香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 10 February 2010
Defendant: Dr LEE Suk Yee (李淑儀醫生)

1. The charges alleged against the Defendant Dr LEE Suk Yee are that:

"On 13 November 2007, she, being a registered medical practitioner, disregarded her professional responsibility to her patient, a minor of about 27 months old and weighing about 13.2kg at that time, in that :-

(a) she, inappropriately or without proper indication, prescribed Indylon (indomethacin) suppository 100mg (hereinafter referred to as the "medication") to the minor patient ;

(b) she inappropriately prescribed the medication at a dose above the recommended dose ; and

(c) she failed to give proper advice to the patient's father on the dosage of the medication when the father raised doubts about the dosage of the medication.

In relation to the facts alleged, she has been guilty of misconduct in a professional respect."

<u>Facts of the case</u>

2. The Defendant has been a registered medical practitioner since 31st August 1996 in Hong Kong. She holds the following qualifications: MBBS(HK) and MRCP(UK). At all material times, the Defendant was a registered medical doctor in Hong Kong.

3. On 13th November 2007 the minor patient was taken by his father to see the Defendant. This was the first occasion on which the Defendant had seen the minor patient. The minor patient was 27 months old and weighed 13.2 kg at the time of the consultation.

4. The child presented with a fever of 38.3ºC and the father sought the Defendant's advice. The diagnosis made by the Defendant was fever. She prescribed Indylon (Indomethacin) to be taken as a suppository, 100 mg to be given rectally every 8 hours. Three doses were prescribed which were to be given over one day, amounting to 300 mg per day.

5. In a telephone call by the father to the Defendant following the consultation on 13th November 2007, the father told the Defendant that the dosage she prescribed was excessive and was not appropriate for the patient. On 15th November 2007, the Defendant telephoned the father and told him that the dosage of Indomethacin prescribed was excessive and inappropriate.

6. It is accepted by the Defendant that she inappropriately or without proper indication prescribed Indylon (Indomethacin) suppository 100 mg to the patient on 13th November 2007.

7. It is accepted by the Defendant that she inappropriately prescribed the medication at a dose above the recommended dose.

8. It is accepted by the Defendant that she failed to give proper advice to the father on the dosage of the medication when the father raised doubts about the dosage of the medication sometime after the consultation, and that on 15th November 2007, the Defendant informed the father that she had rectified the dosage of the medication.

9. It is agreed that the medication was never taken by the patient and that the patient has suffered no harm or injury as a result of this incident.

10. The Defendant admitted that the dosage of Indomethacin she prescribed to the minor patient was excessive and was inappropriate on 15th November 2007. In the PIC submission which was submitted on her behalf in these proceedings, the Defendant admitted the matters set out in paragraph 6 and 7 above. The Defendant admitted the matter set out in paragraph 8 above except for the part

"and that on 15th November 2007, the Defendant informed the minor patient's father that she had rectified the dosage of the medication."

<u>Evidence of the father of the minor patient</u>

11. The father gave evidence. The relevant evidence of the father is as follows-

(a) He took his son who was aged 27 months old on 13th November 2007 to consult the Defendant. The patient had a fever of 38.3 degree Celsius and he weighed 13.2kg.

(b) The diagnosis made by the Defendant was fever caused by viruses.

(c) The Defendant prescribed three suppositories to the patient to be inserted every eight hours if the body temperature exceeded 39 degree Celsius. The suppositories were Indylon (Indomethacin) and each was 100mg.

(d) The father initially thought that the suppositories were Panadol. When he was about to give the medicine to the patient, the father noticed that the medicine prescribed by the Defendant was Indylon (Indomethacin) suppository 100mg. Subsequently, he checked the dosage from the British National Formulary and Lexi-comp Drug Information Handbook, and found that the daily dosage of Indomethacin prescribed (300mg per day) was over five times the recommended dosage of up to 4mg/kg/day.

(e) He called up the Defendant on the same day and informed her that the dosage she prescribed was excessive and was not appropriate for the minor patient. The Defendant replied that the dosage of the medicine prescribed was in accordance with the guidelines issued by the pharmaceutical companies to doctors. Furthermore, she said that she also prescribed the same dosage to children in private clinic as well as in private hospital.

(f) When the father pointed out that the dosage for children should be 4mg/kg/day, the Defendant answered that if the dosage were 4mg/kg/day, then Indomethacin 100mg dosage would be reduced by half for the patient. The Defendant asked if the father would need a written reply. The father replied that it would be up to the Defendant.

(g) The father did not give the patient the suppositories.

(h) On 15th November 2007, the Defendant phoned the father and told him that the dosage of Indomethacin she prescribed to the patient had been excessive and inappropriate.

Expert opinion

12. Dr Barbara CC Lam was called as an expert witness by the Legal Officer. Her opinion included the following –

(a) Indomethacin is a non-steroidal anti-inflammatory agent. According to the British National Formulary (BNF) for children, the indication for use in children is for the relief of pain and inflammation in rheumatic diseases and closure of patent ductus arteriosus in premature infants. Because of the higher risk of side effects and the availability of other antipyretics with fewer side effects e.g. Paracetamol, it is generally not recommended as a first line treatment for fever in young children in the absence of a systemic disease like rheumatic arthritis or other autoimmune disorders.

(b) The prescription of Indomethacin as a first line drug for the relief of fever in a young child of 27 months without an obvious identified focus is considered inappropriate.

(c) The appropriate dosage, even if indicated, for the minor patient who weighed 13.2kg should be at a maximum of 15mg two times per day, a total of 30mg per day at a maximum. Hence the dosage of 300mg for a day was ten times the recommended dosage.

(d) Excessive dosage of Indomethacin can lead to shutdown of the kidneys, accumulation of fluid and rectal irritation and bleeding when given as a suppository.

Findings of Council

13. Neither the evidence of the father nor the evidence of the expert was challenged. In fact, all allegations in the charges were admitted by the Defence. We accept the evidence of both the father and the expert.

14. All medical practitioners owe patients a duty of care. The exercise of that duty includes prescribing the appropriate medications which are specifically

indicated. The dosage of such medication must be accurate. This is especially important in the treatment of children where the dosage varies markedly with body weight.

15. A medical practitioner should advise patients on the treatment to be provided, particularly when the patient specifically asks about it. When a patient raises question about the propriety of the treatment, there is all the more reason to exercise additional care to verify whether the treatment and the medication (including dosage) are appropriate. Timely and accurate answers must be given upon enquiry.

Charge (a)

16. Having considered all the evidence, we are satisfied that the Defendant's prescription of Indomethacin suppository 100mg to the minor patient was inappropriate and without proper indication. We are satisfied that the facts of Charge (a) have been proved, and the Defendant's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that this constitutes misconduct in a professional respect. We find the Defendant guilty of Charge (a).

Charge (b)

17. Having considered all the evidence, we are satisfied that the Defendant prescribed the medication at a dose above the recommended dose. We are satisfied that the facts of Charge (b) have been proved, and the Defendant's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that this constitutes misconduct in a professional respect. We find the Defendant guilty of Charge (b).

Charge (c)

18. Having considered all the evidence, we are satisfied that the Defendant failed to give proper advice to the minor patient's father on the dosage of the medication when the father raised doubts about the dosage of the medication. We are satisfied that the facts of Charge (c) have been proved, and the

Defendant's conduct has fallen short of the standard expected amongst registered medical practitioners. We are satisfied that this constitutes misconduct in a professional respect. We find the Defendant guilty of Charge (c).

Sentencing

19. The Defendant has a clear record.

20. The Defendant cooperated with the investigation conducted by the PIC and this Inquiry. The Defendant has been active in continuous medical education and has completed a course in drug safety in 2009. She has enrolled and started a Diploma course in child health in early 2010.

21. However, this case is serious in that a drug was inappropriately given to a small child. In addition, the dose of that drug was ten times the maximum recommended dose for a child of 27 months old weighing 13.2kg. The overdose of this medication could result in shutdown of the kidneys, accumulation of fluid and rectal irritation and bleeding when given as a suppository.

22. That no harm had come to the child was the result of the vigilance and prompt action of the father who was knowledgeable about drugs.

23. Furthermore, the Defendant failed to give proper advice to the patient's father on the dosage of the medication when the father raised doubts about the dosage of the medication.

24. Having regard to the gravity of the case and the mitigation advanced on the Defendant's behalf, we order that –

    (a) In respect of Charge (a), the name of the Defendant be removed from the General Register for a period of three months.
    (b) In respect of Charge (b), the name of the Defendant be removed from the General Register for a period of three months.
    (c) In respect of Charge (c), the name of the Defendant be removed from the General Register for a period of three months.
    (d) The above orders shall run concurrently.

(e) We further order that the removal order be suspended for a period of one year.

25. We wish to emphasize that had it not been for the remorse shown by the Defendant as reflected by her full cooperation during preliminary investigation and the inquiry and the remedial actions taken, we would not have suspended the operation of the removal orders. We also take into consideration that the likelihood of re-offending is low.

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