IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2019] SMCDT 9

Between

Singapore Medical Council

And

Dr Tan Joong Piang

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension

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Singapore Medical Council
v
Dr Tan Joong Piang

[2019] SMCDT9

Disciplinary Tribunal – DT Inquiry No. 9 of 2019

A/Prof Roy Joseph (Chairman), Dr Boey Wah Keong and Mr Yap Yew Choh Kenneth (Legal Service Officer)

3 July 2019

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

28 May 2020

GROUNDS OF DECISION

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

Introduction

1 Dr Tan Joong Piang (the "**Respondent**") faced 18 charges brought by the Singapore Medical Council ("**SMC**") for professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174) ("**MRA**") in relation to the long-term prescription of hypnotics to six (6) patients. The Respondent pleaded guilty to all charges and this Tribunal ordered that the Respondent (a) be suspended in the Register of Medical Practitioners for a period of 22 months, (b) be issued a written censure, (c) be required to provide a written undertaking to the SMC that he would abstain this or any similar misconduct, and (d) pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors of the SMC, but excluding costs occasioned by the amendments to the SMC's charges. We now provide our reasons.

The Charges

2 In respect of each of his six patients, the Respondent faced three charges under s 53(1)(*d*) of the MRA pertaining to (a) his failure to provide the appropriate care, management and treatment of his patients, (b) his failure to maintain medical records of sufficient detail and (c) his failure to refer his patients to a psychiatrist or other appropriate specialist for management of his patient's condition in a timely manner and/or at all.

3 The six patients in question (collectively referred to as the "**Patients**") are named in the following abbreviated form:

(a) MAK;

(b) LTS;

(c) LKH;

(d) ASC;

(e) CSM; and

(f) TSE.

4 The Respondent originally faced six main charges (one in relation to each patient) and six alternative charges. Prior to the hearing, Counsel for the SMC sought leave from the Disciplinary Tribunal ("**DT**") to reframe the proceeded charges into three separate charges per patient, consistent with the approach taken in recent cases involving inappropriate prescriptions in ***SMC v Looi Kok Poh*** [2019] SGHC 134, as well as ***SMC v Dr Chia Kiat Swan*** [2019] SMCDT 1. The alternative charges were removed following this amendment.

5 The 18 charges brought by the SMC, three for each of the six patients involved, are grouped as follows:

(a) The first set of charges relate to the Respondent's "*failure to provide appropriate care, management and treatment for his patients*" in the prescription of hypnotics (the 1st, 4th, 7th, 10th, 13th and 16th Charges);

(b) The second set of charges relate to the Respondent's "*failure to maintain medical records of sufficient detail*" for his Patients with respect to the prescription of hypnotics (the 2nd, 5th, 8th, 11th, 14th and 17th Charges); and

(c) The third set of charges relate to the Respondent's "*failure to refer his Patients to a psychiatrist or other appropriate specialist for management of his patient's condition in a timely manner and/or at all' in relation to his patients*" use of hypnotics (the 3rd, 6th, 9th, 12th, 15th and 18th).

6 The Counsel for the SMC clarified that while the amended charges resulted in a triple-fold increase in the number of charges to 18, it did not affect the gravamen of the misconduct as the allegations of misconduct remained the same and the number of patients involved remained at six, and that this should not thereby cause any prejudice to the Respondent. On this basis, the Respondent did not object to the proposed amended charges. As such, this DT granted the Counsel for the SMC leave to amend the charges.

7 During the hearing on 3 July 2019, the Counsel for the SMC sought to further amend the starting dates of the charges relating to the Respondent's alleged failure to refer his patients to a psychiatrist or other appropriate specialist (i.e. the 3rd, 6th, 9th, 12th, 15th and 18th Charges). These were amended to reflect a start date of 14 October 2008, as opposed to earlier dates. This amendment arose due to a clarification that the Administrative Guidelines on the Prescribing of Benzodiazephines and other Hypnotics by the Ministry of Health ("**the 2008 Administrative Guidelines**") was issued on 14 October 2008, which meant that the following guidance under Annex A, Paragraph (k) of the 2008 Administrative Guidelines to refer patients to a psychiatrist or other specialist would apply only from this date:

> "Where there are doubts about dosage prescription or tapering of benzodiazepines/ other hypnotics, a psychiatrist or other specialists should be consulted."

8 The final amended charges are reproduced in full as follows:

(a) **<u>The First Charge</u>**

That you … are charged that in the period 15 September 2002 to 24 July 2015, whilst practicing as a general practitioner at United Medical Practitioners located at Blk 201B, Tampines Street 21, #01-1065, Singapore 522201 (the "Clinic"), you failed to provide appropriate care, management and treatment to patient, MAK:-

PARTICULARS

a. You inappropriately prescribed hypnotics (i.e. Diazepam) to your patient as set out in Schedule 1 to this Notice of lnquiry ("NOI");

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(b) **The Second Charge**

That you … are charged that in the period 15 September 2002 to 24 July 2015, whilst practicing as a general practitioner at the Clinic, failed to maintain medical records of sufficient detail for your patient, MAK:-

PARTICULARS

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review.

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

(c) **<u>The Third Charge</u>**

That you … are charged that in the period 14 October 2008 to 24 July 2015, whilst practising as a general practitioner at the Clinic, you failed to refer MAK to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

<u>PARTICULARS</u>

a. You first advised the patient to see a psychiatrist on 25 February 2014;

b. In the period 14 October 2008 to 24 July 2015, you did not refer the patient to a psychiatrist or other appropriate specialist for management of your patient's condition;

c. In the period 14 October 2008 to 24 July 2015, you continued to prescribe hypnotics (i.e. Diazepam) to your patient as set out in Schedule 1 to this NOI.

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

(d) **<u>The Fourth Charge</u>**

That you … are charged that in the period 12 September 2002 to 27 April 2016, whilst practicing as a general practitioner at the Clinic, you failed to provide appropriate care, management and treatment to patient, LTS:-

<u>PARTICULARS</u>

a. You inappropriately prescribed hypnotics (i.e. Diazepam) to your patient as set out in Schedule 2 to this NOI;

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(e) **The Fifth Charge**

That you … are charged that in the period 12 September 2002 to 27 April 2016, whilst practising as a general practitioner at the Clinic, you failed to maintain medical records of sufficient detail to your patient, LTS:-

PARTICULARS

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review.

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

(f) **The Sixth Charge**

That you … are charged that in the period 14 October 2008 to 27 April 2016, whilst practising as a general practitioner at the Clinic, you failed to refer LTS, to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

PARTICULARS

a. You first referred the said patient to see a psychiatrist on 15 January 2009;

b. The patient was seen by a psychiatrist, Dr F1 ("**Dr F1**") on 28 May 2009; following which, Dr F1 advised you in a letter dated 28 May 2009 to reduce and tail off the patient's reliance on Diazepam;

c. You failed to adhere to the advice from Dr F1 to reduce and tail off the patient's reliance on Diazepam, in the period 29 May 2009 to 27 April 2016, you continued to prescribe hypnotics (i.e. Diazepam) to your patient as set out in Schedule 1 to this NOI;

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

(g) **<u>The Seventh Charge</u>**

That you… are charged that in the period 21 May 2003 to 2 July 2015, whilst practicing as a general practitioner at the Clinic, you failed to provide appropriate care, management and treatment to patient, LKH:-

<u>PARTICULARS</u>

a. You inappropriately prescribed hypnotics (i.e. Diazepam, Lormetazepam, Lorazepam, Bromazepam, Dormicum) to your patient as set out in Schedule 3 to this NOI;

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(h) **The Eighth Charge**

That you… are charged that in the period 21 May 2003 to 2 July 2015, whilst practicing as a general practitioner at the Clinic, you failed to maintain medical records of sufficient detail for your patient, LKH:-

PARTICULARS

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review.

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

(i) **The Ninth Charge**

That you … are charged that in the period 14 October 2008 to 2 July 2015, whilst practising as a general practitioner at the Clinic, you failed to refer your patient, LKH, to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

PARTICULARS

a. Particular a is deleted entirely at hearing of 3 July 2019.

b. In the period 14 October 2008 to 2 July 2015, you did not refer patient was seen by a psychiatrist or other appropriate specialist for management of your patient's condition;

c. In the period 14 October 2008 to 2 July 2015, you continued to prescribe hypnotics (i.e. Diazepam, Lormetazepam, Lorazepam, Bromazepam, Dormicum) to your patient as set out in Schedule 3 to this NOI;

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

(j) **<u>The Tenth Charge</u>**

That you … are charged that in the period 27 May 2005 to 2 December 2015, whilst practicing as a general practitioner at the Clinic, you failed to provide appropriate care, management and treatment to patient, ASC:-

PARTICULARS

a. You inappropriately prescribed hypnotics (i.e. Diazepam, Lormetazepam, Bromazepam, Alprazolam) to your patient as set out in Schedule 4 to this NOI.

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(k) **The Eleventh Charge**

That you … are charged that in the period 27 May 2005 to 2 December 2015, whilst practicing as a general practitioner at the Clinic, you failed to maintain medical records of sufficient detail for your patient, ASC:-

PARTICULARS

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review.

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

(l) **The Twelfth Charge**

That you … are charged that in the period 14 October 2008 to 2 December 2015, whilst practising as a general practitioner at the Clinic, you failed to refer your patient, ASC to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

PARTICULARS

a. You first advised the patient to see a psychiatrist on 22 January 2009;

b. The patient was seen by a psychiatrist, Dr F2 ("**Dr F2**") on 20 March 2009, following which Dr F2 advised the patient in a letter dated 20 March 2009 to tail down her use of your prescribed benzodiazepine;

c. You failed to adhere to advice from Dr F2 to tail down the prescribed benzodiazepines, in the period 21 March 2009 to 2 December 2015, you continued to prescribe hypnotics (i.e. Diazepam, Lormetazepam, Bromazepam, Alprazolam) to your patient as set out in Schedule 4 to this NOI.

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

(m) **<u>The Thirteenth Charge</u>**

That you … are charged that in the period 21 January 2006 to 1 March 2016, whilst practicing as a general practitioner at the Clinic, you failed to provide appropriate care, management and treatment to patient, CSM:-

<u>PARTICULARS</u>

a. You inappropriately prescribed hypnotics (i.e. Lormetazepam, Bromazepam and Alprazolam) to your patient as set out in Schedule 5 to this NOI;

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(n) **<u>The Fourteenth Charge</u>**

That you … are charged that in the period 21 January 2006 to 1 March 2016, whilst practising as a general practitioner at the Clinic, you failed to maintain medical records of sufficient detail to your patient, CSM:-

<u>PARTICULARS</u>

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review.

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

(o) **The Fifteenth Charge**

That you … are charged that in the period 14 October 2008 to 1 March 2016, whilst practising as a general practitioner at the Clinic, you failed to refer your patient, CSM, to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

PARTICULARS

a. You first referred the said patient to see a psychiatrist on 1 September 2015;

b. In the period 14 October 2008 to 1 March 2016, you did not refer the patient to a psychiatrist or other appropriate specialist for management of your patient's condition;

c. In the period 14 October 2008 to 1 March 2016, you continued to prescribe hypnotics (i.e. Lorazepam, Bromazepam, and Alprazolam) to your patient as set out in Schedule 5 to this NOI;

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

(p) **The Sixteenth Charge**

That you … are charged that in the period 1 October 2002 to 30 March 2016, whilst practicing as a general practitioner at the Clinic, you failed to provide appropriate care, management and treatment to your patient, TSE:-

PARTICULARS

a. You inappropriately prescribed hypnotics (i.e. Diazepam, Lormetazepam, Lorazepam, Alprazolam, and Zopiclone) to your patient as set out in Schedule 6 to this NOI;

b. You failed to formulate and/or adhere to any management plan for the treatment of the patient's medical condition with the prescription of hypnotics;

c. You failed to carry out an adequate assessment of the patient's medical condition over the period of treatment;

d. You allowed the patient and/or the patient's proxies to collect hypnotics without seeing a physician on various occasions;

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

(q) **The Seventeenth Charge**

That you … are charged that in the period 1 October 2002 to 30 March 2016, whilst practising as a general practitioner at the Clinic, you failed to maintain medical records of sufficient detail to your patient, TSE:-

PARTICULARS

a. You failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review for your patient.

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

(r) **The Eighteenth Charge**

That you … are charged that in the period 14 October 2008 to 30 March 2016, whilst practising as a general practitioner at the Clinic, you failed to refer your patient, TSE, to a psychiatrist or other appropriate specialist for management of your patient's condition in a timely manner and/or at all:-

PARTICULARS

a. You first referred the said patient to see a psychiatrist on 6 January 2014;

b. In the period 14 October 2008 to 30 March 2016, you did not refer the patient to a psychiatrist or other appropriate specialist for management of your patient’s condition;

c. In the period 14 October 2008 to 30 March 2016, you continued to prescribe hypnotics (i.e. Diazepam, Lormetazepam, Lorazepam, Alprazolam, and Zopiclone) to your patient as set out in Schedule 6 to this NOI;

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

Background and Agreed Statement of Facts

9 At all material times, the Respondent was a registered medical practitioner, and was practising as a General Practitioner at a clinic known as “United Medical Practitioners” (the “**Clinic**”).

10 The Agreed Statement of Facts are as follows:

(a) On 21 December 2012, SMC lodged a complaint to the Chairman of the Complaints Panel pursuant to section 39(3)(*a*) of the MRA (the “**Complaint**”). The Complaint attached a letter dated 29 February 2012 from the Ministry of Health (“**MOH**”) containing information relating to the prescribing practice of hypnotics by the Respondent at the Clinic. A Complaints Committee (the “**CC**”) was appointed to investigate the matter.

(b) On 26 March 2016, the Respondent gave his written explanation to the Complaint ("**Explanation**"). Pursuant to issues raised by the Respondent in the Explanation, the Respondent was requested to provide further medical records for the Patients and did so accordingly.

(c) On 9 June 2017, following further investigations, the CC informed the Respondent of its decision to refer the matter to a DT for a formal inquiry. Subsequently, the SMC issued the NOI dated 20 February 2019 setting out six charges against the Respondent. The charges relate to professional misconduct in Respondent's prescription of hypnotics in respect of each of the Patients.

(d) At 6.36 pm on 20 June 2019, the SMC informed Counsel for the Respondent that SMC would be seeking the DT's leave to amend the Charges set out in the NOI. The SMC's letter to the Respondent's Counsel, marked "Without Prejudice" and enclosing a copy of the SMC's proposed amendments were provided to the Respondent's Counsel on 21 June 2019 at 2.57 pm. Subsequently, Counsel for the parties exchanged further correspondence on the proposed amendments to the Charges.

(e) By way of letter dated 26 June 2019, the SMC sought the DT's leave to make the proposed amendments to the Charges as revised, with the Respondent's consent. A copy of the draft Amended NOI was enclosed with the letter. The SMC also informed the DT that the Respondent had agreed to take a certain course on the proposed amended Charges.

<u>Respondent's Plea of Guilt</u>

(f) The Respondent pleads guilty to the proposed amended Charges as contained in the draft Amended NOI.

(g) The Respondent admits that, in respect of each of the Patients, he had failed to provide adequate care, management and treatment; failed to maintain medical records of sufficient detail; failed to refer his patients to a psychiatrist or other appropriate specialist for the management of his patient's condition in a timely manner and/or at all and thereby guilty of professional misconduct under section 53(1)(*d*) of the MRA in that his conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

The Relevant Prescribing Guidelines for Benzodiazepine

(h) At all material times, the Respondent ought to have been aware of the MOH's Guidelines for Prescribing Benzodiazepines dated 17 August 2002 ("**2002 Guidelines**"). Among others, the 2002 Guidelines provide that:

(i) Paragraph 1:

"General Advice on Prescribing Benzodiazepines

(1) The need for a benzodiazepine must be assessed and justified before it is prescribed.

(2) Drug tolerance and dependency can occur with the use of any of the benzodiazepines, even with regular use for only two weeks.

(3) The type of benzodiazepine, the duration of use and other treatment options must be considered before a decision to prescribe is made.

(4) Patients being prescribed benzodiazepines must be advised to follow strictly the prescribed dosage. They should also be asked about the manner in which they are taking the medicines. This should be clearly documented in the patient medical record.

(5) The need for a repeat prescription should be assessed and the following clearly documented in the case notes:

(a) Justification for repeat prescription
(b) Comprehensive assessment of the patient
(c) Diagnosis
(d) Psychological history of the patient
(e) Evidence that the psychological aspects have been attended to."

(ii) Paragraph 4(3):

"Benzodiazepines are rarely helpful in insomnia due to organic disease and may depress respiration in chronic pulmonary disease. However, in terminal conditions, the possibility of drug dependence becomes less important and the regular use of hypnotics should not be denied if they provide symptomatic relief."

(iii) Paragraph 4(4):

"Medical practitioners should warn patients about rebound insomnia with the use of benzodiazepines. They should limit chronic benzodiazepine hypnotic prescription where poser/e and refer patients with refractory insomnia to psychiatrists for further management."

(iv) Paragraph 5(6):

"Repeat prescriptions for benzodiazepines should not be provided without a clinical review."

(v) Paragraph 5(7):

"Consult a psychiatrist if there are doubts about dosage prescription or reduction."

(vi) Paragraph 6(2)(c):

"Central Nervous System (CNS) symptoms in the elderly. The elderly is especially vulnerable to the adverse effects of hypnotic drugs and are more susceptible to CNS depression, confusion and ataxia, leading to falls and fractures. They are also sensitive to respiratory depression and prone to sleep apnoea and other sleep disorders."

(vii) Paragraph 7(1):

"The dependence potential is common to all benzodiazepines, more so for those with greater potency and shorter half-lives e.g. lorazepam,

triazolam, midazolam and alprazolam (see Table 3). These benzodiazepines should be avoided if possible…"

(viii) Paragraph 7(2):

"The management of benzodiazepines withdrawal consists of gradual dosage reduction combined with appropriate psychological support. This is usually done in an outpatient setting at a pace that is tolerable to the patient. The process may take 2-3 months to 1 year."

(i) At all material times, the Respondent was aware or ought to be aware of the MOH's Clinical Practice Guidelines 2/2008 "Prescribing of Benzodiazepines" dated September 2008 ("**2008 Guidelines**"). Among others, the 2008 Guidelines provide that:

(i) Paragraph 5.2:

"For the long-term user who is clearly dependent, there is a need to educate the patient and schedule a benzodiazepine discontinuation plan. These should be clearly documented."

(ii) Paragraph 6.1:

"… Long-term use of benzodiazepines should be avoided in the elderly in view of the increased risk of cognitive impairment and fractures…Benzodiazepines with long half-lives (such as diazepam, flurazepam, clorazepate, chlordiazepoxide) should be avoided in the elderly"

(j) At all material times, the Respondent was aware or ought to have been aware of the Ministry of Health's Administrative Guidelines on the Prescribing of Benzodiazepines and Other Hypnotics dated 14 October 2008 ("**2008 Administrative Guidelines**"). Among others, the 2008 Administrative Guidelines provide that:

(i) Annex A ltem (c):

"The following information <u>must</u> be documented in the medical record of <u>every</u> patient who is prescribed with benzodiazepines/ other hypnotics;

i Comprehensive history, including psychosocial history and previous use of benzodiazepines or other hypnotics;

ii Comprehensive physical examination findings, including evidence of misuse of benzodiazepines or other drugs; and

iii Withdrawal symptoms to benzodiazepines/ other hypnotics previously experienced by the patient, if any"

(ii) Annex A ltem (d):

"The following information <u>must</u> be documented in the medical records of every patient <u>each time</u> he/she is prescribed benzodiazepines / other hypnotics either initially or as repeat prescriptions:

i The prescribed type/name of benzodiazepine/hypnotic, its dosage and duration of use;

ii lndication(s) and/or justification(s) for prescribing benzodiazepines/ other hypnotics; and

iii Physical signs or evidence of tolerance, physical/psychological dependence or any illicit use or misuse of benzodiazepines or other drugs (e.g. Needle tracks on skin, inappropriate lethargy)"

(iii) Annex A Item (g):

> "Medical practitioners should <u>routinely</u> warn patients about rebound insomnia with the use of benzodiazepines and document such warning accordingly."

(iv) Annex A ltem (j):

> "Repeat prescriptions for benzodiazepines / other hypnotics should <u>not</u> be provided without a clinical review"

(v) Annex A ltem (n):

> "The following categories of patients should not be further prescribed with benzodiazepines / other hypnotics and must be referred to the appropriate specialist for further management:
>
> i Patients who require or have been prescribed benzodiazepines / other hypnotics beyond a cumulative period of 8 weeks;"

<u>Facts relating to Patient MAK</u>

(k) In the period 15 September 2002 to 24 July 2015 (a period of 12 years 10 months 10 days), the following hypnotics were prescribed to MAK for the treatment of MAK's insomnia:

(a) Occasions on which prescriptions were made: 125 occasions.

(b) Sum-total of prescriptions: 3,290 tablets of Diazepam (10 mg).

(c) The itemized prescriptions for MAK are set out at Schedule 1 to the NOI.

(d) Diazepam is a benzodiazepine and hypnotic, the use of which can result in drug tolerance and dependency.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of MAK with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A ltem (n) of the 2008 Administrative Guidelines.

(f) On the occasions where the Respondent prescribed Diazepam, he failed to carry out an adequate assessment of MAK's medical condition. There were multiple, repeat prescriptions for hypnotics provided to MAK without clinical reviews and there were occasions where MAK's proxies were allowed to collect the hypnotics on her behalf. This was in breach of paragraph 1 and 5(6) of the 2002 Guidelines, and Annex A Item (j) of the 2008 Administrative Guidelines.

(g) The Respondent failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review. On the occasions that the Respondent did document MAK's medical condition, the Respondent did not do so adequately. This was in breach of paragraphs 1(5) and 5(6) of the 2002 Guidelines and Annex A ltem (a), (c) and (d) of the 2008 Administrative Guidelines.

(h) The Respondent failed to refer MAK to a psychiatrist or an appropriate specialist at all. The Respondent first advised MAK to see a psychiatrist on 25 February 2014, in the 11th year of the Respondent's prescription of hypnotics to MAK since 15 September 2002 but did not refer MAK to a psychiatrist. Until 24 July 2015, MAK continued to be prescribed with Diazepam without any referral to a psychiatrist or an appropriate specialist. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A Item (n) of the 2008 Administrative Guidelines.

Facts relating to Patient LTS

(l) ln the period 12 September 2002 to 27 April 2016 (a period of 13 years 7 months and 16, days), the following hypnotics were prescribed to LTS for the treatment of LTS's insomnia and anxiety:

(a) Occasions on which prescriptions were made: 142 occasions.

(b) Sum-total of prescriptions:

(1) 150 tablets of Diazepam (2mg);

(2) 30 tablets of Diazepam (5mg); and

(3) 4,055 tablets of Diazepam (10mg).

(c) The itemized prescriptions for LTS are set out at Schedule 2 to the NOI.

(d) Diazepam is a benzodiazepine and hypnotic, the use of which can result in drug tolerance and dependency.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of LTS with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A Item (n) of the 2008 Administrative Guidelines.

(f) On the occasions where the Respondent prescribed Diazepam, he failed to carry out an adequate assessment of LTS's medical condition. There were multiple, repeat prescriptions for hypnotics provided to LTS without clinical reviews and there were occasions where LTS's proxies were allowed to collect the hypnotics on his behalf. This is in breach of paragraph 1 and 5(6) of the 2002 Guidelines, and Annex A, Item (j) of the 2008 Administrative Guidelines.

(g) The Respondent failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review. On the occasions that the Respondent did document LTS's medical condition, the Respondent did not do so adequately. This was in breach of paragraphs 1(5) and 5(6) of the 2002 Prescribing Guidelines and Annex A, Item (a), (c) and (d) of the 2008 Administrative Guidelines.

(h) The Respondent failed to refer LTS to a psychiatrist or an appropriate specialist in a timely manner. LTS was first referred to a psychiatrist for his chronic insomnia on 15 January 2009. This referral was made in LTS's 7th year of use of hypnotics since 12 September 2002. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Prescribing Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

(i) LTS was seen by a psychiatrist, Dr F1 ("**Dr F1**"), on 28 May 2009. By way of a letter dated 28 May 2009 to the Respondent, Dr F1 had advised the Respondent to reduce LTS's dosage of diazepam taken, and to gradually help LTS tail off his diazepam prescription. Dr F1 estimated that it would take a few months for LTS to stop the medication. The Respondent failed to closely follow Dr F1's advice as LTS continued to receive his usual dosage and quantity of Diazepam tablets soon after. Until 27 April 2016, LTS continued to be prescribed with Diazepam. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

Facts relating to Patient LKH

(m) In the period, 21 May 2003 to 2 July 2015 (a period of 12 years 1 month and 12 days), the following hypnotics were prescribed to LKH for the treatment of LKH's insomnia:

(a) Occasions on which prescriptions were made: 232 occasions.

(b) Sum-total of prescriptions:

(1) 1,705 tablets of Diazepam (5mg);

(2) 160 tablets of Diazepam (10mg);

(3) 755 tablets of Lormetazepam (1mg);

(4) 7 tablets of Lorazepam (0.5mg);

(5) 20 tablets of Bromazepam (3mg); and

(6) 935 tablets of Dormicum (15mg).

(c) The itemized prescriptions for LKH are set out at Schedule 3 to the NOI.

(d) Diazepam, Lormetazepam, Lorazepam, Bromazepam and Dormicum are benzodiazepines and hypnotics, the use of which can result in drug tolerance and dependence.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of LKH with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

(f) On the occasions where the Respondent prescribed hypnotics, he failed to carry out an adequate assessment of LKH's medical condition. There were multiple, repeat prescriptions for hypnotics provided to LKH without clinical reviews and there were occasions where LKH's proxies were allowed to collect the hypnotics on her behalf. This was in breach of paragraph 1 and 5(6) of the 2002 Guidelines, and Annex A, Item (j) of the 2008 Administrative Guidelines.

(g) The Respondent failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review. On the occasions that the Respondent did document LKH's medical condition, the Respondent did not do so adequately. This was in breach of paragraphs 1(5) and 5(6) of the 2002 Guidelines and Annex A, Item (a), (c) and (d) of the 2008 Administrative Guidelines.

(h) The Respondent failed to refer LKH to a psychiatrist or an appropriate specialist at all. The Respondent first advised LKH to see a psychiatrist on 16 October 2006, the 3rd year of LKH's use of hypnotics, and in the years 2007, 2008, 2009, 2014 and 2015 thereafter. On 16 April 2007, LKH indicated that he did not want to see a psychiatrist. Until 2 July 2015, LKH continued to be prescribed with hypnotics without any referral to a psychiatrist or an appropriate specialist. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

Facts relating to Patient ASC

(n) ln the period 27 May 2005 to 2 December 2015 (a period of 10 years 6 months and 6 days), the following hypnotics were prescribed to ASC to treat her insomnia:

(a) Occasions on which prescriptions were made: 59 occasions.

(b) Sum-total of prescriptions:

(1) 345 tablets of Diazepam (10mg);

(2) 10 tablets of Lormetazepam (1mg);

(3) 25 tablets of Bromazepam (3mg); and

(4) 855 tablets of Alprazolam (0.5mg).

(c) The itemized prescriptions for ASC are set out at Schedule 4 to the NOI.

(d) Diazepam, Lormetazepam, Bromazepam and Alprazolam are benzodiazepines and hypnotics, the use of which can result in drug tolerance and dependence.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of ASC with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

(f) On the occasions where the Respondent prescribed hypnotics, he failed to carry out an adequate assessment of ASC's medical condition. There were multiple, repeat prescriptions for hypnotics provided to ASC without clinical reviews and there were occasions where ASC's proxy was allowed to collect the hypnotics on her behalf. This was in breach

of paragraph 1 and 5(6) of the 2002 Guidelines, and Annex A, Item (j) of the 2008 Administrative Guidelines.

(g) The Respondent failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review. On the occasions that the Respondent did document ASC's medical condition, the Respondent did not do so adequately. This was in breach of paragraphs 1(5) and 5(6) of the 2002 Guidelines and Annex A, Item (a), (c) and (d) of the 2008 Administrative Guidelines.

(h) The Respondent failed to refer ASC to a psychiatrist or an appropriate specialist in a timely manner. The Respondent first advised ASC to see a psychiatrist on 22 January 2009, the 3rd year of the Respondent's regular prescription of hypnotics to ASC since 5 May 2006. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

(i) ASC was seen by a psychiatrist, Dr F2 ("**Dr F2**"), on 20 March 2009. By way of a letter dated 20 March 2009 to the Respondent, Dr F2 noted that ASC was dependent on sleeping pills. Dr F2 prescribed an alternative medication and advised ASC to tail down her use of Alprazolam. After Dr F2's letter, there was no documented plan to wean off and eventually stop the use of benzodiazepines. Until 2 December 2015, ASC continued to be prescribed with hypnotics. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

<u>Facts relating to Patient CSM</u>

(o) In the period 21 January 2006to 1 March 2016 (a period of 10 years, 1 month and 10 days), the following hypnotics were prescribed to CSM to treat her insomnia:

(a) Occasions on which prescriptions were made: 50 occasions.

(b) Sum-total of prescriptions:

(1) 10 tablets of Lorazepam (0.5mg);

(2) 860 tablets of Bromazepam (3mg); and

(3) 394 tablets of Alprazolam (0.5mg).

(c) The itemized prescriptions for CSM are set out at Schedule 5 to the NOI.

(d) Lorazepam, Bromazepam and Alprazolam are benzodiazepines and hypnotics, the use of which can result in drug tolerance and dependency.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of CSM with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

(f) On occasions where the Respondent prescribed Diazepam, he failed to carry out an adequate assessment of CSM's medical condition. There were multiple, repeat prescriptions for hypnotics provided to CSM without clinical reviews and there were occasions where CSM's proxies were allowed to collect the hypnotics on her behalf. This was in breach of paragraph 1 and 5(6) of the 2002 Guidelines, and Annex A, Item (j) of the 2008 Administrative Guidelines.

(g) The Respondent failed to document adequately and/or at all, the indication(s) and justification(s) for prescribing or continuing the prescription of hypnotics at each clinical review. On the occasions that the Respondent did document LTS's medical condition, the Respondent did not do so adequately. There was a lack of documentation of advice on sleep hygiene and the adverse effects of tolerance/dependence on hypnotics. This was in breach of paragraphs 1(5) and 5(6) of the 2002 Guidelines and Annex A, Item (a), (c) and (d) of the 2008 Administrative Guidelines.

(h) The Respondent failed to refer CSM to a psychiatrist or an appropriate specialist at all. The Respondent first advised CSM to see a psychiatrist in 2015, CSM's 9th year of use of hypnotics, but did not refer CSM to a psychiatrist. CSM indicated on 24 November 2015 that he did not want to see a psychiatrist. Until 1 March 2016, CSM continued to be prescribed with hypnotics without any referral to a psychiatrist or an appropriate specialist. This was in breach of paragraphs 4(4) and 5(7) of the 2002 Guidelines and Annex A, Item (n) of the 2008 Administrative Guidelines.

Facts relating to Patient TSE

(p) In the period 1 October 2002 to 30 March 2016 (a period of 14 years, 2 months and 21 days), the following hypnotics were prescribed to TSE to treat her insomnia:

(a) Occasions on which prescriptions were made: 123 occasions.

(b) Sum-total of prescriptions:

(1) 402 tablets of Diazepam (2mg);

(2) 755 tablets of Diazepam (10mg);

(3) 220 tablets of Lormetazepam (1mg);

(4) 70 tablets of Lorazepam (0.5mg);

(5) 10 tablets of Alprazolam (0.5mg); and

(6) 561 tablets of Zopiclone (7.5mg).

(c) The itemized prescriptions for TSE are set out at Schedule 6 to the NOI.

(d) Diazepam, Lormetazepam, Lorazepam, Alprazolam, and Zopiclone are hypnotics, the use of which can result in drug tolerance and dependence.

(e) The Respondent failed to formulate and/or adhere to any management plan for the treatment of TSE with the prescription of hypnotics. This was in breach of paragraph 7(1) and 7(2) of the 2002 Guidelines, paragraph 5.2 of the 2008 Guidelines and Annex A Item (n) of the 2008 Administrative Guidelines.

Submissions on Sentencing

Submissions on Sentencing by the SMC

11 Counsel for the SMC submitted that the appropriate sentence was for the Respondent to be suspended for 36 months as a starting point based on the level of culpability and harm caused to the Patients in this case, and to give no more than a one-third discount on account of inordinate delay in the prosecution of the case. In short, the SMC sought a 24-month suspension as the primary sentence to be awarded in this case.

12 As a starting point, Counsel for the SMC referred to the recent sentencing framework established by the Court of Three Judges in ***Wong Meng Hang v Singapore Medical Council*** [2018] SGHC 253. The following framework laid out by the Court of Three Judges (at [33]) sets out the ranges of starting points based on a harm-culpability matrix,

and is applicable to all cases involving the clinical treatment and mismanagement of patients:

Culpability \ Harm	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

13 Following ***Wong Meng Hang***, the matrix above was applied by a DT in ***Dr Chia Kiat Swan*** [2019] SMCDT 1 in a case involving the inappropriate prescription of hypnotics. In ***Dr Chia Kiat Swan***, Dr Chia faced the same format of charges as the present case in respect of the prescription of hypnotics to four of his patients. Dr Chia had for a time of up to 11 years and 8 months failed to adhere to the 2002 Guidelines, the 2008 Guidelines and the 2008 Administrative Guidelines by inappropriately prescribing benzodiazepines to the patients concerned and in excessive amounts. The DT in ***Dr Chia Kiat Swan***, in applying the harm-culpability matrix, adopted a starting point of 2 years' suspension, on the basis that the harm caused by the Respondent through his offences was moderate, and that his culpability lay somewhere at the upper range of the medium level or lower range of the high level. The DT then found that a discount of one-third was fair and appropriate in the circumstances given the period of delay of 2 years and 8 months from the time of issue of the Notice of Complaint ("**NOC**") to the service of the NOI. The Respondent was accordingly suspended for 16 months, and a fine of $15,000 was imposed.

14 It was pointed out by the SMC that earlier cases involving disciplinary actions against medical practitioners for inappropriate prescription of hypnotics would be of limited guidance as they were decided before the imposition of the new sentencing framework in ***Wong Meng Hang***. These cases typically involved punishments of suspensions ranging from 3 to 12 months, depending on the severity of the factors involved in each

case. The prosecution sought to persuade us that these cases should effectively be recalibrated following the application of the sentencing matrix in ***Dr Chia Kiat Swan***.

15 Applying the sentencing matrix set out in ***Wong Meng Hang***, learned Counsel for the SMC submitted that the Respondent's misconduct in the present case (a) had demonstrated a high degree of culpability; and (b) had caused moderate harm to his patients. This would place the present case in a starting range of a suspension between 2 to 3 years.

16 It was further submitted that given the misconduct and aggravating factors present on the facts, the culpability of the Respondent's conduct coupled with the harm caused to the Patients, the starting point should be at the upper end of this range, i.e. 36 months' suspension. The aggravating factors cited by the SMC were as follows:

(a) The patients of the Respondent were prescribed with hypnotics for upwards of 10 years, with the longest being a period of 14 years and 2 months (for patient TSE). This was the longest period of treatment in the available sentencing precedents involving inappropriate prescription of hypnotics, and was double that of most of the charges in ***Dr Chia Kiat Swan***, where the misconduct ranged upwards from 7 years and 1 month, with the longest period being 11 years and 8 months.

(b) Aside from the long duration over which the Respondent had prescribed hypnotics, the hypnotics prescribed were also done so in excessive quantities without any management plan.

(c) The Respondent also allowed the Patients to collect repeat prescriptions of hypnotics without a physician's review on numerous occasions. This further extended to the Patients' proxies being allowed to collect repeat prescriptions on their behalf. On these occasions, the Patients were not even seen by a physician.

(d) For all Patients, the Respondent had only begun advising the Patients to see a psychiatrist after a prolonged period of prescribing hypnotics. Out of six Patients, and over more than decade of treating each of them, the Respondent only referred two patients to a psychiatrist in the course of his treatment (Patients LTS and ASC). Even after the patients had seen a psychiatrist, the Respondent failed to adhere to the psychiatrists' advice.

(e) The Respondent's misconduct involved multiple patients, more than the four patients in ***Dr Chia Kiat Swan***. Not only were multiple patients involved, two of the Patients were advanced in age, and belonged in an especially vulnerable class of persons, for which the potential drug tolerance, dependence on hypnotics and risk of further harm would be amplified.

(f) The Respondent obtained full registration on 25 April 1981 and has been in practice for the past 38 years. It has been recognised by the Court of Three Judges that a medical practitioner's eminence and seniority would be an aggravating factor (***Ang Peng Tiam v SMC*** [2017] 5 SLR 356 at [93]). The longest material periods in the charges stands at more than one-third the entire duration of the Respondent's career. This undermines any argument that the Respondent's long career without any antecedent disciplinary convictions should be seen as a mitigating factor.

17 However, the SMC conceded that the time period of 2 years and 11 months between the NOC and the NOI, amounted to an inordinate delay in the proceedings would warrant a discount in the sentence. In this regard, the Counsel submitted that a maximum discount of one third off the starting sentence should be applied, with a final minimum suspension of 24 months to be imposed which is in line with the case of ***Dr Chia Kiat Swan***.

18 For the above reasons, the SMC maintained that the Respondent should be suspended for a minimum of 24 months.

Mitigation Plea

19 The learned Counsel for the Respondent submitted that this case involved slight to moderate harm caused to the patients. It was noted that the degree of harm arising from the inappropriate prescription of benzodiazepines could range from potential dependency without further acute detriment, to cases involving acute detriment such as overdose, and/or dysfunctional addiction. In this case, it was submitted that there was no evidence of actual harm caused to the six patients, in the sense that there were no acute detrimental effects on the patients (e.g. overdose or hospitalization) and the patients continued to function normally in other aspects of life.

20 The Counsel for Respondent pointed out that the SMC's own expert, Prof PE ("**Prof PE)**, had stated in her report dated 30 November 2018 that all the Patients:

(a) Were not drug addicts;

(b) Did not develop a physical dependence or addiction to benzodiazepines; and/or

(c) Did not develop any other ill effects from hypnotic use, notwithstanding their prolonged use of hypnotics.

21 Although Prof PE did opine that the patients "*probably had varying degrees of psychological hypnotic dependence*", she did not provide a definitive view or further evidence to substantiate this statement. Accordingly, Counsel submitted that the Respondent's case involves, at the highest, moderate harm, which was in line with the DT's assessment in the case of ***Dr Chia Kiat Swan***.

22 In terms of culpability, the Counsel for Respondent differed from the SMC's view and took the position that culpability lay at the upper range of medium to the lower range of high culpability on the part of the Respondent. It was submitted that there was no suggestion or evidence that Dr Tan had acted with malicious intent, such as to exploit his patients for financial gain, or that he was indifferent or reckless as to his patients' wellbeing. In fact, as Prof PE has observed, all the Patients were regular family practice patients of the clinic. It was suggested that the benzodiazepines had been prescribed by Dr Tan to his long-term patients in a genuine but misguided attempt to help the patients concerned to continue to function in their lives.

23 It was also pointed out that Dr Tan had advised all his patients to seek psychiatric treatment. Four of the patients (MBK, LKH, CSM and TSE) were so advised but did not actually attend before a psychiatrist, while two patients (LTS and ASC) were referred to psychiatrists at Hospital A and were referred back to the Respondent for further management. It was pointed out that this was a distinguishing factor from ***Dr Chia Kiat Swan***'s case, where no efforts were made to refer patients to a psychiatrist and/or specialist for timely treatment until after Dr Chia was notified of the complaint by the SMC.

24 Considering the above factors in totality, the Counsel for Respondent submitted that the upper range of medium to the lower range of high culpability should be attributed to

the Respondent. It was noted that there could be far more egregious behaviour where the doctor was indifferent to the patients' wellbeing, disregarded circumstances suggesting that the patients were abusing the drugs (with the potential for serious incidents such as overdose), was a recalcitrant re-offender, and/or intentionally fed the patient's addiction (for example, for personal financial gain).

25 Taking into account principles of proportionality, consistency and parity in sentencing, together with sentencing precedents and the observations made with regards to the harm caused and Dr Tan's culpability, Counsel for Respondent submitted that the starting point for the Charges (before taking into account mitigating factors) should not exceed a term of suspension of 2.5 years, or 30 months.

26 Finally, Counsel for the Respondent sought to lower this starting point by one third to a suspension of 20 months due to the following mitigating factors:

(a) *Cooperation in the investigations and early plea of guilt*. It was submitted that the Respondent had cooperated with the SMC at every stage of the investigations. After obtaining legal advice, he had demonstrated remorse by acknowledging his errors and accepting responsibility for his actions at the earliest opportunity.

(b) *Respondent's unblemished record.* The Respondent had diligently served the community around the Tampines area for over 38 years. He had no antecedents, and this was his first brush with disciplinary proceedings.

(c) *Delay in prosecution*. There had been a delay in the prosecution of the Respondent's case, the uncertainty of which has brought him anxiety and distress. It was trite that an inordinate delay in prosecution, where the offender was not responsible for the delay and where the delay had resulted in prejudice to the offender, would be a mitigating factor in sentencing.

27 Applying this discount because of the inordinate delay to the starting point for sentencing (2.5 years in this case), as well as taking into account the other mitigating factors, the Counsel for Respondent submitted that the appropriate sentence in this case would be a suspension of 20 months coupled with a fine of $15,000 and a censure, as well as a direction that the Respondent issue a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. It was also

conceded that the Respondent should pay the costs of and expenses incidental to the proceedings, including the costs of solicitors to the SMC.

The Disciplinary Tribunal's Decision

28 Having considered the submissions of both parties, the DT is of the unanimous view that the starting point for sentencing should be 33 months' suspension. Considering the mitigating factors applicable to this case, in particular, the delay in prosecution, we reduced the final sentence by one third, to arrive at a suspension period of 22 months. We note that this represented the median between the SMC's proposed sentence of 24 months, and the Respondent's proposed sentence of 20 months. We provide our detailed reasons as follows.

The applicability of past precedent

29 The first question that we considered in the sentencing exercise was the applicability and relevance of past precedent in light of the new sentencing framework provided by the Court of Three Judges in the case of ***Wong Meng Hang***. This seminal decision laid out a general sentencing matrix for cases where harm was caused to a patient by a doctor's misconduct. Its methodology of applying a "harm-culpability matrix", which guides a sentencing tribunal to the suitable starting point for a sentence, is consonant with the more recent approach taken in criminal cases (see for example the case of *Logachev Valdislav v PP* [2018] 4 SLR 609 at [35]).

30 Prior to the promulgation of this harm-culpability matrix, the punishment for cases involving disciplinary actions against medical practitioners for the inappropriate prescription of hypnotics typically involved suspensions ranging from 3 to 12 months, depending on the severity of the factors relating to the case. While this range of sentences was significantly lesser than the sentencing outcomes under the matrix in ***Wong Meng Hang***, we pause to observe that this did not mean that sentences were lenient as a whole in past cases. In certain cases with aggravated factors, for example, where the respondent was a repeat offender (***Dr AAN*** [2009] SMCDC 2), or where the modus operandi of inappropriate prescription of hypnotics was applied across a chain of clinics (***Singapore Medical Council v Kwan Kah Yee*** [2015] 5 SLR 201), the maximum punishment of striking off from the register had been imposed. Nevertheless,

we do accept as a general observation that as far as suspensions were concerned, the tenor of sentences imposed prior to ***Wong Meng Hang*** was more lenient.

31 The possibility that higher sentences would be imposed as a result of the passage of the new sentencing matrix was recognised by the Court of Three Judges in ***Wong Meng Hang***. In elucidating the effect of the sentencing approach, the Court of Three Judges reviewed the cases of ***In the Matter of Dr Amaldass Narayana Dass*** [2014] SMCDC 2 (at [39]) and ***In the Matter of Dr Fong Wai Yin*** [2016] SMCDT 7, and noted that the applicable sentencing range for each of those cases under the new framework would be higher than the suspension periods meted out in those cases. This made it amply clear that the Court of Three Judges was aware that, in appropriate cases, the effect of the sentencing framework would be to impose more severe sentences than had been awarded in prior cases.

32 Nevertheless, we were careful to remind ourselves that the sentencing matrix in ***Wong Meng Hang*** was conceived as a guide only, and could be departed from in the appropriate circumstances. This was recognised by the court at [33] of the judgment:

> For the avoidance of doubt and misunderstanding, this is set out as a guide only, in order to help sentencing tribunals weigh the relevant considerations in a systemic manner. This 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 this matrix where it is appropriate to do so.

33 We are also mindful of the observations of the Court of Appeal in *Mohd Akebal s/o Ghulam Jilani v PP and another appeal* [2020] 1 SLR 266 at [20], on the approach that should be taken with regard to sentencing guidelines:

> (a) First, guidelines are a means to an end and the relevant end is the derivation of sentences that are just and are broadly consistent in cases that are broadly similar.
>
> (b) Second, sentencing guidelines are not meant to yield a mathematically perfect graph that identifies a precise point for the sentencing court to arrive at in each case. Rather, they are meant to guide the court towards the appropriate sentence in each case using a methodology that is broadly consistent.
>
> (c) Third, sentencing guidelines are meant to be applied as a matter of common sense in the light of the foregoing observations.

34 In summary, we accept that the introduction of the sentencing matrix in ***Wong Meng Hang***, and its subsequent adoption in ***Dr Chia Kiat Swan***, heralds the introduction of a sentencing regime which ratchets upwards the sentences to be imposed for the inappropriate prescription of hypnotics. We are however mindful that the application of a sentencing framework should not result in a purely mathematical exercise that ignores the overall justice of the case. It is always incumbent upon the sentencing court or tribunal to consider whether exceptional factors exist to justify a departure from such sentencing guidelines. Having said this, what is clear to our minds is that an argument based merely on the apparent leniency of prior precedent would not suffice to justify such a departure.

35 Having addressed this preliminary issue, we now turn to applying the four steps in the sentencing approach evinced in ***Wong Meng Hang***, which are summarised as follows:

(a) Identify the level of harm and the level of culpability to determine the seriousness of a particular offence;

(b) Identify the applicable indicative sentencing range based on the level of harm and culpability;

(c) Identify the appropriate starting point within the indicative sentencing range; and

(d) Make adjustments to the starting point to take into account offender-specific factors.

The level of harm caused and the doctor's level of culpability

36 While Counsel for the SMC took the view that a moderate level of harm had been caused to the patients in this case, Counsel for the Respondent pitched it as a slight to moderate level of harm, as no *actual* harm had been caused. We found ourselves in agreement with the SMC's position, and provide our reasons as follows.

37 First, six patients were involved in this case, which is significantly higher than the four patients involved in *Dr Chia Kiat Swan*'s case, where the DT had found that the level of harm was moderate.

38 Second, we note that vulnerable patients were involved. All the patients were advanced in years (the youngest being 57 years at the last date of prescription), and two patients

in particular were of advanced age (68 and 81 years at the last date of prescription). The elderly is an especially vulnerable class of persons, for which the potential risks of drug tolerance and dependency would be amplified. The 2002 Guidelines, in Paragraph 6(2)(c), specifically warns that elderly patients are "especially vulnerable":

> (d) Central Nervous System (CNS) symptoms in the elderly
>
> - The elderly are especially vulnerable to the adverse effects of hypnotic drugs and are more susceptible to CNS depression, confusion and ataxia, leading to falls and fractures. They are also sensitive to respiratory depression and prone to sleep apnoea and other sleep disorders.

39 The two patients who were most advanced in age were CSM and MAK. Patient CSM was already 72 years old when the Respondent started prescribing hypnotics to her. Her use had increased and was at its highest in 2011 when she was at 77 years of age. She continued to be prescribed hypnotics until she was 81 years old. Patient MAK was in her 60s when large amounts of Diazepam (10mg) were dispensed. She also had a fairly high average of 0.7 tablets prescribed per day, as compared to the other patients. The following chart summarises the prescription histories of all six patients:

S/N	Patient	Age at end date of prescription	Duration of prescription	Number of Visits	Average number of tablets prescribed per day
1	MBK	68	12 years, 10 months and 10 days	125	0.7
2	LTS	64	13 years, 7 months and 16 days	142	0.85
3	LKH	60	12 years, 1 month and 12 days	232	0.81
4	ASC	57	10 years, 6 months and 6 days	59	0.32
5	CSM	81	10 years, 1 month and 10 days	50	0.34
6	TSE	66	14 years, 2 months and 21 days	123	0.41

40 Third, as evident in the table above, the prescriptions continued over an extremely lengthy period of time, from upwards of 10 years, to the longest period of 14 years and 2 months. This was by far the longest continuing period of misconduct in the history of cases involving the inappropriate prescription of hypnotics. In ***Dr Chia Kiat Swan***'s case, the misconduct ranged upwards from 7 years and 1 month, to the longest charge covering 11 years and 8 months. Prior to the recalibrated sentencing framework, the longest period of treatment found in the available sentencing precedents was the case of ***Dr Ng Teck Keng*** [2014] SMCDT 9, which involved a prescription period of 7 years and 4 months.

41 The prolonged period in this case exposed the Respondent's patients to a very real risk of developing dependency on the prescribed benzodiazepines, which carried the potential for greater harm. It also prolonged the patients' suffering from insomnia. The 2002 Guidelines had advised that the prescription of benzodiazepines alone was rarely helpful in the treatment of insomnia [at Paragraph 4(3)], and noted that its use may even cause rebound insomnia [at Paragraph 4(4)], a complication which the Respondent had not routinely warned his patients about. The prolonged period of prescription is especially appalling when seen in the light of the warning in the 2002 Guidelines [at Paragraph 1(2)], that drug tolerance and dependence can occur even with regular use of two weeks. This was later followed by a warning in the 2008 Administrative Guidelines which stated at Annex A, Item (n) that patients who had been prescribed hypnotics over a cumulative period of eight weeks should not be prescribed with further hypnotics.

42 We were of the view that where inappropriate prescription of benzodiazepines resulted in potential dependency albeit without further acute detriment, the level of harm should still be considered as moderate. This underscores the very real risk that the inappropriate prescription of hypnotics would lead to dependency or addiction, which in turn carries potential risk of even greater harm. Our view is consistent with that of the DT in ***Dr Chia Kiat Swan***, which likewise found that the harm arising from Dr Chia's offences should be considered moderate given the risk of dependency on the prescribed benzodiazepines (at [15]).

43 Next, we turn to the issue of culpability on the Respondent's part. Here there is again a divergence of views, with the SMC urging us to consider this as a case involving "high" culpability, while the Respondent submits that it should be one involving the upper range of "medium" and the lower range of "high" culpability.

44 The issue of culpability finds a greater degree of variance in cases involving inappropriate prescription by a medical practitioner. An assessment of the degree of blameworthiness should necessarily involve the scale and extent of the wrongdoing, the motivation involved, the extent of the violation of medical practice or procedure and the applicability of any remedial steps taken by the practitioner. These facts may vary greatly, and we turn to consider each of these factors in detail.

45 First, we considered the scale and extent of the wrongdoing to be severe in this case. As earlier mentioned, six patients were involved, with the prescription period per patient ranging from upwards of 10 to more than 14 years, a period which far surpassed any previous case. The actual prescription dates spanned from 12 September 2002 to 27 April 2016, or more than a third of the Respondent's practice of 38 years since he had obtained full registration on 25 April 1981. The duration of time and number of patients involved reveal a persistent and flagrant pattern of disregard for the 2002 Guidelines and 2008 Administrative Guidelines. It also evinces a complete lack of common sense and prudence on the part of the medical practitioner to prescribe treatment over such a prolonged period in deliberate violation of the applicable guidelines.

46 Second, we turn to consider the excessive amounts of hypnotics prescribed, and the lack of adequate documentation and safeguards in the manner of prescription. One glaring aspect of this case was how the Respondent appeared to overprescribe medication both in quantity and type of medication. There were several years in which he had prescribed over and above his own maximum recorded dosage of one tablet per night (or 365 per year). For example, Patient MAK was prescribed with 390 and 380 tablets in 2003 and 2008 respectively, whereas Patient LKH was prescribed with 400 tablets in 2005. It is also notable that for four of the six patients (namely LKH, ASC, CSM and TSE), the Respondent had prescribed them with multiple types of benzodiazepines, some including both short-acting benzodiazepines and long-acting benzodiazepines. However, he did not document the indications and justifications for prescribing these various types of benzodiazepines, or why he had continued with these prescriptions at each and every clinical review.

47 These flagrant shortcomings were exacerbated by the Respondent allowing the patients or even their proxies to collect repeat prescriptions without a clinical review on multiple occasions. This is in blatant breach of the fundamental duty on the part of a medical practitioner to assess a patient's medical condition before issuing a prescription. It is also a breach of specific guidelines that warn that repeat prescriptions must only be granted after clinical review. The cavalier manner in which the Respondent rubber-

stamped the prescription of hypnotics violates the following directions in Paragraph 1 of the 2002 Guidelines, which are reproduced for convenient reference as follows:

> (1) The need for a benzodiazepine must be assessed and justified before it is prescribed.
> …
> (3) The type of benzodiazepine, the duration of use and other treatment options must be considered before a decision to prescribe is made.
> …
> (5) The need for a repeat prescription should be assessed and the following clearly documented in the case notes:
> (a) Justification for repeat prescription
> (b) Comprehensive assessment of the patient
> (c) Diagnosis
> (d) Psychosocial history of the patient
> (e) Evidence that the psychosocial aspects have been attended to.

48 These breaches were also clearly systemic and not just ad-hoc or a result of mere oversight. For example, within LKH's first year of use of hypnotics in 2003, LKH and/or her proxy had collected hypnotics on 19 out of 21 occasions without ever seeing a physician. Patient LTS, in 2003 and 2004, was only reviewed by a physician once out of 23 occasions when he had been prescribed hypnotics. In a similar vein, Patient TSE and/or her proxies were allowed to collect repeat prescriptions on all 11 occasions in 2003 and 2004 without a clinical review.

49 The failure to conduct clinical review before further prescription is a key factor that distinguishes this case from that of ***Dr Chia Kiat Swan***. The DT in that case noted that Dr Chia had conducted careful clinical reviews of his patient, and had advised them on the management of their sleep issues as well as the potential long term side effects of use of benzodiazepines. In contrast, the consistent failure by the Respondent to properly review his patients or to even ensure that the medications were placed directly in their hands was clearly a deliberate and systemic dereliction of duty.

50 To make matters worse, on the occasions when the Patients were reviewed by the Respondent, he had failed to adequately document the indications and justifications for the prescription or continued prescription of hypnotics. There was no history taking or physical examination of the patients recorded, nor was there tracking of the patient's sleep patterns even though they were being treated for insomnia. Nor was there routine advice given to warn them of the effects of rebound insomnia. Given that the treatment of these patients lasted over multiple years, the severe lack of documentation in and of

itself would have critically hampered subsequent clinical review, due to the lack of detailed notes necessary for proper follow-up.

51 The final aspect in relation to departure from proper medical procedure was the Respondent's failure to refer his patients to psychiatrists or the appropriate specialist in a timely manner. In the 2002 Guidelines, it was specifically provided that the general practitioner was to consult a psychiatrist or appropriate specialist for patients with refractory insomnia [Paragraph 4(4) of the 2002 Guidelines], or if there were doubts about dosage prescription or reduction [Paragraph 5(7) of the 2002 Guidelines]. The 2008 Administrative Guidelines further limited the prescription of hypnotics with the introduction of Annex A, Item (n):

> The following categories of patients should not be further prescribed with benzodiazepines / other hypnotics and must be referred to the appropriate specialist for further management:
> Patients who require or have been prescribed benzodiazepines / other hypnotics beyond a cumulative period of 8 weeks; …

52 This meant that as of 14 October 2008 (the operative date of the 2008 Administrative Guidelines), a general practitioner could not prescribe hypnotics for more than eight weeks without ensuring that the patient had consulted with the appropriate specialist. Out of all six patients in this case, and over more than a decade of treatment for each patient, only two of the Respondent's patients, namely LTS and ASC, had seen a psychiatrist in the course of his treatment. Moreover, the first instance of any documented advice to any of the six patients on the need to see a psychiatrist or appropriate specialist was woefully late in the day. The following chart shows that the respective dates of referral only took place between the 3rd to the 11th year of prescription for the Patients:

Patient	**Date of first prescription of hypnotics**	**Date of referral**	**Date of last prescription of hypnotics**
MAK	15 September 2002	25 February 2014 (11th year of prescription)	24 July 2015
LTS	12 September 2002	15 January 2009 (7th year of prescription)	27 April 2016
LKH	21 May 2003	16 October 2006 (3rd year of prescription)	2 July 2015
ASC	27 May 2005	22 January 2009	2 December 2015

		(3rd year of prescription)	
CSM	21 January 2006	1 September 2015 (9th year of prescription)	1 March 2016
TSE	1 October 2002	6 January 2014 (11th year of prescription)	30 March 2016

53 The remaining four patients, MAK, LKH, CSM and TSE, did not follow the Respondent's advice to see a psychiatrist or relevant specialist. Instead of stopping the prescriptions as required, the Respondent continued to prescribe them with medications for substantial periods (nearly 9 years in the case of LKH).

54 For Patients LTS and ASC, even though they had consulted with psychiatrists, the advice given by the specialists was not followed by the Respondent. For Patient LTS, he failed to follow the psychiatrist's advice to reduce and tail off the patient's use of Diazepam, which the psychiatrist estimated would take a few months. Instead, the Respondent continued to prescribe Diazepam to LTS without further referral back to a psychiatrist for the next 7 years. Similarly, in the case of Patient ASC, the psychiatrist had advised for the use of Alprazolam to be tailed down. In contradiction to this advice, the Respondent continued to prescribe ASC with hypnotics for another 5 years and 8 months. It is also notable that in this respect, the Respondent's culpability was greater than that of ***Dr Chia Kiat Swan***. In Dr Chia's case, while he had similarly only managed to ensure that two out of his four patients had consulted with a psychiatrist or specialist, it was not alleged that he had failed to adhere with the psychiatrists' advice on treatment. In contrast, the Respondent had ridden complete roughshod over the requirement to defer to the views of a specialist before continuing the prescription of hypnotics after the passage of eight weeks.

55 These flagrant departures from the guidelines were further exacerbated by the fact that the six patients were all advanced in years and would be considered a vulnerable class of patients, with the youngest (Patient ASC) being 57 years of age at the end date of prescription. Instead of providing additional care and consideration for such vulnerable patients, the Respondent had recklessly placed them at the additional risk of harm by continuing the prescription of their medication.

56 Finally, the frequency and multiplicity of the various breaches committed by the Respondent suggest that they were clearly deliberate. The fact that these were long-standing patients of the Respondent's family practice does not detract from the reality that he stood to profit by "closing one eye" in the way he prescribed hypnotics. In effect, he had monetised the profession's exclusive right to prescribe medication by pointedly ignoring the detailed rules that stand guard against its very abuse.

57 Taking all the above factors into consideration, we came to the conclusion that the SMC was correct in positing the culpability of the Respondent as high or "severe".

The applicable indicative sentencing range and the appropriate starting point within the range

58 A finding that the case involves medium harm and high culpability would place it within an indicative sentencing range of two to three year's suspension.

59 Counsel for the SMC invited the DT to consider the appropriate starting point within this range to be 36 months' suspension, while Counsel for the Respondent invited us to adopt 30 months' suspension as the starting point.

60 In considering the appropriate starting point within a range, the sentencing tribunal should place the actions of offender within a spectrum of wrongful behaviour that could apply to the particular category of harm and culpability. In this case, while the Respondent is clearly within the band of "high" culpability, it is clearly conceivable that this is not the most aggravated case as far as culpability was concerned. For example, the scale of wrongdoing could have been magnified across a chain of clinics (as was the case in *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201), or the number of patients could have been far greater, or the offending period could have been longer than the present case. Put another way, the starting point must leave sufficient headroom for a sentencing court or tribunal to adjust the sentence upwards to properly reflect the offender's culpability in more aggravated cases.

61 By dint of this reasoning, we find ourselves unable to agree with Counsel for the SMC that the Respondent deserves a starting point at the maximum end of the indicative sentencing range. One can certainly conceive of instances where an offender within this highest band of culpability could have acted in a manner more egregious than the

present Respondent. Accordingly, we find that a starting point of 33 months' suspension would be a more accurate reflection of the Respondent's culpability.

Adjusting the starting point to take into account offender-specific factors

62 In the final step of the analysis, we turn to consider offender-specific factors that may serve to mitigate or aggravate the starting point derived within the sentencing framework.

63 Both parties are *ad idem* that a one-third discount should be applied to the sentence on account of the inordinate delay of 2.5 years in the prosecution of the case. This was similar to the case of ***Dr Chia Kiat Swan***, where there had been a delay 2 years and 8 months, and a one-third reduction had been applied by the DT to reduce the starting point of 24 months' suspension to a term of 16 months.

64 Counsel for the Respondent had also asked us to take into account the Respondent's remorse as demonstrated in his cooperation with the SMC and his early agreement to plead guilty to all charges. We did agree that this is a mitigating factor, and considered that it had been similarly factored in the one-third reduction applied in ***Dr Chia Kiat Swan****'s case.*

65 Counsel for the Respondent had also raised the fact that the Respondent had had an unblemished and distinguished service record for over 38 years, and that this should be taken into consideration as a mitigating factor. However, given the extremely long period of offending in this case (over 14 years), we do not agree that this factor carries any mitigating weight. An offender should not stand to benefit from his apparent virtue simply because his actions were discovered late in the day. In addition, where the offences were repeated over more than a decade, it hardly lies in the Respondent's mouth to claim the credit usually accorded to a first offender.

66 As there were no further offender-specific factors that were raised, we agreed with parties that a reduction of one-third of the term of suspension would be just given the delay in prosecution and the Respondent's demonstrated remorse in accepting a plea of guilt. The term of suspension, pegged at a starting point of 33 months, would thus be reduced by a third to 22 months.

67 In the final reckoning, we took a second look at the term of suspension to see if it was inherently fair given the overall circumstances of the case. We note that while it represents a significant step-up over the 16-month term imposed in ***Dr Chia Kiat Swan***'s case, the extent of wrongdoing (especially in terms of the number of patients, the duration of prescription, and the inadequate clinical review as well as disregard of the psychiatrists' advice) clearly justifies a sterner sentence in the Respondent's case. We also note that the numerous disciplinary cases involving the prescription of hypnotics underscores the urgent need to send a deterrent message to those who hold in low regard the safeguards imposed on the dispensation of medicine. The physician's role in the prescription of medication should not be observed in its breach or given lip service, whether for the sake of convenience or for the nefarious purpose of profit.

68 By way of completeness, we wish to highlight that a fine was not imposed in this case as we considered that the term of suspension would be sufficient punishment for the practitioner. We note that there was also no specific request for a fine by Counsel for the SMC.

69 Accordingly, it is this DT's order that –

(a) The Respondent's registration be suspended for a period of **22 months**;

(b) The Respondent be censured;

(c) The Respondent give a written undertaking to the SMC that he will not engage in conduct complained of or any other similar conduct; and

(d) The Respondent pay to the SMC the costs of and expenses incidental to these proceedings, including the costs of the solicitors to the SMC, but shall exclude the costs occasioned by the amendments to the Charges made by the Prosecution.

70 This hearing is hereby concluded.

A/Prof Roy Joseph
Chairman

Dr Boey Wah Keong

Mr Yap Yew Choh Kenneth
Legal Service Officer

Ms Chang Man Phing and Ms Cheronne Lim (M/s WongPartnership LLP)
for the Singapore Medical Council; and

Ms Mak Wei Munn and Ms Rachel Ong Hui Fen (M/s Allen & Gledhill LLP)
for the Respondent