G.N. 6806

MEDICAL REGISTRATION ORDINANCE (Chapter 161)

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

DR TAN JIN MIN JEREMIAH (FORMERLY REGISTERED AS TAN JIN MIN)
(REGISTRATION NO.: M09131)

It is hereby notified that after due inquiry held on 27 September 2023 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 TAN Jin Min Jeremiah (Registration No.: M09131) guilty of the following disciplinary charges:—

"*That in or about November 2021, he, being a registered medical practitioner, disregarded his professional responsibility to his patient Mr KWAN ("the Patient"), in that he:*

(a) failed to ensure that the name of the Patient was correctly labelled in three medicines dispensed to the Patient on 14 November 2021; and/or

(b) failed to ensure that the particulars of three medicines dispensed to the Patient on 14 November 2021 were properly recorded in the Patient's digital file in the computer system of "Chun Hong Medical Center [進康醫務中心]".

In relation to the facts alleged, either singularly or cumulatively, he has been guilty of misconduct in a professional respect."

2. On 14 November 2021, the Patient Mr KWAN ("Mr KWAN") consulted Dr TAN at Chun Hong Medical Center (進康醫務中心) ("the Clinic") for swollen lower left eyelid with redness and mild pain. Dr TAN diagnosed Mr KWAN of conjunctivitis. Dr TAN dispensed Mr KWAN with Chloramphenicol ophthalmic ointment, Tobramycin eye drops, Flagyl tablets and Augmentin tablets, contained in four separate medicine bags.

3. Mr KWAN discovered afterwards on the same day that the name of the patient written on three of the medicine bags was not his name, but the name of another patient, a Mr FU ("Mr FU").

4. On 15 November 2021, Mr KWAN went back to the Clinic because he noticed that his name was not on the medicine bags. The nurse there replaced some of the medicines dispensed on 14 November 2021 (i.e. Tobramycin eye drops, Flagyl tablets and Augmentin tablets) with Stemetil 5mg, Cinnarizine 25mg and Phenergan 10mg.

5. By a statutory declaration dated 22 April 2022, Mr KWAN lodged a complaint with the Medical Council against Dr TAN. Photographs of the medicine bags dispensed on 14 November 2021 and 15 November 2021 were exhibited.

6. In his submission to the Preliminary Investigation Committee ("PIC") of the Medical Council dated 22 July 2022, Dr TAN said that at all material times he was not familiar with the Clinic's computer system. Dr TAN said that on 14 November 2021 Mr FU was originally scheduled to be seen by him before Mr KWAN, but Mr FU did not arrive on time and therefore Dr TAN saw Mr KWAN first. Dr TAN entered his notes and prescriptions for Mr KWAN in Mr FU's digital file. Subsequently when the nurse provided him with the medicines to be dispensed to Mr KWAN, he checked and confirmed that the medications were what he prescribed for Mr KWAN's eye condition, but he did not notice that the patient's name on three of the medicine bags were incorrectly written as Mr FU. Dr TAN then attended another patient, and he mistakenly entered the notes and prescriptions for this another patient (i.e. Gravol, Stemetil, Cinnarizine and Promethazine) into Mr KWAN's digital file. On 15 November 2021, Dr TAN said he was not on duty in the Clinic. He said when Mr KWAN returned to the Clinic, the nurse, without his authority, replaced some of the medicines (i.e. Tobramycin eye drops, Flagyl tablets and Augmentin tablets) already dispensed to Mr KWAN on 14 November 2021 with Stemetil 5mg, Cinnarizine 25mg and Phenergan 10mg. These were medicines prescribed for another patient, which had been erroneously entered in Mr KWAN's digital file.

7. Registered medical practitioners in Hong Kong are in a unique position in that they can prescribe and dispense medicines to patients. As a registered medical practitioner who dispensed medicines to patients, Dr TAN had the personal responsibility to ensure that all dispensed medicines were probably labelled.

8. From the photographs of the medicine bags, it was evident that in three of the four medicine bags dispensed to Mr KWAN on 14 November 2021, the patient's name written was not the name of Mr KWAN, but the name of Mr FU. Clearly Dr TAN had failed to ensure that the name of Mr KWAN was correctly labelled in the three medicine bags before dispensing. In the view of the Inquiry Panel, Dr TAN had by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, Dr TAN was found guilty of professional misconduct as per disciplinary charge (a).

9. Properly documenting a patient's medical records has always been important. A properly documented medical record communicates how a patient was treated and the reasons for such treatment.

10. Given the importance of properly documented medical record, it is unacceptable for Dr TAN to say that he was not familiar with the Clinic's computer system. Although Mr KWAN had pointed out to Dr TAN during consultation that his name was in "the computer program's third row instead of the second row", Dr TAN still entered the medical notes and prescriptions into another patient's digital file (i.e. Mr FU's digital file). When Dr TAN attended a third patient on that day, he again entered the medical notes and prescriptions in the wrong digital file (i.e. Mr KWAN's digital file). Mr KWAN went back to the Clinic on 15 November 2021 to check his medications as he noticed the names of the labels on the medicine bags were not his. He was dispensed by the Clinic nurse with another patient's medications (Stemetil 5mg, Cinnarizine 25mg and Phenergan 10mg). It was only fortunate that Mr KWAN was suspicious of those medications given to him. Similarly, it would be possible that because of the wrong digital file, the other two patients might be affected in their medical care.

11. In any entry in medical record, doctors should exercise due care and prudence in checking patient names before entering clinical findings, diagnosis and treatment. If Dr TAN had exercised due care and prudence, these types of mistakes could have been avoided.

12. In the view of the Inquiry Panel, by failing to ensure that the particulars of three medicines dispensed to Mr KWAN on 14 November 2021 were properly recorded in Mr KWAN's digital file of the Clinic, Dr TAN had by his conduct fallen below the standards expected of registered medical practitioners in Hong Kong. Accordingly, Dr TAN was found guilty of professional misconduct as per disciplinary charge (b).

13. Taking into consideration and nature and gravity of the case against Dr TAN and what the Inquiry Panel had read and heard in mitigation, the Inquiry Panel made a global order in respect of disciplinary charges (a) and (b) that Dr TAN be reprimanded.

14. The order is 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*