SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR TANG YEN HO ANDREW HELD ON 7, 8 AND 9 MAY 2013

Disciplinary Committee:
Prof Ng Han Seong - Chairman
A/Prof Chen Fun Gee
A/Prof Charles Tsang
Mr Kwan Yew Huat – Lay Member

Legal Assessor:
Mr Ravinran Kumaran
(M/s Relianze Law Corporation)

Prosecution Counsel:
Mr Philip Fong
Ms Shazana Anuar
(M/s Harry Elias Partnership LLP)

Respondent-in-Person:
Dr Tang Yen Ho Andrew

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent, Dr Tang Yen Ho Andrew, is a registered medical practitioner. During the material time he was practising as a general practitioner at Tang Medical & Surgery Pte Ltd at Block 8 Jalan Batu, #01-11, Singapore 431008 ('Clinic').

2. On 11th October 2012, 17 charges were preferred against the Respondent by Singapore Medical Council ('SMC') for failing to exercise due care in the management of 17 patients of the Clinic between various dates prior to 2nd September 2010. Another 17 charges were preferred against him in respect of the same 17 patients for failing to properly document in the patients' medical records sufficient clinical details including the patients' diagnoses, symptoms, informed consents and/or investigation results, discussions of treatment options and treatment by the prescription of hypnotic and/or codeine-containing medication such as to enable the Respondent to properly assess the medical condition of the patients over a period of treatment and/or to enable another doctor reading the medical records to take over the management of the cases. All 34 charges stated that the Respondent was guilty of professional misconduct under Section 45(1)(d) of the Medical Registration Act (Cap. 174).

3. The particulars under the charges can be summarized as follows:

(a) The Respondent inappropriately and/or over prescribed Dormicum, Nitrazepam, Diazepam, Zopliclone, Erimin and codeine containing cough mixture (Dhasedyl);

(b) He did not formulate any management plan for the treatment of his patients' medical conditions by the prescription of hypnotics and/or Dhasedyl including:

(i) a lack of an obvious plan towards reducing his patients' intake of the said medications; and/or
(ii) a lack of referrals to specialists for reviews;

(c) He did not record or document in his patients' Patient Medical Records details or sufficient details of:

(i) his patients' diagnoses, symptoms and/or conditions and/or management plans (including plans to reduce or taper off his patients' intakes of hypnotic medications) such as to enable him to properly assess the medical conditions of his patients over the periods of treatments; and/or
(ii) any advice given to the patients including any warnings to the patients about potential addiction to hypnotics and/or Dhasedyl; and

(d) He had breached the Ministry of Health's Guidelines for Prescribing Benzodiazepines, dated 17th August 2002 ('2002 Guidelines') and the Ministry of Health's Administrative Guidelines on the Prescribing of Benzodiazepines and other Hypnotics ('2008 Guidelines').

4. The Respondent claimed trial to all 34 charges. Counsel for the SMC tendered to the Disciplinary Committee ('DC') 3 Bundle of Documents, which were marked PIB-1 to PIB-3. The DC was informed that they contained the relevant correspondence and documents in these proceedings. The Respondent had no objections to these bundles. He also confirmed that the copies of the documents in the bundles are accurate copies of documents from his Clinic.

5. The material facts of this case are that, in 2010 the Ministry of Health ('MOH') received information that the Respondent was indiscriminately prescribing large quantities of Dhasedyl to patients. Officers from the Regulatory Compliance Division conducted an audit at the Clinic of the Respondent's practice. They obtained the medical records of the 21 patients, seen at the Clinic by the Respondent, and also extracts of the Clinic's Drug Dispensing Register ('DDR'). Based on the information discovered the MOH made a complaint to the SMC about the prescribing practice of the Respondent with respect to benzodiazepines and/or Dhasedyl.

6. The Prosecution called one witness, Dr A to give expert evidence on the prescribing practice of the Respondent. Dr A is a Consultant Psychiatrist in private practice. He qualified as a medical doctor in 1987 and is a specialist in psychiatry. He is a member of the National Opiate Treatment Guidelines Committee of the MOH, an advisor to the Committee on Clinical Guidelines for the use of Buprenorphine in the

Treatment of Heroin Dependence in Malaysia of the Malaysian Psychiatric Association and a member of the National Mental Health Sub-Committee on Provision and Co-ordination of Services for Children & Adolescents, MOH. He has given expert evidence in disciplinary proceedings in the SMC and in courts in Singapore and on one occasion in the United Kingdom. He has several other important related credentials and awards. The DC accepted that he is qualified to give evidence as an expert in these proceedings. The Respondent did not challenge Dr A's competency to give expert evidence in these proceedings.

7. Dr A confirmed that he had been requested to give his expert opinion on the prescribing practice of the Respondent. He based his evidence on the documents obtained by Ministry of Health, ensuing correspondence with the Respondent and the Respondent's written explanations to the SMC dated 21st December 2010 and 12th April 2011, amongst other documents. He noted the following concerns regarding the Respondent's medical practice:-

(a) There was no regular documentation in all of the patients' case notes about the need to continue regular prescriptions of Dhasedyl and benzodiazepines;

(b) Those who were suffering from chronic respiratory conditions that require Dhasedyl ought to have chest X-rays or blood investigations arranged for, but this was not done, except in one instance (Patient 11);

(c) There was sparse documentation in the case notes (Patient Medical Records) about warnings of potential addiction to the prescribed medications;

(d) There were many instances where the 2002 Guidelines were breached in that the 2-week prescription limits for benzodiazepines were exceeded, and in many instances benzodiazepines were prescribed together with Dhasedyl, a practice discouraged in the 2002 Guidelines and proscribed in the 2008 Guidelines. There was no documentation of why he did this and whether he had explained to the patients how to safely use these combinations of medications;

(e) There were instances where 2 or 3 benzodiazepines were prescribed concurrently, many together with Dhasedyl;

(f) In one instance he had continuously prescribed Zopiclone (together with another hypnotic, Lexotan), without documenting that he had warned the patient (No. 17) of its potential addictive properties or the need for such a course of treatment. This was a breach of the 2008 Guidelines that required that Zopiclone be regarded with the same strict caution as benzodiazepines;

(g) There was also no noted documentation of dosage reduction plans to tail off such long-term prescriptions;

(h) There was also no indication that the Respondent had warned the patients of potential addiction to the medications that he had prescribed; and

(i) The patients ought to have been referred to specialist reviews as is required under the 2002 Guidelines or the 2008 Guidelines, as the case maybe.

8. The Respondent cross-examined Dr A with the objective of establishing that there was nothing wrong with the manner in which he had treated the 17 patients. He stated that he knew the 17 patients well. They were all 'functioning members of society'. By this he meant that they all worked at one or two jobs (he had asked for their CPF statements or other proof) and were not drug addicts or abusers of the prescribed medications. His patients had a variety of conditions even before they saw him. They knew what medications they needed in order to function normally and saw him for that purpose. They were unable to sleep or sleep properly or breathe properly because of the nature of their work (shifts), working and home environments. His point was that there was no harm in prescribing medications in these circumstances. He sought to establish that by prescribing benzodiazepines his patients could sleep and function better. By doing this he was preventing them from taking illicit drugs or alcohol etc. By prescribing benzodiazepines patients can sleep and/or function well. As regards documentation the Respondent accepted that he did not keep proper notes of his consultations of his patients.

9. Understandably, Dr A had no quarrel with the Respondent. He stated that the Respondent was in the best position to decide what medicine is best for his patients. He however reiterated that the issue was whether the Respondent had complied with the two Guidelines etc.

10. The Respondent, in his defence, stated that his patients' welfare is most important to him. He spoke generally about dependency being of different forms. He then went on to state his criteria for prescribing medication to the patients. This was basically asking himself whether they were taking medication for entertainment or enjoyment or to function normally. He also stated that he screened them by doing physical checks for needle marks or signs of drug abuse. He made sure that they were working people by checking their CPF statements, though this not always possible. In other words, he did not wantonly prescribe medications but had a system of checks and prescribed the medication to enable them to function normally.

11. He then went through his case notes of each of the 17 patients and sought to explain why he prescribed them their respective medications. His evidence essentially was that he prescribed the medications because the patients could not sleep well, or breathe properly, or both, or could not perform their jobs properly without the prescribed medication. The DC noted that in numerous instances, the information was from his recollection and not from his case notes. He was prepared to concede that some of his patients were dependant on the prescribed medications but felt that the fact that they were able to function well was a mitigating factor. The Respondent sought to draw a distinction between dependency on medications and addiction to illegal drugs. He opined that dependency was not a crime by citing examples such as cigarette smokers and alcohol drinkers who can function normally, which is not the case with heroin addicts.

12. The Prosecution's cross-examination focused on the Respondent's prescription practice of each of the 17 patients. They sought to establish that, based on the Patient Medical Records the Respondent did not make proper initial assessments as well as give good reasons for prescribing benzodiazepines and Dhasedyl to his patients on a prolonged basis. He should have been aware that he was creating a drug dependency situation for his patients. He was aware of MOH's letters regarding the prescription of Dhasedyl but had prescribed them in excess of the stipulations. He did not advise sleep hygiene practices or suggest sleep therapy treatments. He had not advised the possibilities of addiction and made no attempts to taper off his patients' medications. He was aware that he was required to keep proper records of all his patients' consultations but did not. Further, another doctor taking over his patients would not be able to understand his notes or his justification for maintaining his patients on benzodiazepines or Dhasedyl. The Respondent conceded that the Patient Medical Records do give the impression as stated by the Prosecution. He however stated that in each instance he had done what was expected of him but did not record the details and this was his usual practise.

13. The Respondent, in closing, made some general statements about the practice of medicine, which are not pertinent to be repeated here. More specifically, he stated the basis upon which he treated these 17 patients. He stated that there is a group of people, because of a variety of past factors such as dependence on illegal drugs, shift work, different sleep times etc, need medication to help them function better or sleep on demand. Alternate methods of non- pharmacological treatments are not options for these people because of a variety of personal factors. He did not see what was wrong in prescribing medications that would help them overcome their conditions. The alternative, he stated, for these patients would be to turn to alcohol or tobacco, which are more harmful to them. He was of the view that it is possible for patients to get off Dhasedyl and benzodiazepines provided that they were not prescribed high doses. He prescribed these medications only on a need basis. In other words, he was providing them maintenance therapy.

14. He conceded that his documentation was scanty, but felt that that was not critical. He was of the view that another doctor would not just rely on previous notes only but would do an examination and take a full history of the patient before commencing treatment. The notes he stated are only a guideline for another doctor. He then alluded to anecdotes of the practice of some doctors who kept comprehensive but fictitious notes.

15. The Respondent conceded that the purpose of the two Guidelines was to prevent illegal drug users abusing medications. He concluded that with all his patients he tries to do no harm but agreed that with the medications he had prescribed there is the problem of dependency.

16. The Prosecution submitted that the Respondent had exhibited a blatant disregard of the two Guidelines as observed from his prescribing patterns. This has led to his patients becoming addicted to or dependent on the medications in order to function. Despite the fact that patients kept coming back repeatedly, the Respondent was not alert or alive to the dangers of prescribing the medications to them. He had also

frequently prescribed highly addictive medicines such as Dormicum and Erimin, which are not to be prescribed for routine outpatient treatment. The Respondent did not sufficiently warn his patients about the risks of addiction nor tried to wean them off the addictive medications. Neither did he refer them to specialists. Many of the patients were prescribed Dhasedyl concurrently with benzodiazepines. The quantities of Dhasedyl prescribed, on many occasions, exceeded the limits set by MOH. Four of the patients were prescribed Dhasedyl for conditions other than for cough, such as for relieving pain in the hand caused by a bruise, keeping alert or overcoming a smoky kitchen environment.

17. The Prosecution submitted that the Respondent had not offered any acceptable reason for his poor documentation.

18. The manner in which a doctor ought to conduct himself in relation to his patients is broadly prescribed in the SMC's Ethical Code & Ethical Guidelines ('ECEG'). In ***Low Cze Hong v. Singapore Medical Council (2008) 3 SLR at page 628*****,** the High Court stated that the ECEG *'represents the fundamental tenets of conduct and behaviour expected of doctors practicing in Singapore and are intended as a guide to all practitioners as to what the SMC regards as the minimum standards required of all practitioners. It is the view of the SMC that persistent failure to meet these standards can potentially lead to harm to patients or bring disrepute to the profession and consequently may lead to disciplinary proceedings'*.

19. The Court went on to describe the circumstances in which professional misconduct can be found:-

"… professional misconduct can be made out in at least two situations: first, where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and second, where there has been such serious negligence that it objectively portrays an abuse of privileges which accompany registration as a medical practitioner…"

20. We summarise below what, in our opinion, are the relevant provisions of the ECEG to these proceedings. Guideline 3, amongst other things, states that a doctor is expected to:-

(a) provide competent, compassionate and appropriate medical care to patients;

(b) endeavour to ensure that patients suffer no harm;

(c) abide by the code of ethics of the profession; and

(d) uphold patients' right to be adequately informed.

21. Guideline 4, in setting out what is the standard of good medical practice, states, amongst other things, that:-

(a) *A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination* (4.1.1.1);

(b) *A doctor shall provide competent, compassionate and appropriate care to his patient. This includes … arranging appropriate and timely investigations… and the most appropriate management is expeditiously provided* (4.1.1.5);

(c) *A doctor should practice within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise. A doctor shall not persist in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having the required experience* (4.1.1.6);

(d) *Medical records kept by a doctor shall be clear, accurate, legible… of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigations, informed consents and treatment by drugs or procedures should be documented* (4.1.2); and

(e) *A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs… Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects* (4.1.3).

22. The DC finds, after hearing the evidence and reviewing the documents that the Respondent had failed to:-

(a) adequately assess his patients' conditions;

(b) arrange appropriate and timely investigations, such as X-rays or blood investigations for his patients;

(c) formulate management plans such as:

(i) refer his patients to appropriate specialists;
(ii) prescribe, dispense or supply medicines on clear medical grounds and in reasonable quantities as appropriate to his patients' needs;
(iii) inform his patients about the prescribed medicines or their side effects.
(iv) advise on alternative treatments/options;
(v) attempts to taper off patients' medicines; and

(d) keep clear, accurate, legible and sufficient records of his attendances, advice and management of his patients' illnesses.

23. The DC makes two points. First, in 1996 the MOH raised concerns to clinics and pharmacies about the dangers of making preparations containing codeine easily

available to customers. The MOH advised that customers be restricted to 240 ml (2 x 120 ml) per customer and no sale to the same customer within four days, wherever possible. This concern was again highlighted to clinics and pharmacists in MOH's letter of 9th October 2000 as the National Pharmaceutical Association reported that cough mixtures containing codeine could easily be obtained from clinics and pharmacies. The MOH sought the cooperation of these agencies to exercise greater control of the sale and supply of codeine preparations to patients. It was and has been common knowledge amongst doctors that codeine containing cough mixtures ought to be prescribed with great care.

24. Second, on 17th August 2002 the MOH issued to all doctors the 2002 Guidelines. MOH's covering letter to the Guidelines warns that *"Benzodiazepines are potentially addictive drugs which should be prescribed under specific circumstances when the benefit of the treatment outweighs the risks of adverse effect*. *Doctors should therefore carefully assess the indications for benzodiazepine use before prescribing the drugs'*. On 14th October 2008 the MOH issued the 2008 Guidelines. MOH's covering letter stated that, "*There is a need for every medical practitioner to ensure that benzodiazepines are used appropriately. These drugs are sometimes used to treat insomnia, anxiety and other psychiatric and medical conditions. Tolerance and drug dependence can be the undesired result*.' The two Guidelines are clear and comprehensive on what a doctor should do when considering prescribing benzodiazepines.

25. The DC finds that the Respondent had ignored MOH's advice on prescribing codeine containing cough mixtures on many occasions that he attended to the 17 patients. He had also exceeded the limit advised by MOH. His conduct in doing this is unacceptable. His conduct in prescribing benzodiazepines to these 17 patients is without a doubt in breach of the provisions of the two Guidelines. The DC notes the Respondent has conceded that he had deviated from the standards of the medical profession as stated above.

26. The DC is of the view that the conduct of the Respondent with regard to his prescription practice and patient management indicates a pattern of intentional, deliberate departure from standards observed or approved by members of the medical profession of good repute and competency particularly, considering that he has been a registered medical practitioner since 1985. Accordingly, we find the Respondent guilty of the 34 charges preferred against him.

27. In mitigation the Respondent stated the following:-

    (a) The amount of the codeine content in the Dhasedyl he had prescribed was not excessive;

    (b) Prolonged use of high doses of codeine has produced tolerance and physical dependence of the morphine type in a very small proportion of users. The Respondent's prescription of codeine containing cough mixture was within the limit of the maximum recommended dose of codeine tablets (360 mg);

(c) His treatment enabled his patients to remain well and be useful and functional members of society. It also prevented them from seeking illicit drugs and alcohol for their symptoms;

(d) The two Guidelines are merely guidelines and treatment had to be tailored to the different requirements of his patients; and

(e) He is a first time offender with many years of practice. He has been practicing in this manner with a view to helping his patients function as normal and useful members of society.

28. In the circumstances of this case the decision of the DC is that the Respondent:-

(a) be fined a sum of **$10,000.00**;

(b) be suspended from medical practice for a period of **6 months**;

(c) be censured;

(d) give a written undertaking to the Singapore Medical Council that he will not engage in the conduct complained of and any similar conduct; and

(e) pay the cost and expenses of and incidental to these proceedings, including the costs of the solicitors to the Singapore Medical Council and the Legal Assessor.

29. We hereby order the Grounds of Decision be published.

30. The hearing is hereby concluded.

Dated this 9th day of May 2013.