香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 21 May 2009

Defendant: Dr LI Sai Lai Ronald (李世澧醫生)

1. The charges alleged against Dr LI Sai Lai Ronald are that:

> "He, being a registered medical practitioner:-
>
> (a) on or about 3 January 2005, after an order for Simethicone had been placed with a pharmaceutical supplier for use in his medical practice, failed to take adequate steps to ensure the drug received from the said supplier was in fact Simethicone; and/or
>
> (b) between January 2005 and May 2005, having prescribed Simethicone to about 153 patients, failed to take adequate steps to ensure that the drug dispensed to the said patients was in fact Simethicone.
>
> In relation to the facts alleged, he has been guilty of misconduct in a professional respect."

Facts of case

2. The Defendant Doctor operated a clinic in Chuk Yuen Shopping Centre, Wong Tai Sin.

3. The Defendant Doctor was included in the General Register from 1 January 2005 up to the present.

4. At the material time, he had in his employment three clinic assistants. These persons did not receive any formal medical or paramedical training.

5. On 2 January 2005 a clinic assistant, Ms. Kwan Mo Yin, placed an order for Quali-Ampclox capsules and Simethicone tablets.

6. On 3 January 2005 two drugs were delivered to the Defendant Doctor's clinic together with an invoice and a Poison Order Form. The two drugs were Quali-Ampclox capsules (3 x 1000 capsules) and Qualizide Tab 80mg (3 x 1000 tablets). The Defendant Doctor signed the Poison Order Form but did not check whether these were the drugs ordered by the clinic. The clinic assistant, Ms. Wong Oi Lan, received the drugs.

7. The clinic assistants Ms. Kwan Mo Yin and Ms. Wong Oi Lan noticed that the name of the drug, size of the bottle and pill size were different from Simethicone. It is unclear whether the clinic assistant Ms. Kwan Mo Yin telephoned Mr. Mar Lick Hang of Quality Pharmaceutical Laboratory Ltd to enquire whether the drug delivered was Simethicone. Nevertheless the bottle that contained Qualizide was labelled by hand as "Simethicone" by clinic assistant Ms. Wong Oi Lan.

8. From the period between January and May 2005 the Defendant Doctor prescribed Simethicone to about 153 patients but the drug dispensed was actually Qualizide. The Defendant Doctor did not personally check the drug dispensed. The dispensing was done entirely by the clinic assistants.

9. In May 2005 the Defendant Doctor was alerted to the fact that he was dispensing Qualizide instead of Simethicone. He then proceeded to cross out "Simethicone" and wrote "Diamicron" on the bottle of Qualizide tablets.

10. The above facts are not in dispute.

Charge (a)

11. Registered medical practitioners in Hong Kong have the privilege of dispensing drugs to patients. Coupled with this privilege is the responsibility to ensure that drugs they obtained for use in medical practice are in fact the ones they sought to obtain. Should the registered medical

practitioner delegate this duty to non-qualified persons, he must exercise effective personal supervision and retain personal responsibility.

12. We are satisfied that the Defendant Doctor failed to take adequate steps to ensure the drug received from the supplier was in fact Simethicone. He signed the Poison Order Form but did not check whether the drugs received were the ones ordered by the clinic.

13. We are satisfied that the Defendant Doctor's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that his conduct constitutes professional misconduct. We find him guilty of charge (a).

Charge (b)

14. Registered medical practitioners in Hong Kong have the privilege of dispensing drugs to patients. Coupled with this privilege is the responsibility to ensure that the correct drug is dispensed to his patients. This is a responsibility that cannot be delegated to non-qualified persons.

15. The dispensing of wrong drugs may lead to dire consequences to the patients. It may lead to death, permanent disability or unnecessary prolongation of the patient's illness.

16. We are satisfied that between January 2005 and May 2005, the Defendant Doctor, having prescribed Simethicone to about 153 patients, failed to take adequate steps to ensure that the drug dispensed to the said patients was in fact Simethicone. The Defendant Doctor did not personally check the drug dispensed. The dispensing was done entirely by the clinic assistants.

17. We are satisfied that the Defendant Doctor's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that his conduct constitutes professional misconduct. We find him guilty of charge (b).

Sentencing

18. The Defendant has a previous record. We note that the previous conviction involved the failure to keep a proper register of Dangerous Drugs.

19. Although the nature of the drugs are different, both incidents involved a lack of proper care in the handling of drugs.

20. There is no mitigating factor of weight apart from the fact that the Defendant has been cooperative in the Inquiry and has admitted all the facts.

21. The dispensing practice of the Defendant has resulted in wrongly giving Qualizide instead of Simethicone to about 153 patients over a period of five months. We would like to emphasize that Qualizide is classified as a Part I, Schedule 3 poison, whereas Simethicone is not. The wrong dispensing of Qualizide can lead to serious and potentially fatal consequences.

22. In general, any wrong dispensing of drugs can have serious consequences, and registered medical practitioners must take adequate steps to prevent this from happening.

23. Having regard to the gravity of the case and the mitigating factors, we order that the Defendant's name be removed from the General Register for two years. We further order that such order shall take effect upon its publication in the Gazette. This will prevent delay of removal by further legal procedures of appeal. We have taken this move as we are satisfied that the Defendant's substandard dispensing practice poses a danger to the public and the immediate removal is necessary for the protection of the public.

24. We would have imposed a heavier sentence of three years if not for the Defendant's cooperation in the Inquiry.

25. Although any application for restoration to the General Register is a matter to be decided when the application is made, we recommend that the Defendant should present plans for improved dispensing of drugs to the satisfaction of the Council.

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