SINGAPORE MEDICAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY FOR DR KWAN KAH YEE
HELD ON 5 TO 6 APRIL, 1 JUNE AND 12 JULY 2011

Disciplinary Committee:
Dr Lim Cheok Peng (Chairman)
Prof Walter Tan
A/Prof Pang Weng Sun
Mr Rajan Menon (Lay Observer)

Legal Assessor:
Mr Andy Chiok
(M/s Michael Khoo & Partners)

Counsel for the SMC:
Ms Josephine Choo
Mr Roger Neo Li-Yang
(M/s WongPartnership LLP)

Counsel for the Respondent:
Mr R. Joethy
Mr Peter Tio
(M/s Cheo & Tio)

DECISION OF THE DISCIPLINARY COMMITTEE

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

1. These proceedings arose out of the demise of a patient ("the Patient") on 16 October 2009. The Respondent Dr Kwan Kah Yee is the registered medical practitioner who attended at the deceased's home on that day, and the certifying officer for the patient's death certificate.

2. Subsequently, in connection with an insurance claim, her family realised that the Respondent had certified that the patient had Ischaemic Heart Disease for the last 6 years, of which they were unaware of. They confronted the Respondent who was allegedly unhelpful.

3. On 13 November 2009, the patient's daughter, ("the Complainant") lodged a complaint against the Respondent. Following the complaint, on 2 February 2010 the SMC wrote to the Respondent inviting him to offer an explanation. An Explanation Letter dated 25 February 2010 was sent by the Respondent to the Complaints Committee, which then referred the matter to this Committee for formal inquiry.

The Charge and the parties' cases

4. By the Amended Notice of Inquiry dated 5 April 2011, a single charge is framed against the Respondent wherein it is alleged that he is guilty of professional misconduct in that he

had wrongly certified the Certificate of Cause of Death (the "CCOD") in respect of the patient's demise. In the particulars of the Charge against the Respondent, the wrong certification of the CCOD is elaborated upon in that

a) "Congestive Cardiac Failure" is not a cause of death; and/or

b) that there is no factual basis for the duration of 6 years in relation to the entry of ischaemic heart disease.

As it will be seen, these are the primary questions to be determined at the inquiry.

5. The Respondent contested the Charge against him. He contended that he was justified in certifying the CCOD in the way that he did. The Respondent also maintained that he had sufficient basis to certify that the patient's cause of death was Congestive Cardiac Failure and that she had ischaemic heart disease for 6 years prior to her demise.

The inquiry

18. At the inquiry, the SMC called the following witnesses:

a) The Complainant;

b) Dr A from A Hospital;

c) Dr B, also from A Hospital; and

d) Dr P, an expert witness.

19. The Respondent gave evidence on his own behalf, and also subpoenaed a witness, Dr C from B Polyclinic.

20. At the inquiry, the following facts are undisputed:

a) On 12 October 2009, the patient attended at the A Walk-in Clinic and was attended to by Dr A. She was diagnosed as having high blood pressure.

b) On 14 October 2009, Dr B attended to the patient and reviewed her. She was scheduled to go for further investigations i.e. a coronary angiography or a CT coronary angiography.

c) The patient passed away on 16 October 2009.

d) When the Respondent certified the Certificate of the Cause of Death i.e. the Form G, he indicated “Congestive Cardiac Failure” under the “cause of death” field. The Respondent also stated that there was onset of ischaemic heart disease 6 years prior to the demise.

(1) Whether “Congestive Cardiac Failure” is a cause of death?

21. One aspect of the Charge against the Respondent that this Committee has to determine is whether the Respondent had wrongly certified congestive cardiac failure as a cause of death.

22. The SMC’s case in this respect is that the Respondent ought not have certified that the cause of death was congestive cardiac failure and relied upon the following:

a) There is no evidence that the cause of death was Congestive Cardiac Failure as the patient was not diagnosed with ischaemic heart disease when she attended at the A Hospital and was examined by Dr A and Dr B. The patient was scheduled for further investigations which she did not undergo.

b) There is no medical record that can support the Respondent’s certification of Congestive Cardiac Failure and ischaemic heart disease.

c) The evidence of Dr P who referred to various medical literature and takes the view that the available medical records do not support the Respondent’s certification in the CCOD.

23. The Respondent’s case at the inquiry is that he had followed the proper protocol and had properly certified the CCOD, as claimed in his Opening Statement. In his written submissions, the Respondent relied upon “guidelines published by the SMA” by Dr Gilbert Lau at AB55 that states:

> "Congestive Cardiac Failure (this has to be spelt out; "CCF" and other abbreviations are unacceptable) is a mode, rather than a cause of death. Ideally, it should be (a) Congestive Cardiac Failure due to (b) Ischaemic (or Hypertensive) Heart Disease or some similar formulation …"

24. Under cross-examination by counsel for the SMC as well as in his re-examination, in respect of the evidence on the certification of a CCOD in cases involving ischaemic heart disease and congestive cardiac failure, the Respondent accepts that the "cause of death" is ischaemic heart disease, and he termed congestive cardiac failure as a "qualifier" for the cause of death.

25. We have perused the medical literature and do not agree with the position taken by the Respondent for the following reasons:

    a) We take the view that there is little evidence on clinical grounds and in the A Hospital documents to arrive at a conclusion that the patient had ischaemic heart disease and congestive cardiac failure. The only conclusion that can be derived from the A Hospital documents is that the patient had hypertension.

    b) While we note the views of Dr Gilbert Lau at AB55, the statements made by Dr Lau were in the context of an interview that was reproduced in the SMA newsletter.

    c) Looking at an article that was published by Dr Gilbert Lau in the SMA News (AB52), we note that when he gave examples of "improperly certified causes of death", Dr Lau provided (at AB53) an example where it was certified:

        > "I (a) CCF
        > (b) AMI
        > (c) IHD
        > II NDDM, Hypertension, Hyperlipidaemia, ESRF, COAD, Pneumonia, Old CVA, Alcoholic Liver Cirrhosis, Myelodysplastic Syndrome, Benign Prostatic Hyperplasia, Sero-negative Rheumatoid Arthritis."

    Dr Lau then stated:

        > "Firstly, refrain from using abbreviations in death certificates. Secondly, congestive cardiac failure is a mode, rather than a cause of death, and *is*

therefore a term that should be avoided as much as possible. Thirdly, in this instance, either acute myocardial infarction or *ischaemic heart disease would suffice as the primary cause of death*. …" (emphasis added)

d) We also refer to the explanatory notes of the "cause of death" field highlighted in bold in Form G. It states "**Disease or condition directly leading to death. (This does not mean the mode of dying e.g. heart failure, asthenia ect (sic). It means the disease, injury or complication which caused death).**" It made clear that heart failure is a mode of dying and not the cause of death, the point made by Dr Gilbert Lau in his article.

26. Given the above, we cannot agree with the position taken by the Respondent. For the reasons above, the Respondent has no reasonable basis to arrive at his conclusion of congestive cardiac failure. Further, the evidence is clear that congestive cardiac failure cannot be a cause of death but a mode of death.

27. For the above reasons, the SMC has proved beyond a reasonable doubt that the Respondent had wrongly certified congestive cardiac failure as a cause of death when it cannot be such.

(2) Was there factual basis for certification of 6-year history of ischaemic heart disease?

28. It is the SMC's case that there is no factual basis for the Respondent's conclusion that the patient had ischaemic heart disease for 6 years prior to her demise.

29. The Respondent takes the contrary position. In particular, the Respondent relied on the evidence that when he made the certification, he had received a call from a "reliable source" that informed him that the patient had developed ischaemic heart disease for 6 years prior to her demise.

30. This Committee finds the Respondent's defence on this aspect of the inquiry to be weak, not credible and false. We make the following observations:

a) The SMC had, from the evidence of Dr A and Dr B as well as the relevant medical records of A Hospital, proved that there is no basis for any conclusion that the patient had ischaemic heart disease for 6 years prior to her demise. The

Respondent himself accepted under cross-examination that the A Hospital documents do not provide sufficient basis for his certification of the CCOD.

b) In his oral evidence-in-chief, the Respondent recounted that when he attended on 16 October 2009, that the documents that he saw did not mention how long the patient had hypertension. He had to resort to calling his informal contacts at the various medical record offices. Then one of his contacts from a medical record office called him back and told him that the patient visited B Polyclinic on 16 September 2008. When he questioned his source further on the onset of ischaemic heart disease, he was told it was 6 years. Later the source told him that the patient's symptoms started when the SARS outbreak happened i.e. in 2003.

c) We note that in the documents attached to his Explanation Letter, the Respondent included a copy of a letter dated 2 November 2009 (at AB32) that was sent by him to the Registry of Births and Deaths. In the said letter, the Respondent stated:

> "2. Based on the Medical Information I clarified with A Hospital, patient was seen by doctors for several occasions including general practitioners and specialists. The diagnosis of Congestive Cardiac Failure of 4 days and the diagnosis of ischaemic heart disease of 6 years was based on clinical history, physical examination and investigations including the result of abnormal ECGs and abnormal blood tests on several occasions."

We note that this document, which is a response to a query to his certification made in connection with the patient's demise, he made no mention of information in connection with B Polyclinic.

d) This Committee finds the evidence of the Respondent relating to sub-paragraphs (b) and (c) above to be unsubstantiated.

e) The Respondent also did not raise the information relating to B Polyclinic in his Explanation Letter to the Complaints Committee, when it would have been reasonable for him to do so, especially when the explanation was provided only about 4 months after the certification by him.

f) The first time when B Polyclinic was raised by the Respondent was when his solicitors wrote to the SMC's solicitors in mid-March 2011, just before the inquiry. In his Opening Statement it is stated that "*Our instructions are that there is a relevant Medical Report at the B Polyclinic which will be of assistance to this Tribunal.*"

g) In fact, we observed that in his notes (see AB33), the Respondent only recorded A Hospital but there is no record of B Polyclinic even though by his evidence this information was available when he made his checks with his own sources on 16 October 2009 and in any case, by the next day.

h) Given that the basis for the Respondent's conclusion of the 6-year period for the onset of the ischaemic heart disease came solely from his information of the patient's attendance at B Polyclinic, we cannot accept that this crucial information, if available at that time would reasonably be omitted from the Respondent's own notes, his letter to the Registry of Births and Deaths and his Explanation Letter to the Complaints Committee. We do not find the explanation offered by the Respondent for such omission satisfactory or credible, and do not accept them.

i) The Respondent relied on an abortive letter dated 2 November 2009 (at AB69) that contained a reference to B Polyclinic. His evidence is that he was advised by someone from the Registry of Births and Deaths not to write that letter so as not to prejudice his source.

j) This Committee does not accept this abortive letter as credible evidence because it was produced late in the day, and in any case, in his letter to the Registry of Births and Deaths of the same date (at AB32), he had no hesitation to name his source as A Hospital. We also note that AB69 carries a reference number that is different from the one reference used by the Respondent in his letters to the Registry of Births and Deaths (AB32) and his Explanation Letter.

k) The Respondent could have called his source of his information relating to the 6-year period as a witness but elected not do so. In the absence of this evidence, the only evidence of how he came to learn of the 6-year period came only from the Respondent, and we have set out above that we do not find the Respondent's own evidence credible.

31. The Respondent was also asked under cross-examination why he did not respond to the family's request for information under a solicitor's letter dated 18 December 2009. The Respondent first testified that he did not respond because there was no consent form and that he was waiting for that. However, subsequently he changed his evidence and testified that he should not correspond with the family once the complaint was made against him.

32. In his written submissions, the Respondent stated that "… *IHD does not develop overnight and the patient should have had this condition for a considerable period before September 16th 2008 when she was last seen at the B clinic.*" While this Committee accepts that medically ischaemic heart disease would have taken some time to develop, we cannot find any evidence, especially contemporaneous evidence that the patient developed ischaemic heart disease 6 years before her demise for the Respondent to make his certification.

33. When Dr C from the B Polyclinic attended at the inquiry, the case notes that were brought by her only showed a consultation on 16 September 2008 at the B Polyclinic. There is no evidence of any record from B Polyclinic that can support a conclusion that the patient had developed ischaemic heart disease 6 years prior to her demise. This absence of evidence directly contradicts the Respondent's own evidence of a source that provided the information of the patient's onset of ischaemic heart disease. This Committee therefore finds that there is no basis for the Respondent to certify that there was an onset of ischaemic heart disease 6 years prior to the patient's demise.

34. For the avoidance of doubt, it is this Committee's view that on this second issue alone, the Respondent is guilty of professional misconduct for certifying that the patient had ischaemic heart disease for 6 years prior to her demise when there is no factual basis to do so.

Finding of the Committee

35. On the totality of the evidence, this Committee finds that the Charge as framed is proved against the Respondent. The conclusions of congestive cardiac failure and ischaemic heart disease made by the Respondent are unsubstantiated.

36. We would add that this Committee is concerned by two further points. Firstly, the misconduct from the present case could have been avoided had the Respondent made the decision to decline to certify the CCOD in view of the insufficient information before

him. The matter ought to have been referred to a coroner. A medical practitioner who elects to certify a CCOD without sufficient basis is guilty of serious professional misconduct, as the CCOD is a legal document. We point out that in Form G, it is stated that "*This Certificate is a legal document. The RBD Act requires it to be filled in accurately. Failure to comply will render the Certifying Officer liable to prosecution*".

37. Secondly, the Respondent appeared to have access via his own contacts to the medical record offices of various medical institutions, and had gained access to medical information of patients. While we accept that a medical practitioner may directly contact a patient's treating physician for information on a patient in connection with treatment or to certify a CCOD, we cannot see how the release of patients' information by the staff of medical records office of hospitals or polyclinics informally to a medical practitioner can be justified under such circumstances. It will be a breach of patients' confidentiality and will attract disciplinary proceedings. The Respondent's conduct in contacting the medical record office to certify the CCOD is also improper. The Respondent himself testified that such communications are neither "strictly allowed" nor "proper".

38. We now call for the Respondent to address us in mitigation.

Sentencing

39. We now turn to the issue of the appropriate sentence to be imposed. In the course of mitigation, the Respondent had stated that he would assist the family to amend the death certificate. The point was also made that the Respondent had voluntarily carried out work for various hospices.

40. Counsel for the SMC had tendered a table of precedents involving misconduct of wrongful certification of medical certificates and death certificates.

41. This Committee takes the view that in the present case there are the following aggravating factors:

    a) The Respondent's misconduct had resulted in hardship to the patient's family. He had also incurred the costs and expense of a full inquiry.

    b) The Respondent also did not exhibit any remorse or regret.

c) The misconduct is serious because the Respondent had effectively plucked from the air a figure of 6 years for the patient's alleged ischaemic heart disease when there is no basis to do so.

d) This Committee also finds that the Respondent had misled it in the course of the conduct of his defence. There is no basis for any exculpatory evidence from B Polyclinic, a point introduced late in the day, and maintained by the Respondent to the end.

42. This Committee, however, finds that the offer to assist the family to amend the death certificate is a mitigating factor.

43. Having regard to the representations made by both counsel and the serious nature of the misconduct, it is this Committee's decision that the appropriate sentence is as follows:-

a) The Respondent's registration in the Register of Medical Practitioners shall be suspended for a period of **3 months**;

b) that the Respondent shall be fined the sum of **$5,000**;

c) that the Respondent shall be censured;

d) that the Respondent shall give a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct;

e) that the Respondent shall also, within 30 days provide assistance to the patient's family in respect of any necessary application to the Registry of Births and Deaths to rectify the death certificate; and

f) that the Respondent pays the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the SMC and the Legal Assessor.

44. The Complainant shall be quickly notified of our decision so that the necessary application under paragraph 43(e) above can be made expeditiously if required.

45. We also order that these grounds be published.

46. The hearing is hereby concluded.