G.N. 5817

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

ORDER MADE BY THE INQUIRY PANEL OF
THE MEDICAL COUNCIL OF HONG KONG

DR THANT MA AYE AYE (REGISTRATION NO.: M12329)

It is hereby notified that after due inquiry held on 6 September 2022 in accordance with section 21 of the Medical Registration Ordinance, Chapter 161 of the Laws of Hong Kong, the Inquiry Panel of the Medical Council of Hong Kong found Dr THANT Ma Aye Aye (Registration No.: M12329) guilty of the following charge:—

> *"That on 5 February 2021, she, being a registered medical practitioner, disregarded her professional responsibility to her patient ("the Patient") in that she failed to ensure that she should not prescribe "Nidol" to the Patient, who was allergic to Aspirin.*
>
> *In relation to the facts alleged, she has been guilty of misconduct in a professional respect."*

2. Briefly stated, the Patient first consulted Dr THANT at her clinic on 14 January 2019. During the consultation, the Patient informed Dr THANT that she might have lip vesicles after taking Aspirin. Dr THANT therefore documented the Patient's possible drug allergy to Aspirin, in red ink, on the first page of her clinical records for the Patient as "*? Aspirin -> lip vesicles*".

3. On 5 February 2021, the Patient consulted Dr THANT again at her clinic for fever, headache, mild sore throat and myalgia. Dr THANT's clinical diagnosis was upper respiratory tract infection. Dr THANT then prescribed the Patient with, among others, 3 days of Nidol, a non-steroidal anti-inflammatory drug ("NSAID"), twice a day, for treatment of her myalgia.

4. According to the Patient, whose evidence was unchallenged by Dr THANT, she developed allergic reactions sometime after taking the medications prescribed by Dr THANT, including Nidol. Aspirin and Nidol are both NSAIDs.

5. On 8 February 2021, the Patient attended the Accident & Emergency Department ("AED") of the Tin Shui Wai Hospital ("TSWH").

6. According to the medical records obtained from TSWH, the Patient presented with "*face swelling + rash*" and "*skin rash on body as well*". As her allergic reactions did not improve much after adrenaline injection treatment at AED, the Patient was admitted to the Emergency Medical Ward of TSWH for further management as an inpatient. The Patient also developed in the course of in-patient treatment liver function derangement. Eventually, the Patient was discharged home on 15 February 2021. According to the Discharge Summary issued to the Patient by TSWH, her likely diagnosis was said to be "*allergic reaction to NSAIDs*".

7. The Patient later lodged complaint against Dr THANT with the Medical Council.

8. Dr THANT admitted the factual particulars of the disciplinary charge against her. In response to the Patient's complaint, Dr THANT admitted to the Preliminary Investigation Committee through her solicitors that she "*overlooked the Patient's drug allergy to Aspirin when she prescribed the Patient with Nidol on 5 February 2021… Had [she] noticed the Patient's allergy history to Aspirin, she would definitely not have prescribed Nidol to the Patient… [she] is very sorry for her oversight and would like to take this opportunity to sincerely apologize to the Patient.*"

9. Patients are entitled to, and they often do, rely on doctors to exercise reasonable care and competence in avoiding prescription of drug to which they have a known allergy. In a patient with a reported allergy to a particular drug or class of drugs, the risk of having an allergic reaction after taking the same drug or class of drug would be high. Allergic reaction to drug can also be very serious and potentially life threatening.

10. Nidol and Aspirin are both NASIDs. Prescription of Nidol to the Patient, whom Dr THANT ought to have known was allergic to Aspirin, was inappropriate and unsafe. In view of the Inquiry Panel, if Dr THANT had taken adequate note of the Patient's history of allergy, she ought to have considered whether there were safer alternatives than Nidol.

11. In this connection, it was the unchallenged evidence of the Patient that she reminded Dr THANT and her clinic assistant of her drug allergy to Aspirin before taking the prescribed medications home.

12. In view of the Inquiry Panel, Dr THANT's conduct during the subject incident had fallen below the standards expected of registered medical practitioners. Accordingly, Dr THANT was found guilty of misconduct in a professional respect as charged.

13. The Inquiry Panel was told in mitigation that Dr THANT had taken prompt remedial measures after the subject incident to ensure safe prescription and dispensation of drugs.

14. The Inquiry Panel accepted that Dr THANT has learnt her lesson. The Inquiry Panel appreciated the effort that Dr THANT had made after the subject incident. However, the best prescription and dispensation system still requires the vigilance of those who put it into practice. The Inquiry Panel needed to ensure that Dr THANT would not commit the same or similar misconduct in the future.

15. Taking into consideration the nature and gravity of the case and what the Inquiry Panel had read and heard in mitigation, the Inquiry Panel ordered that the name of Dr THANT be removed from the General Register for a period of 1 month. The Inquiry Panel further ordered that the operation of the removal order be suspended for a period of 12 months on condition that Dr THANT shall complete courses, to be pre-approved by the Council Chairman and to the equivalent of 10 CME points, on safe prescription of drugs during the suspension period.

16. The aforesaid orders are published in the *Gazette* in accordance with section 21(5) of the Medical Registration Ordinance. The full decision of the Inquiry Panel of the Medical Council is published in the official website of the Medical Council of Hong Kong (http://www.mchk.org.hk).

LAU Wan-yee, Joseph *Chairman, The Medical Council of Hong Kong*