香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 11 August 2010
Defendant: Dr LAM Kam Toa (林金滔醫生)

1. The charge alleged against the Defendant, Dr LAM Kam Toa is that:

> "On or around 22 December 2008 he, being a registered medical practitioner, disregarded his professional responsibilities to his patient Madam [redacted] ("the Patient") in that he caused or failed to prevent the dispensing of Chlorminol Tab 2mg, which contains Chlorpheniramine, to the Patient with the inappropriate or inaccurate instructions on the drug bag that the said drug was to be taken 4 times a day with 4 tablets each time and once every hour, and such instructions represented an overdose.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of the case

2. The Patient attended the clinic of the Defendant on 22 December 2008 for medical consultation with complaints of left shoulder injury, runny nose, cough and sneeze. The Patient's past health was noted to be good with no drug allergy. The Defendant's diagnosis of the Patient's symptoms was flu. The Defendant prescribed medicines for the Patient, including Chlorminol which is equivalent to Piriton and contains Clorpheniramine. The prescribed medicines were filled out by the clinic assistant and handed to the Defendant for checking before being dispensed to the Patient.

3. On the medicine bag containing Chlorminol 2mg tablets which was dispensed to the Patient, the written instructions were 4 tablets to be taken each time for 4 times a day, once every one hour.

4. The Patient followed the written instructions and took the Chlorminol tablets. After taking the tablets the Patient felt very tired and fell asleep for 6 hours before waking up. When the Patient's husband complained over the telephone to the Defendant, the Defendant discovered that the instructions written on the medicine bag did not tally with his prescription.

Findings of the Council

5. There has been some question of whether the prescribed dosage was one or two tablets of Chlorminol for each dose, given that the photocopied medical record submitted to the Preliminary Investigation Committee showed the medical notation of two tablets whereas the original medical record showed the notation of one tablet seemingly with signs of alteration. Having heard explanation from both sides, and given that it is not an element of the charge, we are of the view that it is not necessary for us to make any finding in this respect. We shall resolve this apparent inconsistency between the original and photocopied medical record in favour of the Defendant and proceed on the basis of the prescription of one tablet for each dose.

6. It is agreed between parties that the instructions on the medicine bag were wrong and would cause an overdose if followed. The written instructions could result in the Patient taking 16 tablets within 4 hours, instead of the intended dosage of 1 tablet every 4 hours as prescribed.

7. It is also agreed that the Defendant had checked the medicine bag and the instructions written thereon before the medicine was dispensed to the Patient. However, he did not notice the wrong instructions.

8. The Defence admits that the Defendant's conduct in failing to ensure that proper instructions were written on the medicine bag would constitute professional misconduct.

9. Doctors in Hong Kong are given the legal right to dispense medicines. Corresponding to that legal right there is a professional duty to ensure that the medicines are properly dispensed with the proper instructions. Paragraph 10.1 of the Professional Code and Conduct provided that "*A medical practitioner who dispenses medicine to patients has the personal*

responsibility to ensure that the drugs are strictly in accordance with the prescription and are properly labelled before the drugs are handed over to the patients. The practitioner should establish suitable procedures for ensuring that drugs are properly labelled and dispensed…." It is a personal duty which cannot be delegated, although doctors may engage other persons such as clinic assistants to assist him in discharging that professional duty.

10. Depending on the medicine involved, incorrect instructions for the dosage can have serious consequences. Doctors must exercise due diligence to ensure that the instructions are correct before dispensing the medicines to patients.

11. No explanation has been given as to why upon checking the medicine bag the Defendant did not discover the obvious mistake in the written instructions. Given that the whole purpose of checking is to ensure that the dispensed medicine corresponds with the prescription, the Defendant would have noticed the mistake if he had taken due care to compare the instruction with the prescription.

12. We are satisfied that the Defendant's conduct has fallen below the standard expected amongst registered medical practitioners. We find the Defendant guilty of professional misconduct as charged.

Sentencing

13. The Defendant has a clear record. His name is included in the Specialist Register under the specialty of Paediatrics.

14. Given the potentially serious consequence that can follow from improper drug labelling, all doctors must treat the matter with due care. The requirement of proper labelling of dispensed drugs has been included in the Professional Code and Conduct since 1996. This Council has repeatedly emphasized in previous cases the importance of proper drug labelling, and that improper labelling is a serious misconduct. Since 2002 and with the exception of one case, all cases of improper drug labelling have been consistently dealt with by orders of removal from the General Register, and suspended for a period where there are circumstances justifying suspension. The message to the profession is loud and clear.

15. According to MIMS, the maximum dosage for Chlorphenamine is 24 mg daily If the Patient had followed the instructions, she could have taken 32 mg (i.e. 16 tablets x 2 mg) within 4 hours.

16. The Defendant in this case has taken measures to ensure that the dispensed drugs are properly labelled. He only fell at the last hurdle and failed to exercise due care when checking the medicine and the instructions. This appears to be a one-off incident.

17. The Defendant has taken remedial action after the incident. We shall also give him credit for his honest admission to the Preliminary Investigation Committee and in this inquiry. That reflects his remorse and insight into his misconduct, which in turn will have a bearing on the likelihood of re-offending.

18. We are cognizant of our duty to protect the public. In view of the lesson the Defendant has learned from this case and the remedial action he has taken, we are of the view that it is unlikely that he will re-offend. In the circumstances, this is a case in which we feel that we can temper justice with mercy and make a less severe order.

19. Having regard to the gravity of the case and the mitigating factors, we order that the Defendant be reprimanded. The order shall be published in the Gazette in accordance with the provisions of the Medical Registration Ordinance.

Other remarks

20. We note that the Defendant's name is included in the Specialist Register. While it is for the Education and Accreditation Committee to consider whether any action in respect of his specialist registration should be taken under section 20N of the Medical Registration Ordinance, we do not think that this case reflects adversely upon his suitability to remain on the Specialist Register.

21. In light of the development in this case, we need to urge all parties to exercise proper care in drawing up agreed facts to ensure that the agreed facts are founded upon solid evidential basis. The Legal Officer, given his responsibility for prosecuting the case, should make a proper judgment as to

his position regarding any facts proposed to be agreed. Where necessary, the original documents should be inspected before drawing up the agreed facts. Furthermore, appropriate investigation should be made to ascertain relevant matters, including matters relevant to the gravity of the case, particularly where opposing versions are provided by prosecution and defence witnesses. An example in the present case is the number of Chlorminol tablets taken by the Patient.

Prof. Felice Lieh-Mak, CBE, JP
Chairman, Medical Council