香 港 醫 務 委 員 會

The Medical Council of Hong Kong

DISCIPLINARY INQUIRY
MEDICAL REGISTRATION ORDINANCE, CAP. 161

Date of hearing: 30 June 2011
Defendant: Dr CHAN Sau Ha (陳秀霞醫生) (Reg. no M06003)

1. The charges alleged against the Defendant, Dr CHAN Sau Ha, are that:

> "She, being a registered medical practitioner, disregarded her professional responsibility to her patient A ("the Patient"), a child at the age of 4, in that:-

(a) she dispensed an excessive dose of paracetamol to the Patient on 7 August 2008 by dispensing (1) paracetamol syrup; and (2) Biogesic suspension;

(b) she failed to indicate on the drug label the strength of the paracetamol syrup dispensed to the Patient on 7 August 2008;

(c) she failed to indicate on the drug label the strength of Celexin (Cephalexin granules) dispensed to the Patient on 7 August 2008;

(d) she failed to indicate on the drug label the strength of Chlorpheniramine syrup dispensed to the Patient on 9 August 2008;

(e) she failed to indicate on the drug label the strength of Celexin (Cephalexin granules) dispensed to the Patient on 9 August 2008;

(f) she failed to indicate on the drug label the strength of one of the medicines, which is in liquid form, with the drug name written on the said drug label being not legible, dispensed to the Patient on 9 August 2008;

(g) she failed to properly label one of the medicines, which is in liquid

form, dispensed to the Patient on 9 August 2008 in that the name of the said medicine written on the drug label is not legible.

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

Facts of the case

2. The Patient was 4 year old when she was taken by her aunt to see the Defendant on 7 August 2008. According to the medical record of the Defendant, the Patient had a fever at 38.7 degrees Celsius and the pharynx and tonsils were congested, and the Patient's general condition was satisfactory. The diagnosis was Upper Respiratory Tract Infection. The Defendant prescribed and dispensed 3 medications for the Patient, including paracetamol syrup and "Biogesic 250 Paracetamol" which contained paracetamol.

3. On 9 August 2008, the Defendant saw the Patient again and prescribed and dispensed other medications.

4. It is not disputed that the medications were not properly labelled, either as to the name or strength of the medication.

5. After taking the medications, the Patient's father noticed that the Patient vomitted and lost her appetite. On 21 August 2008, he took the Patient to the Accident and Emergency department of a public hospital. After the doctor in the hospital had clarified over the telephone with the Defendant the dosage of the medications prescribed and dispensed, the Patient was investigated for suspected paracetamol overdose. The investigation findings were unremarkable, and the Patient was discharged from the hospital on 22 August 2008.

Findings of the Council

6. The Defendant in his submission to the Preliminary Investigation Committee argued that there was no overdose of paracetamol, because the Biogesic suspension was dispensed as a replacement for the paracetamol syrup when the Defendant found that the Patient refused to take and spat out the

paracetamol syrup because of its taste. However, the Defendant did not insist on retrieving the paracetamol syrup from the Patient's aunt. The Defendant also claimed that the strength of the Biogesic suspension had been diluted to 125mg/5ml.

7. This position was maintained until the inquiry when the Defendant's solicitors admitted that the Defendant dispensed both the paracetamol syrup and the Biogesic suspension to the Patient.

8. We have examined the original of the medical record maintained by the Defendant. The prescription of paracetamol and Biogesic suspension was recorded in blue ink and consecutively numbered as items 3 and 4. There were other notes in pencil in the 7 August 2008 entry, including that the Patient spat out the paracetamol syrup and that on 11 August the father telephoned to make enquiries. This clearly showed that both the paracetamol syrup and the Biogesic suspension were prescribed at the same time, contrary to the Defendant's claim that the Biogesic suspension was only prescribed as a replacement after the Patient spat out the paracetamol syrup. We find that the Defendant prescribed the two medications concurrently, which is a fact now admitted by the Defendant.

9. Laboratory examination confirmed that the Biogesic suspension contained 240mg/5ml, not 125mg/5ml as claimed by the Defendant.

10. According to the British National Formulary for Children 2007, the maximum daily dosage of paracetamol for a child of age 1 to 5 years is 1,000mg, and in case of severe symptoms 90mg/kg of the patient's body weight. According to the Patient's weight of 17 kg, the maximum daily dosage for severe symptoms was 1,530mg.

11. The dosage of paracetamol (including the paracetamol syrup and the Biogesic suspension) being prescribed and dispensed to the Patient was 2,250mg/day. This was more than two times the maximum dosage of 1,000mg/day. It is a clear case of overdosage.

12. According to the medical record of the Defendant, in particular the note that the Patient's general condition was satisfactory, we are of the view that the Patient did not have severe symptoms. Even if the Patient had severe

symptoms, the dosage was still well in excess of the maximum dosage of 1,530mg/day.

13. There are well recognized problems associated with paracetamol overdosage in children, including liver toxicity after acute overdose.

14. Paragraph 10.1 of the Professional Code and Conduct (as amended in August 2005) 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*". It is a personal responsibility of a doctor which cannot be delegated to other persons.

15. The Defendant's conduct in prescribing and dispensing medications which represented an overdose of paracetamol has clearly fallen below the standard expected amongst registered medical practitioners and constituted professional misconduct. We find her guilty of charge (a).

16. Charges (b) to (f) are all related to failure to label the dispensed medications with the strength of the medications. Under paragraph 10.2 of the Professional Code and Conduct (August 2005), all medications should be properly labelled with the essential information including, inter alia, the dosages where appropriate. Whether it is necessary to label the strength of the medication depends on the nature of the medication. While it is not necessary in respect of medications (such as commercially marketed capsules and tablets with standardized strength) the strength of which is readily ascertainable, this is essential in respect of medications (such as medications prepared or reconstituted by the doctor) where the strength cannot be readily ascertained. Without information on the strength, it is not possible to know the dosage of the medication dispensed. This is particularly important where the medication has potentially serious consequence if taken excessively.

17. Doctors should bear in mind that the purpose of mandatory labelling of dispensed medication is to ensure that other doctors involved in the subsequent treatment of the patient can readily ascertain the nature and dosage of medications which the patient has taken.

18. The medications in question in charges (b) to (f), i.e. paracetamol, Celexin, chlorpheniramine and Eurotolin, are all potentially dangerous if taken excessively. The respective strength is not readily ascertainable. It is essential that the medications be labelled with the strength.

19. We are satisfied that the Defendant's conduct in failing to label the medications in question with the respective strength has fallen below the standard expected and constituted professional misconduct. We find her guilty of charges (b) to (f).

20. As to charge (g), the name of the medicine on the label was illegible. Although a person knowing the name of the medication may be able to discern the poor handwriting as a resemblance of the word "Eurotolin", it must be borne in mind that the drug label is intended to be read by other persons not the writer of the drug label. To label a medication in an illegible manner defeats the very purpose of drug labeling. We are satisfied that the Defendant's conduct in this respect was below the standard expected and constituted professional misconduct. We find her guilty of charge (g).

21. In conclusion, we find the Defendant guilty of each and every charge against her.

Sentencing

22. The defendant has a clear record.

23. We shall give the Defendant credit for admitting the charges. The admission came just about a week before the inquiry, thus requiring full investigation by the Preliminary Investigation Committee and extensive preparation for the inquiry by the Legal Officer, requiring that four expert reports be prepared by the expert witness. Nevertheless, as Defence Counsel said, a late admission is better than no admission at all. However, the credit will be less than the credit to be given in cases of admission at the earliest opportunity.

24. We must have regard to the fact that the medications are potentially dangerous when overdosed, particularly in a patient of tender age. The way the prescription was made causes us concern as to whether the Defendant was aware of the danger of prescribing two different formulations of the same

medication concurrently. It was only fortunate that the Patient has not suffered permanent physical damage. If she continues in such practice, it will be dangerous to her patients. While Defence Counsel urged on us that the likelihood of re-offending is low, there is no evidence that the Defendant realizes the problem with her prescription approach or that she has taken any remedial measure to address that problem. Nevertheless, we accept that her last minute admission to some extent reflects her insight into the problem and her remorse.

25. We have to reiterate with emphasis the following statement made by this Council in a case on 11 August 2010:-

> "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 (now replaced by the Code of Professional Conduct) since 1996. This Council has repeatedly emphasized in previous cases the importance of proper drug labelling, and that improper drug labelling is a serious misconduct. Since 2002 and with the exception of one case, all cases of improper 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."

26. We accept that the labelling charges in this case are in respect of poor labelling rather than deliberate non-labelling, and it is not a case of concealment of the nature of the medications.

27. Having regard to the gravity of the case and our duty of protecting the public from those who are unfit to practise medicine, we are of the view that an appropriate order in respect of charge (a) would be removal from the General Register for a period of 4 months.

28. We have thought long and hard whether the order should be suspended. If the Defendant had persisted in contesting the charges in the inquiry which would have shown the complete lack of insight and remorse, we certainly would have seen no reason for suspension of the order. Having regard to all

mitigating factors, we are prepared to give her a chance to improve her knowledge and competence by suspending the order.

29. Taking all the relevant factors into consideration, we make the following orders:-

(i) in respect of charge (a), the Defendant's name be removed from the General Register for a period of 3 months;

(ii) in respect of charges (b) to (g) cumulatively, the Defendant's name be removed from the General Register for a period of 1 month, concurrent with the order in respect of charge (a);

(iii) the above orders be suspended for a period of 2 years from the date of this order, subject to the condition of satisfactory peer audit and supervision by a supervising doctor to be appointed by the Council on the following terms:-

(a) Within 3 months from the date of this order, the Defendant shall produce to the supervising doctor cogent evidence of concrete measures to improve her system of drug prescription, labelling and dispensing.

(b) The supervising doctor shall conduct random audit and supervision, with particular regard to drug prescription, labelling and dispensing.

(c) The audit and supervision should be conducted without prior notice to the Defendant.

(d) The audit and supervision should be conducted at least once every 6 months within the suspension period.

(e) During the audit and supervision, the supervising doctor shall be given unrestricted access to all parts of the Defendant's clinic and the relevant records which in the supervising doctor's opinion is necessary for proper discharge of his duty.

(f) The Defendant shall undergo continuing medical education in medical therapeutics equivalent to 15 CME points, and produce evidence to the supervising doctor before the 12th month from the date of this order to prove her satisfactory completion of the continuing medical education.

(g) The supervising doctor shall report directly to the Council the findings of the audit and supervision at the end of the 6th, 12th, 18th and 24th month from the date of this order. If any irregularity is observed, the supervising doctor shall report such irregularity as soon as possible.

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