SINGAPORE MEDICAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY FOR DR R
ON 2, 3, 6 AND 27 MAY 2013, 19 AND 20 AUGUST 2013, 9 JANUARY 2014 AND 16 JUNE 2014

Disciplinary Committee:
Dr Wong Sin Yew - Chairman
A/Prof Pang Weng Sun
A/Prof Tan Suat Hoon
Mr Ong Ser Huan – Lay Member

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

Counsel for the SMC:
Mr Edmund Kronenburg
Mr Kevin Ho
(M/s Braddell Brothers LLP)

Counsel for the Respondent:
Mr Charles Lin
(M/s MyintSoe & Selvaraj)

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent, Dr R, is a Senior Consultant at the Department of X at the X Hospital. The Complainant is Mr C, whose mother Mdm P (Mdm P) was a patient under the care and management of the Respondent.

2. The relevant facts are:

   (a) The Respondent managed Mdm P for her chronic myeloproliferative disease. Mdm P also participated in a clinical trial involving the prescriptions of Traditional Chinese Medication (TCM).

   (b) The Respondent also managed Mdm P's hyperuricaemia. It is undisputed that on 11 November 2009, the Respondent prescribed Allopurinol to Mdm P. Apart from this medication, she was also on other medications.

(c) On 23 December 2009, Mdm P's son, Mr C, contacted the Respondent by telephone and informed her that Mdm P was experiencing itch and rash. He asked her whether it could be due to the TCM medication.

(d) The Respondent advised Mr C to stop the TCM medication. She prescribed Hydroxyzine.

(e) Mdm P was admitted to the X Hospital on 26 December 2009. She was subsequently diagnosed with DRESS (Drug-induced Rash with Eosinophilia and Systemic Symptoms), a known severe adverse reaction to Allopurinol.

3. The complainant, Mr C, lodged a complaint with the SMC on 12 May 2010. The Respondent provided an explanation through her letter to the Complaints Committee dated 10 August 2010. On 26 October 2010, the Complaints Committee sought a clarification about the details of the telephone call between the Respondent and Mr C on 23 December 2009.

The Charge

4. The Charge against the Respondent is:

Amended Charge

That you DR R are charged that on or about 23 December 2009, whilst practising as a Senior Consultant at the Department of X, X Hospital located at XXX, Singapore XXXXXX ("X Hospital"), in respect of your patient one Mdm P ("Patient") you did provide medical advice to the Patient:-

(a) without performing any personal evaluation of the Patient;
(b) without obtaining or attempting to obtain the Patient's medical history;
(c) without equipping yourself with sufficient information as to the specific medication the Patient had been prescribed and was taking as at 23 December 2009; and
(d) in violation of Section 4.1.1.1 of the Singapore Medical Council's Ethical Code and Ethical Guidelines.

Particulars

(1) Over the telephone on 23 December 2009, you spoke with one Mr C, the son of the Patient, who sought medical advice from you on behalf of the Patient.

(2) You informed Mr C of your medical advice that the Patient should stop taking the Traditional Chinese Medicine ("TCM") medication that she had been prescribed as part of the TCM trial she was participating in, at X Hospital.

(3) During the same telephone call, you also prescribed hydroxyzine to the Patient.

(4) You provided the medical advice at (1) to (3) above:-

(i) without performing any personal evaluation of the Patient;
(ii) without obtaining or attempting to obtain the Patient's medical history; and
(iii) without equipping yourself with sufficient information as to the specific medication the Patient had been prescribed and was taking as at 23 December 2009,

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

5. In the course of the inquiry, the Complainant, Mr C, provided his testimony and was the only witness called by the SMC. The Respondent testified and also called various witnesses who testified on her behalf.

The SMC's case

6. The SMC's case against the Respondent is straightforward. Briefly, its case is that based on a plain reading of Section 4.1.1.1 of the Ethical Guidelines, it is a general rule that doctors must conduct good history taking and personal / clinical examination of their patients, with only the following 2 exceptions:

   (a) Exception 1: the doctor has satisfied himself that he has sufficient information (transmitted to the treating doctor by voice, electronic or other means by a referring doctor) available and that the patient's best interest is being served; OR

   (b) Exception 2: in "exceptional or emergency" circumstances.

7. The SMC's contentions are that there was no good history taking and personal / clinical examination of Mdm P by the Respondent. Further, the facts and circumstances did not warrant the operation of either exception to the general rule to exculpate the Respondent from a failure to adhere to Section 4.1.1.1.

The Respondent's case

8. Briefly, the Respondent's case is *inter alia* that the conduct alleged in the charge does not amount to professional misconduct. The Respondent also takes the position that the elements of the Charge was not made out on the evidence. We will refer below to the appropriate positions taken by the Respondent.

Our decision

9. The interpretation of Section 4.1.1.1 is crucial to this inquiry. Counsel for the SMC seeks a plain or literal interpretation of this Section, while the Respondent's counsel seeks a broader interpretation of it, to cater to different relationships between doctors and their patients, as well as to the situations on the ground.

10. We are inclined to agree that Section 4.1.1.1 cannot be applied rigidly across the board. In our view, the spirit and intent of Section 4.1.1.1 is to ensure that a doctor knows his patient, and that he has the requisite information to administer the correct

management and treatment plan for the patient. The concern that Section 4.1.1.1 seeks to address is that of a doctor treating a patient without first assessing the necessity for the treatment. The objective is to ensure that the treatment provided to a patient is an appropriate one.

11. There is another factor in the present case. It is undisputed that Mdm P was a subject of a clinical trial conducted by the X Hospital. Such patients require closer monitoring because there are other additional factors that may influence the patient's condition and well-being apart from the condition being treated. This point was accepted by the Respondent and her expert witness, Dr DE.

The Respondent's evaluation of Mdm P

12. The SMC's case is that the Respondent ought to have personally examined Mdm P when Mr C contacted the Respondent about the rash and itch experienced by his mother. From the evidence, it appeared that the Respondent had considered and decided that it was not necessary to see Mdm P after speaking with Mr C.

13. We are of the view that the evaluation carried out by the Respondent was inadequate. Bearing in mind that Mdm P was a clinical trial patient, it would have been prudent for the Respondent to examine Mdm P. Counsel for the Respondent sought to rely on the fact that if such an examination was carried out, it would not have been useful because when she was eventually admitted on 26 December 2009, her adverse reaction to Allopurinol was not diagnosed until a few days later. The point being made by the Respondent is that it would not have been possible for her to diagnose the adverse drug reaction on 23 December 2009, even if she had seen Mdm P personally.

14. We are unable to agree with this argument that relies on the events post-Mdm P's admission. While with the benefit of hindsight this was the factual scenario, the point by the SMC is: When the Respondent spoke with Mr C on 23 December 2009, she ought to have asked that Mdm P attend a personal examination so that a proper evaluation could be made. Nonetheless, we accept that the nature of medical practice is such that doctors do receive queries from patients or their caregivers through the telephone. It will be too harsh and impractical to impose an absolute rule that doctors must only provide medical care following a physical examination of their patients. In

our view, the necessity for a personal evaluation must be considered in the context of the nature of the relationship between the Respondent and Mdm P at that point in time.

15. The relevant portion of the charge alleges that the Respondent did not perform "any personal evaluation" of Mdm P. We are of the view that an evaluation need not be achieved only through a personal examination of the patient. Communication of symptoms through the telephone could be part of the evaluation process, even though it may not have been the best means of evaluation.

16. We cannot say that no evaluation was performed by the Respondent as alleged in the Charge, when it is undisputed that she had discussed Mdm P's symptoms with Mr C on that day. The discussion of Mdm P's symptoms amounted to a form of evaluation and for that reason, we cannot find that there was no personal evaluation of Mdm P. As we will set out below, we are of the view that Mr C was an effective conduit for the Respondent to receive information from Mdm P.

17. However, this is not to say that the Respondent's evaluation of Mdm P on 23 December 2009 was *adequate*. Given the fact that Mdm P was a patient under a clinical trial, there was a necessity for closer monitoring. Being a senior consultant, and because Mdm P was involved in a clinical trial, we would expect the Respondent to personally examine and review Mdm P before making a decision to stop any medication. While it may well have been the Respondent's judgment not to see Mdm P, we deem the Respondent's judgment was poor, given the fact that since this involved a patient on a clinical trial, there was a possibility that the rash could have been drug or non-drug related and if drug related, whether it might have been due to the trial drug or some other concurrent drug that she was taking. This evaluation would not be possible without having access to a full drug history and the objective clinical evaluation of the nature and extent of rash. It is noted that the Respondent would have been familiar with the patient to know that she is on medication other than the trial drug. This should have been in the Respondent's mind even if consultation was over the telephone.

18. It appears from the evidence that when she spoke with Mr C on 23 December 2009, the Respondent did not consider whether the rash could have been an adverse

reaction from Allopurinol. While the Respondent had testified at the inquiry that she did not think it was Allopurinol because that was prescribed to Mdm P about 6 weeks earlier in November 2009 and without adverse reaction, this appears to be an afterthought. In her response dated 9 November 2009 to the Complaints Committee's query whether she was aware that Mdm P was on Allopurinol during the call, the Respondent stated that she "… *did not recall and was not alerted to the fact that the patient was on allopurinol …*". This omission is relevant to the other aspects of the Charge as we set out below. In our view this omission is a serious one given the circumstances. However, we have to bear in mind that this omission is not the subject matter of this inquiry, a point agreed by both counsel.

<u>The failure of the Respondent to communicate with Mdm P directly / the issue of taking Mdm P's medical history</u>

19. It is undisputed that the Respondent did not communicate with Mdm P directly. The SMC argued that the Respondent did not communicate with Mdm P directly and hence there was no personal evaluation. On the other hand, the Respondent contended that the communication was made with her son Mr C and was adequate.

20. We accept that in certain situations, a doctor may communicate with a patient through a third party. Such communications are fairly common, particularly when the patients are infants or the elderly. We think that it is an accepted medical practice that doctors speak with family members on occasions. Whether it is appropriate to do so depend on many factors, e.g. the nature of the patient, the level of involvement of the care-giver and the communication skills of the patient, to name a few. This is a matter that this tribunal is competent to determine without the necessity for expert evidence.

21. In the present case, from Mr C's testimony, we accept that at the material time, he was the primary care-giver of Mdm P. When he appeared before us, Mr C struck us as a filial son who was very attentive to the needs of his mother. We note that he was specific in his description of her symptoms and was well-versed with the chronology of the treatments. We had no doubt that in that role as a primary care-giver, Mr C was in as good a position as Mdm P herself to communicate with the Respondent about Mdm P's condition.

22. We now turn to the portion of the Charge that alleged that the Respondent failed to obtain or did not attempt to obtain Mdm P's medical history. The basis for this is Section 4.1.1.1 which states, that a doctor is to provide medical care for a patient "*… after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.*"

23. At the onset, there is a distinction between a new patient and an existing patient when one considers the duty of a doctor to obtain a patient's history. Obviously, for an existing patient the duty is less onerous because the doctor would have dealings and knowledge of the patient under his management. In contrast, for a new patient, the duty is more onerous and the history taking must be more comprehensive. This is because the appropriate treatment plan will be based on the patient's medical history, amongst other considerations.

24. While the Respondent had contended that Section 4.1.1.1 is intended for new patients, we do not agree. It can be applied to new as well as existing patients. The key point to note is that there are varying degrees of conduct that can be pursued by a doctor in relation to Section 4.1.1.1, and the appropriate conduct is one that will be dictated by the circumstances of the case.

25. One aspect of a patient's medical history is the medication that had been prescribed. This is even more relevant in the case of a patient like Mdm P who was on multiple medications. The Respondent had relied on her recollection than Mdm P's case notes. While during the call the Respondent did not have the case notes, she provided medical advice based on her recollection. Her counsel submitted that retrieving the case notes would have been a "logistical impossibility". While the retrieval of the case notes may take time, this argument is undermined by the Respondent's own evidence that on the same day, she had sight of the previous prescriptions when she accessed the prescription software (XXX).

26. We note that the Respondent reviewed and treated Mdm P over October and November 2009. She last saw Mdm P on 17 December 2009. She had on 23 December 2009 communicated with her care-giver Mr C about Mdm P's symptoms. While we are of the view that the Respondent could have done more to obtain Mdm P's medical history other than relying on mere recollection, we are unable to say with

certainty that the Respondent had failed to obtain or did not attempt to obtain Mdm P's medical history as alleged. We are prepared to give the benefit of doubt on this aspect.

Whether the Respondent had sufficient information of Mdm P's medication

27. We now turn to the portion of the Charge that the Respondent had, "*without equipping [herself] with sufficient information as to the specific medication [Mdm P] had been prescribed and was taking as at 23 December 2009*", provided medical advice. After hearing the witnesses and evaluating the evidence, we accept that the SMC had proved this aspect of the Charge.

28. It cannot be disputed that one of the main factors that the Respondent must consider when faced with the complaint of rashes is the medication that Mdm P was on. We are not satisfied that when the Respondent spoke with Mr C on 23 December 2009, she had sufficient information about the details of Allopurinol that was prescribed to Mdm P previously. In particular, the Respondent had in her response to the Complaints Committee accepted that she then did not have in mind that the earlier prescription of Allopurinol could have been linked to the rashes. In fact, the response of the Respondent to the Complaints Committee was that she did not recall that Mdm P was on that medication.

29. The Respondent tried to counter this point by arguing that when she accessed the XXX software later in the same day to prescribe the Hydroxyzine, she would have seen the list of prior medications including Allopurinol and considered it. This submission missed the point of the Charge that when the medical advice was given to Mr C during the telephone call earlier in the day, the Respondent did not have this information. It was only later, and *after* the call that the Respondent accessed the XXX. This could not have been operative on the mind of the Respondent when she spoke with Mr C.

30. In any case, it was not even the evidence that the Respondent had considered the prescription of Allopurinol to be relevant. On the contrary, by her own evidence, that factor was never operative on her mind when she dispensed the medical advice to Mr C. Once again, the Respondent's reply to the Complaints Committee on her state of mind is telling.

31. We are therefore of the view that this aspect of the Charge against the Respondent is proven.

Whether there was sufficient grounds for "professional misconduct"

32. Finally, the Respondent had submitted that the misconduct alleged of her, even if it is proven on the facts, is not within the class of misconduct that would be labelled as "professional misconduct".

33. On the facts of the present case, we are of the view that while the Respondent had omitted to consider the prior prescription of Allopurinol, we are not convinced that this failure amounted to professional misconduct. We do not think that there was an "*intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency*" nor was there any abuse of the privileges of a medical practitioner. While the Respondent, in exercising her clinical judgment on that day may have exercised poor judgment, or could even be said to be negligent, we are not convinced beyond a reasonable doubt that there was professional misconduct that warrants a conviction on the Charge as framed.

Observations about expert witnesses

34. In the course of the inquiry, the Respondent called Dr DE as an expert witness and A/Prof DW as a factual witness. While both of them offered their views and opinions on areas of medical practice, we noted that they also volunteered their views on the good character and work ethics of the Respondent. We expect witnesses, in particular an expert witness, to assist this inquiry with unbiased viewpoints, even though they may be sympathetic to a party's cause. The partiality of a witness can undermine his evidence and may even lead to a rejection of his testimony.

35. We express the view above as a reminder to witnesses who may come forward to provide their assistance in these inquiries.

Conclusion

36. The various elements of the Charge were framed in the conjunctive. In this regard, if any of these elements is not proven, then the Charge should fail. We have stated that there was some evaluation and history taking by the Respondent, contrary to the assertions in the Charge.

37. For the above reasons, we are of the view that the Charge against the Respondent should be dismissed.

38. However, we would add that in the course of our deliberations, we had considered whether the Respondent should bear any costs. It is our view that these proceedings had suffered some delay because of firstly, adjournments caused by the Respondent, and secondly, we do not find that it was necessary to delve into matters post Mdm P's admission, which took up sometime during the inquiry. We also found that Dr DE appeared to come unprepared to address the issues at hand in this inquiry, because he was not properly briefed on the nature of the Charge. It is in our view unfair that the SMC be made to bear these costs which are not attributable to the way the SMC had conducted the inquiry. To us, it would have been appropriate such costs be borne by the Respondent since it had been unreasonably incurred, whether by the Respondent or her counsel. As counsel to a large extent influence the manner an inquiry is conducted, we want to make it clear that a tribunal should be ready to make an appropriate order on costs if conduct of a party or its counsel had hampered the conduct of the inquiry, regardless of the outcome.

39. Nonetheless, we had been advised by the Legal Assessor that under the appropriate legislation there is no power to award costs in the event where the Charge is not founded against the Respondent. No order on costs could thus be made.

Publication of the Grounds

40. Finally, we were advised that grounds of an inquiry like the present are usually not published if the charge is not proven against the doctor. However, we order that the grounds and outcome of this inquiry be published, with the names of the Respondent, the institution involved and the various witnesses redacted. We hope that our concerns expressed above will be noted by the relevant healthcare institutions, medical

practitioners and healthcare professionals such that the quality of care for patients is improved. In particular, where it is suspected that a patient suffers a drug allergy, doctors should be apprised of all medications that the patient has been prescribed, before forming an opinion on the possible cause of the allergy. This is all the more so when like in the instant case, it is well-highlighted that Allopurinol is a drug that can have a severe adverse drug reaction. Doctors must also be alert because the onset of symptoms of adverse reaction may be delayed and take some time to manifest, up to 8 weeks. This was what happened in the present case.

41. The hearing is hereby concluded.

Dated this 16th day of June 2014.