

*This is the document marked A referred to in the Statutory Declaration  
of Wong Chen Li-Chu affirmed/sworn before me.  
(Name of Complainant)*

*\_\_\_\_\_  
(Signature of Justice of the Peace, Notary  
Public or other officer empowered by law  
to administer oaths, affirmation or affidavit)*

This letter is to verify that I, Wong Chen Li Chu, (IC No: [REDACTED], DOB: [REDACTED], Age: 60) would like to lodge a formal complaint against Dr Chan [REDACTED] ([REDACTED] [REDACTED]), [REDACTED], [REDACTED]. I am charging Dr. Chan for medical negligence in administering the medication, ACLASTA. His negligence resulted in immense physical, emotional and financial suffering for me, for which I would like to seek compensation.

Dr. Chan's medical negligence included the following:

- 1) Flouting standard practice when administering ACLASTA
- 2) Negligent aftercare treatment
- 3) Violation of medical ethics: Breach of patient-doctor trust

The combination of these three forms of medical negligence leads me to believe that Dr Chan's actions were willful, and beyond the realms of reasonable care as expected from a professional doctor. His medical negligence resulted in disastrous consequences for me and my family. Apart from emotional trauma, I am also faced with hefty hospital bills and the possibility of permanent renal failure and dialysis. In this letter, I will relate the sequence of events that led up to my current condition.

## **(I)AN ACCOUNT OF MY MEDICAL CONDITION FROM Oct 6<sup>th</sup> to Nov 17<sup>th</sup> 2008**

### **Dr. Chan's process of administering ACLASTA**

My association with Dr Chan began on 23<sup>th</sup> June 2008 after I fractured my wrist. He was recommended to me by a friend. Despite the high cost of his medical services, I sought him out as my primary doctor to assist in my healing. This was because my insurance company MSIG provided compensation for my medical expenses up to one month after the injury. On Monday, 6<sup>th</sup> October 2008, I visited Dr Chan's clinic to follow up on the condition of my fractured arm which he had operated upon on 24<sup>th</sup> June 2008. He told me that I have osteoporosis and suggested that I take an injection of a medical product. According to Dr. Chan, the medication would last me for a year and cost me S\$1500 (see appendix 1).

Apart from that, Dr. Chan did not elaborate on the medication, obliterating as well any information on the name or warnings of side effects which may be caused by the medication. Furthermore, he did not convey that any blood tests should be undertaken for my blood calcium level, nor did he ask me then about my kidney condition. I was not asked to read through or sign any document that would inform me more about the medication. Trusting Dr. Chan's medical judgment and professionalism, I did not push him further to provide me with more information. I also did not provide additional information that he did not ask for. I was led to believe that Dr Chan would have my interest as a patient at heart and provide me with the necessary medical treatment. As a result, I decided to heed his advice despite the hefty cost of the injection.

On the next day, Tuesday 7<sup>th</sup> October 2008, I was accompanied by my maid to visit the clinic again for the injection. Dr Chan advised me to drink 2 cups of water and take 2 Panadol pills. After the injection administered by Dr. Chan, I was directed to the clinic receptionist, Margaret. It was only through her that I learned that I should take Panadol pills every eight hours after the injection. Since Dr. Chan had not told me that there would be any side effects I should be concerned about for which the Panadol pills were prescribed, I asked for an explanation on why it was necessary to take the pills. However, I was told to just do as I was told. The only medication I received after the injection was a box of Panadol. Later, after going home, it was from the receipt that my husband realized that I had just been injected with ACLASTA 5MG/100ML.

### **Side effects of ACLASTA and absence of expertise through Dr Chan's clinic**

Next day morning, Wednesday, 8<sup>th</sup> of October, I experienced sharp pain throughout my limbs, chest, heart and waist. My face also became swollen. Rashes also appeared throughout my body and I felt extremely itchy. I called up the clinic to ask for Dr Chan's advice but was told by Margaret that he had gone overseas and would be back by the 20<sup>th</sup> of October. Margaret did not direct me to any other medical personnel, she just instructed me to take Panadols again to ease the pain.

On Thursday, 9<sup>th</sup> of October, my head and limbs started to feel numb and sensations similar to those of slight electric shocks started to go through my body. On Friday morning, 10<sup>th</sup> of October, my condition had worsened. Those feelings of numbness had got stronger, my head started to shake involuntary and there were tingling sensations around my mouth. I immediately suspected that it might be due to allergy or some form of response to the injection I had. I called up the clinic again and related my condition to a receptionist by the name of Doris. Despite the urgency of my call, she failed to direct me to any medical personnel who could explain the symptoms and offer me any medical advice. I am inclined to believe that prior to his departure a day after administering me with ACLASTA, Dr Chan had failed to leave any instructions for alternative medical expertise to be made available to me should side effects occur.

The level of patient care that Dr Chan and his clinic could offer me was severely insufficient and inefficient. The receptionist, Doris, said she would get representatives from the drug company to talk to me. After some time, Margaret called me back and said nobody else showed such symptoms except for me. Apparently, she was not well informed about the side effects of the drug. She said she was willing to

refer me to a neurologist 3 days later, on the coming Monday (13<sup>th</sup> October). Later when I called them back, I was told by Doris that I would not be able to talk to the representatives of the drug company.

### **Emergency admission to Mount Elizabeth hospital**

By the evening of Friday Oct 10<sup>th</sup>, around 9pm, my condition had severely worsened. My whole body started to feel numb, my heart began to tense up, breathing became difficult and I went into a spasm. My husband immediately sent me to the A&E department of Mount Elizabeth hospital. The doctor on duty thought my condition was due to hypertension. After he saw rashes over my body, he diagnosed that I was having an allergy and immediately gave me an injection to stabilize my condition. However, my condition persisted even after some time.

At that time, my husband told him about the ACLASTA injection I had recently taken. The doctor looked it up over the internet. He did a blood test on me. At 22:42 pm, the result of my blood test showed that:

Bicarbonate	14	(21 - 32 mmol/l)	
Urea	20	(2.8 - 7.7 mmol/L)	
Creatinine	503	(35 - 97 umol/L)	
Calcium	1.47	(2.10 - 2.6 mmol/L)	(see Appendix 2)

The doctor explained to my husband that the test indicated hypocalcemia and critical renal condition. He advised me be warded for the night as he feared my condition will worsen when I get home. A nurse told my husband that they were running full house on the normal wards and the only room available was a private ward at \$900/per night. Though we found the room rate too costly, we had no choice but to accept given my severe health condition.

After being warded, I was subsequently referred to Dr. Anthony Hiong, a specialist doctor at Mount Elizabeth Hospital. My husband related to me that upon seeing my condition, Dr. Hiong had specifically asked if the doctor administering ACLASTA performed a blood test prior to the injection. When I said no, Dr. Hiong appeared surprised and kept silent in discretion.

After warning my husband that I was in critical condition, Dr. Hiong immediately instructed the nurses to infuse calcium into my blood until the next day. My condition gradually stabilized over the night.

### **Critical condition persists amid increasing financial concerns**

On the next morning, Saturday, 11<sup>th</sup> October, at 9:08 am, my blood test result showed:

Bicarbonate	14	(21-32 mmol/l),	
Urea	19.2	(2.8-7.7 mmol/L)	
Creatinine	493	(35-97 umol/L)	
Calcium	1.66	(2.10-2.6 mmol/l)	(see Appendix 2)

Nonetheless, Dr Hiong told me that my condition was still very serious and suggested that I remain hospitalized. However, my husband and I decided that the fees were too expensive as the total charge for the night was S\$2,200. I decide to check out and seek help from our family doctor whom I have been seeing for the last 18 years, Dr Alfred Loh of Raffles Hospital.

On Wednesday, 15<sup>th</sup> October, my husband and I met with Dr Loh. He put me through a series of medical tests. As I was waiting for the results, my husband and I went to the cafeteria. I had a bite of toast which I could not swallow and I vomited some blood. After a while, a nurse came and said that the doctor had decided that I should be hospitalized after viewing the results of my blood tests.

My blood test results stated the following:

Bicarbonate	17	mmol/l	(21 – 32 mmol/l)
Urea	144	mg/dl	(10 – 50 mg/dl)
Creatinine	5.46	mg/dl	(0.50 – 1.6 mg/dl)
Calcium	6.0	mg/dl	(8.8 – 10.2 mg/dl)

(see Appendix 3)

After being warded, Dr. Ekachai Danpanich, a nephrologist, was referred to me. He said that my kidneys were in a critical condition and I was also suffering from hypocalcemia. My calcium deficiency still persisted and I was again infused with 'calcium' in addition to oral calcium supplements. On 20<sup>th</sup> October at 9:31 am my blood test results revealed:

Bicarbonate	18	(21-32 mmol/l)
Urea	101	(10-50 mg/dl)
Creatinine	5.41	(0.50-1.60 mg/dl)
Calcium	8.1	(8.8-10.2 mg/dl)

(see Appendix 3)

I was told by Dr. Ekachai Danpanich MD that the possibility of permanent dialysis was very high and I might have to plan for a renal replacement therapy should my renal function continue its deterioration. At this point, my hospital fees had accumulated to around \$14,000. Despite Dr. Danpanich's concern, my husband and I decided that I should be discharged due to financial considerations.

On Tuesday, 4<sup>th</sup> November, I returned to the hospital for a review of my condition. The blood test showed:

Bicarbonate	20	(21 – 32 mmol/l)
Urea	155	(10 – 50 mg/dl)
Creatinine	5.96	(0.50 – 1.60 mg/dl)
Calcium	8.2	(8.8 – 10.2 mg/dl)

Due to financial considerations, Dr. Ekachai Danpanich advised that I should visit a nephrologist at a restructured hospital for further review and treatment of renal replacement or dialysis.

On 14<sup>th</sup> to 17<sup>th</sup> November, I was hospitalized at SGH. After doing an ultrasound on my kidneys, the results showed that my kidneys have contracted and now it measures 8.2cm on the right and 8.4cm on the left. On the day I was discharged, my discharge summary showed:

(see appendix 4)

Creatinine serum	520	(40-85 UMOL/L)
Creatinine clearance	10	(70-150 ML/MIN)

(see appendix 4)

The doctor diagnosed my condition as CRF (Chronic Renal Failure) and will have to go for dialysis eventually.

(see appendix 4)

For further details of my condition, please refer to the attached blood test results and medical reports done by doctors of Mount Elizabeth Hospital, Raffles Hospital and Singapore General Hospital in the Appendix.

### **Dr Chan expresses no remorse or concern after the course of events**

According to Margaret, the receptionist, Dr Chan was supposed to be back by the 20<sup>th</sup> of October (Monday). We decided to wait for him to call us since I had already informed his staff regarding my condition. However, I did not hear anything from him or his staff until Wednesday, 23<sup>th</sup> October, when my husband and son decided to make an appointment with Dr Chan to clarify the issue. After listening to our explanation, he denied any wrongdoing on his side. He refused to acknowledge any responsibility for his negligent attitude when administering ACLASTA, nor his negligence in providing reasonable patient aftercare. [REDACTED] I am extremely

disappointed with his irresponsible and nonchalant attitude. He did not even bother to get back to me even after he had returned from overseas. I had turned to him for his medical expertise trusting that his experience and treatment will regain my health and that it was in my best interest to seek someone as experienced as him. I hope the Medical Council will conduct an inquiry into this issue justly so as to uphold Singapore's image as a place renowned for her medical expertise.

## **(II) COMPLAINTS AGAINST DR CHAN'S MEDICAL NEGLIGENCE AND MALPRACTICE**

I hereby would like to charge that Dr. Chan was medically negligent when he administered ACLASTA to me as a patient. He lacked reasonable care and exhibited willful negligence with regard to my medical condition. This is exhibited by his lack of concern when it came to informing me about the possible side effects of the drug. Apart from the information of S\$1500 price tag of the drug, I was not provided with any information about the medication. His actions resulted in physical and aggravated medical damage to my body and emotional stress.

I believe Dr. Chan did not do what was reasonable or prudent by

### **1) Flouting standard practice when administering ACLASTA**

- a) Dr. Chan failed to reasonably exercise due care in assessing the state of my kidney function to prevent the occurrence of renal dysfunction despite instructions to health providers provided by the drug manufacturer.**

The Health Sciences Authority in Singapore has clearly specified the following information on their official site regarding Novartis ACLASTA (SIN13192P)<sup>1</sup>.

In Section 4.4 Special warnings and precautions of **Clinical Particulars**, the manufacturer warns the health practitioner against administration of Aclasta to patients with renal impairment. It says:

Aclasta is not recommended for patients with severe renal impairment (creatinine clearance <40ml/min) due to limited clinical experience in this population. Patients should have their creatinine serum level measured before receiving Aclasta.

In Section 4.2 Posology and method of administration of **Clinical Particulars**, the manufacturer again warns:

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<sup>1</sup> <http://eservice.hsa.gov.sg/prism/common/enquirepublic/SearchDRBProduct.do?action=getProductDetails>

**Patients with Renal Impairment:** Use of Aclasta in patients with creatinine clearance <40 mL/min is not recommended due to limited clinical experience in this population.

In Section 4.8 Undesirable Effects of Clinical Particulars, the manufacturer warns the health practitioner that Zoledronic acid, an active component in Aclasta, has been associated with renal dysfunction:

Zoledronic acid has been associated with renal dysfunction manifested as deterioration in renal function (ie, increased serum creatinine) and in rare cases acute renal failure. Renal dysfunction has been observed following the administration of zoledronic acid, **especially in patients with preexisting renal compromise** or additional risk factors (eg, oncology patients with chemotherapy, concomitant nephrotoxic medications, severe dehydration), the majority of whom received a 4-mg dose every 3-4 weeks, but it has been observed in patients after a single administration. (emphasis mine)

Dr Chan failed to heed the specific and clear instructions described above by the manufacturer as endorsed by HSA Singapore. Dr. Chan failed to responsibly prevent renal dysfunction and impairment when administering ACLASTA on the following two counts.

First, Dr Chan did not conduct a test to assess my creatinine serum levels. He also did not confirm that I did not have renal impairment or dysfunction at the time of infusion. Moreover, he did not request for any health checkup report or performed blood tests that would identify these conditions without him personally having to administer the blood tests.

Second, Dr. Chan subjected me to increased risk for renal dysfunction when he failed to assess my blood creatinine levels to identify a possible “preexisting renal compromise.”

Unfortunately, Dr Chan’s failure to fulfill the manufacturer’s assessment criteria resulted in severe renal deterioration with serious consequences of permanent renal failure and dialysis for me. [see Dr. Danpanich, Appendix]

**b) Dr. Chan failed to reasonably exercise due care in assessing the level of calcium and Vitamin D in my blood, or the possibility of hypocalcemia prior to administering Aclasta.**

The Health Sciences Authority in Singapore has clearly specified the following information on their official site regarding Novartis ACLASTA (SIN13192P)<sup>2</sup>.

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<sup>2</sup> <http://eservice.hsa.gov.sg/prism/common/enquirepublic/SearchDRBProduct.do?action=getProductDetails>

In Section 4.4 Special warnings and precautions of **Clinical Particulars**, the manufacturer warns the health practitioner against administration of Aclasta to patients with hypocalcaemia. It says:

**Preexisting hypocalcaemia must be treated by adequate intake of calcium and vitamin D before initiating therapy with Aclasta** (see Contraindications). Other disturbances of mineral metabolism must also be effectively treated (eg, diminished parathyroid reserve, intestinal calcium malabsorption). Physicians should consider clinical monitoring for these patients.

Dr Chan did not conduct any blood test that would have determined whether I had hypocalcaemia or low serum calcium count before administering Aclasta. He also did not request for any information from me which might have helped him know of pre-existing hypocalcaemia conditions I might have without him having to personally administer a blood test.

**c) Dr Chan failed to prevent hypocalcaemia after the administration of Aclasta by not providing adequate supplements of calcium and Vitamin D.**

In Section 4.2 Posology and method of administration of **Clinical Particulars**, the manufacturer warns that:

Adequate calcium and vitamin D intake are recommended in association with Aclasta administration.

Once more in Section 4.4 Special warnings and precautions of **Clinical Particulars**, the manufacturer cautions that:

Adequate calcium and vitamin D intake are recommended in association with Aclasta administration [...] **Patients should be informed about symptoms of hypocalcaemia and receive adequate clinical monitoring** during the period of risk. (emphasis mine)

In Section 4.8 Undesirable Effects of **Clinical Particulars**, the manufacturer states that the possibility of low calcium count **without** symptomatic result of hypocalcaemia is possible **only** with adequate supplementation of calcium and vitamin D . The manufacturer states:

In a large clinical trial, approximately 0.2% of patients had notable declines of serum calcium levels (<1.87 mmol/L) following Aclasta administration. No symptomatic cases of hypocalcaemia were observed [...] **All patients received adequate supplementation with vitamin D and**

**calcium** in both the postmenopausal osteoporosis trial and the Paget's disease trials (emphasis mine)

Dr Chan failed to heed the specific and clear instructions described above by the manufacturer. Dr. Chan failed to responsibly prevent hypocalcaemia as an adverse drug reaction on the following counts.

First, Dr Chan did not inform me of the symptoms of hypocalcemia. Neither did he provide any adequate clinical monitoring during the period of risk. In fact, he left the country without leaving any medical expertise for me to follow up on (see pg 2 "Side effects of Aclasta and absence of expertise").

Second, Dr Chan did not recommend that I take adequate amount of calcium or Vitamin D alongside the Aclasta administration. In fact, the only prescription he gave me was Panadol. Through his failure to supply calcium and Vitamin D, Dr Chan put me at risk of low calcium count with symptomatic hypocalcaemia. His lack of medical expertise made me unaware of my adverse drug reaction which resulted in much physical, financial and emotional suffering due to hypocalcaemia [see Dr. Danpanich, Appendix].

**(c) Dr Chan failed in his duty as a doctor to warn me of potential side effects. In doing so, he also denied me of my own right to assess the risks to my own health in taking ACLASTA**

In failing to notify me of the potential side effects of ACLASTA, Dr. Chan denied me the right to assess my own health risk, and make a careful, informed choice on whether to take the ACLASTA medication. It is especially disturbing that the only information that Dr Chan made available to me was the price of the medication. I am inclined to believe that his failure to notify me of the potential risks and side effects of this medication was a willful concealment, with the purpose of inducing me to purchase the drug without considering due care concerning its detrimental effects.

The hurried nature of Dr Chan's treatment meant he did not give pause to consider prescribing me with calcium and Vitamin D supplements. Dr Chan's failure to be available or to make available professional medical expertise during his absence also inflicted much financial, emotional and physical hardship upon me.

Dr Chan's failure to abide by the precautionary practices that are described clearly, specifically and repeatedly in the manufacturer's manual leads me to believe that my adverse drug reactions, including hypocalcemia and renal dysfunction are avoidable and brought about only because of Dr Chan's willful and deliberate negligence.

## 2) Negligent patient aftercare treatment

As outlined in the paragraph above, despite warnings by the manufacturer to provide adequate clinical monitoring during the period of risk for patients who may experience hypocalcemia, Dr Chan failed to be available, or to make available medical expertise during his absence. His negligence inflicted much financial, emotional and physical hardship upon me.

## 3) Violation of Medical Ethics: Breach of patient-doctor trust

As I have outlined in the paragraphs above, Dr Chan's failure to abide by clearly stated instructions issued by the manufacturer, **reflects his failure to abide by the standard practice** that his fellow doctors should reasonably engage in when administering ACLASTA. Dr Chan's willful negligence, lack of reasonable care and skill in administering ACLASTA brought about immense physical, emotional and financial damage to me and my family. He also committed a breach of trust that patients reasonably have in their doctors. His unrepentant, unremorseful attitude after the fact of causing severe harm to my health and great distress upon my family also serves to exacerbate the degree of his unprofessionalism as a doctor.

## REQUEST FOR A CAUSE OF ACTION FROM SINGAPORE MEDICAL COUNCIL

As an elderly, I believe there will be many other old age people who might be in danger of osteoporosis. If doctors here do not adhere to the standard requirements set by Novartis (manufacturer of Aclasta) such as taking a blood test before knowing the suitability of a patient for the drug, then I suppose many more incidents like mine are likely to occur. Singapore is an important hub of medical technology and expertise in Asia. Longstanding medical ethics need to be preserved for the medical field to flourish and grow. Doctors like Dr Chan project a negative image of the medical field as unprofessional, manipulative, and concerned only with the financial benefits of the profession. I believe that the Singapore Medical Council will do its utmost to uphold this reputation and look into Dr Chan's unconscientious medical negligence. I am hereby requesting compensation from Dr Chan for the emotional, physical and financial hardship he has caused me and my family.

I look forward to hearing from the Singapore Medical Council. ....

Sincerely,

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Wong Chen Li Chu (November 22, 2008)

## **APPENDIX:**

### **Medical Results & Receipt**

- 1) Payment receipt of injecting ACLASTA 5MG/100ML**
- 2) Mount Elizabeth Hospital – Blood Test result (Date: 10 & 11 October , 2008)**
- 3) Raffles Hospital – Blood Test results & Medical Report br Dr Ekachai Danpani ( Date: 15 October & 04 November, 2008)**
- 4) Singapore General Hospital – Blood Test Result & Medical Report by Dr Tan Han Khim (Date: 17 November 2008)**