香港醫務委員會
The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Dates of hearing: 17 May 2011 (Day 1), 26 Aug 2011 (Day 2), 22 November 2011 (Day 3)
Defendant: Dr SUNG Kei Yu (宋奇瑜醫生) (M06400)

1. The charge against the Defendant, Dr. SUNG Kei Yu, is that:

> "On or about 5 July 2009, she, being a registered medical practitioner, disregarded her professional duty to her patient [redacted] ("the Patient") in that she prescribed Amoxil to the Patient when she knew or should have known that the Patient was allergic to penicillin and ampicillin.
>
> In relation to the facts alleged, she has been guilty of misconduct in a professional respect."

2. The Defendant appeared in person on Day 1 and confirmed that it was her decision not to be legally represented. From Day 2 onwards she was represented by Defence Counsel.

3. Amoxicillin is the generic name for Amoxil, and we use them interchangeably for the purpose of this case.

Facts of the case

4. In 1995 the Patient had severe allergic reaction to penicillin, and was told to carry an allergy card (which stated that she was allergic to penicillin and ampicillin) with her whenever she sought medical treatment. She was warned that there would be serious consequence if she took penicillin, and could even die from the allergic reaction. From then on, she made sure that she informed the doctor that she was allergic to penicillin.

5. The Patient had been consulting Dr Ho since 2005. When she first consulted Dr Ho, she told Dr Ho of her allergy and showed him the allergy card.

6. The Defendant started to work as a locum doctor at the clinic of Dr Ho in March 2009. On 7 July 2009 the Patient went to the clinic to seek treatment for her stomach pain. Dr Ho was on leave and the Patient was seen by the Defendant. After consultation, the Defendant prescribed 6 medicines including Amoxil to the Patient.

7. After returning home, the Patient took the medicines as instructed and started to feel itchy. As she had told the Defendant about her allergy, she did not suspect that the Defendant would have prescribed to her a drug to which she was allergic. She continued to take the medicines as instructed. Shortly after taking the 2nd dose, she began to have swelling and severe itchiness, increased heart rate and difficulty in breathing. She telephoned her son for help.

8. When the Patient's son learned of her mother's symptoms after taking the medicines prescribed by the Defendant, he immediately took her to the hospital. The Patient was given treatment for allergy. After her condition stabilized, she was discharged from the hospital. She continued to suffer from allergic reaction of shedding of skin until August 2009.

Findings of the Council

9. The Defendant admitted that the Patient had informed her of her allergic history, and that she had prescribed Amoxil to the Patient. The Defendant claimed that the Patient could not name the offending drug and that no drug allergy was documented in the medical record.

10. According to Dr Ho, the Patient's allergy was documented on the front page of the Patient's medical record as "*Drug Allergy: Penicillin*". The allergy entry was also prominently highlighted by a red asterisk and a red sticker.

11. Both the Patient and her son testified that on the first consultation in 2005, they had informed Dr Ho of the Patient's allergy to penicillin and had seen Dr Ho writing down the allergy in the medical record.

12. The Patient said that on 7 July 2009, she told the Defendant that she was

allergic to penicillin and would have reactions including facial swelling, oozing from the skin and breathing difficulty.

13. The Defendant alleged that:-

    (a) the Patient had only said that she had allergy but did not know the name of the offending drug;
    (b) she had asked the Patient for the allergy card but the Patient did not bring it with her;
    (c) she had checked the medical record but could not find any documentation of drug allergy;
    (d) she had noted that Buscopan had been prescribed and hyosine injection had been given previously, therefore she prescribed the six medicines which included Buscopan and Amoxil, and told the patient that she should stop taking the medicines and see a doctor if she developed any allergic reaction such as itchiness or skin rash.

14. The Defendant also claimed that the medical record she saw on 5 July 2009 began with entries in 2009 with several pages filled up, and was not the one produced by Dr Ho as evidence in this inquiry.

15. Having considered all the evidence, we find the Patient, the Patient's son and Dr Ho to be honest and reliable witnesses. We accept their evidence. We shall highlight the salient reasons for doing so:-

    (a) Their evidence is consistent with each other.

    (b) Their evidence is corroborated by the medical record of the clinic.

    (c) Although the Patient was 75 years old in 2009 and was illiterate, her evidence was candid and clear.

    (d) While the pharmacological names of drugs may be difficult to remember by lay persons, in particular illiterate persons, penicillin has been a household term for decades and is familiar to most people in Hong Kong.

    (e) A patient who has had severe allergic reactions to penicillin and has been warned of the risk of death will be eager to ensure that the doctor knows about the allergy before prescribing medicines.

(f) Dr Ho's evidence was consistent with the evidence of the Patient and her son in respect of documentation of the Patient's allergy in the medical record.

(g) According to the medical record, Dr Ho had never prescribed to the Patient any drug in the penicillin group in any of the sixteen consultations from 6 April 2005 to 28 April 2009. This is consistent with the documentation of allergy in the front page of the medical record.

16. We find the Defendant to be an unreliable witness. We reject her evidence. Again, we shall highlight only the salient reasons for doing so:-

(a) The pages in the medical record produced by Dr Ho were continuous from 6 April 2005 to 12 October 2009, with the entry on 5 July 2009 written by the Defendant in the middle of the 6th page. There was no room for insertion of another front page in the manner as alleged by the Defendant.

(b) The Defendant said that she had seen previous prescription of Buscopan in the medical record which allegedly commenced in 2009. However, according to the medical record, there was prescription of Buscopan only on 20 February 2006, 17 March 2006 and 7 May 2008. If she had seen the documentation of Buscopan prescription, the record she saw must have commenced before 2009.

(c) The Defendant also said that she had seen previous entry of injection of Hyosine in the medical record. However, there was no record of such injection being given to the Patient.

(d) During cross-examination of the Patient, the Defendant put to the Patient that she had been given Buscopan injection. However, later she changed her evidence that oral Buscopan and Hyosine injection had been given.

(e) Given the deep impression of the allergic reaction on the Patient, it was unlikely that the Patient was unable to name the offending drug when asked by the Defendant.

17. We are satisfied that the Patient had told the Defendant that she was allergic to penicillin, and that the medical record clearly stated that the Patient had penicillin allergy.

18. The group of penicillin antibiotics includes Amoxil. A doctor should know that patients who are allergic to penicillin will also be allergic to Amoxil.

19. Given the Patient's known allergy to penicillin, the Defendant should not have prescribed Amoxil to the Patient.

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

Sentencing

21. The Defendant has a previous disciplinary record in 1998. She was convicted of 6 counts of the criminal offence of failing to keep proper records of dangerous drugs.

22. We note with surprise that Defence Counsel in his address to this Council on Day 2 that the Defendant has a clear record and therefore is of a lesser propensity to commit the misconduct or to lie about the facts. This is a blatant misrepresentation of the true position, which has the effect of misleading the Council in deciding on the judgment. Although Defence Counsel said that he was given the instruction that the Defendant was of clear record, we must point out that it is the professional duty of all legal representatives to verify the position before acting on such instruction. There was no reason that Defence Counsel did not verify the position with the Secretary before making that submission. Defence Counsel and those instructing him must bear in mind that it is serious misconduct to mislead the Council sitting as an adjudicatory tribunal. If necessary, we will bring such matters to the attention of the relevant professional regulatory body for consideration.

23. We see no mitigating factor at all. Defence Counsel argued that the Patient was to blame, because she should have known that penicillin was a type of antibiotic and should have refrained from taking the medicine which she

knew was an antibiotic. He also argued that there would have been no complaint if the Patient's son had not demanded compensation. He also blamed the nurse for not drawing the Defendant's attention to the Patient's allergy to penicillin.

24. We are concerned that the Defendant had no insight whatsoever into her misconduct. All that she was doing was to blame others (including the nurse, the Patient and her son) for her own misconduct. We are also surprised that she would have told Defence Counsel that she had no previous disciplinary record. We are concerned that if she continues to practise with that attitude, she will be a danger to the public.

25. Having considered the gravity of the case and our duty to protect the public, we order that the Defendant's name be removed from the General Register for a period of 3 months. The order cannot be suspended.

26. While it is for the Council to consider the application for restoration (if any) as and when it is made, we recommend that the Council should require cogent evidence of the Defendant's rehabilitation from her misconduct, including but not limited to completion of continuing medical education on medical therapeutics and safe prescribing to the equivalent of 10 CME points.

Dr James CHIU
Temporary Chairman, Medical Council