in the medical records

53. This particular supports all of the Charges in this inquiry, and stems from paragraph 4.1.2 of the SMC Ethical Guidelines:

> "4.1.2 Medical records
> 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."

54. In the course of the inquiry, the Respondents were painstakingly taken through the patients' medical records and the SMC's case on various omissions in the recording of details of the treatment. Some of the more material omissions highlighted are:

a. The failure to take a comprehensive history, including the details of previous treatments at other clinics as highlighted above,

b. When there were irregularities with the patients' management, even though the irregularities were recorded, the reasons for the irregularities and the action plan taken to address it were not recorded. An example is the situation where dosages were adjusted.

c. The failure to record all urine tests results (an integral part of the treatment regime) in the patients' medical records or alternatively, the failure to maintain the urine test sheets with the patients' medical records in the first place.

d. There is no indication in the urine test sheets whether the results came from actual tests done in the clinic or from the adoption of CNB urine test results.

e. The Respondents also failed to record all of their checks of needle marks, even though their case is that they had done so.

f. In respect of the CAMP referral forms, these documentations were also not kept with the patients' medical record cards and hence there was poor record keeping by the Respondents. The dates of the referrals also did not tally with the entries in the patients' medical record cards.

g. During the examination of both Respondents, there were occasions when both were unable to comment on certain aspects of the management of patients within the knowledge of the other Respondent. This illustrates how the records were insufficient and did not satisfy the criteria in paragraph 4.1.2 of the Ethical Guidelines that "*any other doctor reading them would be able to take over the management of a case*". While the SMC's Ethical Guidelines envisage a situation where a patient is transferred from the care of one physician to another, it equally applies in the present situation where both Respondents were co-managing these patients.

h. We also find that the Respondents were not thorough in their entry of information (including urine tests performed) into the CARDS system set up to monitor the patients on Subutex treatment. This has a serious consequence of undermining the CARDS system.

55. We would add that in certain respects, the Respondents were commendable in that they had implemented the Subutex User Consent Form and the interim assessment forms for their patients, something that is not common place with medical practitioners who undertake Subutex treatment as part of their clinical practice. While such efforts evinced the Respondents' intentions to do the best for their patients, it does not necessarily mean that Respondents had actually done enough. In the present case, we are of the view that the record keeping had serious flaws that undermined the Respondents' Subutex treatment.

56. For completeness, the record keeping for Patient 4 by Dr Kong is a borderline case in respect of its adequacy. In this regard, we decided to let him have the benefit of doubt. He is acquitted on the Charge involving Patient 4.

Veracity of the Respondents' testimonies

57. In the course of the inquiry, we are not convinced that the Respondents had been entirely truthful. In particular, we are concerned with the discrepancies with the urine test sheets and the unsatisfactory explanations put forward to explain them. We also note that the Respondents' oral accounts vary from the versions set out in their explanation to the Complaints Committee. Even if one considers that the explanation was in general terms, we find the inconsistencies disconcerting.

58. We also found Dr Chong to be evasive when he was cross-examined on the receipt of the MOH Guidelines. His explanation was not satisfactory and we agree that he was trying to avoid being pinned with the knowledge of the MOH Guidelines.

Framing of the charges and the particulars

59. In respect of the framing of the Charges, the Respondents take the position that the particulars to the Charges are worded conjunctively i.e. that if any particular is not proved under a Charge, then the entire Charge will fail since all of the particulars have to be proved, citing *Lim Teng Ee Joyce v Singapore Medical Council* [2005] SGHC 129 and *Ho Paul v Singapore Medical Council* [2008] SGHC 9.

60. While the SMC confirmed that the particulars are worded conjunctively, it takes the diametric position that this does not doom a charge where one or more of its particulars are not proved, citing the case of *Gan Keng Seng Eric v Singapore Medical Council* [2010] SGHC 325. Further, in its submissions the SMC made the point that the DC has the power to amend the Charges if necessary.

61. We are of the view that with the cases cited, and in particular the decision in *Gan Keng Seng Eric v Singapore Medical Council* [2010] SGHC 325, the crux is whether a respondent was misled or prejudiced by the charges such that he was unable to present his defence effectively. It is clear from the following paragraphs of the decision in *Gan Keng Seng Eric v Singapore Medical Council* [2010] SGHC 325 that to this end, the focus is on the main body of the charge rather than the supporting particulars:

> "*28 In the present case, Dr Gan argues that the finding of the DC, that he was in breach of his duties because he did not personally attend to the Patient on the night of 6 December 2005, is a finding that does not fall within the scope of the Charge.*
>
> *29 This court is of the opinion that even though Dr Gan'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, Dr Gan's entire conduct in relation to the care of the Patient was necessarily put in issue when he was charged with willful neglect of his*

duties and gross mismanagement in the post-operative treatment of the Patient for the period 6 December 2005 to 8 December 2005."

62. It is our view that guided by the principles in the above case, the central question of this inquiry is whether the Respondents had taken the appropriate steps to assess their patients before prescribing Subutex to them. The particulars contain the steps the Respondents ought to, but failed to take. In the conduct of their defence, the Respondents had adopted the position of tackling each and every particular, and in our view, were not misled or prejudiced by the case that they had to meet. Furthermore, the Respondents were given the opportunity to present evidence after the charges were amended, and they confirmed that no further evidence will be presented.

63. More importantly, in our view, the fact that certain (and not all) particulars had been proven for various charges is sufficient to make out professional misconduct on the part of the Respondents. Specifically, we are of the view that failures to conduct the urine tests properly or at all, and/or the poor patient record keeping are matters which by themselves are of sufficient severity to prove the main plank of the charges. In other words, these particulars by themselves are steps that the Respondents needed to satisfy to properly assess their patients before prescribing Subutex, but failed to do so.

64. The above is sufficient to dispose of this issue on the framing of the charges. Nonetheless, on 9 May 2012, in exercise of our powers under Reg. 23A of the Medical Registration Regulations (2000 Ed), we amended the charges by the removal of the particular in respect of the failure to perform sufficient checks on the patient for inappropriate use or abuse of Subutex prescriptions by intravenous use before prescribing take-home doses of Subutex. The amendments affect:

a. In respect of Dr Kong, the Charges in respect of patients 9, 11, 12, 14, 16 and 19, and

b. In respect of Dr Chong, the Charges in respect of patients 9, 12 and 14.

65. We are of the view that the amendments are appropriate for the following reasons:

a. We are of the view that in respect of each particular to the Charges, a failure by the Respondents on each particular is sufficient to prove the charge as framed, given that such a breach would undermine the strict regime of the Buprenorphine treatment. The different nature of each particular also meant that the gravity of each breach is different, a matter that is relevant to the issue of mitigation.

b. As it can be seen from our analysis above, apart from Charges 4, 17 and 18 of which Dr Kong has been acquitted, the sole particular on which we have doubts about its validity for the amended Charges is in respect of the checks by the Respondents for intravenous use. We had perused the relevant records and are prepared to give the Respondents the benefit of doubt and accept that the Respondents were diligent, even though there may be the odd omission.

c. Given our views of *Gan Keng Seng Eric v Singapore Medical Council* [2010] SGHC 325 as set out above, it is not necessary to effect the amendments but we do so for good order.

Conclusion

66. We will conclude where the Respondents' submissions begin. They had urged that the failings of the Respondents, even if proven, do not amount to professional misconduct. We are of the view that professional misconduct is not ascribed to mere omissions by a medical practitioner in administering treatment. It is more than that. The decision in *Low Cze Hong v Singapore Medical Council* [2008] SGHC 78 is often cited on this point. In the present case, we are of the view that the conduct of the Respondents had breached the standards of the medical profession as set out in the relevant Ethical Guidelines, and of the MOH Guidelines. While these guidelines do not have the same force as legislation, they are codifications of the standards "observed or adopted" by the medical profession.

67. In summary, our decision on the Charges are:

a. In respect of Dr Kong, he is convicted of all Charges except for the Charges involving Patients 4, 17 and 18 for which he is acquitted, and

b. In respect of Dr Chong, he is convicted of all Charges against him.

68. We then invited counsel for the SMC and the Respondents to address us on mitigation.

69. After the delivery of the grounds, counsel for the SMC drew our attention to the fact that in respect of Patient 5, after the Guidelines were implemented Dr Chong did not participate in the management of this patient except for the record of a telephone call. This was confirmed by counsel for Dr Chong and is an agreed fact. Given the views taken by us at paragraph 11 of the grounds, Dr Chong has to be acquitted of the charge involving Patient 5. We have reviewed the patient medical records and agree with counsel's submissions and order accordingly.

70. Counsel for the Respondents then invited us to reconsider the decisions in respect of Patient 2 for Dr Kong and Patients 3 and 19 for Dr Chong if we were to limit the time for an examination of the Respondents' conduct to post-MOH Guidelines. We then took time and reviewed the relevant evidence, including the patient medical records. Our views are:

a. In respect of Patient 2, Dr Kong did not conduct direct visual therapy for the second consultation on 19 January 2006. We remain satisfied that the other particulars relating to the failure to carry out the requisite urinary tests and the maintenance of medical records have been proven and our decision stands.

b. In respect of Patient 3, our review of the materials and evidence does not alter our findings that Dr Chong is guilty of misconduct in respect of his treatment of this patient.

c. Finally, in respect of Patient 19, we had reviewed the materials and evidence. While Dr Chong had only seen the patient on one occasion, on 29 November 2005, this does not mean that he cannot be guilty of the misconduct framed against him. For example, he did not check for IV marks and hence we did not amend the Charge to remove this particular. Going by the patient's medical record (in view of our decision not to rely on the urine test sheets and the use of CNB tests), no urine test was conducted on that consultation when the last verifiable urine test was on 26 May 2005, about 6 months ago. In respect of the referral made in April 2006, we had addressed this in paragraph 52 above. Our decision therefore stands, although we would make the additional observation that Dr Chong's misconduct for the treatment of this patient is limited to a single consultation may well be a mitigating factor.

71. Following from the above, we will vary our decision to the extent that Dr Chong is convicted of all Charges against him except for Charge No. 5.

72. Dr Kong is convicted of 16 charges of 19 charges and Dr Chong is convicted of 16 charges of 17 charges. We now turn to the issue of sentencing. Counsel for the SMC had addressed us and cited various sentencing precedents. The following arguments were advanced by counsel for the SMC:

a. The Respondents elected not to plead guilty which led to a prolonged 32-day inquiry.

b. The Respondents had also acted unreasonably by contesting each and every aspect of the charges in this inquiry.

c. While we had for the purpose of determining misconduct, focused on the post-MOH Guidelines period, there is a basis for the SMC to present a case of misconduct in respect of the Respondents' treatment of the relevant patients before, as well as after the MOH Guidelines were implemented.

d. Questions were raised on, and we had given our views on the lack of authenticity of the medical records, in particular the urine test sheets. It was contended that this is an aggravating factor.

e. Based on the precedents cited, while the Court and the disciplinary committees had only imposed a fine with the usual consequential orders, later decisions had imposed a period of suspension as part of the punishment.

73. Counsel for the Respondents took time and prepared a written mitigation plea. The salient points of the Respondents' mitigation are:

a. While the Respondents are guilty of misconduct, their defaults in the various aspects of the treatment were not committed deliberately. In certain regards, the Respondents had honestly misinterpreted the MOH Guidelines.

b. The Respondents had embarked on the program of Buprenorphine treatment after a request from a temple to help drug addicts.

c. There was no mixing of hypnotic medication with Buprenorphine during the course of treatment of their patients.

d. Testimonials were provided in favour of both Respondents.

74. In the course of mitigation, it was also brought to our attention that Dr Kong had been previously convicted by the SMC of professional misconduct in 2005 for failing to refer a patient for treatment of appendicitis and for not keeping adequate clinical records.

75. We had expressed our views on the professional misconduct of the Respondents and need not repeat ourselves. We would state that the following are relevant factors in determining the appropriate sentence:

a. Patients on Buprenorphine treatment require strict monitoring if the treatment is to be effective. Any lapse by the Respondents would undermine the strict regime of the treatment and in this manner potentially cause harm to the patients and impair their rehabilitation. We think more could be done by the Respondents in this respect.

b. While we had focused on the periods of treatment post-MOH Guidelines, this is not to say that there was no basis for an inquiry into the treatment period prior to the implementation of the Guidelines. As stated in paragraph 11 of our grounds, after examining the relevant records and evidence, we are satisfied that some measures had been taken by the Respondents towards the monitoring of the patients, at a time when no MOH guidelines existed to stipulate the steps that ought to be taken by physicians. Our focus on the post-MOH Guidelines period should not be taken to mean that there was no basis for the MOH's complaint in respect of the pre-MOH Guidelines period in the first place. It follows that charges that incorporated treatment during the pre-MOH Guidelines period are not necessarily misconceived.

c. It was submitted on behalf of the Respondents that they had acquainted themselves with Buprenorphine treatment even prior to the implementation of the MOH Guidelines. Armed with this information, we would have expected a higher standard of care from the Respondents.

d. We would accept the following to be mitigating factors:

    i) The Respondents had periodic reviews of the patients which were documented. While this practice does not absolve the Respondents of misconduct, such a practice is mitigating. We also note that some of the periods of consultations are short and not lengthy.

    ii) The Respondents had started Buprenorphine treatment at the request of a temple.

iii) We accept that Dr Kong had contributed to society, and Dr Chong had helped to set up the cardiology department at the hospital.

iv) Dr Chong has an unblemished record to date.

e. Having seen the precedents cited by the parties, we are of the view that the appropriate sentence must involve a period of suspension. Notably, in the present case, a large portion of the charges involved different aspects of misconduct, and in all cases, it involved a failure to document the treatment properly, which in our view is a serious shortcoming. There are also aggravating factors as we will set out. An imposition of only a fine, which under the legislation cannot exceed the maximum of $10,000, will not do justice under these circumstances, or uphold public confidence in the medical profession.

f. We note that while the patients were co-managed by both Respondents, Dr Kong was the primary physician at King's Clinic and implemented the treatment systems. Regard has to be given to this factor.

g. The remorsefulness of the Respondents is also a relevant factor. While they have stated that they are sorry in their written mitigation plea, we do not think that the Respondents' conduct of the proceedings show that they were contrite and remorseful. While we accept that the Respondents have the right to answer the charges against them, the reliance on documents and evidence that lacked veracity leaves us to conclude that they were not truly remorseful as portrayed in their written plea of mitigation. To use materials which are not contemporaneous or authentic in judicial proceedings is a serious matter, and is an aggravating factor that cannot be viewed lightly.

h. In respect of Dr Kong's previous convictions, we do not think that it is relevant except insofar as the part of it that concerns a failure to keep adequate clinical records. We think that with this previous conviction, Dr

Kong ought to have been more mindful of this aspect of his practice when he started the Buprenorphine treatment program.

76. For the above reasons, the appropriate sentences are:

a. that the 1st Respondent, Dr Kong's registration in the Register of Medical Practitioners shall be suspended for **4 months**, and that he be fined **$7,000**,

b. that the 2nd Respondent, Dr Chong's registration in the Register of Medical Practitioners shall be suspended for **4 months**, and that he be fined **$5,000**;

c. that both of the Respondents be censured;

d. that both of the Respondents shall give a written undertaking to the SMC that they will not engage in the conduct complained of or any similar conduct; and

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

Costs

77. We want to address the issue of costs. We wanted to provide some consideration on the costs to be paid by the Respondents because (a) they were acquitted of 4 charges in total, (b) they had some basis to raise a legal argument on the conjunctive nature of the particulars by the way they were framed and (c) managed to amend the charges to exclude particulars that went outside the MOH complaint. However, we had also considered that the Respondents had adopted the urine test sheets (the authenticity of which we do not accept) as part of their defence and had lengthened these proceedings considerably by doing so. Much time was also spent providing their oral evidence of matters which were ultimately rejected by us. All in all, we are of

the view that it is fair under the circumstances that the Respondents bear the costs of these proceedings without any discount.

78. Finally, we want to raise a point on punctuality for inquiry hearings. On more than a few occasions the inquiry did not start on schedule because the Respondents and/or their counsel were late. We want to emphasise that it is important for parties and their counsel to be punctual for hearings because costs will be unnecessarily incurred and the inquiry will not be able to be carried out expediently, apart from the basic point of according due respect to the proceedings. For the avoidance of doubt, this is a matter which had no impact on sentencing.

79. We will also order that the grounds of this decision be published.

80. The hearing is hereby concluded.

Dated this 17th day of August 2012.