IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2023] SMCDT 2

Between

Singapore Medical Council

And

Dr Ang Yong Guan

… *Respondent*

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Professional misconduct under section 53(1)(*d*) Medical Registration Act (Cap. 174, 2014 Rev Ed)

Medical Profession and Practice – Professional Conduct – Failure to provide professional services under section 53(1)(*e*) Medical Registration Act (Cap. 174, 2014 Rev Ed)

Medical Profession and Practice – Professional Conduct – Suspension

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Singapore Medical Council
v
Dr Ang Yong Guan

[2023] SMCDT 2

Disciplinary Tribunal – DT Inquiry No. 2 of 2023
A/Prof Roy Joseph (Chairman), Dr Michael Wong Tack Keong, Mr Toh Han Li (Judicial Service Officer)
18, 24, 25 February 2022, 1, 2, 4 March 2022, 8 April 2022, 22, 26, 29 July 2022, 22 November 2022, 16 December 2022 and 13 April 2023

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Professional misconduct under section 53(1)(*d*) Medical Registration Act (Cap. 174, 2014 Rev Ed)

Medical Profession and Practice – Professional Conduct – Failure to provide professional services under section 53(1)(*e*) Medical Registration Act (Cap. 174, 2014 Rev Ed)

Medical Profession and Practice – Professional Conduct – Suspension

11 May 2023

GROUNDS OF DECISION

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

Introduction

The Notice of Inquiry and the Charges

1. The Respondent is a psychiatrist and medical practitioner registered under the Medical Registration Act (Cap 174) ("**MRA**"). The Respondent is in private practice and his clinic is Ang Yong Guan Psychiatry Pte Ltd. At the material time, the late Mr P ("**the Patient**") was under the Respondent's care for management and treatment of various psychiatric conditions.

2. The SMC preferred three charges against the Respondent for professional misconduct under section 53(1)(*d*) MRA ("**the professional misconduct charges**") together with three Alternate charges for failing to provide professional services of the quality which was reasonable to expect of him under section 53(1)(*e*) of the MRA ("**the professional services charges**"). The charges are at **Annex A-1**.

3. The Amended 1st Charge ("**1st Charge**") and the Amended Alternate 1st Charge ("**Alternate 1st Charge**") stated that the Respondent, between 8 February 2010 and 31 December 2011, while the Patient was under his care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety did:

(a) prescribe antidepressants to the Patient on numerous occasions and switching from one to another without ensuring that each antidepressant was continued for at least 4 to 6 weeks before such switching;

(b) concurrently prescribed two or more benzodiazepines to the Patient on various occasions;

(c) prescribed benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 to 4 weeks);

(d) prescribed benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g., 1 night in 2 or 3 nights); and

(e) prescribed benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by one Dr F ("**Dr F**") for management of his chronic lower back pain.

4. The SMC averred that this was in breach of the following Guidelines:

(a) The Ministry of Health ("**MOH**") Clinical Practice Guidelines for Depression (3/2004) ("**2004 CPG (Depression)**") which provides that all antidepressants, once started, should be continued for at least 4 to 6 weeks, and caution is needed when switching from one antidepressant to another because of the possibility of drug interactions [*see* guideline 4.2 of 2004 CPG (Depression)];

(b) The MOH Administrative Guidelines on the Prescribing of Benzodiazepines and other Hypnotics (MH 70:41/24 Vol. 3 14 October 2008) ("**2008 Admin Guidelines (Benzodiazepines)**") which provides that:

(i) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of 2008 Admin Guidelines (Benzodiazepines)];

(ii) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g., 1 night in 2 or 3 nights) and only when necessary [*see* paragraph (f) of 2008 Admin Guidelines (Benzodiazepines)];

(iii) The MOH Clinical Practice Guidelines on the Prescribing of Benzodiazepines ["**2008 CPG (Benzodiazepines)**"] which provides that benzodiazepine use should be limited to short-term relief (between 2 to 4 weeks), at the lowest dose [*see* guideline 5.1.1 of 2008 CPG (Benzodiazepines) and the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(iv) Guideline 4.1.3 of the 2002 edition of Singapore Medical Council Ethical Code and Ethical Guidelines ("**2002 ECEG**"), as the prescription of the said medicines was not on clear medical grounds and in reasonable quantities as appropriate to the Patient's needs.

5. The Re-amended 2nd Charge ("**2nd Charge**") and the Re-amended Alternate 2nd Charge ("**Alternate 2nd Charge**") averred that the Respondent, between 1 January 2012 and 31 July

2012, while the Patient was under his care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety, did:

(a) concurrently prescribe two or more benzodiazepines to the Patient on various occasions;

(b) prescribe benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g., 1 night in 2 or 3 nights);

(c) prescribe benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 to 4 weeks);

(d) allow for long-term chronic use of benzodiazepines by the Patient by prescribing a 6-months' supply of benzodiazepines to the Patient on 31 July 2012; and

(e) prescribe benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by Dr F for management of his chronic lower back pain.

6. The SMC averred that this was in breach of the following Guidelines:

(a) the 2008 Admin Guidelines (Benzodiazepines) which provides that:

(i) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of 2008 Admin Guidelines (Benzodiazepines)];

(ii) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g., 1 night in 2 or 3 nights) and only when necessary [*see* paragraph (f) of 2008 Admin Guidelines (Benzodiazepines)];

(b) the 2008 CPG (Benzodiazepines) which provides that benzodiazepine use should be limited to short-term relief (between 2 to 4 weeks), at the lowest dose [*see* guideline 5.1.1 of 2008 CPG (Benzodiazepines)]; and

(c) the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(d) Guideline 4.1.3 of the 2002 ECEG, as the prescription of the said medicines was not on clear medical grounds and in reasonable quantities as appropriate to the Patient's needs.

7. The 3rd Charge and the Alternate 3rd Charge averred that the Respondent on 31 July 2012 prescribed to the Patient who was under the Respondent's care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety had inappropriately prescribed, dispensed and/or supplied medicines in excess of their licensed maximum daily dosages as follows:

S/No.	Name of medicine	Dosage prescribed	Licensed maximum daily dosage
1.	*Mirtazapine*	60 mg every night	45mg every night
2.	*Zolpidem Controlled Release (CR)*	25mg every night	12.5mg every night

8. In the 3rd Charge, this was averred to be in breach of Guideline 4.1.3 of the 2002 ECEG, as the prescribed medicines was not in reasonable quantities as appropriate to the Patient's needs. In the Alternate 3rd Charge, it was averred that the Respondent knew, or ought to have known, that it was inappropriate for him to prescribe the medicines, in breach of the standard that as a psychiatrist and a medical practitioner registered under the MRA, that he was obliged to follow and/or comply with the requirement to prescribe, dispense and/or supply medicines only in reasonable quantities as appropriate to the patient's needs.

9. The Respondent's detailed prescriptions to the Patient can be found at **Annex A-2** and **Annex A-3**.

10. The Respondent claimed trial to all charges. At the end of the trial the Disciplinary Tribunal ("**DT**") acquitted the Respondent of the three professional misconduct charges and convicted him of the three professional services charges.

Agreed statement of facts ("ASOF")

11. The ASOF was revised during the course of the Inquiry as the Respondent had highlighted some discrepancies in the prescriptions during the Respondent's testimony. In the ASOF (revised) it was stated as follows:

12. The Patient first consulted the Respondent on 8 February 2010 at Mount Elizabeth Hospital ("**MEH**") through a referral by Dr F, an anaesthesiologist who was treating the Patient for his chronic lower back pain.

13. From 8 February 2010 to 31 July 2012 (the "**Material Period**"), the Patient was:-

(a) admitted to MEH five times as follows:-

(i) 2 February 2010 to 11 February 2010;
(ii) 10 March 2010 to 12 June 2010;
(iii) 13 June 2010 to 28 August 2010;
(iv) 25 October 2010 to 29 October 2010; and
(v) 1 March 2011 to 26 May 2011;

(b) admitted to Mount Elizabeth Hospital Novena ("**MEHN**") from 2 July to 31 July 2012; and

(c) treated as outpatient at the Respondent's Clinic from 27 September 2011 to 22 June 2012.

14. During the Material Period:

(a) The Patient was under the Respondent's care for the co-management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder, obsessional ruminations and anxiety;

(b) The Respondent and/or the Patient's other treating doctors (including Dr F) respectively and/or jointly reviewed / monitored the Patient as inpatient at MEH and MEHN;

15. The Respondent also reviewed and managed the Patient as outpatient at the Clinic and by way of telephone consultations on several occasions between 27 September 2011 and 3 August 2012;

(a) The Patient was prescribed with various medications for the treatment of his mental and psychiatric disorders ("**Prescribed Medications**") [details of which are set out in Annex A-2 and A-3];

(b) Dr F prescribed opioid analgesics to the Patient for the management of his chronic lower back pain;

(c) on or about 31 July 2012, the Respondent prescribed to the Patient *inter alia* the following medicines:-

S/No.	Name of medicine	Dosage prescribed
1.	*Mirtazapine*	60mg every night
2.	*Zolpidem Controlled Release (CR)*	25mg every night

16. On 4 August 20212, the Patient passed away. The Final Cause of Death was certified by the pathologist as "multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication." Post-mortem revealed that the post-mortem blood concentrations of Olanzapine, Duloxetine, Mirtazapine and Bromazepam were elevated compared to the therapeutic concentrations found in ante-mortem plasma levels of living subjects.

The Civil Proceedings

17. After the Patient's passing, the Patient's sister, Mdm PW1, who was also the Complainant in the present Inquiry, commenced a civil suit in the High Court on behalf of Patient's estate against the Patient's insurers, American International Assurance Co Ltd in Suit 820 of 2014 ("**HC Proceedings**").

18. The central issue before the High Court was whether the Patient had consumed certain medicinal drugs expecting to die. The High Court dismissed the claim brought by the Patient's estate in *PW1 (executrix of the estate of P, deceased) and another v American International Assurance Co Ltd and another* [2016] 3 SLR 93 ("**HC Judgment**"). The High Court held that the Patient had consumed overdoses of at least three drugs, and that as a result, his death was not an accident entitling the Patient's estate to payment under the relevant insurance policies. The Respondent testified as a witness on behalf of the Patient's estate in the HC Proceedings.

19. The Patient's estate subsequently filed an appeal to the Court of Appeal against the HC Judgment. The CA allowed the appeal in *PW1 (executor of the estate of P, deceased) and another v American International Assurance Co Ltd and another* [2017] 1 SLR 461 ("**CA Judgment**").

20. Notably, the CA made the following findings at [76], [111] and [113]:

> "76 In our judgment, what emerges from the evidence of the scientific and medical experts, which we have considered above, is that the quantity and variety of drugs prescribed to the Deceased were such that even if these had been taken in their prescribed doses (which were at the high end to begin with), this could have resulted in the adverse reactions that led to his death.
> […]
>
> 111 There are only three broad scenarios that can account for the Deceased's actions and intentions prior to his death. These are as follows:
>
> (a) The Deceased took an overdose of his medication with the intention or expectation of suffering injury that would result in death.
> (b) The Deceased took an overdose of his medication without intending or expecting thereby to suffer any injury resulting in death.
> (c) The Deceased took his medication in accordance with the prescription and harboured no intention or expectation of suffering injury resulting in death. […]
>
> 113 Given the weight of the psychiatric evidence and the evidence concerning the Deceased's outlook on life, we find instead that on a balance of probabilities,

> what occurred on the night of 3 August 2012 was either scenario (b) or (c) rather than scenario (a). Indeed, in our judgment, on the weight of all the evidence, scenario (c) offers the best explanation of all the surrounding circumstances. Hence, we find that the Deceased died even though he took his medicine in accordance with the prescribed dosage**.**"

The expert evidence of the SMC

21. For the present Inquiry, the SMC called Dr PE1 ("**Dr PE1**") as an expert witness. Dr PE1 is a fully qualified and registered consultant psychiatrist since 2000 and the [designation redacted] at the Institution A.

22. In his expert report of 13 April 2020 Dr PE1 stated the following (with the relevant paragraph numbers of Dr PE1's report indicated):

> 1.2.1: The Respondent's prescription of multiple medications of the same class and across multiple classes to the Patient was a high-risk clinical practice and may not have been appropriate in the circumstances.
>
> 1.2.10: It was risky for the Respondent to practice polypharmacy on the Patient as he was not necessarily a treatment resistant patient.
>
> 2.2 and 2.3.1: The Respondent dispensed and supplied an excessive amount of medications to the Patient which was contrary to 2002 SMC ECEG, although he tried to monitor its effects through outpatient visits and telephone consults.
>
> 2.3.5: Although 6 month's supply of medications were used in stable and chronic patients, it was unusual to provide this immediately upon discharge.
>
> 4.1: The Respondent attempted to meet the standard of professional medical care expected of a responsible and competent doctor in relation to the treatment and care rendered to the Patient.
>
> 4.3: The Respondent's treatment of the Patient was a high risk one in trying to meet the standard of professional medical care expected of him.

4.4: The Respondent's conduct was clinically risky and the Patient was exposed to unnecessary risks of having multiple medications at high doses which could interact with one another resulting in a fatal adverse event as it turned out.

5.1: The Respondent should have explained the benefits, risks, possible complications and option to the Patient in making the decision to prescribe, dispense and supply the medication to the Patient.

23. Dr PE1 summarised his findings as follows:

> "In summary, I recognise that Mr P was suffering from chronic anxiety and depression with intractable back pain whose condition was complex and difficult to manage. Dr Ang has shown care and concern in helping Mr P providing inpatient, outpatient and telephonic care. However, Dr Ang progressively over the two years, increasingly gave multiple medications across several classes, several of which were at high doses. He also gave excessive supplies of these medications immediately post discharge for up to a duration of 6 months. Although Dr Ang took precautions and explained his practice to Mr P, I am of the opinion that these practices are high risk and failed to meet the acceptable standards of clinical practice by a psychiatrist."

24. The SMC also called E2 ("**Mr PE2**"), [designation redacted] at the Department of Pharmacy at the Institution A.

25. A summary of Mr PE2's report was as follows:

(a) There were significant safety concerns from the drug-drug interactions of each type of medication prescribed to the patient. The top concern was that of increased risks for central nervous system depression, along with increased risks of sedation, respiratory depression and/or cardiovascular depression when the Patient took all the medications together in accordance with the prescribed dosing instructions.

(b) Even though the fatal poisoning with each of these medications alone was unlikely to occur in the does prescribed to the Patient, the possibility of a causal relationship between these medications and the death could not be completely ruled out.

(c) The Respondent should have taken the precautions to counsel, educate and warn the Patient on the potential serious adverse effects of drug-to-drug interactions (in particular sudden and severe CNS depression, including excessive sedation) with the concomitant administration if all the medications as directed by the dosing instructions.

The Defence

26. The Respondent testified for the Defence.

27. The Respondent had been a practising psychiatrist for the past 36 years. He served as a psychiatrist with the Singapore Armed Forces for 17 years from 1986 to 2003 before retiring as a Colonel in 2003 and has been in private practice since then.

28. Out of the more than 6500 patients he has seen in his private practice, the Respondent has managed a handful of patients who presented with chronic and complex psychiatric disorders. These patients require special care comprising a judicious combination of medications and non-pharmacological methods such as individual and family psychotherapy as well as electro-convulsive therapy.

29. The Respondent stated that he had explained to the Patient the possible side effects of the medications prescribed and also warned him that if he took more than the prescribed dose of medication, it may cause him to have difficulty breathing or to collapse. The Respondent did not document the abovementioned discussion in his clinical notes.

30. On 1 April 2011, Dr F organised a case conference involving all the doctors who were attending to the Patient. This case conference was to highlight the Patient's various medical and psychiatric problems so that all the doctors involved in managing him were aware and clear about their roles. Apart from Dr F and the Respondent, the doctors who were present at this case conference included Dr F3, an endocrinologist, who was treating the Patient's low testosterone, and Dr F4, an orthopaedic surgeon, who was exploring the option of surgery for the Patient chronic low back pain.

31. During the case conference, the Respondent submitted a summary of his psychiatric assessment of the Patient in the DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) format covering the five axes, which stated the multi-faceted problems he was facing ranging from Axis I (his psychiatric diagnosis), Axis II (his personality), Axis III (his medical problems), Axis IV (psycho-social stressors) and Axis V (his usual coping mechanisms).

32. As part of his holistic treatment plan for the Patient, the Respondent tried to help him cope with his psycho-social stressors by discussing with him some wellness principles and healthy coping skills.

33. The Respondent also conducted a number of outpatient telephone consultations with the Patient.

34. At the end of the consultation, the Respondent had prescribed six months' worth of medications to the Patient because:

(a) Although he had scheduled to review the Patient quarterly, the Patient only wanted to come as and when he could find time to come in the midst of his work schedule;

(b) The Patient continued to have a phobia of coming to a psychiatric clinic due to an incident on 25 May 2010 involving another doctor who said to the Patient in public: *"I am a doctor dealing with mad people like you"*.

(c) The Respondent had assessed him to be capable of being responsible for managing his medications with the knowledge and support of family members.

35. While the Respondent was aware that the Patient had a balance of about two months' worth of medication from his previous six-month supply prescribed on 26 May 2011, the Patient assured the Respondent that he would treat them as a reserve supply in case he could not come for a review in six months' time due to his hectic work schedule.

36. During the telephone consultation with the Patient on 9 March 2012, the Respondent had advised the Patient that he should be careful with taking the combination of hypnotics and he warned him about the dangers of excessive medication (*i.e.,* giddiness, unsteadiness, drowsiness which may eventually lead to breathing difficulties and a collapse).

37. The Respondent asserted that in his private practice over the last 19 years, and having managed more than 6,500 patients, he had encountered only a handful of patients with chronic, multiple and complex psychiatric disorders requiring appropriate combination of medications. The Patient was one such unique patient who had innate biological high tolerance towards medications which necessitated high dosages and special combination of medications to help him function effectively.

38. The Respondent stated that he had the Patient's best interests in mind and his ultimate goal for the Patient was to wean him off the medications once he learnt to cope with his psychosocial stressors. During his final admission to MEHN, this was discussed on 4 July 2012. The Respondent knew that the Patient was facing immense stress because of the legal tussle with his brother, and the Respondent intended to have him undergo detoxification in the hospital once the court case was over, or about six months after (*i.e.* January 2013) had he come to terms with his issues with his brother, if he was still dependent on the combination of medications at that time in spite of the Respondent's efforts to wean him off.

39. In the meantime, the Respondent intended to slowly taper down his medications when he assessed the Patient to be able to better manage his condition. At no point in time did the Respondent assess the Patient to be addicted to the medications.

40. Unfortunately, the Patient passed away before he could carry out the Respondent's further treatment plan.

The expert evidence of the Defence

41. The Defence called Dr DE ("**Dr DE**"), a practising psychiatrist as its expert witness.

42. Dr DE stated that the Patient's case was a complicated one with multiple comorbidities and required the intervention of two specialists, a pain specialist and a psychiatrist. In the

circumstances it was hard for any clinical guideline to provide adequate guidance for such challenging cases. Dr DE opined that the Respondent's prescription of medications to the Patient was reasonable in the circumstances.

43. In terms of the frequency of review of the Patient, Dr DE opined that the telephone review and in clinic outpatient review of the Patient was reasonable if the Respondent assessed the Patient to be stable. Dr DE noted that when the Patient was admitted to hospital for a significant amount of time when he was under two or more benzodiazepines where he would have been monitored for any adverse side effects. The Patient did not appear to have suffered any adverse effects which would show that he tolerated well to the prescription regime.

44. While benzodiazepines were not typically prescribed on a long-term basis for most patients, there are cases where patients have a highly complex medical condition with multiple psychiatric conditions such as the present case. The Patient was shown to be able to function well and focus on his business with the prescription of benzodiazepines by the Respondent for over 2 years 5 months and did not show any obvious side effects. In Dr DE's opinion, the benefit of long-term use of benzodiazepines for the Patient outweighed the risks.

45. With respect to Mr PE2's opinion on the effectiveness and safety of the off-label prescribing of Mirtazapine and Zolpidem CR, Dr DE opined that this did not appear to have been scientifically substantiated by the best available evidence from a robust body of randomised controlled trials as patients with complex psychiatric disorders like the Patient would usually be excluded from randomised controlled trials. As there were patients with complex psychiatric conditions that did not respond to standard treatment, the off-label use of drugs was a common feature of prescribing in general psychiatric settings.

The SMC's Closing Submissions

46. The SMC submitted that the Respondent had objectively failed to demonstrate that he had clear medical grounds for his conduct, based on all the available evidence, and he therefore should be found guilty under the charges against him.

47. The applicable standard of conduct was the Guideline 4.1.3 of 2002 ECEG, which states that *"A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs"*.

48. The Relevant Guidelines (applicable between 8 February 2010 and 31 December 2011) were applicable to all doctors including the Respondent. The Relevant Guidelines form the compulsory starting point that all doctors should comply with. At all material times, the Respondent was aware of the applicable standard of conduct.

49. The Respondent had deviated from the Relevant Guidelines in his treatment of the Patient.

50. The onus was thus on the Respondent to prove that he had clear medical grounds for deviating from the Relevant Guidelines, i.e., the Respondent bore the evidential burden of proving that he had:

(a) undertaken a risk-benefit analysis each and every time that he chose to deviate from the Relevant Guidelines;

(b) discussed such risks and benefits with the Patient each time before he chose to deviate from the Relevant Guidelines; and

(c) obtained the Patient's consent each time he deviated from the Relevant Guidelines.

51. The SMC submitted that at all material times, the Respondent had breached the applicable standard of conduct in his prescriptions of medicines to the Patient. The Respondent had objectively failed to demonstrate that he had clear medical grounds for each of his deviations from the Relevant Guidelines.

52. The SMC submitted that in the absence of any actual contemporaneous evidence, there was no reason why the DT should just take the Respondent's word for it when he said that he did conduct a risk-benefit analysis and/or discussed such risks with Mr P. It was apparent that whatever excuses the Respondent put forward in the Inquiry were afterthoughts designed to

justify his conduct and such excuses had no support whatsoever in the medical records and/or clinical notes.

53. While the Respondent's main excuse was that the Patient was a highly complex case that warranted deviations from the Relevant Guidelines, the SMC submitted that the reality was that the Patient's case was not in fact as highly complicated or complex a case as the Respondent had hyped him up to be in the present proceedings. The SMC submitted that the Respondent's self-serving narrative stands in stark contrast to his very own sworn testimony stated elsewhere prior to these proceedings in the High Court civil proceedings. The SMC submitted that the truth was that the Patient was merely suffering from temporary reactive depression and was not a psychiatric case. His mental conditions were secondary to his primary problem – his chronic lower backpain. This was repeatedly emphasised by the Respondent in his own clinical notes, reports, and sworn testimony in the High Court civil proceedings.

54. The Respondent also claimed that he had a "strategy" for his prescriptions. The SMC submitted that this "strategy" was an afterthought as no "strategy" was articulated anywhere whatsoever in the clinical notes or medical records. The reality was that the Respondent objectively had no clear strategy in deciding whether and/or when to deviate from the Relevant Guidelines. The SMC submitted that the truth was that the Respondent was just treating the Patient's symptoms as he went along, as opposed to treating the Patient's underlying conditions.

55. With regard to the Respondent's claim that the Patient was "*functioning well*", this did not change the fact that the Respondent was still subjecting the Patient to the risks involved in deviating from the Relevant Guidelines. The SMC submitted that just because a patient has managed to walk a tightrope all the while does not mean that he was *not* placed at risk of falling the very next moment. What cannot be disputed was that each and every time the Respondent deviated from the Relevant Guidelines, he subjected the Patient to serious risks arising from such deviations.

56. The SMC submitted that there was no evidence from the clinical notes or medical records that the Respondent had any sort of plan to taper off and wean the Patient off the medicines and the Respondent completely failed to make any attempts to wean the Patient off the medicines. In fact, the Respondent's prescriptions *kept increasing in type and quantity* over

the relevant period. By the end of the relevant period, the Patient was taking much more medication than compared to what he was taking at the very start.

The Defence's Closing Submissions

57. The Defence asserted that that the Patient was a complicated and unusual case, which necessitated a deviation from the standard treatment for "run-of the-mill" psychiatric patients. The Patient developed the added problem of PTSD following the 25 May 2010 incident, which worsened his existing problems of depression, anxiety with insomnia and negative, ruminative thinking. Because of this, the Respondent made a clinical decision to increase the number and dosage of medications the Patient was on to help him function and get the rest he required.

58. The Defence submitted that "it was evident" from the medical records that the different medications (including benzodiazepines) prescribed by the Respondent to the Patient served different purposes. To this end, the Respondent was mindful of the need to balance the dosage and number of medications while managing the Patient's psychiatric and psychological well-being. In other words, there was, at all material times, a balancing of the risk and benefits of the medications prescribed.

59. The Defence submitted that the Patient was coping well under the medication regime and the Complainant admitted that the Patient was in a good condition upon his discharge from his last admission on 31 July 2012 which was four days before his demise. Out of the two years and five months that the Patient was under the care of the Respondent, he was admitted to hospital for a significant portion of the time, and there was close in-patient monitoring for possible adverse side effects from the medications prescribed. Throughout the course of the Patient's admissions, the Respondent had also assessed him during bedside visits on numerous occasions and there was no indication on the records that the Patent was not coping well with the medications.

60. On the Respondent's level of documentation, the Defence submitted that inadequate documentation was not one of the charges preferred against the Respondent and the Respondent only had to answer to the charges preferred against him and nothing more. In any case, it was evident from the medical records and Dr DE's expert evidence that the Respondent

had documented his strategic treatment plans for the Patient, and it was sufficient for purposes of another psychiatrist taking over the management of the Patient.

61. In relation to the 3rd Charge / Alternate 3rd Charge, the Respondent submitted that the SMC's expert, Mr PE2 had relied on randomised controlled trials ("**RCTs**") in support of his opinion that Mirtazapine and Zolpidem controlled release were not to be prescribed past the respective dosages of 60mg / day and 25mg / day was plainly unjustifiable, given that there was no legal provision or regulation which mandated the "*licensed maximum daily dosages*" of both Mirtazapine and Zolpidem. The Respondent submitted that the RCTs were carried out on subjects with conditions far less complex as compared to the Patient. Therefore, it was seriously questionable if the suitable dosages for someone like the Patient of Mirtazapine and Zolpidem controlled release should or could be dictated by the findings of the RCTs and in any event, the Respondent submitted that as a pharmacist, Mr PE2's knowledge on the purposes of the medications, their efficacy, and the appropriateness of their dosage is limited, and in any case, far lesser than what a psychiatrist, like the Respondent possessed.

The DT's findings on the charges

62. We first review the relevant authorities for charges of professional misconduct and charges for failure to provide professional services of the quality reasonably expected.

Professional misconduct

63. In *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 ("*Lim Lian Arn*") the Court of Three Judges held at [28] that a court / tribunal should conduct a three-stage inquiry to determine whether a charge of professional misconduct is made out.

(a) First, the court / tribunal should establish the relevant benchmark that is applicable to the doctor.

(b) Secondly, the court / tribunal should establish whether there has been a departure from the applicable standard.

(c) Thirdly, the court / tribunal should determine whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limbs set out in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 *("Low Cze Hong")*, in the case against the doctor.

64. With respect to the third stage of the inquiry, *Low Cze Hong* establishes at [37] that professional misconduct is made out in the following situations:

(a) Whether there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency (the "**1st Limb**");

(b) Whether there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner (the "**2nd Limb**").

65. In *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 at [40] it was held that under each limb of *Low Cze Hong* these are discrete elements that have to be proved by the SMC and these set out a high threshold that have to be crossed before a conviction can be sustained.

66. For professional misconduct to be met, there must be *"serious disregard of or persistent failure"* to meet these standards; not every departure from the acceptable standards of conduct would necessarily amount to professional misconduct. (*Lim Lian Arn* at [30] to [34].)

67. Unlike civil proceedings involving patients seeking compensation from doctors for negligence, the disciplinary proceedings conducted pursuant to the MRA are quasi-criminal in nature and concerned with punishment and regulation. To this end, doctors should not be punished for "*mere technical breach*[es] *of the relevant standards*" or "*relatively minor breaches or failures*", or else it would pose an intolerable burden for each doctor if each failure were visited with sanctions (*Lim Lian Arn* at [30]). As a general rule, mere negligence or incompetence on the part of the doctor will not be enough. There has to be something more. (*Lim Lian Arn* at [37]).

68. In the present case, the SMC had chosen to proceed on the first limb of *Low Cze Hong*, namely "an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency" for the three charges.

Failure to provide professional services of the quality reasonably expected

69. In *Singapore Medical Council v Lam Kwok Tai Leslie* (2016) (*"SMC v Leslie Lam")*, while the DT's Grounds of Decision was not published as Dr Lam's conviction under section 53(1)(*d*) of the MRA was overturned on appeal, the DT's acceptance of the SMC's legal reasoning on the applicable test for section 53(1)(*e*) of the MRA and how it differed from section 53(1)(*d*) of the MRA is instructive.

70. The relevant paragraph of the DT's Grounds of Decision in *SMC v Lam Kwok Tai Leslie* is as follows:

> *"47. … In this regard, we agree with the SMC's submissions, in particular the following:*
>
> The plain words of section 53(1)(e) demonstrated that section 53(1)(e) was meant to capture conduct that was less egregious than professional misconduct, but still serious enough to warrant disciplinary action. The conduct proscribed in section 53(1)(e) was failing to provide "professional services of the quality which is reasonable to expect of him". The DT noted that one of the reasons for the 2010 MRA amendment was to deal with "new issues in professional conduct and standards have arisen due to changing demands and expectations of patients and the public". As a result, the range of disciplinary sanctions was expanded. The newly enacted section 2A MRA provides that the object of the Act was to protect the health and safety of the public by providing for mechanisms to "uphold the standards of practice within the medical profession". With this in mind, the DT agreed with the SMC's submissions that a plain and literal interpretation of section 53(1)(e) would lead the inescapable conclusion that the said provision was meant to cover conduct which does not rise to the same level of professional misconduct, but was sufficiently serious to warrant disciplinary actions."

71. In *SMC DT inquiry for Dr Yong Thiam Look Peter* [2016] SMCDT 5, the DT, taking reference from the Australian jurisprudence, held (at [35]) that a useful starting point in determining whether the doctor has breached section 53(1)(*e*) of the MRA was to consider the professional services of the quality which is reasonable to expect, the objective standard applicable to a doctor of equivalent training and experience and/or what the public or the doctor's peers expect of him.

72. In *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 ("*Peter Yong")* the Court of Three Judges accepted the principles propounded in the DT proceedings below in holding that a charge under section 53(1)(*e*) of the MRA at [11]:

> "involves an objective assessment of the standard of medical care which can be reasonably expected of medical practitioners. This calls for a consideration of what reasonable medical practitioners would expect of their peers in delivering medical care and the minimum standards of acceptable care derived from the expectations of reasonable medical practitioners."

73. The DT respectfully agreed with this statement in *Peter Yong.* Simply put, section 53(1)(*e*) MRA concerns the failure to provide professional services of the quality which was reasonable to expect in a given case.

The relevance of the Court of Appeal's findings in the Civil Proceedings to the Inquiry

74. The Court of Appeal had made specific findings in the Civil Proceedings with regard to the Patient's death namely that, on a balance of probabilities, the Patient died even though he took his medicine in accordance with the prescribed dosage.

75. The DT was fully aware that the Inquiry was of a completely different nature from the Civil Proceedings. As the decision maker on the charges preferred against the Respondent by the SMC, the DT would need to consider the issues afresh on the evidence before it as to whether the charges have been made out *beyond a reasonable doubt*.

76. In this regard, in the ASOF for this Inquiry it was stated as follows:

> On 4 August 20212, the Patient passed away. The Final Cause of Death was certified by the pathologist as "multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication." Post-mortem revealed that the post-mortem blood concentrations of Olanzapine, Duloxetine, Mirtazapine and Bromazepam were elevated compared to the therapeutic concentrations found in ante-mortem plasma levels of living subjects.

77. The Respondent's expert, Dr DE, conceded on the witness stand that he had no reason to dispute the Court of Appeal's findings. During cross-examination, Dr DE also

acknowledged that the risk to the Patient from taking benzodiazepines and opioid analgesics together[1]:

> Q. So as a reasonable person, reasonable expert, would you accept from all these statements that Mr P's taking the medications given to him by Dr Ang eventually resulted in Mr P's death?
>
> A. Yah, fair enough.
>
> Q. So basically, that risk of somebody dying from benzos or mixing benzos with opiates eventuated, right?
>
> A. Yes

78. During the Inquiry, the Respondent admitted on the witness stand that he did not disagree with the findings of the Court of Appeal, he nonetheless stated that if the Patient had reacted adversely, he would have done so, and it would have been shown at [MEHN] and the first three days when he was at home.

79. That said, SMC had confirmed during the Inquiry that it *was not accusing the Respondent for having caused the Patient's death* and to this end, the DT also notes that this was not alleged in any of the charges preferred against the Respondent.

The role of the Guidelines and the Respondent's reasons for departing

80. It was common ground between the SMC and the Respondent that the relevant Guidelines were the compulsory starting point for the Respondent and any departure can be made must be on clear medical grounds. It was also not in dispute that the Respondent had deviated from the relevant Guidelines as averred in the charges in the prescription of medicines to the Patient. Where the SMC and the Respondent diverged was whether the Respondent had clear medical grounds from deviating from the relevant Guidelines.

81. As for what constituted clear medical grounds for such a deviation, the parties agreed that this was whether the Respondent did the following:

(a) Conducted a risk/benefit analysis for departing from the relevant Guidelines;

[1] Transcript (29 July) page 109 lines 9 to 16

(b) Discussed the risk/benefits with the Patient; and

(c) Obtained the Patient's consent to that course of action.

82. In *SMC v Foo Chee Boon Edward* [2018] SMCDT 14 the DT observed as follows at [59] to [60]:

> "The DT accepted that it was not the case that all product inserts must be "*slavishly followed*" as pointed out by the Respondent. Instead, in certain circumstances, doctors may depart from the product insert and prescribe a different dosage, if and only if, in the doctor's judgment, it would be in the interest of the patient to do so.
>
> **However, in cases of any departure from the product insert, the burden was on the doctor to justify the said departure. As such, the doctor should ensure that the patient had been so advised of the benefits and risks, and the patient's informed consent should be obtained and documented**. In this case, none of that was done."
>
> [emphasis added]

83. This was also confirmed by the Defence's expert, Dr DE[2]:

> Cross examination of Dr DE
>
> Q. […] would you confirm that all opinions are given you have given in your two expert reports and in this hearing are premised on the following, okay. First, that Dr Ang made a proper risk benefit analysis whenever giving the patient medication or a combination of medication, yes?
>
> A. Yes.
>
> Q. And your opinions are also premised on Dr Ang having discussed this course of action with the patient beforehand, yes?
>
> A. Yes.
>
> Q. And your opinions are all premised on Dr Ang obtaining the patient's agreement to this course of medications?
>
> A. […] Yes.
>
> **Q. Now, if any one of these three points is missing, that Dr Ang didn't make a proper risk benefit analysis or he didn't discuss the course of action with his patient, or the patient didn't agree, then Dr Ang would not have acted responsibly or reasonably in giving the medication, right? Agree?**

[2] Transcript (26 July 2022) page 135 line 22 to page 137 line 3

A. Yes, I will agree, yah.

Q. **And certainly, he wouldn't have acted professionally if any one of these elements is missing, right? Making a risk benefit analysis, discussing it with the patient and obtaining the patient's agreement, right?**

A. Yah, I will agree.

[emphasis added]

84. In the circumstances, while SMC bore the legal burden to prove the charges beyond a reasonable doubt, the Respondent bore the evidential burden to show that he had clear medical grounds for departing from the relevant Guidelines.

85. At the Inquiry, the Respondent conceded on the witness stand that his clinical notes and medical records did not show any reasons each and every time he did so when he chose to deviate from the Relevant Guidelines.

Cross-examination of Dr Ang[3]

Q. Dr Ang, could you please, since you have I think 8AB there, could you please turn to 5724? Again to Prof PE1's supplemental medical expert report, at paragraph 8. Look at what Dr PE1 says: "From my review of Dr Ang's medical records, I am unable to find any evidence that Dr Ang had documented any explanation where he had deviated from the Guidelines and the 2004 CPG (Depression). There is also no record that the deviations were explained to the patient. Mr P… I do however note, that in Dr Ang's written explanation dated 28 November 2017, at paragraph 29, he has indicated that he discussed his use of medications even though he did not document it." Do you agree with what Prof PE1 says here?

A. Yes, in terms of documentation.

86. The Respondent also conceded that his clinical notes did not demonstrate that he undertook any risk-benefit analysis before deciding whether and/or when to deviate from the Relevant Guidelines. He admitted on the witness stand that his clinical notes did not state whether he explained any such risks to the Patient before deviating from the Relevant Guidelines.

Cross-examination of Dr Ang[4]

Q: Now in order to determine whether to give him certain kinds of medication, at every juncture, you would need to weigh the risks and benefits to that medication.

[3] Transcript (22 July 2022) page 97 line 19 to page 98 line 8
[4] Transcript (26 July 2022) page 12 lines 1 to 13

A: Yes. Yes, Your Honour.

Q: And that risk benefit analysis would similarly have to be discussed with the patient?

A: Yes, Your Honour.

Q: And that analysis and the discussion would have to be documented in the notes, if it actually happened?

A: Yes, Your Honour. Ideally, yes.

Q: And you would agree that that analysis and those discussions are not documented in the notes?

A: Not in details, Your Honour.

87. Dr PE1 opined that from his review of the Respondent's medical records, he was unable to find any evidence that the Respondent had documented any explanation where he had deviated from the Relevant Guidelines, and that there was no record that the Respondent had explained the risks of such deviations to the Patient.

88. We wish to emphasise that this was not simply an exercise of considering whether there was an adequacy of documentation (or the lack thereof) in the Respondent's clinical notes *per se*, but rather the clinical management by the Respondent of the Patient through the prescription of medicines; and whether factually the Respondent had demonstrated that he had clear medical grounds from departing from the relevant Guidelines. In this regard, it was Dr PE1's evidence that in attempting to meet the standard of professional medical care expected of him, the Respondent conduct was clinically risky and that the Patient was exposed to unnecessary risks of having multiple medications at high doses which could interact with one another.

89. In our view, it was insufficient for the Respondent to simply assert that the Patient was a complex and difficult case and he therefore used his "clinical judgment" in choosing to depart from the relevant Guidelines. The DT was obliged to consider the process and the reasons in which the Respondent had chosen to depart from the relevant Guidelines. To this end, the Respondent conceded at the Inquiry that the clinical notes should give the reason from the Guidelines so that any other doctor treating the patient would understand what the Respondent was doing for the Patient[5]. We agree with Dr PE1's opinion that the Respondent should have

[5] Transcript (22 July 2022) page 59 lines 6 to 10

explained the benefits, risks, possible complications and option to the Patient in making the decision to prescribe, dispense and supply the medication to the Patient.

90. The clinical notes would be contemporaneous evidence that the Respondent explained the benefits, risks, possible complications and option to the Patient in making the decision to prescribe, dispense and supply the medication to the Patient. Given the Respondent's own admission that the analysis and discussions were not documented in detail in the clinical notes, it was the DT's view and finding that he *did not* explain the benefits, risks, possible complications and option to the Patient in making the decision to prescribe, dispense and supply the medication to the Patient. We elaborate.

91. In many instances, the Respondent's clinical notes merely stated that the drug was prescribed in response to a complaint by the patient and nothing more. For instance, in the Respondent's clinical notes of 4 July 2012 it was stated as follows[6]:

> S: Slept Ok last night. Appetite not so good. Attended physiotherapy this afternoon. Watched television most of the time. Still has persistent pain. Mood: 5 out of 10. At home, mood was worse; 2 to 3 out of 10.
> Sister F2 is hoping for further reduction of his night medication.
> Patient is aware that the medication given to him is a lot but he feels that he needs the medication for his sleep, anxiety and mood.
>
> O: Patient is orientated to place, time and person. He is relevant and rational. He is able to give an account of the current situation. He spoke about his court case involving him and his elder brother over property matters. He hopes that he can be discharged by Monday or later.

92. The Respondent had noted in the clinical notes that the Patient was aware that the medication given to him was "a lot" but the Patient felt that he needed the medication for sleep, anxiety and mood. In this regard, the Patient's sister had hoped for a further reduction of his night medication but this was not done. Significantly, the Respondent's clinical notes merely documented that the Patient was aware that he was taking a lot of medication, but there was *no explanation by the Respondent to the Patient of why he needed to be on so much medication nor did he highlight to the Patient or his sister the risks/benefits of taking these medications*. The clinical notes in fact suggested that the Patient was given the medication by the Respondent as the Patient (as opposed to the Respondent) felt he needed the medications.

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[6] Clinician's Collaborative Progressive Notes by the Respondent on 4 July 2012 (ABOD Volume 4, Page 2246)

93. Further, the Respondent's own evidence suggested that his treatment of the Patient was self-internalised and *not* discussed with the Patient[7]:

> Q: Well Doctor, you know I just have to put it to you that in effect, you disregarded the guidelines either at the get-go or too quickly, and you substituted your own thinking.
>
> A: Yes and no, I did a lot of my own thinking. I did a lot of judgment. I wanted to follow the guideline, I did. But it was complicated by his PTSD.

94. The Respondent replied in similar fashion when asked if there was a strategic plan to treat the Patient[8]:

> Q: …As from your first consultation to the 4th admission, would you agree there's nothing in your clinical notes that sets out your strategic plan for Mr Quek?
>
> A: Your Honour, **in terms of documentation, I would agree it's not documented, but all the time it was in my mind**.
>
> [emphasis added]

95. Even the Respondent's own evidence was that he warned the Patient from taking *more than the prescribed dose* of medication, this was quite different from warning the Patient on the possible risks of drug-drug interactions when taken in the prescribed amounts.

96. With regard to the Respondent's claim that the Patient was "*functioning well"*, we agreed with the SMC's submission that the Respondent was nonetheless subjecting the Patient to the high risks involved in deviating from the Relevant Guidelines. Simply because the Patient had managed to walk a tightrope all the while did not mean that he was *not* placed at risk of falling off the very next moment. In this regard, each and every time the Respondent deviated from the Relevant Guidelines, he subjected the Patient to serious risks arising from such deviations.

97. It was also not in dispute that the Respondent had progressively over the two years, increasingly gave multiple medications across several classes, several of which were at high

[7] Transcript (22 July 2022) page 59 lines 6 to 10
[8] Transcript (22 July 2022) page 99 lines 9 to 14

doses. It was Dr PE1's opinion that the Respondent had given excessive supplies of these medications immediately post discharge for up to a duration of six months. In the exercising of his clinical judgment in departing from the relevant Guidelines, the Respondent did not *explain* the risks and benefits of this high-risk treatment to the Patient for his consideration and consent. The Defence's expert, Dr DE acknowledged that the risk of the Patient dying from taking benzodiazepines and opioid analgesics together eventuated, although we wish to highlight that SMC's had confirmed during the hearing that it was not the SMC's case that the Respondent had caused the Patient's death.

98. Whilst the Respondent was not facing charges of informed consent, in considering whether the Respondent had clear medical grounds from departing from the relevant Guidelines, the DT considered whether the Respondent did the following:

(a) Conducted a Risk/benefit analysis for departing from the relevant Guidelines;

(b) Discussed the risk and benefits with the Patient; and

(c) Obtained the Patient's consent to that course of action.

99. For professional misconduct to be met, there must be *"serious disregard of or persistent failure"* to meet these standards but not every departure from the acceptable standards of conduct would necessarily amount to professional misconduct. (*Lim Lian Arn* at [30] to [34]). It was also the opinion of Dr PE1, SMC's expert who opined that the Patient was suffering from chronic anxiety and depression with intractable back pain whose condition was complex and difficult to manage and that the Respondent had shown care and concern in helping the Patient providing inpatient, outpatient and telephonic care. Dr PE1 opined that the Respondent had attempted to meet the standard of professional medical care expected of a responsible and competent doctor in relation to the treatment and care rendered to the Patient.

100. Further, it was common ground between SMC and the Respondent that there was no malicious intent on the part of the Respondent in prescribing the various medicines to the Patient. In the circumstances, we were unable to say that the Respondent's clinical management of the Patient amounted to *an intentional and deliberate* departure from the

relevant Guidelines as averred in the Primary Charges and we acquitted the Respondent of the professional misconduct charges under s 53(1)(*d*) of the MRA.

101. That said, Dr DE also agreed that if the Respondent did not make a proper risk benefit analysis, discuss the course of action with his patient, or the patient did not agree to the course of action, the Respondent would not have acted responsibly or reasonably in the giving of the medication to the Patient. It was also Dr PE1's opinion that the Respondent's practices were high risk and failed to meet the acceptable standards of clinical practice by a psychiatrist. Given the multiple breaches of the relevant Guidelines over a significant period of time, we were of the view that this amounted to a wilful disregard by the Respondent of the relevant Guidelines such that he failed to meet the acceptable standards of clinical practice by a psychiatrist.

102. The Respondent had accordingly failed to provide professional services of the quality reasonably expected by a psychiatrist and the DT convicted him of the Alternate 1st, 2nd and 3rd charges under s 53(1)(*e*) of the MRA.

Submissions on sentencing

SMC's Submissions on Sentence

103. The SMC sought the following orders against the Respondent:

(a) an aggregate period of 36 months' suspension from practice;

(b) a censure;

(c) an order that the Respondent give a written undertaking to refrain from engaging in the same or similar conduct in future;

104. The SMC's submission for a 36 months' suspension was derived as follows:

(a) Determine the starting position for all three Alternate Charges based on all relevant factors:-

(i) Alternate 1st Charge: Starting position of 33 to 36 months' suspension (based on Moderate Harm and High Culpability from the harm-culpability matrix set out in *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("*Wong Meng Hang*"). The SMC submitted that this was the most serious charge.

(ii) Alternate 2nd Charge: Starting position of 30 to 33 months' suspension (based on Moderate Harm and High Culpability).

(iii) Alternate 3rd Charge: Starting position of 12 months' suspension (based on Moderate Harm and Medium Culpability). The SMC's submitted that this was the least serious charge.

105. In submitting for moderate harm and high culpability for Alternate 1st and 2nd Charges, the SMC's submission on harm where as follows:

(a) There was a high likelihood of harm arising from the Respondent's conduct. Dr PE1 opined that, if multiple benzodiazepines were prescribed, a doctor in the Respondent's position should counsel the patient on the risks of these drug-drug interactions and the impact on liver enzymes and metabolism in the liver. A doctor should avoid prescribing more than two benzodiazepines; prescribing two benzodiazepines is already risky and was not recommended under the 2008 Admin Guidelines (Benzodiazepines). The risk in prescribing three or more benzodiazepines outweighed any potential therapeutic effects. Dr PE1 and Dr DE both agreed that a doctor did not have free reign to provide a long-term prescription of benzodiazepines indefinitely. The package inserts and product monographs of opioids and benzodiazepines consistently recommend that the concomitant use of opioids and benzodiazepines should be avoided or limited to the minimum dosage and duration. Dr PE1 opined that the utility of the opioid-benzodiazepine combination was negative (i.e., the chance of harm is greater than the chance of benefit) save for a possible utility in patients suffering from terminal illness. Mr PE2 opined that fatalities have been reported with overdoses of multiple CNS depressants taken altogether. Dr DE

conceded that there was increased risk of respiratory (breathing) difficulties and if a patient overdosed on opiates or benzodiazepines, then adverse effects like death may occur.

(b) Even though the Patient did not have an existing drug dependency at the *start* of the Material Period, the Respondent's prescription for long-term use of benzodiazepines created and/or fuelled the Patient's dependence and tolerance toward benzodiazepines during the Material Period.

(c) The Respondent's conduct undermined public confidence in the medical profession as this was not a one-off minor / technical breach of the Relevant Guidelines. By repeatedly prescribing medication with no clear medical grounds in breach of the Relevant Guidelines, the Respondent's misconduct seriously harmed public confidence in the medical profession as registered medical practitioners were accorded the unique privilege and serious responsibility of prescribing medication to patients. Such harm to public confidence was exacerbated by the fact that the Respondent was a specialist. As a specialist in psychiatry, the Respondent ought to be held to a higher standard expected of him as compared to a non-specialist doctor.

106. In submitting that the Respondent's culpability for Alternate 1st and 2nd Charges was high, the SMC submitted as follows:

(a) The Respondent's culpability was, at the very least, that of recklessness / wilful disregard. At all material times, the Respondent was aware of the applicable standard of conduct. He admitted on the witness stand that he was aware of, and that he was bound by, the Relevant Guidelines applicable during the period and conceded that if a doctor wished to deviate from the Relevant Guidelines, he should weigh the risks and benefits in doing so, explain and discuss such risks with the patient, and document the above in his medical records. The Respondent conceded that he did in fact deviate from the Relevant Guidelines in his prescriptions. Despite deviating from the Relevant Guidelines, the Respondent objectively failed to demonstrate that he had clear medical grounds

for deviating from the Relevant Guidelines in his prescriptions of medication during the Material Period.

(b) As the Respondent had sold his medication to the Patient he obtained a financial benefit from his conduct. In the circumstances, the Respondent indisputably obtained a significant financial benefit from his conduct.

(c) This was not a one-off minor / technical breach of the Relevant Guidelines. The Respondent breached the Relevant Guidelines multiple times and to a great degree.

(d) The duration of the Respondent's offending behaviour was significantly lengthy as the Respondent had repeatedly breached the relevant Guidelines for 29 months, his culpability is higher as compared to a doctor who committed a one-off breach of the Relevant Guidelines.

(e) Given that the Respondent was the lead psychiatrist and a very senior doctor, his culpability should be higher as compared to a doctor in the same position in a junior position.

(f) The Patient was not medically trained; he would not have known the specific risks that could potentially arise from the Respondent's prescriptions. He trusted the Respondent as his medical practitioner to ensure that the prescriptions of medication were in his best interests. By repeatedly breaching the Relevant Guidelines under Alternate 1st charge without discussing the risks and benefits with the Patient each time before he chose to deviate from the said guidelines and failing to obtain the Patient's consent each time he deviated from the said guidelines, the Respondent abused his position of trust and confidence to a significant extent.

107. For Alternate 3rd Charge, the SMC submitted that harm was moderate and the Respondent's culpability was medium. In respect of harm, the SMC submitted as follows:

(a) There was serious harm that could have been caused by the Respondent's misconduct. The maximum daily dosages of Mirtazapine and Zolpidem Controlled Release are set out in their respective package inserts submitted for approval by the HSA. Prescribing these medications above their maximum daily dosages (i.e., off-label) may compromise the patient's well-being, as the effectiveness and safety of such off-label prescriptions are not scientifically substantiated by the best available evidence from a robust body of randomised controlled trials.

(b) The Respondent had had deviated significantly from the maximum daily dosages of Mirtazapine and Zolpidem Controlled Release as set out in their respective package inserts. He had prescribed Mirtazapine in excess of its maximum daily dosage (by 50% of the maximum daily dosage) and Zolpidem Controlled Release (by twice of the maximum daily dosage). Further, he gave a six months' supply of the medication with no evidence of any plan to wean / taper off the medication.

(c) The risks of Mirtazapine and Zolpidem Controlled Release at the Respondent's prescribed dosages to the Patient far outweighed any potential benefits. The package inserts of both Mirtazapine and Zolpidem Controlled Release both expressly stated that there were risks of "*fatalities*" when overdoses of these medications are prescribed, especially "*with mixed overdoses*" (for Mirtazapine) and "*when overdoses of multi CNS depressants were taken.* Dr DE, conceded on the witness stand that the prescription of Mirtazapine and Zolpidem Controlled Release at an overdose carried a "*risk of suppression of the breathing*".

(d) The Respondent was not only aware of the risks of prescribing an overdose of Mirtazapine and Zolpidem Controlled Release (including the risk of fatality), he also admitted on the witness stand that in prescribing a daily dosage of 60 mg of Mirtazapine to the Patient, the prescription of Mirtazapine had exceeded the therapeutic range.

(e) As at 31 July 2012, the Patient had been prescribed with Mirtazapine and Zolpidem Controlled Release for over two years. The Patient was first prescribed Mirtazapine on 1 April 2010 and Zolpidem Controlled Release on 9 April 2010 by the Respondent. It was the Respondent's own assertion (which SMC denied) that, as at 31 July 2012, the prescription of the excessive dosages of Mirtazapine and Zolpidem Controlled Release were "*necessary*" because "*Mr P's tolerance for Mirtazapine and Zolpidem evidently grew*". Hence, even based on the Respondent's own (which SMC submitted was unfounded) reasoning for his prescriptions on 31 July 2012, the Respondent conceded that his long-term prescriptions of Mirtazapine and Zolpidem Controlled Release created and/or fuelled the Patient's dependence.

(f) By knowingly prescribing Mirtazapine and Zolpidem Controlled Release well in excess of their respective maximum daily dosages on 31 July 2012, the Respondent's misconduct undoubtedly undermined public confidence in the medical profession.

108. As for culpability for Alternate 3rd Charge, the SMC submitted as follows:

(a) The Respondent's culpability was, at the very least, that of recklessness / wilful disregard. He was aware that the package inserts should be followed where possible and conceded on the witness stand that if someone were to take a look at the list of medicine prescribed to the Patient on 31 July 2012, "*he will get a shock out of his life*". The Respondent admitted that in prescribing a daily dosage of 60 mg of Mirtazapine to the Patient, he had the Patient at the edge of "the killing range for most people…for 6 months".

(b) The Respondent's failure to prescribe Mirtazapine and Zolpidem Controlled Release within their maximum daily dosages were not minor / technical breaches and the risks involved in the Respondent's prescriptions were also exacerbated by the fact that he gave a six-months' supply of the medication with no evidence at all of any plan to wean / taper off the medication.

(c) As the Respondent was the lead psychiatrist and a very senior doctor; his culpability should be higher as compared to a doctor in the same position in a junior position.

(d) The Patient was not medically trained; he would not have known the specific risks that could potentially arise from the Respondent's prescriptions. He trusted the Respondent as his medical practitioner to ensure that the prescriptions of medication were in his best interests. The Respondent abused his position of trust and confidence to a significant extent.

(e) The Respondent indisputably sold his medication to the Patient and had obtained a financial benefit from his conduct.

109. As for adjustment to aggregate sentencing position after balancing aggravating and mitigating factors, the SMC submitted that the Respondent's seniority and the fact that there were multiple breaches of the Relevant Guidelines should be regarded as aggravating factors, to which significant weight should be attributed.

110. To reflect the seriousness of the Respondent's misconduct, the SMC submitted that two of the most serious charges (i.e., Alternate 1st Charge and Alternate 2nd Charge) ought to run consecutively while the least serious charge (i.e., Alternate 3rd Charge) ought to run concurrently.

111. This would result in a calibrated total sentence of 63 to 69 months' (i.e., 5.25 to 5.75 years) suspension.

112. The SMC submitted that there could be possible discount for some delay in prosecution and if the DT was minded to grant a discount, the SMC submitted that at most a one-third discount ought to be applied to the sentence, *after* taking into account the aggravating factors in the present case (i.e. any upward adjustment to the calibrated starting position arising therefrom), and the SMC's legitimate reasons for any delay on its part. Applying a one-third discount, this would lead to a discounted sentencing recommendation of 42 to 46 months' (i.e., 3.5 to 3.8 years) suspension.

113. Taking into account the totality principle, the SMC submitted that an aggregate period of suspension ought to be capped at a maximum of 36 months' suspension in view of section 53(2)(*b*) MRA.

Respondent's Submissions on Sentence

114. The Respondent submitted for a fine for each Alternate Charge. The Respondent submitted for a fine of $30,000 each for the Alternate 1st Charge and Alternate 2nd Charge, and $15,000 for the Alternate 3rd Charge as a starting point.

115. The Respondent submitted that his case fell in the category of slight harm and low culpability for each of the Alternate Charges. Based on the harm-culpability matrix, the indicative sentencing range was a fine or other punishment not amounting to suspension.

116. First, the Respondent was providing necessary psychiatric treatment to a patient who had various psychiatric conditions, including insomnia, depression, post-traumatic stress disorder and anxiety. The SMC's expert had agreed that the Patient was a complex and difficult case.

117. Secondly, although the Respondent was deeply saddened by the unexpected and untimely demise of the Patient, someone whom the Respondent had become very familiar with through the years, it was not suggested that the death was caused by the Respondent. SMC had also confirmed that they were not accusing the Respondent of causing the death of the patient.

118. Based on the contemporaneous medical records, the Patient did not display plausible signs of addiction.

119. The Respondent submitted that there was no or low harm to public confidence in the medical profession as there is only a single patient involved, and the potential harm to him was slight. This must also be assessed in the context of the Patient being a complicated case to manage.

120. The Respondent submitted that he was convicted of failing to provide services of the quality that is reasonable to be expected of him under section 53(1)(*e*) of the MRA. There was

no conviction under section 53(1)(*d*) of the MRA, and no finding of serious negligence, or intentional and deliberate departure from the standards.

121. There was no suggestion from the evidence, that the Respondent was acting with any malicious intent, motivated by financial gains, or that he was deliberately indifferent or reckless as to the Patient's wellbeing.

122. The Respondent submitted that after accounting for mitigating factors, the starting point fines of each Alternate Charge under Step 3 ought to be adjusted downwards as follows:

(a) $15,000 fine for Alternate 1st Charge (adjusted from $30,000);

(b) $15,000 fine for Alternate 2nd Charge (adjusted from $30,000); and

(c) $7,500 fine for Alternate 3rd Charge (adjusted from $15,000).

123. The Respondent submitted that a total fine of $37,500 for all three Alternate Charges was appropriate, in the absence of any extraordinary cumulative aggravating factors or public interests.

The DT's Decision on the Appropriate Sentence

124. Both parties agreed that the sentencing framework a set out in *Wong Meng Hang* was applicable in this case.

125. In *Wong Meng Hang* the Court of Three Judges had set out a four-step sentencing framework to lay down an indicative sentencing range, taking into account offence specific factors of harm and culpability, as well as offender-specific aggravating and mitigating factors. This four-step sentencing framework has been elucidated and elaborated on in the Sentencing Guidelines 2020 for Disciplinary Tribunals ("**Sentencing Guidelines 2020**") and the steps are as follows:

(a) Step 1: Evaluate the seriousness of the offence with reference to harm and culpability. Harm is the type and gravity of the harm or injury that was caused

to the patient and society by the commission of the offence. Culpability measures the doctor's degree of blameworthiness. In general, a less culpable state of mind would be one where ill intention on the part of the doctor is lacking.

(b) Step 2: Identify the applicable indicative sentencing range using the harm-culpability matrix. The indicative range is a guide only and does not displace the duty upon each sentencing tribunal to consciously seek, determine and impose the sentence which is appropriate in all the circumstances, and therefore to depart from the matrix where it is appropriate to do so.

Harm / Culpability	**Slight**	**Moderate**	**Severe**
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

(c) Step 3: Identify the appropriate starting point *within* the indicative sentencing range. This is to be done with regard to: (i) the level of harm caused by the offence; and (ii) the level of the doctor's culpability. While this involves engaging the same factors in Step 1, it is not an instance of double-counting but rather granulating the case in order to arrive at a sense of what the starting point should be.

(d) Step 4: Adjust the starting point by taking into account offender specific aggravating and mitigating factors.

126. Where a doctor is found guilty of multiple offences (as in the present case), the following steps need to be applied.

127. To ensure proportionality, the DT ought to apply the one-transaction rule and the totality principle when calibrating the overall sentence to be imposed. The one-transaction rule provides that sentences for unrelated offences should run consecutively, while sentences for two or more offences which form part of the same transaction should generally be ordered to run concurrently if there is only a single invasion of the same legally protected interest. When determining whether the offences form part of the same transaction, the DT may consider whether, in the commission of the offences, there was proximity in time, proximity in location, proximity in type of offence, whether the same interest was being invaded, whether there was continuity of action, and/or continuity of purpose.

128. Where two of the multiple offences are related, then the one transaction rule and the general rule ought to operate in tandem such that the sentence for one of the related offences and the sentence for the other unrelated offences should be ordered to run consecutively (with the sentence for the remaining related offence to run concurrently).

129. The totality principle is applied at the end of the sentencing process to ensure that the overall aggregate sentence is neither excessive nor manifestly inadequate. This is a broad-brush "last look" at all the facts and circumstances to ensure the overall proportionality of the aggregate sentence.

130. To ensure that the overall sentence is not excessive, the DT should consider two limbs, namely:

(a) Whether the aggregate sentence is substantially above the normal level of sentences for the most serious of the individual offences committed; and

(b) Whether the effect of the sentence on the offender is crushing and not in keeping with his or her past records and future prospects.

131. The DT first made the observation that that while the Respondent had been convicted of the professional services charges section 53(1)(*e*) MRA offence as opposed to the

professional misconduct charges section 53(1)(*d*) MRA, applying the *Wong Meng Hang* framework did not automatically mean that the Respondent should only be fined. We also did not agree with the Respondent's submission that a conviction under a section 53(1)(*e*) MRA charge was necessarily "less serious" than one under 53(1)(*d*) MRA. Much would depend on the facts of the case, and where harm/culpability was situated in the *Wong Meng Hang* framework.

132. Next, although have been some sentencing precedents involving section 53(1)(*e*) cited by both parties, given that the facts in those precedents were rather dissimilar to the present case, the DT did not find them especially helpful as reference point for the sentence in the present case. In any event, given that the *Wong Meng Hang* framework was applicable here, that should be the basis upon which the appropriate sentence will be arrived at in the present case. The DT thus proceeded to assess the seriousness of the offences with regard to harm/culpability under the *Wong Meng Hang* framework.

Harm

133. In the Sentencing Guidelines 2020 at paragraph 52, "moderate harm" included "substantial potential for serious personal injury" whereas "slight harm" included low potential for personal injury.

134. The SMC had conceded that it was not attributing the Patient's death to have been caused by the Respondent's prescriptive practices. As such, this was a case of *potential harm rather than actual harm*. To this end, Dr PE1 had opined that the Respondent's prescription practices had exposed the Patient to unnecessary risks of having multiple medications at high doses which could interact with one another resulting in a fatal adverse event. Mr PE2 opined that there were significant safety concerns from the drug-drug interactions of each type of medication prescribed to the patient. The concern was that of increased risks for central nervous system depression, along with increased risks of sedation, respiratory depression and/or cardiovascular depression when the Patient took all the medications together in accordance with the prescribed dosing instructions. Even the Defence's expert, Dr DE opined that there was a risk of fatality from multiple prescription of benzodiazepines or mixing benzodiazepines with opiates.

135. In view of the above opinion of the experts, we did not agree with the Respondent's submission that there was low potential for personal injury. We found that there was substantial potential for serious personal injury and that the harm was moderate in the present case for all three Alternate charges. On a more granular level, on the basis of the number of breaches of the relevant Guidelines or standards, this was the highest for the Alternate 1st Charge and the fewest in the Alternate 3rd Charge. As such, the harm would be at the lower end of moderate for the Alternate 3rd Charge whilst the harm in Alternate 1st Charge would be at the higher end of moderate with the harm in the Alternate 2nd Charge being in between.

136. The DT did not accept the SMC's submission that even though the Patient did not have an existing drug dependency at the *start* of the Material Period, the Respondent's prescription for long-term use of benzodiazepines created and/or fuelled the Patient's dependence and tolerance toward benzodiazepines during the Material Period as there was insufficient evidence make such a finding, and further it was Dr PE1's opinion that the Patient was not necessarily a treatment resistant patient.

137. The DT agreed with the SMC that the Respondent's conduct undermined public confidence in the medical profession. Whilst there was only one patient involved, there were multiple breaches of the relevant Guidelines over a period of 29 months exposing the Patient to substantial potential for serious personal injury. The Respondent's conduct had harmed public confidence in the medical profession as registered medical practitioners were accorded the unique privilege and serious responsibility of prescribing medication to patients. Such harm to public confidence was exacerbated by the fact that the Respondent was a specialist. As a specialist in psychiatry, the Respondent ought to be held to a higher standard expected of him as compared to a non-specialist doctor.

Culpability

138. In terms of culpability, we disagree with the SMC that the Respondent's culpability was high for the Alternate 1st and 2nd Charges. We explain. The SMC had conceded (which we agree with) that the Respondent was acting without any malicious intent. That said, there were multiple breaches of the relevant Guidelines over a substantial period of 29 months. For Alternate 1st Charge, the SMC had set this out as follows (which the Respondent did not dispute in terms of occurrences or periods):

(a) there were at least three occurrences of the Respondent prescribing antidepressants for one day's use only in breach of Guideline 4.2 of the 2004 CPG (Depression);

(b) there were at least 10 occurrences of the Respondent prescribing antidepressants for less than four weeks' use in breach of Guideline 4.2 of the 2004 CPG (Depression) ranging from two days to 3.5 weeks;

(c) there were 38 occurrences of the Respondent prescribing two or more benzodiazepines for use at the same time in breach of paragraph (i) of the 2008 Admin Guidelines (Benzodiazepines), including four occurrences of the Respondent prescribing three benzodiazepines for use at the same time;

(d) there were six periods over which the Respondent prescribed benzodiazepines for continuous use exceeding four weeks in breach of paragraph (f) of the 2008 Admin Guidelines (Benzodiazepines) and Guideline 5.1.1 of the 2008 CPG (Benzodiazepines), ranging from five weeks to six months; and

(e) there were 50 occurrences of the Respondent prescribing benzodiazepines while the Patient was concomitantly taking opioid analgesics prescribed by Dr F.

139. For Alternate 2nd Charge, the SMC had set this out as follows (which the Respondent did not dispute in terms of occurrences or periods):

(a) there were seven occurrences of the Respondent prescribing two or more benzodiazepines for use at the same time in breach of paragraph (i) of the 2008 Admin Guidelines (Benzodiazepines), including one occurrence where the Respondent prescribed three benzodiazepines for use at the same time;

(b) there were three periods over which the Respondent prescribed benzodiazepines for continuous use exceeding four weeks in breach of paragraph (f) of the 2008 Admin Guidelines (Benzodiazepines) and Guideline

5.1.1 of the 2008 CPG (Benzodiazepines), all within the period of six months; and

(c) there were four occurrences of the Respondent prescribing benzodiazepines while the Patient was concomitantly taking opioid analgesics prescribed by Dr F.

140. In the circumstances, the DT agreed with the SMC that the Respondent had acted with wilful disregard for both the Alternate 1st and 2nd Charges.

141. The DT also found the Respondent's culpability for the Alternate 1st Charge should be on the higher end of medium in view of the longer duration as opposed to the Alternate 2nd Charge due to more occurrences of Guideline breaches for the Alternate 1st Charge.

142. Given that the Respondent was the lead psychiatrist and a senior doctor, the DT agreed with the SMC that his culpability should be higher as compared to a doctor in the same position in a junior position. The Patient was not medically trained; he would not have known the specific risks that could potentially arise from the Respondent's prescriptions. He trusted the Respondent as his medical practitioner to ensure that the prescriptions of medication were in his best interests. By repeatedly breaching the Relevant Guidelines without discussing the risks and benefits with the Patient each time before he chose to deviate from the said guidelines and failing to obtain the Patient's consent each time he deviated from the said guidelines, the Respondent had breached his position of trust and confidence to a significant extent.

143. Even though he charged the Patient for the medicines prescribed, the DT did not accept the SMC's submission that financial benefit was a relevant sentencing factor. The SMC had conceded that there was no evidence that he was trying to make money off the Patient with regard to the instances where he had breached the relevant Guidelines. As such, as financial gain was not the Respondent's primary motive for his departure from the relevant Guidelines, the DT did not consider this as a relevant aggravating factor.

144. For the Alternate 3rd Charge, the DT agreed with the SMC that the Respondent's culpability was at the lower end of medium. While there were no multiple breaches of the relevant Guidelines over a significant duration unlike the Alternate 1st and 2nd Charges, for the

Alternate 3rd Charge, the Respondent had had deviated significantly from the maximum daily dosages of Mirtazapine and Zolpidem Controlled Release as set out in their respective package inserts. He had prescribed Mirtazapine in excess of its maximum daily dosage (by 50% of the maximum daily dosage) and Zolpidem Controlled Release (by twice of the maximum daily dosage). Further, he gave a six months' supply of the medication with no evidence of any plan to wean / taper off the medication. Dr PE1 had opined that while a six month's supply of medications were used in stable and chronic patients, it was unusual to provide this immediately upon discharge. In the circumstances, the DT was of the view that the Respondent had acted with wilful disregard for the Alternative 3rd Charge.

Sentencing range and starting point

145. At Step 2, the applicable sentencing range based on the *Wong Meng Hang* framework would be between one to two years' suspension given that the harm was medium and culpability was moderate.

146. In the circumstances, based on the *Wong Meng Hang* framework the DT assessed at Step 3 taking into account the different levels within medium harm and moderate culpability for each Alternative charge, the starting points for the Alternate Charges were as follows:

(a) For the Alternate 1st Charge, suspension of two years;

(b) For the Alternate 2nd Charge, suspension of 18 months; and

(c) For the Alternate 3rd Charge, suspension of one year.

Offender specific factors

147. The DT next turned to Step 4 of the *Wong Meng Hang* framework to consider offender-specific factors. While the seniority of the Respondent and whether there were multiple breaches in relation to the Patient can be considered as offender specific factors, given that these had been considered in assessing the Respondent's harm / culpability, the DT did not see the need to adjust further as an aggravating factor in order to avoid double counting.

148. As for mitigating factors, the DT turned to the issue of prosecutorial delay. The DT noted that simply because there may be a substantial gap between the issuance of the Notice of Complaint and the Notice of Inquiry that did not automatically justify a discount for prosecutorial delay.

149. In SMC *v Dr Pang Ah San* [2020] SMCDT 2, the DT found that there was no undue delay warranting any discount in the respondent doctor's sentence, notwithstanding *inter alia* the lapse of around 1.5 years for the Complaints Committee to complete its preliminary inquiry and refer the matter for a formal inquiry. *In the Matter of Dr Goh Yong Chiang Kelvin* [2018] SMCDT 2 the DT found that there was no inordinate delay warranting any discount in the respondent doctor's sentence, notwithstanding *inter alia* the lapse of around 2.5 years between the date of the complaint and the issuance of the NOI.

150. That said, the SMC was prepared to concede that a period of around 3.5 years had passed between the issuance of the Notice of Complaint on 11 April 2017 and the Notice of Inquiry on 26 October 2020 and a one-third discount could be warranted in the circumstances. The DT did not agree with the Respondent that the discount should be as much as half. Specifically, we note that 3.5-year period included significant disruption in business operations arising from the COVID-19 pandemic; in particular in or around the Circuit Breaker period (between 7 April 2020 and 1 June 2020). Further, the DT also noted that there were a voluminous amount of documents in this case which required to prepare the NOI.

151. All things considered, the DT was prepared to afford a one-third discount as conceded by the SMC to the starting points on account of prosecutorial delay.

152. Accordingly, after applying a one-third discount for prosecutorial delay, the suspension periods are as follows:

(a) For the Alternate 1st Charge, suspension of 16 months;

(b) For the Alternate 2nd Charge, suspension of 12 months; and

(c) For the Alternate 3rd Charge, suspension of 8 months.

Consecutive sentences

153. Turning to whether the suspension period should be consecutive or concurrent, we note that the breaches as averred for the Alternate 1st and 2nd charges were almost the same and that the period in the Alternate 2nd Charge (1 January 2012 and 31 July 2012) ran immediately after the period in the Alternate 1st Charge (8 February 2010 and 31 December 2011). In other words, the conduct in the Alternate 1st and 2nd charges were practically the same from 8 February 2010 to 31 July 2012.

154. As such, the DT was of the view the suspension terms for the Alternate 1st and 2nd Charges should run concurrently.

155. For the Alternate 3rd Charge, this related to different medicines from the Alternate 1st and 2nd Charges, namely the prescription of Mirtazapine and Zolpidem Controlled Release (CR) in excess of the licensed maximum daily dosage, there was a different offence and the suspension terms should run consecutively.

156. As the Alternate 1st Charge was the most serious charge given the number of occurrences of breach and the duration, the DT ordered the suspension term in that charge to run consecutively with the Alternate 3rd Charge.

157. In the circumstances, the total period of suspension would be 16 months (Alternate 1st Charge) + 8 months (Alternate 3rd Charge) = **24 months**.

158. Applying the totality principle with a "last look", the DT was of the view that considering all the facts and circumstances, the **aggregate sentence of 24 months' suspension was proportionate in the circumstances of this case**.

Costs

SMC's submissions on costs

159. On costs, the SMC sought the following orders:

(a) That the Respondent pay all the costs and expenses of the Inquiry proceedings, including the costs of the SMC's solicitors.

(b) That the DT certify that the costs for more than one solicitor be paid; and

(c) For such costs to be subsequently taxed by the General Division of the High Court if the parties are unable to reach an agreement on the quantum of costs.

160. The SMC submitted that the Respondent be ordered by the learned Tribunal to pay all the costs and expenses of the Inquiry proceedings, including the costs of the SMC's solicitors ("**Usual Costs Orders**").

161. The SMC submitted that the Usual Costs Orders should apply for the following reasons:

(a) The facts in relation to the 1st Charge and Alternate 1st Charge and the 2nd Charge and Alternate 2nd Charge were the same. They related to the Respondent's prescription practices and breaches of the relevant Guidelines for the periods from 8 February 2010 to 31 December 2011 and 1 January to 31 July 2012 respectively.

(b) The facts in relation to the 3rd Charge and Alternate 3rd Charge were the same. While Alternate Charge 3 does not refer to Guideline 4.1.3 of the 2002 ECEG, that was not a factual aspect of the charge.

(c) Accordingly, there had been a virtually complete overlap in the work and the common witnesses in the prosecution of the 1st Charge and Alternate 1st Charge, 2nd Charge and Alternate 2nd Charge, and 3rd Charge 3 and Alternate 3rd Charge. The present circumstances do not warrant the learned Tribunal making any modification to the Usual Costs Orders.

162. The SMC submitted that the DT ought to certify that the costs for more than one solicitor for the following reasons:

(a) The present Inquiry was complex;

(b) The Inquiry involved *inter alia* voluminous documents, expert reports and a history involving the HC Proceedings and its appeal. The SMC had to address the Respondent's numerous objections to certain facts which he had previously agreed to in the ASOF, the applicability of all the relevant Guidelines and disputed that there were maximum daily dosages to Mirtazapine and Zolpidem Controlled Release. All objections raised by the Respondent had to be addressed by the SMC in the course of its prosecution; and

(c) At the Inquiry, the Respondent was represented by three solicitors.

Respondent's submissions on costs

163. The Respondent submitted that the primary charges which constituted half the total number of charges had been dismissed. As a starting point, this should reduce the amount of costs payable by the Respondent by 40%. The Respondent submitted that the factual basis of the Primary Charges and Alternate Charges only overlapped insofar as they relate to the number and types of medications prescribed (which parties had agreed to in the ASOF). The Respondent did not agree with the SMC that there was a "*virtually complete overlap in the work*", as the charges ostensibly did not overlap when it came to the factual basis of the Respondent's *mens rea* (*i.e.*, his state of mind). In relation to the *mens rea*, the Primary Charges and Alternate Charges totally differed.

164. The Respondent submitted that the Prosecution had only indicated that it would be withdrawing particular 3(a)(ii) and (c)(i) of the 2nd Charge and Alternate 2nd Charge late into the proceedings on 4 March 2022. These particulars relate to the SMC's allegation that Respondent had prescribed Mirtazapine to the Patient on 22 June 2012, and in doing so, failed to ensure that Mirtazapine was continued for at least 4 to 6 weeks. This had led to considerable wasted costs and should be reflected in a 10% reduction**.**

165. Additionally, the SMC's pharmacological expert, Mr PE2 had adduced literature, none of which were published at the material time (between 2010 to 2012). The Respondent submitted that they were irrelevant for purposes of assessing the appropriateness of the

Respondent's prescriptions between 2010 and 2012. In any event, Mr PE2 was not qualified to comment on what the Respondent ought or ought not to have done. The Defence had to spend a substantial amount of time to go through the medical literature, which amounted to significant wasted costs. This should lead to a further reduction of 10% to the adverse costs ordered against the Respondent.

166. The Respondent submitted there was inordinate delay on the part of the SMC which was relevant to the issue of costs, and that there should be a further reduction of a 10%.

167. Accordingly, the Respondent submitted that the adverse costs against the Respondent should appropriately be reduced by 70% of the SMC's costs incidental to the inquiry proceedings, and that the Respondent should only be ordered to pay 30% of the SMC's costs.

168. The Respondent submitted that there was no basis for certification of more than one solicitor. The Respondent submitted that simply because documents were voluminous did not warrant a certification of more than one solicitor. The Respondent referred to *Shorvon Simon v SMC* [2006] 1 SLR(R) 182 (*"Shorvon Simon"*) which the Respondent submitted was more complex but nonetheless only certificate of costs for one solicitor was ordered.

The DT's decision on costs

169. The DT agreed with the SMC that there was virtually a complete overlap on the facts of the Primary charges and the Alternate charges. Further, given that it was not in dispute that the Respondent had departed from the relevant Guidelines, the Respondent bore the evidential burden of explaining why he did so, and the Respondent's explanation would be relevant to *both* the Primary and Alternate charges. As such, the DT did not agree with the Respondent that there should be a 40% discount and even if the Respondent was acquitted of the 1st, 2nd and 3rd charges and convicted on the Alternate charges, the Usual Costs Orders should apply.

170. Further, the DT disagreed with Respondent that he should be afforded additional discounts on the basis of the amendment of charges by the SMC, Mr PE2's cited literature and prosecutorial delay. In the DT's view, the amendment of the charges was occasioned by the amendment of the ASOF and only because the Respondent subsequently raised some discrepancies when he was testifying despite having agreed to the ASOF earlier. As for Mr

PE2's evidence, the DT found it to be relevant as to the potential harm occasioned by the Respondent's prescriptive practices. As we had already discounted the Respondent's suspension period on account of prosecutorial delay, we did not see why costs should also be discounted on account of this.

171. As for certificate for more than one solicitor, the SMC conceded that a certificate for more than one solicitor would be awarded only in exceptional cases and that the norm for such Inquiries was costs for one solicitor.

172. In *Shorvon Simon* although the SMC did not decide to seek an order for certificate for more than one solicitor before the DT, the Court in *Shorvon Simon* did suggest that that the case was of sufficient complexity and at [41] the Court stated that the respondent doctor's insurers had mounted *inter alia* a "*root-and-branch attack on all facets of the NNI Report including its ultimate conclusions*" and held as follows:

> This was clearly **not some prosaic disciplinary proceeding that could be routinely and mechanically prepared for and prosecuted**. The prosecution of this matter required a thorough understanding of scientific and medical practices, methodologies, ethics as well as a mastery of the copious relevant documents. It was **nothing less than imperative for the SMC's solicitors to independently probe into and verify the factual and legal substratum of the complaint**.
>
> [emphasis added]

173. In the present case, while the documents in this case were fairly voluminous, we were of the view that that alone was not sufficient to make this an exceptional case of sufficient complexity so as to justify a certificate for more than solicitor. The DT would add that it was not in dispute that the Respondent had prescribed the medication to the Patient in departure of the relevant Guidelines. The DT had already noted that the revision of the ASOF and the amendment to NOI was occasioned by the Respondent raising this only when he took the stand and as such no discount should be made. Further, the mere calling of experts by both sides in itself did not take the case over the threshold of sufficient complexity. Indeed, there was consensus between the SMC and Defence's experts in several areas such as the potential risks occasioned by the Respondent's prescriptions, that the Respondents should have conducted a risks/benefits analysis for departing from the relevant Guidelines, the need for the Respondent to have discussed the risk and benefits with the Patient and obtaining the Patient's consent to

that course of action. For completeness, the mere fact that that both parties had more than one solicitor assisting in the case did not, of itself, take the case over the threshold of sufficient complexity.

174. At the end of the day, the key issue was whether the Respondent had clear medical grounds for departing from the relevant Guidelines, including conducting a risks/benefits analysis for departing from the relevant Guidelines, discussing these risks/benefits with the Patient, and obtaining the Patient's consent to that course of action. That was ultimately a factual determination by the DT.

175. In the circumstances, the DT declined to award costs for more than one solicitor.

Conclusion

176. The DT hereby orders the Respondent:

(a) be suspended from practice for an aggregate period of **24 months**;

(b) be censured;

(c) gives a written undertaking to refrain from engaging in the conduct complained of, or any similar conduct in future;

(d) pays all the costs and expenses of and incidental to these proceedings, including the costs of the counsel to the SMC [limited to costs for one solicitor].

177. It is further ordered that the period of suspension is to commence 40 days after the date of the order herein.

178. The DT also orders that the Grounds of Decision be published.

179. The hearing is hereby concluded.

A/Prof Roy Joseph	Dr Michael Wong Tack Keong	Mr Toh Han Li
Chairman	Member	Judicial Service Officer

Mr Edmund Kronenburg, Ms Angelia Thng and Mr Colin Wu
(M/s Braddell Brothers LLP)
for Singapore Medical Council; and

Mr Christopher Chong, Ms Audrey Sim and Mr Jeremy Mark Sia
(M/s Dentons Rodyk & Davidson LLP)
For Dr Ang Yong Guan

ANNEX A-1

CHARGES

AMENDED 1ST CHARGE

That you, **DR ANG YONG GUAN**, are charged that between 8 February 2010 and 31 December 2011, whilst practicing as a medical practitioner at the Ang Yong Guan ~~Psychiatric~~Psychiatry Pte Ltd, located at 290 Orchard Road, #11-09, Singapore 238859 (the "**Clinic**"), had inappropriately prescribed, dispensed and/or supplied medicines to one **P** (the "**Patient**"), to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the Medical Registration Act (Cap. 174) ("**MRA**"), you were aware that you were obliged to follow and/or comply with the following requirements in relation to the prescription of medicines to your patients:

(i) a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs;

(ii) the Ministry of Health ("**MOH**") Clinical Practice Guidelines for Depression (3/2004) ("**2004 CPG (Depression)**") which provides that all antidepressants, once started, should be continued for at least 4 to 6 weeks, and caution is needed when switching from one antidepressant to another because of the possibility of drug interactions [*see* guideline 4.2 of 2004 CPG (Depression)];

(iii) the MOH Administrative Guidelines on the Prescribing of Benzodiazepines and other Hypnotics (MH 70:41/24 Vol. 3 14 October 2008) ["**2008 Admin Guidelines (Benzodiazepines)**"] which provides that:

(1) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of 2008 Admin Guidelines (Benzodiazepines)];

(2) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g. 1 night in 2 or 3 nights) and only when necessary [*see* paragraph ~~(e)~~(f) of 2008 Admin Guidelines (Benzodiazepines)];

(iv) the MOH Clinical Practice Guidelines on the Prescribing of Benzodiazepines ["**2008 CPG (Benzodiazepines)**"] which provides that benzodiazepine use should be limited to short-term relief (between 2 – 4 weeks), at the lowest dose [*see* guideline 5.1.1 of 2008 CPG (Benzodiazepines)]; and

(v) the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(b) Between 8 February 2010 and 31 December 2011, the Patient was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety.

(c) During the period set out at paragraph (b) above, you inappropriately prescribed to the Patient various medicines in that:

(i) you prescribed antidepressants to the Patient on numerous occasions, and in doing so, switched from one antidepressant to another without ensuring that each antidepressant was continued for at least 4 to 6 weeks before such switching;

(ii) you concurrently prescribed two or more benzodiazepines to the Patient on various occasions;

(iii) you prescribed benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 to 4 weeks);

(iv) you prescribed benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g. 1 night in 2 or 3 nights); and

(v) you prescribed benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by one Dr F ("**Dr F**") for management of his chronic lower back pain ,

in breach of the guidelines and/or standards set out in paragraph (a) above, the particulars of which are set out herein.

(d) At all material times, you knew, or ought to have known, that your prescription of the medicines [as set out in **ANNEX A-2]** was inappropriate and in breach of Guideline 4.1.3 of the 2002 edition of Singapore Medical Council Ethical Code and Ethical Guidelines ("**2002 ECEG**"), as the prescription of the said medicines was not on clear medical grounds and in reasonable quantities as appropriate to the Patient's needs.

And your aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the MRA.

AMENDED ALTERNATE 1ST CHARGE

That you, **DR ANG YONG GUAN**, are charged that between 8 February 2010 and 31 December 2011, whilst practicing as a medical practitioner at the Clinic, had inappropriately prescribed, dispensed and/or supplied medicines to the Patient, to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the MRA, you were obliged to follow and/or comply with the following requirements in relation to the prescription of medicines to your patients:

(i) a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs;

(ii) the 2004 CPG (Depression) which provides that all antidepressants, once started, should be continued for at least 4 to 6 weeks, and caution is needed when switching from one antidepressant to another because of the possibility of drug interactions [*see* guideline 4.2 of the 2004 CPG (Depression)];

(iii) the 2008 Admin Guidelines (Benzodiazepines) which provides that:

(1) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of the 2008 Admin Guidelines (Benzodiazepines)];

(2) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g. 1 night in 2 or 3 nights) and only when necessary [*see* paragraph ~~(e)~~(f) of 2008 Admin Guidelines (Benzodiazepines)];

(iv) the 2008 CPG (Benzodiazepines) which provides that benzodiazepine use should be limited to short-term relief (between 2 to 4 weeks), at the lowest dose [*see* guideline 5.1.1 of 2008 CPG (Benzodiazepines)]; and

(v) the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(b) Between 8 February 2010 and 31 December 2011, the Patient was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety.

(c) During the period stated in paragraph (b) above, you knew, or ought to have known, that it was inappropriate for you to:

(i) prescribe antidepressants to the Patient on numerous occasions, and in doing so, switch from one antidepressant to another without ensuring that each antidepressant was continued for at least 4 to 6 weeks before such switching;

(ii) concurrently prescribe two or more benzodiazepines to the Patient on various occasions;

(iii) prescribe benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 to 4 weeks);

(iv) prescribe benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g. 1 night in 2 or 3 nights); and

(v) prescribe benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by one Dr F for management of his chronic lower back pain,

in breach of the guidelines and/or standards set out in paragraph (a) above.

And that in relation to the facts alleged you have failed to provide professional services of the quality which is reasonable to expect of you under section 53(1)(*e*) of the MRA.

RE-AMENDED 2ND CHARGE

That you, **DR ANG YONG GUAN**, are charged that between 1 January 2012 and 31 July 2012, whilst practicing as a medical practitioner at the Clinic, had inappropriately prescribed, dispensed and/or supplied medicines to the Patient, to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the MRA, you were aware that you were obliged to follow and/or comply with the following requirements in relation to the prescription of medicines to your patients:

(i) a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs;

(ii) ~~the MOH Clinical Practice Guidelines for Depression (1/2012) ["**2012 CPG (Depression)**"] which provides that all antidepressants, once started, should be continued for at least 4 to 6 weeks [*see* guideline 4.2.1 of 2012 CPG (Depression)];~~

~~(iii)~~(ii) the 2008 Admin Guidelines (Benzodiazepines) which provides that:

(1) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of 2008 Admin Guidelines (Benzodiazepines)];

(2) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (eg. 1 night in 2 or 3 nights) and only when necessary (*see* paragraph ~~(e)~~(f) of 2008 Admin Guidelines (Benzodiazepines));

~~(iv)~~(iii) the 2008 CPG (Benzodiazepines) which provides that benzodiazepine use should be limited to short-term relief (between 2 – 4 weeks), at the lowest dose [see guideline 5.1.1 of 2008 CPG (Benzodiazepines)]; and

~~(v)~~(iv) the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(b) Between 1 January 2012 and 31 July 2012, the Patient was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety.

(c) During the period set out at paragraph (b) above, you inappropriately prescribed to the Patient various medicines in that:

(i) ~~you prescribed Mirtazapine (an antidepressant) to the Patient on 22 June 2012, and in doing so, failed to ensure that Mirtazapine was continued for at least 4 to 6 weeks;~~

~~(ii)~~(i) you concurrently prescribed two or more benzodiazepines to the Patient on various occasions;

~~(iii)~~(ii) you prescribed benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g. 1 night in 2 or 3 nights);

~~(iv)~~(iii) you prescribed benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 to 4 weeks);

~~(v)~~(iv) you failed to prevent the long-term chronic use of benzodiazepines by the Patient by prescribing a 6-months' supply of benzodiazepines to the Patient on 31 July 2012; and

~~(vi)~~(v) you prescribed benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by Dr F for management of his chronic lower back pain,

in breach of the guidelines and/or standards set out in paragraph (a) above.

(d) At all material times, you knew, or ought to have known, that your prescription of the medicines [as set out in **ANNEX A-3]** was inappropriate and in breach of Guideline 4.1.3 of the 2002 ECEG, as the prescription of the said medicines was not on clear medical grounds and in reasonable quantities as appropriate to the Patient's needs.

And your aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the MRA.

RE-AMENDED ALTERNATE 2ND CHARGE

That you, **DR ANG YONG GUAN**, are charged that between 1 January 2012 and 31 July 2012, whilst practicing as a medical practitioner at the Clinic, had inappropriately prescribed, dispensed and/or supplied medicines to the Patient, to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the MRA, you were obliged to follow and/or comply with the following requirements in relation to the prescription of medicines to your patients:

(i) a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs;

(ii) ~~the 2012 CPG (Depression) which provides that all antidepressants, once started, should be continued for at least 4 to 6 weeks [*see* guideline 4.2.1 of 2012 CPG (Depression)];~~

~~(iii)~~(ii) the 2008 Admin Guidelines (Benzodiazepines) which provides that:

(1) the concurrent prescribing of two or more benzodiazepines should be avoided [*see* paragraph (i) of 2008 Admin Guidelines (Benzodiazepines)];

(2) benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g. 1 night in 2 or 3 nights) and only when necessary [*see* paragraph ~~(e)~~(f) of 2008 Admin Guidelines (Benzodiazepines)];

~~(iv)~~(iii) the 2008 CPG (Benzodiazepines) which provides that benzodiazepine use should be limited to short-term relief (between 2 to 4 weeks), at the lowest dose [*see* guideline 5.1.1 of 2008 CPG (Benzodiazepines)]; and

~~(v)~~(iv) the concomitant use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration, if prescribed.

(b) Between 1 January 2012 and 31 July 2012, the Patient was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety.

(c) During the period stated in paragraph (b) above, you knew, or ought to have known, that it was inappropriate for you to:

(i) ~~prescribe Mirtazapine (an antidepressant) to the Patient on 22 June 2012, and in doing so, failed to ensure that Mirtazapine was continued for at least 4 to 6 weeks;~~

~~(ii)~~(i) concurrently prescribe two or more benzodiazepines to the Patient on various occasions;

~~(iii)~~(ii) prescribe benzodiazepines to the Patient to treat his insomnia on various occasions beyond the limit of intermittent use (e.g. 1 night in 2 or 3 nights);

~~(iv)~~(iii) prescribe benzodiazepines to the Patient on various occasions beyond the limit of short-term relief (between 2 – 4 weeks);

~~(v)~~(iv) allow for long-term chronic use of benzodiazepines by the Patient by prescribing a 6-months' supply of benzodiazepines to the Patient on 31 July 2012; and

~~(vi)~~(v) prescribe benzodiazepines to the Patient on various occasions despite being aware that the Patient was concomitantly taking opioid analgesics prescribed by Dr F for management of his chronic lower back pain,

in breach of the guidelines and/or standards set out in paragraph (a) above.

And that in relation to the facts alleged you have failed to provide professional services of the quality which is reasonable to expect of you under section 53(1)(*e*) of the MRA.

3RD CHARGE

That you, **DR ANG YONG GUAN**, are charged that on 31 July 2012, whilst practicing as a medical practitioner at the Clinic, had inappropriately prescribed, dispensed and/or supplied medicines to the Patient, to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the MRA, you were aware that you were required to prescribe, dispense or supply medicines only in reasonable quantities as appropriate to the patient's needs.

(b) On or about 31 July 2012, you prescribed to the Patient (who was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety) the following medicines in excess of their licensed maximum daily dosages:

S/No.	Name of medicine	Dosage prescribed	Licensed maximum daily dosage
1.	*Mirtazapine*	60 mg every night	45mg every night
2.	*Zolpidem Controlled Release (CR)*	25mg every night	12.5mg every night

(c) At all material times, you knew or ought to have known that your aforesaid prescription of the medicines (as set out in paragraph (b) above) was inappropriate and in breach of Guideline 4.1.3 of the 2002 ECEG, as you did not prescribe medicines in reasonable quantities as appropriate to the Patient's needs.

And your aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and

competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the MRA.

ALTERNATE 3RD CHARGE

That you, **DR ANG YONG GUAN**, are charged that on 31 July 2012, whilst practicing as a medical practitioner at the Clinic, you had inappropriately prescribed, dispensed and/or supplied medicines to the Patient, to wit:

Particulars

(a) At all material times, as a psychiatrist and a medical practitioner registered under the MRA, you were obliged to follow and/or comply with the requirement to prescribe, dispense and/or supply medicines only in reasonable quantities as appropriate to the patient's needs.

(b) On or about 31 July 2012, you prescribed to the Patient (who was under your care for management and treatment of his various psychiatric conditions including insomnia, depression, post-traumatic stress disorder and anxiety) the following medicines in excess of their licensed maximum daily dosages:

S/No.	Name of medicine	Dosage prescribed	Licensed maximum daily dosage
1.	*Mirtazapine*	60 mg every night	45mg every night
2.	*Zolpidem Controlled Release (CR)*	25mg every night	12.5mg every night

(c) During the period stated in paragraph (b) above, you knew, or ought to have known, that it was inappropriate for you to prescribe the medicines (as set out in paragraph (a) above), in breach of the standard set out in paragraph (a) above.

And that in relation to the facts alleged you have failed to provide professional services of the quality which is reasonable to expect of you under section 53(1)(*e*) of the MRA.

ANNEX A-2

MEDICINES PRESCRIBED BY THE RESPONDENT DURING THE PERIOD OF 08.02.2010 TO 31.12.2011

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
1st admission: 02.02.2010 to 11.02.2010				
1.	08.02.2010	Antidepressant - Selective serotonin and norepinephrine reuptake inhibitor antidepressant ("**SNRI**")	Duloxetine	30mg ON
		Atypical Antipsychotic	Olanzapine	2.5mg ON
		Benzodiazepine	Flurazepam	30mg ON
			Alprazolam XR	1mg OM
2.	09.02.2010 to 10.02.2010	Antidepressant – SNRI	Duloxetine	30mg ON
		Antidepressant – Tricyclic antidepressant ("**TCA**")	Clomipramine	50mg ON
		Benzodiazepine	Flurazepam	30mg ON
			Alprazolam	1mg OM
		Hypnotic	Zopiclone	(7.5mg STAT prescribed twice on 09.02.2010)
3.	11.02.2010 (date of discharge) to 09.03.2010	Antidepressant – SNRI	Duloxetine	30mg ON for 4 weeks
		Antidepressant – TCA	Clomipramine	50mg ON for 4 weeks
		Benzodiazepine	Alprazolam XR	1mg OM for 4 weeks

		Hypnotic	Zopiclone	7.5mg ON for 4 weeks

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
2nd admission: 10.03.2010 to 12.06.2010				
4.	10.03.2010 to 11.03.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON (reduced to 2.5 mg ON on 11.03.2010)
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
5.	12.03.2010 to 13.03.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Hypnotic	Zopiclone	7.5mg ON (7.5mg STAT prescribed on 13.03.2010)
6.	14.03.2010 to 19.03.2010	Antidepressant – SNRI	Duloxetine	60mg ON (increased to 90mg ON on 15.03.2010 to 19.03.2010)
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
7.	20.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON and 30mg OM
		Antidepressant - Selective serotonin reuptake inhibitor ("**SSRI**")	Escitalopram	5mg OM

		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
8.	21.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON and 30mg OM

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Atypical Antipsychotic	Olanzapine	2.5 mg ON
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
9.	22.03.2010 to 23.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON and 30mg OM (reduced to 90mg ON on 23.03.2010)
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
10.	24.03.2010 to 29.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON and 30mg OM
		Atypical Antipsychotic	Olanzapine	2.5 mg ON
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
11.	30.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON and 30mg OM
		Benzodiazepine	Alprazolam XR	1mg OM

		Hypnotic	Zopiclone	7.5mg ON
12.	31.03.2010	Antidepressant – SNRI	Duloxetine	90mg ON
		Benzodiazepine	Alprazolam XR	1mg OM
		Hypnotic	Zopiclone	7.5mg ON
13.	01.04.2010	Antidepressant – Noradrenergic and specific serotonergic antidepressant ("**NaSSA**")	Mirtazapine	30mg ON

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Atypical Antipsychotic	Quetiapine	50mg ON
		Hypnotic	Zopiclone	7.5mg ON
14.	02.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Atypical Antipsychotic	Olanzapine	1.25mg ON
		Benzodiazepine	Flurazepam	30mg ON
		Hypnotic	Zopiclone	7.5mg ON (another 7.5mg STAT prescribed subsequently in the day)
15.	03.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Benzodiazepine	Flurazepam	30mg ON
		Hypnotic	Zopiclone	7.5mg ON

		Atypical Antipsychotic	Olanzapine	1.25mg ON (taken off subsequently on the same day at 1535 hours)
16.	04.04.2010 to 08.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Atypical Antipsychotic	Quetiapine	25mg ON
		Benzodiazepine	Flurazepam	30mg ON
		Hypnotic	Zopiclone	7.5mg ON
17.	09.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Atypical Antipsychotic	Quetiapine	25mg ON
		Benzodiazepine	Flurazepam	30mg ON

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Hypnotic	Zopiclone	7.5mg ON
			Zolpidem	6.25mg STAT (prescribed twice)
18.	10.04.2010 to 12.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON (increased to 90mg ON on 11.04.2010 to 12.04.2010)
		Atypical Antipsychotic	Quetiapine	25mg ON
		Benzodiazepine	Flurazepam	30mg ON
		Hypnotic	Zopiclone	7.5mg ON
19.	13.04.2010 to 23.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON

		Atypical Antipsychotic	Quetiapine	25mg ON (increased to 50mgto ON on 14.04.2010 23.04.2010)
		Hypnotic	Zopiclone	7.5mg ON
20.	24.04.2010 to 27.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Atypical Antipsychotic	Quetiapine	50mg ON
		Benzodiazepine	Diazepam	10mg ON
21.	28.04.2010	Antidepressant – SSRI	Paroxetine	12.5mg OM
		Atypical Antipsychotic	Quetiapine	50mg ON
		Benzodiazepine	Diazepam	10mg ON
22.	29.04.2010	Antidepressant – SSRI	Paroxetine	12.5mg OM
		Atypical Antipsychotic	Quetiapine	50mg ON

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Benzodiazepine	Diazepam	10mg ON
23.	30.04.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Antidepressant – SSRI	Paroxetine	12.5mg OM
		Antidepressant – Serotonin receptor antagonist and reuptake inhibitor ("**SARI**")	Trazodone	50mg ON

		Benzodiazepine	Diazepam	10mg ON
24.	01.05.2010 to 04.05.2010	Antidepressant – SNRI	Duloxetine	60mg ON
		Antidepressant – SSRI	Paroxetine	25mg OM
		Benzodiazepine	Diazepam	10mg ON
25.	05.05.2010	Antidepressant – SNRI	Duloxetine	90mg ON
		Antidepressant – SSRI	Paroxetine	12.5mg OM
		Benzodiazepine	Flurazepam	30mg ON
26.	06.05.2010 to 08.05.2010	Antidepressant – SNRI	Duloxetine	90mg ON
		Benzodiazepine	Flurazepam	30mg ON
27.	09.05.2010 to 11.05.2010	Antidepressant – SNRI	Duloxetine	90mg ON
		Benzodiazepine	Flurazepam	30mg ON
			Alprazolam XR	1mg OM
			Diazepam	10mg ON
28.	12.05.2010	Antidepressant – SNRI	Duloxetine	120mg

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Benzodiazepine	Diazepam	10mg ON
		Hypnotic	Zolpidem	12.5mg ON

29.	13.05.2010	Antidepressant – SNRI	Duloxetine	60mg ON and 60mg OM
		Benzodiazepine	Diazepam	10mg ON
			Bromazepam	1.5mg OM
		Hypnotic	Zolpidem	12.5mg ON
30.	14.05.2010 to 16.05.2010	Antidepressant – SNRI	Duloxetine	60mg ON and 60mg OM (decreased to 60mg OM on 16.05.2010)
			Venlafaxine XR	75mg OM
		Benzodiazepine	Diazepam	10mg ON
			Bromazepam	1.5mg OM
		Hypnotic	Zolpidem	12.5mg ON
31.	17.05.2010 to 19.05.2010	Benzodiazepine	Diazepam	10mg ON
			Bromazepam	1.5mg OM
		Hypnotic	Zolpidem	12.5mg ON
32.	20.05.2010 to 26.05.2010	Antidepressant – SARI	Trazodone	50mg ON (increased to 100mg ON on 21.05.2010 to 26.05.2010)
		Benzodiazepine	Diazepam	10mg ON
			Bromazepam	1.5mg OM (increased to 3mg OM on 22.05.2010 to 26.05.2010)
		Hypnotic	Zolpidem	12.5mg ON

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**

33.	27.05.2010	Antidepressant – SARI	Trazodone	150mg ON
		Benzodiazepine	Diazepam	10mg ON
			Flurazepam	30mg STAT
			Bromazepam	3mg OM
		Hypnotic	Zolpidem	12.5mg ON (another 12.5mg STAT prescribed on the same day)
34.	28.05.2010 to 31.05.2010	Antidepressant – SARI	Trazodone	150mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Diazepam	10mg ON (increased to 15mg ON from 29.05.2010 to 31.05.2010)
		Hypnotic	Zolpidem	12.5mg ON
35.	01.06.2010 to 03.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Benzodiazepine	Diazepam	10mg ON
			Bromazepam	3mg OM
			Flurazepam	30mg ON
		Hypnotic	Zolpidem	12.5mg ON
36.	04.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Flurazepam	30mg ON

		Hypnotic	Zolpidem	12.5mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
37.	05.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Flurazepam	30mg ON
		Hypnotic	Zolpidem	12.5mg ON
38.	06.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - TCA	Clomipramine	50mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Midazolam	15mg STAT
		Hypnotic	Zolpidem	12.5mg ON
		Typical Antipsychotic	Haloperidol	5mg STAT
39.	07.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant – TCA	Clomipramine	50mg ON
		Benzodiazepine	Bromazepam	3mg OM
		Hypnotic	Zolpidem	12.5mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON

40.	08.06.2010	Antidepressant –	Trazodone	150mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		SARI		
		Antidepressant – TCA	Clomipramine	50mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Diazepam	10mg STAT
			Bromazepam	3mg OM
		Hypnotic	Zolpidem	12.5mg OM
41.	09.06.2010 to 10.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - TCA	Clomipramine	75mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Midazolam	7.5mg ON
		Hypnotic	Zolpidem	12.5mg ON
42.	11.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - TCA	Clomipramine	75mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Midazolam	7.5mg ON
		Hypnotic	Zolpidem	12.5mg ON
43.	12.06.2010 (date of	Antidepressant – SARI	Trazodone	150mg ON

	discharge)	Antidepressant - TCA	Clomipramine	75mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg OM
			Midazolam	7.5mg ON
		Hypnotic	Zolpidem	12.5mg ON
3rd admission: 13.06.2010 to 28.08.2010				
44.	14.06.2010 to 18.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - TCA	Clomipramine	75mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON (increased to 10mg ON on 18.06.2010)
		Benzodiazepine	Bromazepam	3mg OM (another 3mg STAT prescribed on 18.06.2010)
			Midazolam	7.5mg ON
		Hypnotic	Zolpidem	12.5mg ON
45.	19.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant – TCA	Clomipramine	75mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	3mg OM

			Midazolam	7.5mg ON
		Hypnotic	Zolpidem	12.5mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
46.	28.06.2010 to 29.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg ON
		Hypnotic	Zolpidem	12.5mg ON
47.	30.06.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	3mg OM
		Hypnotic	Zolpidem	12.5mg ON
48.	01.07.2010 to 03.07.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - SNRI	Duloxetine	30mg OM

		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg ON
		Hypnotic	Zolpidem	12.5mg ON
49.	04.07.2010	Antidepressant – SARI	Trazodone	150mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Hypnotic	Zolpidem	12.5mg ON
50.	05.07.2010	Antidepressant – SARI	Trazodone	150mg ON
		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	1.5mg BD
		Hypnotic	Zolpidem	12.5mg ON
51.	06.07.2010 to 07.07.2010	Antidepressant – SARI	Trazodone	150mg ON

		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg ON
		Benzodiazepine	Bromazepam	1.5mg BD
		Hypnotic	Zolpidem	12.5mg ON
52.	08.07.2010 to 23.07.2010	Antidepressant – SARI	Trazodone	150mg ON (decreased to 100mg ON on 14.07.2010; increased to 150mg ON on 15.07.2010 to 23.07.2010)

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	1.5mg BD
		Hypnotic	Zolpidem	12.5mg ON
53.	24.07.2010 to 01.08.2010	Antidepressant – SARI	Trazodone	150mg ON (increased to 200mg ON on 30.07.2010 to 01.08.2010)
		Antidepressant – NaSSA	Mirtazapine	30mg ON (increased to 45mg ON on 28.07.2010 to 01.08.2010)
		Antidepressant - SNRI	Duloxetine	60mg OM (on 01.08.2010)

		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	1.5mg BD
		Hypnotic	Zolpidem	12.5mg ON
54.	02.08.2010 to 03.08.2010	Antidepressant – SARI	Trazodone	200mg ON
		Antidepressant - SNRI	Duloxetine	60mg OM (on 02.08.2010)
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Hypnotic	Zolpidem	12.5mg ON
55.	04.08.2010	Antidepressant – SARI	Trazodone	150mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Hypnotic	Zolpidem	12.5mg ON
56.	05.08.2010 to 10.08.2010	Antidepressant - SNRI	Duloxetine	60mg ON (increased to 90mg OM on 10.08.2010)
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON (decreased to 5mg ON from 07.08.2010 to 10.08.2010)

		Hypnotic	Zolpidem	12.5mg ON
57.	11.08.2010	Antidepressant - SNRI	Duloxetine	60mg ON
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Hypnotic	Zolpidem	12.5mg ON
58.	12.08.2010 to 13.08.2010	Antidepressant - SNRI	Duloxetine	60mg OM
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Hypnotic	Zolpidem	12.5mg ON

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
59.	14.08.2010 to 16.08.2010	Antidepressant - SNRI	Duloxetine	30mg OM (increased to 60mg ON on 16.08.2010)
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	2.5mg ON
		Hypnotic	Zolpidem	12.5mg ON

60.	17.08.2010 to 21.08.2010	Antidepressant - SNRI	Duloxetine	30mg OM
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Hypnotic	Zolpidem	12.5mg ON
61.	22.08.2010 to 25.08.2010	Antidepressant – NaSSA	Mirtazapine	45mg ON
		Hypnotic	Zolpidem	12.5mg ON
62.	26.08.2010	Antidepressant – NaSSA	Mirtazapine	45mg ON
		Benzodiazepine	Bromazepam	3mg STAT
		Hypnotic	Zolpidem	12.5mg ON
63.	27.08.2010	Antidepressant – NaSSA	Mirtazapine	45mg ON
		Hypnotic	Zolpidem	12.5mg ON
64.	28.08.2010 (date of discharge)	Antidepressant – NaSSA	Mirtazapine	30mg ON for 3 months 15mg ON for 3 months
		Benzodiazepine	Diazepam	10mg ON for 3 months 5mg ON for 3 months
			Bromazepam	3mg ON for 3 months

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Hypnotic	Zolpidem	12.5mg ON for 3 months
4th admission: 25.10.2010 to 29.10.2010				

65.	29.10.2010 (date of discharge)	Antidepressant – NaSSA	Mirtazapine	45mg ON for 6 months
		Benzodiazepine	Diazepam	10mg ON for 6 months 5mg ON for 6 months
			Bromazepam	3mg ON for 6 months
		Hypnotic	Zolpidem	12.5mg ON for 6 months
5th admission : 01.03.2011 to 26.05.2011				
66.	01.03.2011	Antidepressant – Melatonin agonist	Agomelatine	25mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Quetiapine	100mg STAT
		Benzodiazepine	Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON
67.	02.03.2011 to 04.03.2011	Antidepressant – Melatonin agonist	Agomelatine	25mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Hypnotic	Zolpidem	12.5mg ON
68.	05.03.2011 to 06.03.2011	Antidepressant – Melatonin agonist	Agomelatine	25mg ON (increased to 50mg ON on 06.03.2011)
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Benzodiazepine	Bromazepam	3mg STAT

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Hypnotic	Zolpidem	12.5mg ON (and another 12.5mg STAT on 05.03.2011)
69.	07.03.2011	Antidepressant – Melatonin agonist	Agomelatine	25mg ON 50mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Benzodiazepine	Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON
70.	08.03.2011 to 10.03.2011	Antidepressant – Melatonin agonist	Agomelatine	50mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	2.5mg ON
		Benzodiazepine	Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON
71.	11.03.2011 to 12.03.2011	Antidepressant – Melatonin agonist	Agomelatine	50mg ON
		Antidepressant – NaSSA	Mirtazapine	45mg ON
		Atypical Antipsychotic	Olanzapine	1.25mg ON
		Benzodiazepine	Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON

		Opioid Analgesic	Oxycodone	10mg STAT prescribed on 11.03.2011 and twice prescribed on 12.03.2011
72.	13.03.2011	Antidepressant – Melatonin agonist	Agomelatine	50mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Quetiapine	25mg ON
		Benzodiazepine	Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON
		Opioid Analgesic	Oxycodone	10mg STAT prescribed thrice
73.	14.03.2011 to 17.03.2011	Antidepressant – Melatonin agonist	Agomelatine	50mg ON
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Quetiapine	25mg ON
		Benzodiazepine	Bromazepam	3mg ON (additional 3mg STAT prescribed on 16.03.2011 and 17.03.2011)
		Hypnotic	Zolpidem	12.5mg ON
74.	18.03.2011 to 23.03.2011	Antidepressant – Melatonin agonist	Agomelatine	50mg ON
		Antidepressant – SNRI	Desvenlafaxine	50mg OM

		Antidepressant – NaSSA	Mirtazapine	15mg ON
		Atypical Antipsychotic	Quetiapine	50mg ON (decreased to 25mg ON on 20.03.2011; increased to 50mg ON on 21.03.2011 to 23.03.2011)
		Benzodiazepine	Bromazepam	3mg ON (another 3mg STAT prescribed on 20.03.2011, 21.03.2011 and 23.03.2011)

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Hypnotic	Zolpidem	12.5mg ON
75.	24.03.2011 to 10.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM (increased to 100mg OM on 27.03.2011 to 06.04.2011; decreased to 50mg OM on 07.04.2011 to 10.04.2011)
		Antidepressant – NaSSA	Mirtazapine	30mg ON (increased to 45mg ON on 04.04.2011 to 06.04.2011; decreased to 30mg ON on 07.04.2011 to 10.04.2011)
		Atypical Antipsychotic	Quetiapine	50mg ON (increased to 100mg ON on 29.03.2011; increased to 125mg ON on 30.03.2011; increased to 150mg on 31.03.2011 to 02.04.2011; decreased to 125mg ON on 03.04.2011 to 06.04.2011; decreased to 25mg x 4 ON on 07.04.2011 to 09.04.2011; increased to 25mg x 6 ON on 10.04.2011)

		Benzodiazepine	Bromazepam	3mg ON (another 3mg STAT prescribed on 24.03.2011 to 26.03.2011, 30.03.2011, 03.04.2011, 04.04.2011, 06.04.2011)
		Hypnotic	Zolpidem	12.5mg ON
76.	11.04.2011 to 17.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
77.	18.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
			Quetiapine	25mg ON
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
78.	19.04.2011 to 24.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON (another 3mg STAT prescribed on 23.04.2011)
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON

79.	25.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Quetiapine	50mg STAT prescribed twice
			Olanzapine	5mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
80.	26.04.2011 to 28.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Quetiapine	100mg STAT
			Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
		Opioid Analgesic	Oxycodone	10mg STAT
81.	29.04.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON

		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
82.	30.04.2011 to 01.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
			Olanzapine	5mg ON

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
		Atypical Antipsychotic	Quetiapine	100mg STAT (prescribed twice on 30.04.2011)
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
		Opioid Analgesic	Oxycodone	10mg STAT
83.	02.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON

			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
84.	03.05.2011 to 04.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
			Quetiapine	100mg STAT
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
		Opioid Analgesic	Oxycodone	10mg STAT
85.	05.05.2011 to 08.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
86.	09.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM

		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	5mg ON
			Quetiapine	100mg STAT
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
87.	10.05.2011 to 12.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
88.	13.05.2011 to 19.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM

S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg x 4 STAT
		Benzodiazepine	Bromazepam	3mg ON

			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
89.	20.05.2011 to 24.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg x 4 ON PRN
		Benzodiazepine	Bromazepam	3mg ON
			Midazolam	15mg ON
		Hypnotic	Zolpidem	12.5mg ON
90.	25.05.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM
		Antidepressant – NaSSA	Mirtazapine	30mg ON
		Atypical Antipsychotic	Olanzapine	10mg ON
			Quetiapine	25mg x 4 ON PRN
		Benzodiazepine	Midazolam	15mg ON
			Bromazepam	3mg ON
		Hypnotic	Zolpidem	12.5mg ON
		Opioid Analgesic	Oxycodone	10mg STAT
S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
91.	26.05.2011 (date of	Antidepressant – SNRI	Desvenlafaxine	50mg OM for 6 months

	discharge)	Antidepressant – NaSSA	Mirtazapine	30mg ON for 6 months
		Atypical Antipsychotic	Olanzapine	10mg ON for 6 months
			Quetiapine	25mg x 4 ON for 6 months
		Benzodiazepine	Bromazepam	3mg ON for 6 months
			Midazolam	15mg ON for 6 months
		Hypnotic	Zolpidem	12.5mg ON for 6 months
Outpatient consultation: 27.09.2011				
92.	27.09.2011	Antidepressant – SNRI	Desvenlafaxine	50mg OM for 6 months
		Antidepressant – NaSSA	Mirtazapine	30mg ON for 6 months
		Atypical Antipsychotic	Olanzapine	10mg ON for 6 months
			Quetiapine	25mg x 4 ON for 6 months
		Benzodiazepine	Bromazepam	3mg ON for 6 months
			Midazolam	15mg ON for 6 months
			Diazepam	10mg for 6 months
		Hypnotic	Zolpidem	12.5mg ON for 9 months

ANNEX A-3

MEDICINES PRESCRIBED BY THE RESPONDENT DURING THE PERIOD OF 01.01.2012 TO 31.07.2012

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
Outpatient consultations and telephone reviews: 02.02.2012 to 22.06.2012				
1.	02.02.2012	Antidepressant – SNRI	Desvenlafaxine	50mg OM for 3 months
		Antidepressant – NaSSA	Mirtazapine	30mg ON (no new supply given; Patient was to use the previous supply prescribed on 27.09.2011)
		Atypical Antipsychotic	Olanzapine	10mg ON (no new supply given; Patient was to use the previous supply prescribed on 27.09.2011)
			Quetiapine	25mg x 4 ON for 3 months
		Benzodiazepine	Bromazepam	3mg ON for 3 months
			Midazolam	15mg ON for 3 months
			Diazepam	10mg ON for 3 months
		Hypnotic	Zolpidem	12.5mg ON for 3 months
2.	09.03.2012	Antidepressant - SNRI	Duloxetine	60mg ON 30mg ON for 3 months
		Atypical Antipsychotic	Quetiapine	100mg ON for 6 months
		Benzodiazepine	Bromazepam	3mg ON for 6 months
			Midazolam	15mg ON for 6 months
			Diazepam	10mg ON for 6 months

		Hypnotic	Zolpidem	12.5mg ON for 6 months
3.	22.06.2012	Antidepressant – NaSSA	Mirtazapine	30mg ON for 3 months
		Atypical Antipsychotic	Quetiapine	100mg ON for 3 months

S/No.	Period of time	Class of medicines	Medicines prescribed by Respondent	Dosage / supply given
			Olanzapine	10mg ON for 3 months
		Benzodiazepine	Bromazepam	3mg ON for 3 months
			Midazolam	15mg ON for 3 months
			Diazepam	10mg ON for 3 months
		Hypnotic	Zolpidem	12.5mg ON for 3 months
6th admission : 02.07.2012 to 31.07.2012				
4.	02.07.2012	Atypical Antipsychotic	Quetiapine	200mg ON
			Olanzapine	10mg ON
		Antidepressant - SNRI	Duloxetine	60mg BD
		Antidepressant – NaSSA	Mirtazapine	30mg
		Benzodiazepine	Bromazepam	3mg BD
			Midazolam	15mg
		Hypnotic	Zolpidem CR	25mg ON
5.	03.07.2012	Antidepressant - SNRI	Duloxetine	60mg BD

		Antidepressant – NaSSA	Mirtazapine	30mg
		Atypical Antipsychotic	Quetiapine	200mg ON
			Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	3mg BD
			Midazolam	15mg
		Hypnotic	Zolpidem CR	25mg ON
S/No.	**Period of time**	**Class of medicines**	**Medicines prescribed by Respondent**	**Dosage / supply given**
6.	04.07.2012 to 30.07.2012	Antidepressant - SNRI	Duloxetine	60mg BD (another 30mg STAT prescribed on 19.07.2012)
		Antidepressant – NaSSA	Mirtazapine	60mg ON
		Atypical Antipsychotic	Quetiapine	200mg ON
			Olanzapine	10mg ON
		Benzodiazepine	Bromazepam	3mg BD
			Midazolam	15mg ON
		Hypnotic	Zolpidem	25mg ON
7.	31.07.2012 (date of discharge)	Antidepressant - SNRI	Duloxetine	60mg BD for 6 months
		Antidepressant – NaSSA	Mirtazapine	30mg x 2 ON for 6 months
		Atypical Antipsychotic	Quetiapine	100mg x 2 ON for 6 months

			Olanzapine	10mg ON for 6 months
		Benzodiazepine	Bromazepam	3mg BD for 6 months
			Midazolam	15mg ON for 6 months
			Diazepam	10mg ON for 6 months
		Hypnotic	Zolpidem CR	12.5mg x 2 ON for 6 months