SINGAPORE MEDICAL COUNCIL

DISCIPLINARY INQUIRY AGAINST

DR AAC HELD ON 24-25 JULY 2007,

11 AUGUST 2007 AND 27 MARCH 2008

Disciplinary Committee:
Dr Tan Kok Soo (Chairman)
Prof Tay Boon Keng
Dr Koo Wen Hsin
Mrs Chan Ek Huar (Lay Member)

Legal Assessor:
Mr Giam Chin Toon S.C.

Prosecution Counsel (M/s WongPartnership LLP):
Mr Alvin Yeo S.C.
Mr Sean La'Brooy

Defence Counsel (M/s Rodyk & Davidson LLP):
Mr Christopher Chong
Ms Vanessa Lim

DECISION OF THE DISCIPLINARY COMMITTEE

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

VERDICT:

1. Dr AAC (the Respondent) is registered as a medical practitioner under the Medical Registration Act (Cap. 174). The Respondent was the licensee of Clinic A and also practised at the said address.

2. As a result of an investigation initiated by the Ministry of Health (MOH), the Respondent was referred to the Singapore Medical Council (SMC) for further action concerning the Respondent's prescribing practices with regard to Erimin, Dormicum and Nitrazepam.

3. After considering the written explanation received from the Respondent on the matters raised, the Complaints Committee of the SMC referred the matter for a formal inquiry before the Disciplinary Committee (DC).

4. The Respondent stands charged with 20 charges for failing to exercise due care in the management of his patients named specifically in each of the 20 charges set out in the Agreed Bundle (marked AB Pages 1 to 14).

5. The 20 charges as therein particularized in each one of them charged that the patients named and the various periods relating to each of them, the Respondent had:

(1) engaged in inappropriate prescribing practice by regularly prescribing benzodiazepines (Erimin, Dormicum, Nitrazepam, Midazolam and/or other drugs of similar nature more specifically set out in each of the 20 charges) without exercising an acceptable standard of diligence and care ; and/or

(2) failed to properly record or document details of the patients symptoms, medical condition and diagnosis in the case notes for the period of treatment; and/or

(3) in disregard of his professional duties, failed to properly counsel the patients.

6. The Respondent claimed trial to all the charges. It was agreed by the Prosecution and the Respondent that in the interest of expediency, evidence would be led on 6 of the charges while the other 14 charges be stood down and dealt with after the conclusion of the hearing of these 6 charges.

7. The 6 charges selected for this hearing are:

(1) Charge No. 5 [relating to patient Ms P5]

(2) Charge No. 6 [relating to patient Ms P6]

(3) Charge No. 10 [relating to patient Mr P10]
(4) Charge No. 13 [relating to patient Mr P13]
(5) Charge No. 19 [relating to patient Mr P19]; and
(6) Charge No. 20 [relating to Ms P20].

8. The medical records of all 6 patients were examined by the respective experts of the Prosecution and the Defence.

9. Dr PE, a Consultant Psychiatrist gave evidence on behalf of the Prosecution. He had examined the medical records of the patients and divided the 20 patients into 2 groups namely:

(1) Patients with Mainly Repeat Prescriptions of Benzodiazepines/Hypnotics but without warning or specialist referral.
(For our purpose, patients named in Charges 10, 19 and 20 belong to this group)

(2) Patients treated for other conditions besides Repeat Prescriptions of Benzodiazepines/Hypnotics.
(Patients named in 5, 6 and 13 are included in this group)

10. He found that the dose of the sleeping pills prescribed to each of these patients had exceeded the recommended dose for the drug or drugs named in each of the charges.

11. His conclusion is that the guidelines for Prescribing Benzodiazepines issued by the MOH dated 17 August 2002 had not been complied with.

12. Dr DE, a Senior Consultant Psychiatrist and Psychotherapist at Hospital B gave evidence on behalf of the Defence.

13. Dr DE was given the findings and opinion of Dr PE and gave his rebuttal evidence regarding the said 6 patients. In brief, he is of the view that the

Respondent had strived to use and dispense sleeping pills in a responsible manner. In fact, within the 20 patients, there were a number that had a good outcome. This may have helped spur the Respondent in continuing to manage patients with difficult conditions rather than turn them away.

14. At the hearing, the Prosecution's case is simply that the Respondent had clearly exceeded what was appropriate as summarized below:

(i) Charge No. 5

A total of 360 Erimin tablets were prescribed from 24 July 2003 to 23 July 2004. This works out to an average of almost 1 tablet every day for a period of one year. In some instances, the patient took 1½ to 2 tablets a day.

(ii) Charge No. 6

A total of 502 Erimin tablets were prescribed in 2003. This averaged 1⅓ tablets every day.

A total of 794 Erimin tablets were prescribed from 14 January 2003 to 31 July 2004 (about 1½ years).

(iii) Charge No. 10

A total of 442 tablets (Dormicum and Erimin) were prescribed for a period of 11 months in 2003. This averaged 1⅓ tablet every day.

A further 270 tablets were prescribed in 2004 which means that for period of 1 year and 7 months in 2003 and 2004, an average of 1¼ tablets were prescribed for each day.

(iv) Charge No. 16

A total of 570 tablets (Midazolam) were prescribed in 2002. This averaged 1½ tablets every day.

(v) Charge No. 19

The charge relates to consultations from 27 May 2000 to 22 July 2004 (more than 4 years). There were noticeable increases in dosage over time from 10 tablets to 20 tablets to 30 tablets. The Respondent admitted that the patient was effectively taking more than 1 tablet a day. In fact for a specific period of 1 year and 11 months within the said 4 years, a total of 1038 tablets (mainly Midazolam) were prescribed.

(vi) Charge No. 20

A total 443 tablets (Midazolam) were prescribed for 2003 which averaged more than a tablet a day for a whole year.

15. It is submitted that no clear and substantiated justification exists for the Respondent in prescribing such high dosage and breaching the MOH Guidelines. What the Respondent had testified was that while he tried (in some instances) to refer the patients to a psychiatrist and on a few occasions to treat them with other drugs, the patients kept on asking for more Erimin or Midazolam to help them sleep. The Respondent duly obliged and did so to the extent of over 1 tablet a day for periods of 1 to 4 years. The Prosecution submits that this cannot be appropriate prescribing practice of potentially additive drugs with documented adverse effects.

16. The Respondent's Counsel contends inter alia that the case notes show that the prescription of benzodiazepines for each patient was medically indicated and documented. These patients are chronic insomniacs, whose insomnia was caused by underlying social factors.

17. The Respondent had constantly recommended to patients that they should use non-benzodiazepine alternatives, reduce their dosages or allow themselves to be referred to psychiatrists. Further, he had kept a lookout for abuse by regularly carrying out urine tests for opiates on the patients and he has had occasion to deny medication to some of these patients.

18. Having heard the evidence of the experts and the Respondent, and considering the written and oral submissions of both the Prosecution and the Defence, the DC is of the view that the Respondent had engaged in inappropriate prescribing practice by regularly prescribing benzodiazepines to his patients without exercising standard of diligence and care.

19. The Committee found Dr AAC guilty of inappropriate medical practice. In treating insomnia, it is prudent to start with antihistamine or mild benzodiazepine first. However, Dr AAC starts off with a potent short- acting benzodiazepine like Midazolam or controlled drug like Erimin. The amount given usually exceeds two weeks. There is no strategy or plan to reduce the dosage. What is disturbing is the frequency of the prescription, with no interval between prescriptions. This pattern of prescribing is clinically inappropriate in prescribing benzodiazepine excessively over period of months and years. Dr AAC should know or ought to know that this pattern of prescribing was clearly inappropriate making the patient physically and/or psychologically dependent on the drug.

20. As regards to the charge of failing to record or document details of the patients' symptoms, medical condition and diagnosis in the case notes for the period of treatment, we are of the view that the Respondent's case notes appear to be well documented. This charge is therefore not substantiated.

21. As regards the charge of failing to properly counsel the patients, we did find on record some indication of counseling although the Prosecution did not accept these as sufficiently adequate. We find that there were attempts in some cases to counsel the patient and irrespective of the Prosecution's position, we find that we have no reason to dispute what was recorded and that the Respondent could have made an effort to counsel his patients. We therefore find that this charge has not been substantiated.

22. Accordingly, we find that the Respondent is guilty of the 6 charges in engaging in inappropriate prescribing practice by regularly prescribing

benzodiazepines to his patients without exercising standard of diligence and care which has been substantiated.

23. Following the conclusion of the hearing on the aforesaid 6 charges, the Prosecution applied to the DC to withdraw the following 3 charges:
    (1) Charge No. 2 [relating to patient Mr P2]
    (2) Charge No. 7 [relating to patient Ms P7]; and
    (3) Charge No. 15 [relating to patient Mr P15].

24. As to the remaining 11 charges, Prosecution applied to proceed with these charges only on the 1st limb set out in the charges namely, being engaged in inappropriate prescribing practice by regularly prescribing a benzodiazepine (as specifically named in each of the charge) to the patient without exercising an acceptable standard of diligence and care.

25. The Respondent pleaded guilty to the said remaining 11 charges as amended:
    (1) Charge No. 1 [relating to patient Mr P1]
    (2) Charge No. 3 [relating to patient Mr P3]
    (3) Charge No. 4 [relating to patient Mr P4]
    (4) Charge No. 8 [relating to patient Mr P8]
    (5) Charge No. 9 [relating to patient Mr P9]
    (6) Charge No. 11 [relating to patient Mr P11]
    (7) Charge No. 12 [relating to patient Mr P12]
    (8) Charge No. 14 [relating to patient Ms P14]
    (9) Charge No. 16 [relating to patient Mr P16]
    (10) Charge No. 17 [relating to patient Mr P17]; and
    (11) Charge No. 18 [relating to patient Mr P18].

26. In considering the proper sentence to be imposed on the Respondent, the DC had taken into account the Respondent's clean record of his practice of about 11 years.

27. The DC has also considered the fact that the Respondent has decided to plead guilty to the remaining 11 amended charges. Defence counsel has said that his client has taken this course of action after having been guided by the findings of the DC on the 6 charges which Respondent had claimed trial to.

28. However, the DC feels that the sentence must befit the charges to uphold the integrity of the profession.

SENTENCE:

29. With this in mind we would determine as follows:
    (1) that he be suspended from practice for a period of **12** months;
    (2) that he be fined the sum of $8,000;
    (3) that he be censured;
    (4) that he gives a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct;
    (5) that he pay the costs and expenses of the incidental to these proceedings including the costs of the solicitors to the Council and the Legal Assessor; and
    (6) that he is acquitted of Charge Nos. 2, 7 and 15.

30. The hearing is concluded.

Dated this 27th Day of March 2008.