SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR GARUNA MURTHEE KAVITHA HELD ON 21 APRIL 2015

Disciplinary Tribunal:
Prof Raj Nambiar - Chairman
A/Prof Rathi Mahendran
Mr James Leong - Legal Service Officer

Counsel for SMC:
Mr Burton Chen
Mr Tham Chang Xian
(M/s Tan Rajah & Cheah)

Counsel for the Respondent:
Mr Lek Siang Pheng
Mr Melvin See
Ms Audrey Sim
(M/s Rodyk & Davidson LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL

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

Introduction

1. These proceedings emanate from a complaint made against the Respondent, Dr Garuna Murthee Kavitha for professional misconduct. The Respondent was referred to this Disciplinary Tribunal by the Singapore Medical Council (SMC) Complaints Committee and the Notice of Inquiry (NOI) dated 4 December 2014 was duly served on her to attend a Pre-Inquiry Conference (PIC) on 21 January 2015. The Respondent informed the Tribunal through her Counsel from the outset that she was not contesting the charge in the NOI and a date was duly fixed for the hearing. The charge against the Respondent read as follows:

"*CHARGES*

1. That you Dr Garuna Murthee Kavitha, are charged that on 31 July 2012, whilst practising as a Medical Officer at Singapore General Hospital, Outram Road, Singapore 169608, you erroneously administered Velcade intrathecally instead of intravenously to a patient, namely one P, deceased ("the Patient"), without ensuring that the route of administration was correct, thereby putting the Patient at risk of severe neurological damage;

Particulars

(a) On or around 23 May 2012, the Patient was confirmed to have a relapse of diffuse large B cell lymphoma.

(b) *On or about 30 July 2012, the Patient was admitted to the Singapore General Hospital for his third cycle of chemotherapy and was scheduled to have chemotherapy administered at the Interventional Radiology Department on 31 July 2012.*

(c) *On or around 31 July 2012, you had erroneously administered Velcade intrathecally to the Patient without checking on the chemotherapy order form which had indicated that the route of administration ought to be intravenous.*

and that in relation to the facts alleged, you have been guilty of professional misconduct within the meaning of section 53(1)(d) of the Medical Registration Act (Cap 174) and in breach of Article 4.1.1.5 of the Singapore Medical Council's Ethical Code and Ethical Guidelines, which is punishable under Section 53(2) of the said Act."

Agreed Statement of Facts

2 At the hearing on 21 April 2015, the Respondent admitted to the charge without qualification. Counsel for SMC and the Respondent agreed to the statement of facts which read as follows:

"***AGREED STATEMENT OF FACTS***

1. *The Respondent (MCR No. M14598Z), is a registered medical practitioner who at the material time was practising as a Medical Officer (in training) at the Singapore General Hospital ("SGH").*

2. *The Respondent faces 1 charge of erroneously administering Velcade intrathecally instead of intravenously to one Mr P ("the Patient"), without ensuring that the route of administration was correct, thereby putting the Patient at risk of severe neurological damage. The charge is found in the Notice of Inquiry dated 4 December 2014.*

3. *On 23 May 2012, the Patient was confirmed to have a relapse of diffuse large B cell lymphoma.*

4. *On 30 July 2012, the Patient was admitted to the SGH for his 3rd cycle of chemotherapy.*

5. *On the morning of 31 July 2012, Dr PF, the haematology consultant in charge of the Patient ordered chemotherapy, namely intravenous Velcade and intrathecal Methotrexate, to be administered to the Patient. For the intrathecal chemotherapy medication (i.e. Methotrexate) that was to be administered to the Patient, arrangements were made for the Patient to undergo lumbar puncture under radiological guidance at the Interventional Radiology Department ("IRD").*

6. *At around 3.20pm on 31 July 2012, the Respondent was informed that the Patient had arrived at the IRD procedure room. The Respondent went to the procedure room to administer chemotherapy medication to the Patient.*

7. *There was only one syringe of chemotherapy medication in the procedure room and it was labelled "Bortezomib 2.6mg in 2.6mls". The accompanying chemotherapy order form stated that there was an order for Velcade 2.6mg (Velcade being the brand name for Bortezomib). Unfortunately, the ward had sent the Patient with the intravenous chemotherapy medication down to the IRD instead of the intrathecal chemotherapy medication.*

8. *The Respondent did not check the route of administration of the Velcade stated on the chemotherapy form, which indicated that the Velcade should be administered intravenously.*

9. *The Respondent then proceeded to administer the Velcade intrathecally, which placed the Patient at risk of severe neurological damage.*

10. *When the Respondent was about to sign the chemotherapy order form after the Velcade was administered, she realised that the Velcade was to be administered intravenously and not intrathecally. She immediately called Dr PF to inform her of what had happened. Dr PF came immediately to attend to the Patient.*

11. *In the circumstances, the Respondent is guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) as alleged in the charge.*"

Mitigation

3. In mitigation, Counsel for the Respondent tendered a written mitigation plea (RSA) highlighting that the error was unintentional and it was unfortunate that the ward had also sent the wrong medicine which the Respondent did not check. The Respondent also disclosed the error immediately and never shield away from accepting responsibility. It was stressed that the Respondent was a very young doctor who had learnt from this unfortunate incident. A financial settlement between the Respondent, the Hospital and the legal representatives of the estate of the patient had also been reached.

4. Strong testimonials from her superiors, colleagues and feedback from the family of a patient were also admitted in evidence to attest to her many admirable qualities as a doctor, human being and friend. A common thread that ran through many of these testimonials was her strong work ethic and sense of integrity. As noted by A/Professor T1 in his testimonial of 12 February 2015:

> "*I am aware of the unfortunate incident for which Dr Kavitha is under investigation. Talking to her current supervisors, including*

the Program Director of her Senior Residency Program and her Head of Department (HOD), T2, as well as the Head of the Department, T3, SGH where the unfortunate event took place, all of them found her remorseful of the incident was a genuine intention to make amends. Dr T3, , was impressed by her honesty and integrity as demonstrated by her reporting of the event at the very first instance, so as to ensure that the patient has the highest chance of accessing to the corrective measures for improvement of the patient chance of survival."

5. The Respondent was also recognised at the Singhealth Best Junior Doctors and Medicine Scholarship Awards 2013 as the Best Medical Officer. This award recognises "… *our top performing Medical officers for their outstanding contributions and service, based on their work performance during their postings at SingHealth over the past 2 years.*"

Submissions on Sentencing

6. Counsel for SMC tendered a written submission on sentencing (PS). They highlighted two cases for the Tribunal's consideration in determining the appropriate sentence.

7. In the first case, a Dr A, was found guilty of infamous conduct in a professional respect (as it was then known) in 1999. He was charged with being grossly negligent in failing to retrieve a long tonsil swab from the patient's trachea immediately after its use or alternatively by failing to take adequate steps to find the said swab despite being told by a Senior Nurse that the swab was missing and only performing a bronchoscopy on the patient after a delay of almost 3 hours. By this time, the patient had died. The Disciplinary Committee (DC) found at page 2 of the Verdict at page 19 of PS that "*if an x-ray had been taken at about 5pm [instead of at 7.30pm after she died], the patient's life could have been saved because it was highly likely [Dr A] would have seen the pneumothorax and the missing swab.*" Dr A was sentenced to a censure, to give a written undertaking to abstain from the conduct complained of, and to pay the costs of the proceedings.

8. In the second case, Dr Eric Gan Keng Seng (Dr Gan) was found guilty of professional misconduct for the wilful neglect of his duties and gross mismanagement of the post-operative management of his patient. Dr Gan had performed a pre-cut sphincterotomy on his patient which concluded unsuccessfully at around 3.50pm. 2 hours later, he was informed that his patient was unwell, but did not examine the patient until the next day, nearly 17 hours after the procedure. The DC found that, at [12] of the Grounds of Decision at page 26 of PS that:-

"12. …..Dr Gan should have personally attended on the Patient and evaluated his condition on 6 December 2005 when he notified that the Patient was unwell following a procedure done by him, especially as results of initial tests were available. Being the

consultant in charge, and by virtue of his accreditation by the hospital to perform the procedure, he would be in the best position to holistically evaluate all available information and adapt management decisions according to the clinical picture, especially as the Patient's condition evolved…."

9. Furthermore, the DC held at [15] that "*a reasonably responsible doctor who has performed a procedure which was unsuccessful and associated with known risks of significant complications, has the responsibility to see the patient in a timely fashion when the Patient had symptoms, signs and tests consistent with such a complication.*" Dr Gan was sentenced to a suspension of 6 months, a censure, to give a written undertaking not to repeat his conduct, and to pay 70% of the costs and expenses of the proceedings, including the costs of the Council's solicitor and the Legal Assessor. He appealed the decision of the DC to the High Court which upheld both the conviction and the sentence.

10. Returning to the facts of the present case, the Prosecution submitted at [20] of their written submission "… *that the Respondent's failure to ensure that the administration of Velcade was done by the correct route did also have the risk of serious complications for the Patient. It is fortunate that she noticed her mistake quickly and informed the senior consultant in charge immediately.* "

11. Counsel for the Respondent tendered separate written submissions on sentencing (RSB) and for the anonymisation of the Grounds of Decision (RSC). With regard to sentencing, it was urged at [2] of RSB that the *"… appropriate sentence to be imposed for this case would be a fine, censure, undertaking not to repeat and the usual cost order.*" In terms of precedents, they also referred to the following table at [5] reproduced below:

	Doctor	No. of Charges found guilty of	Sentence		
			Censure	Suspension	Fine
1	Dr B	1	Yes	-	$3,000
2	Dr X (Medical Council of New South Wales)	-	Yes	-	-
3	Cheah Way Mun	2	Yes	-	$10,000
4	Teh Tze Chen Kevin	4 out of 6	Yes	-	$10,000

12. In stressing that a fine was the appropriate sentence in the instant case, Counsel for the Respondent highlighted various distinguishing factors in each of the precedent cases that made them more serious than in our case. These included the fact that the doctors in those cases were generally more senior, the error took longer to detect before the patient was informed i.e. 4 days in the case of Dr X and a month in the case of Dr Cheah. As for the case of Dr Teh, which was clearly more serious involving tampering with medical records, the similarity relied upon by Counsel for the Respondent was the relative youth of the doctors and the involvement of nursing error.

13. Relying on the Australian case of Dr X found at tab 12 of the Respondent's Bundle of Authorities (RBA), Counsel for the Respondent urged the Disciplinary Tribunal to exercise our discretion to order that the Grounds of Decision be published with the Respondent's name and the name of the institution redacted. It was submitted that the Respondent would be adequately punished by the appropriate orders and the aims of deterrence and the protection of public confidence in the medical profession could be achieved without naming the Respondent. In the case of Dr X, the Australian Medical Tribunal took the position at [20] of their decision that:

> "*The Tribunal considers that the only available appropriate response to the conduct is a reprimand and orders which ensure that those responsible for Dr X's training during the remainder of his period as a registrar are aware of the conduct. By majority, the Tribunal has decided that it is not necessary that the Royal Australian and New Zealand college of Radiologists be made aware of Dr X's identity as there is no risk that the conduct will be repeated.*"

14. In closing, Counsel for SMC stressed that they were not pressing for any particular sentence but were objecting to the application of the Respondent to anonymise the Grounds of Decision to redact the name of the Respondent and the hospital.

15. In arriving at the appropriate sentence, we gave full regard to the Respondent's early plea of guilt and efforts to accept full responsibility for her actions, including sounding an early alert as soon as the mistake was discovered and also apologising, on her own accord, to the family of the patient. We also note the strong testimonials on her behalf and were conscious that she was a young medical officer at the time of the incident. We also gave full regard to the other strong mitigating factors highlighted by Counsel for the Respondent that were not disputed by Counsel for SMC.

16. Having regard to all the circumstances of the case and considering the submissions and precedents cited, we were of the view that the Respondent's culpability was not as high as in the two precedent cases cited by the Counsel for SMC. It is pertinent to note in this regard that unlike in the case of Dr A or Dr Gan, the Respondent noticed her error and reported it immediately, thereby allowing corrective measures to be undertaken. While the patient unfortunately ultimately succumbed to the underlying illness, serious as the mistake was, it did not lead directly to the demise of the patient. On the facts, we also feel that the behaviour of Dr Gan as outlined by the DC at [8] above were more aggravating, thereby eminently justifying the sentence that was imposed on him by the DC and upheld by the High Court.

17. It is axiomatic that each case must be considered on its own facts and circumstances. To this end, while the two cases cited by the Counsel for SMC and those highlighted by Counsel for the Respondent can serve as trend indicators, especially the decision of the DC in Dr Gan's case which was

affirmed on appeal by the High Court, it nevertheless fell on the Disciplinary Tribunal to determine what was appropriate in all the circumstances of the case.

18. While we were of the view that the culpability of the Respondent was not as high as in the two precedent cases cited by the Prosecution as well as those highlighted by Counsel for the Respondent, we did not feel that a sentence of censure as was imposed in the case of Dr A or Dr X was appropriate. In our view, it would not sufficiently register the seriousness of the conduct. Nor would a censure deter such lapses or preserve public confidence in the medical profession. On the other hand, a sentence of suspension as was imposed in Dr Gan's case would also not be appropriate having regard to the circumstances, especially the lower level of culpability and strong mitigating factors. All things considered, we were of the view that a fine of $ 2000 would be the most appropriate sentence in the circumstances, reminding all doctors that they should never fail to check the route of administration before drugs are administered to patients.

19. As for the request to anonymise the publication of the Grounds of Decision, we were not convinced that this was an appropriate case for the Disciplinary Tribunal to exercise such discretion. As noted by Counsel for SMC, it was not entirely clear why the Australian Medical Tribunal decided to anonymise the decision. There was also no indication that the policy considerations and circumstances in Singapore were similar to that in Australia, calling for the adoption of a similar approach. In this regard, we saw no compelling reason to make an exception and depart from the prevailing policy for all Grounds of Decisions to be published without redaction, save as to the identity of the patient.

Orders by this Disciplinary Tribunal

20. Accordingly, the Disciplinary Tribunal determines that the Respondent:-

a) be fined a penalty of **S$2,000.00**;

b) be censured;

c) give a written undertaking to the SMC that she will not engage in the conduct complained of and any similar conduct; and

d) pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Publication of Decision

21. We order that the Grounds of Decision be published.

22. The hearing is hereby concluded.

Dated this 21st day of April 2015.