IN THE COURT OF 3 JUDGES OF THE GENERAL DIVISION OF THE REPUBLIC OF SINGAPORE

[2024] SGHC 126

Originating Application No 8 of 2023

Between

Ang Yong Guan

… *Appellant*

And

Singapore Medical Council

… *Respondent*

Originating Application No 9 of 2023

Between

Singapore Medical Council

… *Appellant*

And

Ang Yong Guan

… *Respondent*

JUDGMENT

[Professions — Medical profession and practice — Professional conduct]

Ang Yong Guan
v
Singapore Medical Council and another matter

[2024] SGHC 126

Court of 3 Judges of the General Division of the High Court — Originating Applications Nos 8 of 2023 and 9 of 2023
Sundaresh Menon CJ, Tay Yong Kwang JCA, Belinda Ang Saw Ean JCA
16 November 2023

13 May 2024 Judgment reserved

Sundaresh Menon CJ:

1 Dr Ang Yong Guan ("Dr Ang") is a psychiatrist who issued a number of prescriptions to his former patient, the late Mr Quek Kiat Siong (the "Patient"). These prescriptions were not in conformity with various guidelines promulgated by the Ministry of Health ("MOH"). The Patient passed away four days after the last of these prescriptions was issued. Subsequently, a complaint was lodged against Dr Ang, pursuant to which the Singapore Medical Council ("SMC") brought against him three charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("the MRA"), and three alternate charges under s 53(1)(*e*) of the MRA. In *Singapore Medical Council v Dr Ang Yong Guan* [2023] SMCDT 2 ("the Decision"), the Disciplinary Tribunal ("DT") acquitted Dr Ang of the three charges under s 53(1)(*d*) of the MRA (the "professional misconduct charges"), but convicted him of the three alternative charges under s 53(1)(*e*) of the MRA (the

"professional services charges"). Various sanctions were imposed, notably a suspension from practice for a period of 24 months. Both Dr Ang and the SMC have appealed against various aspects of the DT's decision.

2 By C3J/OA 8/2023 ("OA 8"), Dr Ang appeals against his conviction on the three professional services charges. In C3J/OA 9/2023 ("OA 9"), the SMC appeals against his acquittal on the professional misconduct charges, and also against the sentence imposed by the DT in connection with Dr Ang's conviction on the professional services charges, contending that he ought to have been suspended for a period of 36 months. While the parties have made written submissions on sentence in these appeals, at the hearing, we directed them to confine their arguments to the question of Dr Ang's liability under each of the charges, and indicated that we would hear them on sentence after the question of Dr Ang's liability had been decided. This judgment therefore concerns only Dr Ang's liability under each of the charges. We first set out the relevant factual background.

Facts

3 The Patient first consulted Dr Ang on 8 February 2010, after being referred to him by another doctor who had been treating him for his lower back pain. Dr Ang treated the Patient between 8 February 2010 and 31 July 2012 (the "material period"), for various conditions including insomnia, depression, post-traumatic stress disorder, obsessional ruminations and anxiety. The Patient was treated on some occasions as an inpatient at Mount Elizabeth Hospital ("MEH") or Mount Elizabeth Hospital Novena ("MEHN"), where Dr Ang (or other doctors) would monitor and review him, and on other occasions, the Patient was managed as an outpatient by Dr Ang at his clinic and through telephone consultations.

4 In the course of treating the Patient, Dr Ang issued numerous prescriptions which form the subject matter of the charges that have been brought against him. As we explain below (at [12]), these prescriptions were not in compliance with the standards of treatment set out in the MOH guidelines that were applicable to Dr Ang (the "Relevant Guidelines").

5 Dr Ang's final prescription to the Patient, issued on or about 31 July 2012, was for, among other things, a nightly dose of 60mg of Mirtazapine, and a nightly dose of 25mg of Zolpidem Controlled Release ("Zolpidem CR"), and the prescription of these drugs form the subject of the third pair of charges. The Patient subsequently passed away on 4 August 2012. His Final Cause of Death was certified as "multi-organ failure with pulmonary haemorrhage, due to mixed drug intoxication", and his post-mortem blood concentrations of various drugs including Olanzapine, Duloxetine, Mirtazapine, and Bromazepam, all of which had been prescribed by Dr Ang, were found to be elevated beyond the therapeutic concentrations found in living subjects. This pointed to the possibility of multiple drugs having been prescribed together, and in excessive quantities.

6 After the Patient's demise, the Patient's sister, who is also the complainant in the present case, commenced a civil suit in the High Court against the Patient's insurers (the "Civil Proceedings") on behalf of his estate: see *Quek Kwee Kee Victoria (executrix of the estate of Quek Kiat Siong, deceased) and another v American International Assurance Co Ltd and another* [2016] 3 SLR 93. The central issue in the Civil Proceedings was whether the Patient had deliberately consumed an overdose of his prescribed medication in circumstances where the probability of death was or ought to have been foreseen. On appeal to the Court of Appeal ("CA") in *Quek Kwee Kee Victoria (executor of the estate of Quek Kiat Siong, deceased) and another v American*

International Assurance Co Ltd and another [2017] 1 SLR 461, the CA observed (at [76]) that "from the evidence of the scientific and medical experts", the "quantity and variety of drugs prescribed to the [Patient] were such that even if these had been taken in their prescribed doses (which were at the high end to begin with), this *could* have resulted in the adverse reactions that led to his death" [emphasis in original]. The CA further observed that the most probable scenario was that the Patient had taken "his medication in accordance with the prescription" while harbouring no intention or expectation of suffering injury resulting in death (at [111]–[113]). In essence, the CA found that on the balance of probabilities, the Patient had ingested no more than the prescribed doses and without expecting or anticipating that this would result in his death (at [113]). The CA was not concerned with and did not pronounce on the appropriateness or otherwise of the medical care that the Patient had been receiving.

7 The CA's decision was issued on 2 February 2017. Thereafter, on 11 April 2017, the complainant filed a complaint against Dr Ang with the SMC, in relation to his treatment and care of the Patient.

The charges

8 As has been mentioned, before the DT, Dr Ang faced three charges of professional misconduct under s 53(1)(*d*) of the MRA. Each of these charges avers that the underlying conduct constituted an "intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency". This phrasing mirrors that used in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37], which held that professional misconduct may be made out where:

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

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

9 As the charges did not aver that Dr Ang's conduct constituted serious negligence, the SMC's case on the professional misconduct charges is properly understood as being premised only on the first limb of *Low Cze Hong*.

10 Additionally, Dr Ang also faced three corresponding alternative charges under s 53(1)(*e*) of the MRA for failing to provide professional services of the quality which it is reasonable to expect of him. Each pair of charges essentially covers three periods of time. The first professional misconduct and the first professional services charge concerned prescriptions issued by Dr Ang between 8 February 2010 and 31 December 2011; the second pair of charges concerned prescriptions issued between 1 January 2012 and 31 July 2012; and the third pair concerned the prescription issued on 31 July 2012, which was Dr Ang's last prescription to the Patient before the Patient's death four days later. The full charges are annexed to this judgment, but for convenience, we summarise the key factual elements of each pair of charges in the following table:

<table>
<tr><th>First pair of charges</th><th>Second pair of charges</th><th>Third pair of charges</th></tr>
<tr><td>Switching between antidepressants without ensuring that each was continued for at least 4 to 6 weeks</td><td>Allowing for long-term chronic use of benzodiazepines by prescribing a 6-months' supply to the Patient on 31 July 2012</td><td>Prescribing a daily dosage of 60mg of Mirtazapine, in excess of the permitted maximum daily dosage of 45mg</td></tr>
<tr><td colspan="2">Concurrent prescription of two or more benzodiazepines to the Patient on various occasions</td><td rowspan="4">Prescribing a daily dosage of 25mg of Zolpidem CR, in excess of the permitted maximum daily dosage of 12.5 mg</td></tr>
<tr><td colspan="2">Prescription of benzodiazepines to the Patient beyond the limit of short-term relief (2 to 4 weeks)</td></tr>
<tr><td colspan="2">Prescription of benzodiazepines to the Patient to treat his insomnia beyond the limit of intermittent use (for example, 1 night in 2 or 3 nights)</td></tr>
<tr><td colspan="2">Prescription of benzodiazepines despite being aware that the Patient was concurrently taking opioid analgesics</td></tr>
</table>

11 We will elaborate on the factual averments where necessary, when we consider each of the charges later in this Judgment. However, it should be noted here that in relation to the third pair of charges, the dosages of the two drugs in question (*ie*, Mirtazapine and Zolpidem CR) were increased by Dr Ang to the levels they were at during the time of the Patient's final admission, and this had been done on 4 and 2 July 2012 respectively.

12 It is common ground that Dr Ang had prescribed the medications in the manner described in the charges, and that in doing so, his prescriptions deviated

from the Relevant Guidelines. We summarise the key provisions of the Relevant Guidelines as follows:

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

(b) Paragraph (i) of the MOH Administrative Guidelines on the Prescribing of Benzodiazepines and other Hypnotics (MH 70:41/24 Vol. 3 14 October 2008) ("2008 Admin Guidelines (Benzodiazepines)"), provides that the concurrent prescribing of two or more benzodiazepines should be avoided;

(c) Paragraph (f) of the 2008 Admin Guidelines (Benzodiazepines), provides that benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (such as 1 night in 2 or 3 nights) and only when necessary;

(d) Guideline 5.1.1 of the MOH Clinical Practice Guidelines on the Prescribing of Benzodiazepines ("2008 CPG (Benzodiazepines)"), provides that benzodiazepine use should be limited to use for short-term relief (between 2 to 4 weeks), at the lowest dose and be taken intermittently (e.g. 1 night in 2 or 3 nights).

13 In addition, the package inserts and product monographs of opioids, benzodiazepines, and zolpidem, all recommend that the concurrent use of benzodiazepines and opioid analgesics should be avoided or limited to the lowest effective dosage and minimum duration if prescribed. Similarly, the

product inserts for Mirtazapine and Zolpidem CR set out a maximum dosage limit of 45mg and 12.5mg per night.

14 The Relevant Guidelines exist to encourage or discourage certain practices, for reasons such as to reduce the risks to which patients are exposed. They are "based on the best available evidence at the time of development". When evaluating the reasonableness of departures from the Relevant Guidelines, it is important to consider why each guideline exists. The rationales behind the Relevant Guidelines may be summarised as follows:

(a) There does not appear to be expert evidence suggesting that there was any danger or risk inherent in the early discontinuation of an antidepressant in and of itself. However, the reason for the continuation of antidepressants for at least four to six weeks is to afford the doctor sufficient time to determine whether an antidepressant is truly effective or ineffective. The Relevant Guidelines further advised that caution is needed when switching from one antidepressant to another given the possibility of adverse drug interactions. This concern about adverse drug interactions due to switching does not appear to have been explored in the evidence, or by parties at the trial below, or on appeal, save to the limited extent that we touch on in this judgment.

(b) The reason why the concurrent prescribing of two or more benzodiazepines should be avoided, is because it could result in potential interactions occurring between drugs which might give rise to significant safety concerns, the foremost of which include central nervous system ("CNS") depression, increased risks of sedation, respiratory depression, or cardiovascular depression. It could also increase the likelihood of rare events such as Serotonin Syndrome,

Neuroleptic Malignant Syndrome, and benzodiazepine related respiratory depression.

(c) The reason why benzodiazepines should be limited to use for short-term relief, or be limited to intermittent use (when used for treating insomnia) is because the long term use of benzodiazepines has been widely recognised to produce physical and/or psychological dependence, and even give rise to abuse.

15 The reason why the concurrent use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration (if prescribed) is because their concurrent use may disproportionately increase the CNS depressant effects of the medications, and may "result in profound sedation, cardiorespiratory depression, hypotension, coma and death". This is highlighted in the package inserts and product monographs of opioids, benzodiazepines and Zolpidem.

16 As for the maximum dosages set out in the product inserts for Mirtazapine and Zolpidem CR, the product inserts themselves do not contain reasons for such limits. Therefore, much will depend on the available evidence as to the risks of exceeding these limits or of how consumption of these drugs at these levels might interact with other medication that the Patient had been prescribed. In this connection, the expert evidence does not say that dosages of Mirtazapine at 60mg or dosages of Zolpidem at 25mg were in themselves unsafe. And, some of the medical literature referred to suggests that doses higher than that found on the product inserts may be helpful to patients in certain cases.

17 The charges further aver that, having departed from these guidelines, Dr Ang had breached the applicable standard of conduct contained in Guideline 4.1.3 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines ("2002 ECEG"), which provides that doctors shall prescribe, dispense, or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. In essence, all the charges aver that the manner in which Dr Ang had prescribed medication, as outlined above, was inappropriate and unsupported by clear medical grounds.

The Decision Below

18 The DT acquitted Dr Ang of the three professional misconduct charges but convicted him of the three professional services charges.

The professional services charges

19 On the professional services charges, the DT noted that it was common ground between the parties that the Relevant Guidelines were "the compulsory starting point", and that any departure therefrom had to be made "on clear medical grounds". The DT also found that the parties were in agreement that whether there were clear medical grounds turned on whether Dr Ang had done the following:

(a) Conducted a risk-benefit analysis for departing from the Relevant Guidelines;

(b) Discussed the risks and benefits of the proposed treatment with the Patient; and

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

20 In accepting this formulation of "clear medical grounds", the DT referred to the following observations made by another Disciplinary Tribunal in its decision *In the Matter of Dr Foo Chee Boon Edward* [2018] SMCDT 14 ("*Edward Foo*") at [59]–[60]:

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

21 Additionally, the DT found further support for this formulation of "clear medical grounds" from the answers given in the course of the cross-examination of Dr Ng Beng Yong ("Dr BY Ng"), a practising psychiatrist called by Dr Ang as his expert witness:

> Q. […] would you confirm that all opinions you have given in your two expert reports and in this hearing are premised on the following, okay. First, that Dr Ang made a proper risk benefit

> analysis whenever giving the patient medication or a combination of medications, yes?
>
> A. Yes.
>
> Q. And your opinions are also premised on Dr Ang having discussed this course of action with the patient beforehand, yes?
>
> A. Yes.
>
> Q. And your opinions are all premised on Dr Ang obtaining the patient's agreement to this course of medications?
>
> A. […] Yes.
>
> **Q. Now if any one of these three points is missing, that Dr Ang didn't make a proper risk benefit analysis or he didn't discuss the course of action with his patient, or the patient didn't agree, then Dr Ang would not have acted responsibly or reasonably in giving the medication, right? Agree?**
>
> **A. Yes, I will agree, yah.**
>
> **Q. And certainly, he wouldn't have acted professionally if any one of these elements is missing, right? Making a risk benefit analysis, discussing it with the patient and obtaining the patient's agreement?**
>
> **A. Yah, I will agree.**
>
> [Emphasis in original]

22 Finally, the DT held that while the SMC bore the legal burden of proving the charges beyond a reasonable doubt, Dr Ang bore the evidential burden of demonstrating that he had clear medical grounds for departing from the Relevant Guidelines.

23 Applying these principles to the case before it, the DT found that Dr Ang had failed to discharge this burden. On the question of whether Dr Ang had undertaken a proper risk-benefit analysis, the DT rejected Dr Ang's assertions that he had used his "clinical judgment" in deciding to deviate from the Relevant Guidelines. In essence, the DT appeared to think that it was insufficient for Dr

Ang to fall back on his clinical judgment to justify his actions without explaining the reasons and considerations that were taken into account or the process by which he arrived at his conclusions. The DT took the view that these considerations should have been recorded in his clinical notes, so that any other doctor treating the patient would understand what he was doing for the Patient and on what basis. It agreed with Dr Daniel Shuen Sheng Fung ("**Dr Fung**"), the Chairman, Medical Board and Senior Consultant at the Institute of Mental Health who had been called as the SMC's expert witness, that the clinical notes did not reflect any such reasons, or demonstrate that Dr Ang had undertaken any risk-benefit analysis. This was not simply a matter of the inadequacy of documentation. Rather it reflected Dr Ang's failure to demonstrate that he had in fact addressed his mind to the risks and benefits of the proposed treatment, evaluated the risks and benefits and concluded that there were clear medical grounds for his decisions. This in effect meant that Dr Ang had prescribed the medications in a manner that departed from the Relevant Guidelines without in fact considering whether this was appropriate and justified.

24 The DT also found that because the clinical notes did not reflect that he had explained the risks of such deviations to the Patient, Dr Ang had not in fact done so. While his clinical notes stated that the Patient was aware that he was taking "a lot of medication", they did not record any reasons why this was necessary, or that any explanation had been provided to the Patient as to the risks and benefits. In many instances, Dr Ang's notes merely stated that medications were prescribed in response to the Patient's complaints and nothing more, suggesting that he had simply prescribed medication because the Patient desired this, rather than because Dr Ang thought it was needed. The DT's view was that Dr Ang's own evidence suggested that whatever his reasoning had been, this was "self-internalised" and not discussed with the Patient, and more specifically, that he had merely warned the Patient about the risks of exceeding

the prescribed dose of medication, rather than the risks of the potential interactions among the various drugs he had been prescribed, even if he took these in the prescribed amounts.

25 Finally, on the objective merits of Dr Ang's prescriptions, the DT concluded that even if the Patient had been "functioning well", Dr Ang was nonetheless subjecting the Patient to considerable risks in deviating from the Relevant Guidelines. Dr BY Ng too had acknowledged that taking benzodiazepines and opioid analgesics together posed a risk of death and as it turned out, this had eventuated. The DT also agreed with Dr Fung's opinion that Dr Ang's conduct was "clinically risky" and had exposed the Patient to "unnecessary risks" that came with taking multiple medications at high doses which could interact with one another".

26 The DT therefore concluded that Dr Ang's multiple breaches of the Relevant Guidelines constituted a wilful disregard thereof, such that he failed to meet the acceptable standards of clinical practice applicable to a psychiatrist. Accordingly, it convicted him of the three professional services charges. As these charges were framed under s 53(1)(*e*) of the MRA for failure to meet the applicable professional services standards, rather than under s 53(1)(*d*) for professional misconduct, the two-limb test set out in *Low Cze Hong* was not applicable to them.

The professional misconduct charges

27 On the professional misconduct charges, the DT accepted that not every departure from acceptable standards of conduct would amount to professional misconduct (*Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 ("*Lim Lian Arn*") at [30]–[34]). As alluded to above at [8], even if it is shown that a doctor has departed from standards applicable to him, a charge of

professional misconduct would only be made out if either of the two limbs of *Low Cze Hong* is established.

28 The DT accepted Dr Fung's opinion that Dr Ang had shown "care and concern" in helping the Patient, and had "attempted to meet the standard" expected of him. It was also common ground between the parties that there had been no malicious intent on Dr Ang's part in his treatment of the Patient. Given that the SMC had chosen to run its case on the professional misconduct charges under only the 1st Limb of *Low Cze Hong*, the DT therefore concluded that Dr Ang's conduct did not amount to a "intentional and deliberate departure" from the Relevant Guidelines, and acquitted Dr Ang of the professional misconduct charges.

Parties' cases on appeal

29 Both Dr Ang and the SMC have appealed against the DT's decision in OA 8 and OA 9 respectively.

The professional services charges

Dr Ang's case

30 Preliminarily, Dr Ang suggests that the operative standard under s 53(1)(*e*) of the MRA, against which a medical practitioner's conduct is to be assessed, are "elementary clinical standards which any doctor, especially one with the applicant's experience, should be familiar with" (*Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 ("*Yong Thiam Look Peter*")). He also argues that the pronouncement in *Lim Lian Arn* at [30], that not every departure from acceptable standards of conduct would necessarily amount to professional misconduct under s 53(1)(*d*) of the MRA, should also apply to a charge under s 53(1)(*e*) of the MRA. That said, his case is that his

prescriptions were all based on clear medical grounds, and that none of them gave rise to any breach of any standard which might have been applicable to him.

31 Dr Ang's argument is that his prescriptions were objectively justifiable on the specific facts of the Patient's case. At a broad level, he highlights Dr Fung's observations that the Patient's condition was "complex and difficult to manage", and argues that it had "evolved and become more complex in the course of the treatment" as a result of a "series of unfortunate events". This being the case, Dr Ang maintains that the standards set out in the Relevant Guidelines could not be applied because these would be relevant only to the usual or common cases and not to a complex case such as the one he was dealing with. Dr Ang also sought to justify the individual deviations from the Relevant Guidelines forming the subject of the charges. Specifically, he sought to justify: (a) the discontinuation of various antidepressants before the recommended four to six weeks (which we deal with at [94]–[95], [99]–[101], [104] below); (b) the concurrent prescription of benzodiazepines with opioid analgesics (which we deal with at [108] below); (c) the concurrent prescription of multiple benzodiazepines (which we deal with at [109] below); (d) the prescription of benzodiazepines beyond the limits of intermittent use and short-term relief (which we deal with at [119] and [123] below); and (e) the prescription of Mirtazapine and Zolpidem CR in excess of the maximum limits specified in the product insets (which we deal with at [137] below).

32 Dr Ang also highlights the various measures he implemented to manage the risks inherent in deviating from the Relevant Guidelines, such as inpatient monitoring, attempts at alternatives to pharmacological treatment, joint reviews and case conferences with the Patient's other doctors, and his plan to wean the Patient off his medication. He also points to Dr BY Ng's opinion that if there

had been any unwanted drug interaction or signs thereof, these would have occurred and been picked up during the Patient's stay in hospital, but the Patient's blood and liver function tests during his last admission showed that all parameters were within normal limits. Dr Ang argues that it was therefore not accurate to say, as the DT did, that the Patient was walking a "tightrope" under his management, and at risk of falling off at any time. He submits that in coming to its decision on the appropriateness of his clinical management of the Patient, the DT failed to accord sufficient weight to the complexity and evolving nature of the Patient's case, engage with Dr Ang's justifications for the individual deviations, or consider the risk management measures that he implemented.

33 Next, Dr Ang contends that the DT erred in finding that he had not engaged in a risk-benefit analysis, because it had incorrectly focused primarily on what was documented in the medical records even though the inadequacy of documentation was not an element of the charges. He submits that even if he had not documented the risk-benefit analysis or explained it to the Patient, this did not mean that he had not undertaken such an analysis or implemented the proper risk management measures. His position is that the DT should have instead considered the risk management measures that he did carry out, his explanations of the Patient's condition from a diagnostic and/or symptomatic viewpoint, his documented plans to wean the Patient off his medications when possible, and the Patient's positive response to the prescribed regime of medication. He submits that, if the DT had considered all of these points, it would have been evident that he had appreciated and considered the risks and benefits of his prescription regime.

34 Dr Ang also submits that the DT was incorrect to find that he had not explained the risks of his prescription regime to the Patient and therefore did not obtain his informed consent. Dr Ang maintains that the DT erred because it

had again placed undue emphasis on the fact that such explanations were not documented in Dr Ang's clinical notes. He contends that there was no reason for the DT to reject his evidence that he had explained the risks and benefits of the prescribed medications to the Patient, which according to Dr BY Ng would be the usual practice for a psychiatric specialist.

35 Finally, Dr Ang submits that since departures from the Relevant Guidelines are permissible if justifiable from a risk-benefit perspective, the SMC had to establish that his prescription regime was not made on clear medical grounds in order to prove the charges beyond a reasonable doubt. Dr Ang argues that, in this case, this would require the SMC to prove that:

(a) The Patient's condition was *not* of the severity or complexity to justify deviation from the Relevant Guidelines;

(b) The risks of each deviation outweighed its benefits such that the prescription regime was *not* appropriate to the Patient's needs;

(c) Dr Ang did *not* exercise proper clinical judgment or engage in the proper risk-benefit analysis, and failed to implement any risk management measures.

36 Drawing on these arguments, Dr Ang says the evidence is clear that the Patient's case was complex and difficult. He also submits that the SMC failed to establish that the risks of each deviation from the Relevant Guidelines outweighed its benefits, or that Dr Ang did not exercise his clinical judgment or engage in a risk-benefit analysis in respect of each. He therefore submits that the SMC had not discharged its burden of proving the professional services charges.

The SMC's case

37 The SMC maintains that the DT was correct in convicting Dr Ang on the professional services charges. On the appropriate standard of conduct, the SMC reiterates its position that the Relevant Guidelines represented codifications of the standards "observed or adopted" by the medical profession (*In the Matter of Dr Eric Chong Yu and Dr Kong Kok Leong* [2012] SMCDC 10 ("*Eric Chong*") at [66]), and so form the mandatory starting point for all doctors. Any departure therefrom had to be justified on clear medical grounds, and as accepted by the DT, this required Dr Ang to conduct a risk-benefit analysis, discuss this analysis with the Patient, and obtain the Patient's informed consent.

38 On the burden of proof, the SMC argues that once it has established that a doctor's treatment is not "generally accepted by the profession", the evidential burden shifts to the doctor to justify his departures therefrom by demonstrating clear medical grounds for doing so. The SMC was *not* required to prove that any particular departure was in fact unsafe for the patient (*Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 ("*Gobinathan*") at [62]; *Huang Danmin v Traditional Chinese Medicine Practitioners Board* [2010] 3 SLR 1108 ("*Huang Danmin*") at [48]).

39 The SMC's position is that Dr Ang failed to discharge his evidential burden. The crux of its argument is that Dr Ang did not explain each of his deviations from the Relevant Guidelines or document any "benefits versus risks analysis" in his clinical notes. The SMC also maintains on the evidence that Dr Ang did not advise the Patient of the risks that were inherent in deviating from the Relevant Guidelines.

40 In relation to the first and second professional services charges, SMC points out that Dr Ang's clinical notes do not explicitly reflect his reasons for deviating from the Relevant Guidelines, and also challenges the various "belated" justifications which Dr Ang offered in respect of individual prescriptions. For instance, where Dr Ang claims that the Patient had chronic insomnia which needed the medication that Dr Aug prescribed, the SMC characterises this as an attempt to "hype up" the Patient's condition, and suggests that Dr Ang should instead have attempted cognitive behavioural therapy and should actively have monitored the Patient's long-term benzodiazepine use to address the risk of tolerance and psychological dependence.

41 In connection with the third professional services charge, the SMC highlights the apparent inconsistency between Dr Ang's claim that the Patient had reported "good results and no side effects" in respect of the previous medication, and his decision to increase the dosages of Mirtazapine and Zolpidem CR by doubling this to a level that was well above the permitted maximum dosage. It similarly juxtaposes Dr Ang's claim to have "carefully and judiciously titrated" the dosages of Mirtazapine and Zolpidem CR, with the fact that he only ever adjusted their dosages once and on that occasion, he doubled the dose for no apparent reason. The SMC points out that Dr Ang did not see the Patient on 19 out of the 30 days of the Patient's final admission to MEHN. This, the SMC argues, undercuts his claim to have monitored the Patient for any negative side effects which may have arisen from the increased dosages of Mirtazapine and Zolpidem CR, and reduces the force of his assertion that there were no negative or adverse side effects reported. Finally, the SMC argues that even if Dr Ang had been monitoring the Patient, this would not have obviated or lowered the risks inherent in deviating from the Relevant Guidelines.

42 The SMC further argues that the Patient did not present as complicated a case as Dr Ang had claimed. It points out that during the Civil Proceedings, Dr Ang had testified that the Patient "was not a psychiatric case" and "was just suffering from stress related reactive depression", and that the Patient's stressor was "predominantly his chronic lower back pain" to which his mental conditions were secondary. In any case, even if this was a complex case, the SMC argues that this would not automatically justify deviation from the Relevant Guidelines, or relieve him of his onus to demonstrate that he had clear medical grounds for doing so.

The professional misconduct charges

The SMC's case

43 On the professional misconduct charges, the SMC's position is that the DT erred in acquitting Dr Ang of the professional misconduct charges. It argues that the relevant test is whether there was an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency. Crucially, it argues that an intentional and deliberate departure will be found so long as a doctor knows what the applicable standard of conduct is and chooses nonetheless not to comply with it (*Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Jen Shek Wei*") at [141]).

44 In this connection, the DT had found that Dr Ang had departed from the Relevant Guidelines, despite being fully aware of what they required. According to the SMC, it followed that in the absence of any justification, Dr Ang's deviation from the Relevant Guidelines would have been intentional and deliberate, thus satisfying the three-stage inquiry under the 1st Limb of *Low Cze Hong* (see at [50(a)] below). The SMC submits that the absence of malice is an irrelevant factor, and that the DT erred in concluding that the professional

misconduct charges were not made out simply because it found there was no malice or bad faith. It also argues that Dr Ang could not have shown "care and concern" to the Patient, given that his conduct was clinically risky.

Dr Ang's case

45 Dr Ang's case on the professional misconduct charges is that the DT was correct to find that they were not made out. In support of this, he makes three broad points.

46 First, Dr Ang argues that the SMC has mischaracterised the DT's decision because the finding of an absence of malicious intent was not in fact determinative in the DT's decision to acquit him of the professional misconduct charges. This was simply a response to the SMC's allegations that Dr Ang had been motivated by financial gains, which could have been relevant to the question of professional misconduct. Its decision to acquit Dr Ang had instead been made on the basis of Dr Fung's opinion that Dr Ang had undertaken appropriate risk management measures and attempted to meet the standard expected of him.

47 Second, Dr Ang submits that while the Relevant Guidelines may be the applicable standard for general practitioners, they do not invariably represent the applicable standard of care for a psychiatric specialist. He argues that this distinction is implicit in their express indication that they are "not intended to serve as a standard of medical care…nor should they be construed as including all proper methods of care or excluding other acceptable methods of care", and their recommendation to refer patients to specialists should the standard treatment regime set out therein prove inefficacious. Dr Ang submits that this is also consistent with the fact that precedents that have treated the Relevant Guidelines as the applicable standard of conduct have involved general

practitioners ("GPs") rather than specialists. Further, cases involving inappropriate prescriptions of benzodiazepines by GPs commonly also involve charges for failure to refer the patient to an appropriate specialist.

48 Finally, Dr Ang stresses that both Dr Fung and Dr BY Ng agreed that this was a difficult and complex case, that deviations from the Relevant Guidelines could be a reasonable course of action in certain situations, and that doing so would be permissible so long as adequate risk management measures are put in place. His implementation of such measures was a crucial fact which the DT rightly considered in acquitting him of the professional misconduct charges, and was a key factor distinguishing his case from precedents involving doctors who had been convicted of the inappropriate prescription of medication.

Issues before this court

49 The following issues arise for our determination:

(a) What are the elements of each of the professional misconduct charges and of the professional services charges and how are these elements different?

(b) What is the relevant standard of care that applies in relation to each of the professional misconduct charges and the professional services charges?

(c) Insofar as it is common ground that the prescriptions were all not in accordance with the Relevant Guidelines in the case of the first two pairs of charges, and with the product inserts in the case of the third pair of charges, who bears the burden of proving that the deviations were or were not justified, and what does proving this entail?

(d) Are each of the professional misconduct charges and/or each of the professional services charges made out?

The elements of the charges

s 53(1)(d) of the MRA

50 As held in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San*") at [39] and affirmed in *Lim Lian Arn* at [29], for a charge of professional misconduct under s 53(1)(*d*) of the MRA to be made out, either of the following sets of findings must be made:

(a) In relation to the 1st limb of *Low Cze Hong*:

(i) what the applicable standard of conduct was among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct related to;

(ii) whether the applicable standard of conduct required the doctor to do something and, if so, at what point in time such duty crystallised; and

(iii) whether the doctor's conduct constituted an intentional and deliberate departure from the applicable standard of conduct without due cause.

(b) In relation to the 2nd limb of *Low Cze Hong*:

(i) whether there was serious negligence on the part of the doctor; and

(ii) whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

51 As noted above at [9], the SMC chose to run its case on the 1st limb of *Low Cze Hong*, and the professional misconduct charges are framed accordingly. Moreover, as we shall discuss below, there is no serious dispute as to what the applicable standard of conduct was in relation to the prescriptions that Dr Ang issued to the Patient. The key question in the present case is therefore whether Dr Ang's departures were deliberate and intentional within the meaning of the 1st limb of *Low Cze Hong*. This element will be satisfied where it is shown that "a doctor knows of the applicable standard of conduct but chooses not to comply with it" (*Jen Shek Wei* at [141]). The SMC is thus correct that the absence of malicious intent or financial motive is not determinative against a finding of professional misconduct. Further, contrary to Dr Ang's suggestion, that a doctor might have shown "care and concern" for a patient does not itself necessarily mean that a departure from the applicable standard of conduct cannot be considered intentional and deliberate. Such "care and concern" is not relevant to this inquiry. A doctor may intentionally and deliberately choose to depart from acceptable standards of conduct for many reasons, such as out of "care and concern" for a patient. This does not change the doctor's intention. All that is required to be shown is that the doctor was conscious of that standard and decided to depart from it without due cause (*Singapore Medical Council v Looi Kok Poh and another matter* [2019] 5 SLR 456 ("*Looi Kok Poh*") at [45(c)]). Of course, care and concern, and more generally a sense of professionalism, may prompt a doctor to search for solutions and this may lead to a departure from the standards on justifiable grounds. In such a case, there may be no breach of the standards, not because the doctor acted out of care and concern, but because there were justifiable grounds for the departure from the generally applicable standard.

s 53(1)(e) of the MRA

52 As for liability under s 53(1)(*e*) of the MRA, this court held in *Ho Tze Woon v Singapore Medical Council* [2023] SGHC 254 ("*Ho Tze Woon*") at [37] that the test is "best articulated using the words of the MRA itself". Hence, the question is whether a medical practitioner has failed to provide professional services of the quality which it is reasonable to expect of him. It goes without saying that one of the qualities which may reasonably be expected of the professional services rendered by a medical practitioner is adherence to generally accepted standards of care.

53 However, we pause briefly to deal with Dr Ang's attempt to advance a more stringent test for liability under s 53(1)(*e*) of the MRA, according to which the medical practitioner must be shown to have breached a "minimum or elementary" standard, and that such conduct must pass a certain threshold of seriousness. As noted above at [30], his argument is predicated on the court's reference in *Yong Thiam Look Peter* to "elementary clinical standards", and the statement of this court in *Lim Lian Arn* that a conviction for professional misconduct requires "serious disregard of or persistent failure" to meet the standards of conduct applicable to the medical practitioner.

54 First, this court rejected almost identical arguments in *Ho Tze Woon*. It noted that the reference to "elementary standards" in *Yong Thiam Look Peter* was simply an observation made in respect of the specific facts of that case, and was not intended to suggest any additional requirement or threshold beyond the plain wording of s 53(1)(*e*) of the MRA (*Ho Tze Woon* at [32], [36]). As for *Lim Lian Arn*, that case involved a one-off incident, and concerned charges of professional *misconduct*, which are "quite different from a charge which simply involves a failure to provide professional services of a reasonably expected

quality" (*Ho Tze Woon* at [33]). The facts of *Ho Tze Woon* show that even a one-off breach, of lesser severity than necessary to make out a charge of professional misconduct under s 53(1)(*d*), may nonetheless attract liability under s 53(1)(*e*). In fairness to Dr Ang, *Ho Tze Woon* was published slightly over a month *after* his written submissions were filed. However, it forecloses his argument for a higher threshold for liability to arise under s 53(1)(*e*). And in our judgment, this is entirely appropriate because there is no reason to **wholly** exonerate a failure by a medical practitioner to meet reasonable standards of quality in relation to professional services, simply because that failure might have been of a lower degree of severity. Where the departure from reasonable standards is of a less severe nature, it is conceivable that the matter may instead be dealt with at the various stages of the disciplinary process before the matter reaches the DT or the court, or it might also be reflected in the type of sanctions that are imposed.

The relevant standard of care in relation to each of the charges

55 We next consider the standards of care relevant to the prescriptions which Dr Ang issued to the Patient. In the usual case, to make out a charge of professional misconduct under the MRA, the SMC would have to prove what the applicable standard of conduct was, and that the medical practitioner's conduct constituted an intentional and deliberate departure therefrom (*Low Cze Hong* at [37]). As for the alternative charges under s 53(1)(*e*) of the MRA, the SMC would typically have to undertake "an objective assessment of standards of medical care which can be reasonably expected of medical practitioners" (*Yong Thiam Look Peter* at [11]). The medical practitioner's conduct in the case at hand is then assessed against these yardsticks. Given that a disciplinary proceeding is quasi-criminal in nature, it is for the SMC to establish these

elements beyond a reasonable doubt (*Wee Teong Boo v Singapore Medical Council (Attorney-General, intervener)* [2023] 3 SLR 705 at [41]).

56 To the extent that a MOH guideline sets out a particular and relevant standard of care, the SMC may be taken as having discharged its burden of establishing that standard, and the medical practitioner's conduct is then to be assessed against it. This is because such MOH guidelines represent "codifications of the standards 'observed or adopted' by the medical profession" (*Eric Chong* at [66]), and are based on the "best available evidence at the time of development". Accordingly, under the standard of care applicable to the first and second professional misconduct charges and the corresponding alternate charges, Dr Ang ought to have continued all antidepressants for at least four weeks before switching to another, avoided the concurrent prescription of two or more benzodiazepines, and limited the Patient to intermittent and short-term use of benzodiazepines. As set out above at [12], these standards are codified in Guideline 4.2 of the 2004 CPG (Depression), paragraph (i) of the 2008 Admin Guidelines (Benzodiazepines), paragraph (f) of the 2008 Admin Guidelines (Benzodiazepines), and Guideline 5.1.1 of 2008 CPG (Benzodiazepines).

57 As for the concurrent prescription of benzodiazepines with opioid analgesics, we note that the charges as framed by the SMC do not locate this prohibition in the Relevant Guidelines. Rather, the SMC relies on package inserts and product monographs of opioids, benzodiazepines, and zolpidem, all of which recommend that the concurrent use of benzodiazepines and opioid analgesics should be avoided or limited to the minimum dosage and duration if prescribed. It also relies on the general agreement of Mr Ng Boon Tat, Dr Fung, and Dr BY Ng, that the concurrent prescription of benzodiazepines and opioid analgesics ought to be avoided. This being the case, we accept that the prohibition against the concurrent prescription of benzodiazepines and opioid

analgesics formed part of the standard of conduct applicable to Dr Ang, with which his treatment of the Patient was inconsistent.

58 In a similar vein, we accept that the maximum dosages of Mirtazapine and Zolpidem CR as set out in their package inserts, of 45mg and 12.5mg per day respectively, constitute the standard of conduct applicable to prescriptions of these two medications underlying the third professional misconduct charge and the corresponding alternate charge. As stated by Mr Ng Boon Tat in his expert report, regulatory approval for all therapeutic products, along with their manufacturer's product labels and package inserts, is granted by the Health Sciences Authority ("HSA") on the basis of an evaluation of, among other things, the products' recommended dosing regimens and recommended maximum dosages. In other words, regulatory approval for local use of both medicines is predicated on a presumption of at least general adherence to the maximum dosages set out in their package inserts. These maximum dosages thus likewise form the applicable standard of conduct governing prescriptions of these medicines, by which Dr Ang would have been expected to abide.

59 However, this is not to say that a medical practitioner can *never* deviate from the standards codified in MOH guidelines. Such guidelines do not have the same force as legislation (*Eric Chong* at [66]), and the Statements of Intent of both the 2004 CPG (Depression) and the 2008 CPG (Benzodiazepines) also clarify that they are not meant to be mandatory and that the relevant standard of care is instead "determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge advances and patterns of care evolve". It thus follows that, while MOH guidelines set out a presumptive or baseline standard of care, departures therefrom may be permissible in individual cases if they are justified or supported by good reasons (*In the Matter of Dr Tan Yang Khai* [2012] SMCDC 11 ("*Dr Tan Yang Khai*")

at [7]; *In the Matter of Dr ABJ* [2010] SMCDC 7 ("*Dr ABJ*") at [15]). The same applies to the standards derived from the package inserts and product monographs of the different medicines prescribed.

60 Crucially, the evidential burden falls upon the medical practitioner to demonstrate that the deviation from codified standards is justified or supported by good reasons (*Dr Tan Yang Khai* at [7]; *Dr ABJ* at [15]; *Gobinathan* at [61]; *Huang Danmin* at [48]). Hence, once it is proven that a treatment is not indicated for a condition, or a stipulation in a product insert has been departed from, the evidential burden shifts to the defending medical practitioner to negative an assumption of inappropriate treatment (*Gobinathan* at [62]) or otherwise to justify such a departure (*Edward Foo* at [60]). Contrary to Dr Ang's arguments outlined above at [35], the SMC need not go further to show that each deviation was unjustified, that the risks outweighed the benefits, or that the medical practitioner did not exercise proper clinical judgment. The burden instead lies on Dr Ang to show the converse. This is in line with the observations of this court in *Gobinathan* at [62], that this strikes the correct balance between protecting the well-being of the patient from practices which are known to carry a high level of risk, and affording medical practitioners the flexibility to innovate and tailor their treatment to the specific needs and challenges of each case with which they are confronted.

61 We also briefly address Dr Ang's submission that there might be some difference in the degree to which the Relevant Guidelines are binding upon psychiatric specialists as opposed to general practitioners, and that the standard applicable to the former ought somehow to be "more nuanced than the blanket position adopted by the SMC". Dr Ang points to the Guidelines' directive that patients who require or have been prescribed benzodiazepines ought not be given further prescriptions and must instead be referred to a specialist for further

management, and suggests this implicitly gives specialists more leeway to depart from the guidelines which general practitioners do not enjoy.

62 We disagree. The Relevant Guidelines themselves make clear that they are "intended to apply to *all* doctors" [emphasis added], that "all medical practitioners are to comply", and make no distinction between general practitioners and psychiatric specialists. As Dr Ang himself conceded in his testimony before the DT, the Relevant Guidelines remain applicable even where specialists are concerned. Indeed, it is telling that, in connection with the directive to refer patients who have been prescribed benzodiazepines beyond a cumulative period of eight weeks to a psychiatric specialist, the 2008 Admin Guidelines (Benzodiazepines) define an "appropriate specialist" as a "SMC-registered specialist (eg. psychiatrist, …)" who has the necessary competence to *treat the underlying condition that resulted in the patient's persistent use of benzodiazepines*" [emphasis added], thus placing the emphasis on addressing the root cause of dependence on this type of medication rather than simply leaving it to any specialist to *continue* the prescription of benzodiazepines beyond eight weeks. We emphasise that this does *not* mean that specialists can *never* depart from the standards set out in MOH guidelines, indications, or package inserts. On the other hand, they also do not have free reign to disregard the standards set out therein by virtue of their standing as specialists, and remain under an obligation to justify any departures therefrom. One would expect that by virtue of their particular expertise, a specialist would be better placed to assess whether a departure may be justified; but it remains incumbent on them to make this assessment and to explain it.

The burden of proving or justifying departures from the applicable standard of care

63 Once it is shown that a medical practitioner has departed from the standards of care applicable to them, the evidential burden falls upon him or her to show that such departure was justified or supported by good reasons, failing which he or she may be subject to liability under s 53(1)(*e*) of the MRA, as well as s 53(1)(*d*) if the departure or departures in question are found to be intentional and deliberate (1st Limb), or an abuse of the privileges of registration as a medical practitioner (2nd Limb).

64 The question then arises as to how this burden is to be discharged, and what must be shown for this purpose. In this regard, the DT held that it was common ground between the parties that it was for Dr Ang to demonstrate clear medical grounds for his departures, which in turn revolved around whether he had done the following:

(a) Conducted a risk-benefit analysis of each prospective departure from the Relevant Guidelines;

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

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

We have some difficulties with this. The test articulated by the DT focuses on whether a doctor *subjectively* conducted a risk-benefit analysis as he saw it, whether the patient was advised of the risks, and whether the informed consent of the patient was obtained. It does not entail any consideration of the *objective* reasonableness or merits of the treatment in question in the circumstances of the specific case. In our view, the appropriate test combines both these elements. We explain.

65 In assessing whether a departure from applicable standards is justified, the point of reference must necessarily be the rationale behind the relevant standard of conduct in question, or to put it another way, the reason why the standard exists. Take as an example the 2008 Admin Guidelines (Benzodiazepines), which provides that the concurrent prescription of two or more benzodiazepines should be avoided (at [12] above). The reason behind this directive, as borne out in the expert evidence, is the real concern that the concurrent prescription of multiple benzodiazepines could lead to potential drug interactions occurring which might give rise to significant health concerns, with the foremost of these being CNS depression, increased risks of sedation, respiratory depression, or cardiovascular depression. This is the harm which the 2008 Admin Guidelines (Benzodiazepines) seeks to avoid. Therefore, a medical practitioner who wishes to depart from the guidelines must keep *this* danger in mind and assess whether his or her departure from the guideline is nonetheless warranted and appropriate in the circumstances. The medical practitioner's conduct in departing from the guidelines might be justifiable if, for instance, the risk of such interaction is non-existent (based on the particular prescription), or if the benefits of the treatment clearly outweigh the dangers associated with such a prescription. However, it would be very difficult for a medical practitioner to justify a departure from the relevant guidelines, if to begin with, he did not consider why the guidelines exist, and what the relevant danger is.

66 However, for a medical practitioner to justify departing from relevant standards of conduct, beyond considering the rationale behind that standard and conducting a risk-benefit analysis of each prospective departure in the light of that rationale, it would be essential to demonstrate that he or she had then come to *an objectively defensible conclusion* that the departure was justified in the circumstances.

67 We recognise that individual guidelines (such as MOH guidelines and product inserts) themselves may not always contain the rationales that underlie a given guideline. In such cases, a medical practitioner who contemplates departing from it must take reasonable steps to discover what the underlying concern is. Otherwise, there is a real danger that any deviation may give rise to the precise risk that was meant to be avoided.

68 However, the point we emphasise is that in addition to the need for a medical practitioner to be aware of the reasons behind the applicable standards of conduct, and to come to a reasoned conclusion that a departure was justified in the circumstances, it is equally important that the medical practitioner's conduct be seen as objectively justifiable in the circumstances. A medical practitioner could very well have understood the standards of conduct, and still reached an ill-conceived conclusion that it was appropriate for him to depart from such standards in the circumstances. For instance, if the medical evidence suggested that the decision to depart from an applicable guideline in a given case was not justified in the circumstances, the medical practitioner's conduct would be unjustifiable even if, for some ill-conceived reason, he or she subjectively thought it was appropriate. The court's assessment of the objective reasonableness of a medical practitioner's conduct will depend on the expert evidence that is available, and this is not affected by the fact that the medical practitioner may in fact have thought about the issues.

69 The need for such an objective assessment is grounded in precedent. In *Gobinathan*, the appellant had been convicted by the Disciplinary Committee ("DC") of professional misconduct for administering Therapeutic Ultrasound on a patient, which he knew or ought to have known was not generally accepted by the medical profession as appropriate for the patient's condition (at [6]). As the Court of Three Judges ("C3J") observed at [62]:

> … where the charge is for inappropriate treatment because that treatment is not indicated for that condition and not generally accepted by the profession, then the evidential burden is on the defending doctor to prove that **safety of the patient** is a reason to negative an assumption of inappropriate treatment.
>
> [emphasis in original removed, emphasis added in bold]

70 In *Ho Tze Woon*, the C3J had to assess whether the appellant's conduct in failing to reposition the patient from a seated position to a supine position before performing cardiopulmonary resuscitation ("CPR") constituted a failure to provide professional services of the quality which was reasonable to expect of him. In deciding that the appellant had failed to provide the appropriate standard of services because medical practitioners were reasonably expected to first reposition a patient in a supine position before performing CPR (if possible), the C3J made two findings. First, "there was a consensus between the experts that effective CPR requires the patient to be lying flat on his back on a firm surface" (at [40]). Second, in the Basic Cardiac Life Support course where CPR was taught, it was explicitly stated that "for CPR to be effective, the patient must be lying on his or her back on a firm, flat surface" (at [45]). The C3J was of the view that it would "be clear to anyone, more so a medical practitioner, who had attended and passed the BCLS course that it is important to place the patient in a supine position on a firm, flat surface for CPR to be effective" (at [45]).

71 This also finds support in Guideline 4.1.3 of the 2002 ECEG, which reads as follows:

> … A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. This includes prescription by a doctor for his own use. Patients shall be appropriately

> informed about the purpose of the prescribed medicines, contraindications and possible side effects.

72 This extract from the 2002 ECEG makes it clear that a doctor is under a duty to prescribe, dispense or supply medicines only in certain specified circumstances and these depend upon the existence of "clear medical grounds" and on whether medication quantities are "reasonable" and "appropriate to a patient's needs". These are questions to be answered by an objective assessment of each specific case. This is consistent with the only other usage of the phrase "medical grounds" in the 2002 ECEG, which concerns the issuance of medical certificates:

> The issuance of a medical certificate by a doctor carries with it the responsibility to ensure that the patient deserves it on proper medical grounds and that such grounds have been arrived at through good clinical assessment as detailed above.

73 This likewise adopts an understanding of "medical grounds" as referring to the *objective* circumstances of a patient's case, which justify a particular course of action or renders the patient "deserving" thereof.

74 As the DT's holding was that it was common ground between the parties as to what "clear medical grounds" meant, the formulation it applied (at [64] above) did not incorporate this objective element. Nonetheless, both parties placed considerable emphasis on objective factual questions, such as how risky Dr Ang's deviations were, whether and to what extent the risk management measures he implemented attenuated those risks, and whether those risks were justified in light of the Patient's objective condition and history at the material times. In OA 8, Dr Ang emphasises the DT's failure to consider the complexity and evolving nature of the Patient's case, the risk management measures he had implemented, whether the risks of his prescriptions outweighed their benefits, and the improvement in the Patient's overall condition. And the SMC's case in

OA 8 places great emphasis on Dr Ang's failure to explain his reasons for the various deviations, because without such explanation, it would be difficult to understand how the various departures could be seen to be justifiable.

75 It follows that a medical practitioner's deviation from the applicable standards of conduct can only be justified, in addition to the elements considered by the DT and summarised at [64] above, if it was objectively warranted in the circumstances of the patient's case. In keeping with the test for medical negligence set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, supplemented in *Bolitho v City and Hackney Health Authority* [1998] AC 232, and endorsed locally in *Khoo James and another v Gunapathy d/o Muniandy and another appeal* [2002] 1 SLR(R) 1024 ("*Gunapathy*"), this turns on whether the deviation is supported by a responsible body of medical opinion which satisfies a threshold test of logic (*Gunapathy* at [63]). This threshold test of logic in turn entails a two-stage inquiry, which first considers whether the doctor directed their mind to the comparative risks and benefits relating to the matter, and second, whether the conclusion is objectively defensible, in that it is internally consistent on its face and does not fly in the face of proven medical facts or advances in medical knowledge (*Gunapathy* at [64]–[65]). As we have noted above at [60], the burden of demonstrating this lies on the medical practitioner.

76 Finally, there is one other element of the test applied by the DT that needs to be refined. As framed at [64] above, it suggests that in every case, to justify any departure from the applicable guidelines, it would be essential for the medical practitioner to show that he or she had discussed with and obtained the consent of the patient to the intended departure. We are considering there, not the general duty to obtain informed consent, which is a separate, self-standing obligation, and which Dr Ang has not been charged with breaching,

but rather, the distinct question of when this requirement must be met in order to justify a departure from the applicable guidelines. In our judgment, even if the medical practitioner is able to show that he considered the MOH guidelines or the limits in the product inserts and their rationales, and that the departure was objectively justifiable on the evidence, yet, in some situations, doing so will only be considered appropriate if the medical practitioner also shows that he had advised the patient of the fact of the departure and the risks inherent therein, and the patient gives his informed consent. We take this view because the limits contained in the applicable guidelines or product insert will in many cases be rooted in safety concerns of one type or another. As we have noted, the MOH guidelines represent "codifications of the standards 'observed or adopted' by the medical profession" (*Eric Chong* at [66]), and are based on the "best available evidence at the time of development". Similarly, regulatory approval for local use of medication is granted by the HSA on the basis of an evaluation of the products' recommended dosing regimens and recommended maximum dosages contained in their product inserts. A departure from applicable guidelines of this sort may be expected to carry with it certain risks. Even if the risk is objectively justifiable in the specific case, there is a chance that the risk may materialise and that some harm may befall the patient. Where the possibility of harm is sufficiently high and the potential consequences are of sufficient severity, it cannot be appropriate to subject the patient to the risk unless he knowingly consents to it. Additionally, proper risk management will almost invariably require that the Patient is made aware of the risks and dangers associated with the treatment in question, so as to enable him to minimise the likelihood that the harm in question would eventuate, and recognise and deal with it if it does.

77 This also finds support in the part of the 2002 ECEG that deals with the standards of good medical practice, and which provides the following guidelines in relation to the prescription of medicine:

> **4.1 STANDARD OF GOOD MEDICAL PRACTICE**
>
> **…**
>
> 4.1.3 Prescription of medicine
>
> A doctor may only prescribe medicines that are legally available in Singapore and must comply with all the statutory requirements governing their use.
>
> A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. This includes prescription by a doctor for his own use. ***Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects.***
>
> A doctor shall prescribe medicines only following an adequate personal consultation and relevant investigations. A decision to prescribe solely based on information provided by telephone or any electronic means is allowable for continuing care, or for exceptional situations where a patient's best interests are being served by doing so.
>
> [Emphasis in bold and italics added]

78 When prescribing medicines, the medical practitioner has an obligation to appropriately inform patients about the medicines that are prescribed. In cases where a prescription deviates from MOH guidelines or the limits found in the product inserts, this duty to inform would extend to the fact that the prescription is a departure from such standards, the rationale behind the standard, the risks inherent in departing from it, and the countervailing needs or benefits which the medical practitioner believes outweighs those risks and makes the prescription justified in the specific case.

79 This requirement to inform the patient that a prescription departs from MOH guidelines, or the limits found in product inserts, and to obtain the

patient's consent to that course is, as we have noted, distinct from the wider doctrine of informed consent. The general duty to obtain informed consent is found in a different part of the 2002 ECGC, which deals with a medical practitioner's relationships with his or her patients:

> **4.2 RELATIONSHIPS WITH PATIENTS**
>
> 4.2.2 Informed consent
>
> ***It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment.*** If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him. If the patient is a minor, or of diminished ability to give consent, this information shall be explained to his parent, guardian or person responsible for him for the purpose of his consent on behalf of the patient.
>
> [Emphasis in bold and italics added]

80 The wider doctrine of informed consent "is guided by the important concept of patient autonomy" and "seeks to ensure that patients give their considered consent to any medical test or treatment" (*Yong Thiam Look* at [9]). The patients must "have been given enough information to enable them to meaningfully participate in decisions about the care that they may receive from medical practitioners" (*Yong Thiam Look* at [9]). It reflects the principle that it is "not [the doctor's] role to decide, but to inform", so that the patient would have the "right to choose" (*Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356 at [86]).

81 This is distinct from the obligation that we have set out for a medical practitioner to inform a patient that a prescription departs from MOH guidelines, or the limits found in product inserts, and to obtain the patient's consent to proceed. The latter obligation is narrower, and it arises because the medical practitioner's proposed departure from the relevant guidelines or other codified

standards of conduct, is likely to expose the patient to the particular risks or harms that the relevant guidelines were meant to prevent (or minimise). In our judgment, in certain circumstances, it would not be reasonable for the medical practitioner to do so without informing the patient of this fact and obtaining the patient's agreement. This is especially important because the safety concerns and risk management measures would surely require the patient to be apprised of the risks and what the patient may do to mitigate those risks.

82 However, where the risk inherent in the departure was minimal, the nature and extent of the potential harm was low, the departure was objectively justifiable, and the appropriate risk-benefit analysis was carried out, we do not think that a conviction can be sustained solely on a doctor's failure to inform the patient of that risk. Ultimately, whether justifying a departure from codified guidelines requires proof that the patient was informed of the fact and risks of that departure, must turn on the probability of the risk and the magnitude of the harm which the patient would suffer if that risk were to materialise. In this connection, we find that the principles laid down in *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] 2 SLR 492 ("*Hii Chii Kok*") in relation to breaches of duty in the context of patient advice, are applicable in the present context. In *Hii Chii Kok*, the Court of Appeal held that the standard of care owed by a doctor to his patient requires that he advise the patient in question of all matters to which the patient was reasonably likely to have attached significance in arriving at his decision as to whether to consent to a particular course of treatment, or matters on which, the doctor in fact knew or had reason to believe, the patient in question would have placed particular emphasis (at [137]). In our view, the same test governs whether a departure from codified standards of care carries a sufficient degree of risk, that the appropriateness of that departure must turn in part on whether the patient has been advised on the associated risks. Thus, justifying a departure from codified standards of care requires proving

that the patient was informed of the fact and risks of the departure, *where these would be considered material from the patient's perspective*. This may be a fact-sensitive inquiry, in that what makes a risk sufficiently material to a reasonable patient will vary along the dimensions of likelihood and severity (see *Hii Chii Kok* at [140]). The more severe the risk inherent in a departure or the more likely it is that the risk will materialise, the more likely the patient will need to be informed. Naturally, where a treatment or practice has been found to warrant the promulgation of a specific guideline regulating it, it will not be unusual for the analysis of the inherent risks to be such that justifying a departure from that guideline will require proof that the patient was informed of the departure and the associated risks. However, this will remain a fact-sensitive inquiry to determine whether disclosure is required to justify the departure from applicable guidelines.

83 As a practical matter, this means in the present case, that even though SMC did not frame the charges against Dr Ang in terms that he had not obtained the Patient's informed consent to proceed with the prescriptions as he did, the fact that SMC brought charges against Dr Ang for inappropriate prescriptions because these departed from the Relevant Guidelines and the product inserts would be sufficient to encompass this inquiry, in those instances where the duty to inform and explain and secure the patient's consent is engaged.

84 To summarise, the relevant principles (as set out in [63]–[83] above) are as follows. A medical practitioner can justify his departures from the applicable standards of care (for example departures from MOH guidelines or product inserts), if:

(a) he has considered the rationale behind that standard and concluded after a risk-benefit analysis of a prospective departure from it that it is justified;

(b) the medical practitioner's conduct is objectively defensible in the circumstances, as determined with reference to the prevailing test for medical negligence; and

(c) at least in certain circumstances, the medical practitioner has first discussed a prospective departure with the patient including any safety measures, and the patient must have consented to such a departure.

Once the departure is established, the evidential burden will be on the medical practitioner to make out the elements set out above.

The standard of appellate intervention

85 Before we turn to consider the merits of the appeals, we touch finally on the threshold for appellate intervention. Section 55(11) of the MRA provides that in any appeal to the High Court against a decision of the DT, the appellate court shall accept as final and conclusive "any finding of the DT relating to any issue of medical ethics or standards of professional conduct unless such finding is in the opinion of [the appellate court] unsafe, unreasonable or contrary to the evidence". In *Jen Shek Wei* at [36]–[37] (citing *Ang Pek San* at [32], *Low Cze Hong* at [39]–[42], and *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [39]–[40]), this threshold was explained as follows:

> 36 This threshold would only be met if (a) there is something clearly wrong either (i) in the conduct of the disciplinary proceedings; and/or (b) the findings of the DT are sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence has been misread…

> 37 The court will be slow to overturn the findings of the DT, given that it is a specialist tribunal with its own professional expertise and which understands what the medical profession expects of its members… But this is not to say that a court will accept the DT's findings uncritically: a court should not give undue deference to the views of a DT in a way that would effectively render its powers of appellate review nugatory… The effect of these two statements is that the threshold for appellate intervention is high but by no means insurmountable.

86 On the issue of whether Dr Ang had informed the Patient about his departures from generally acceptable standard of practice and obtained the Patient's consent before doing so, the DT found that Dr Ang did not "explain the benefits, risks, possible complications and option to the Patient in making the decision to prescribe, dispense and supply the medication to the Patient". This was based on the deficiencies in Dr Ang's clinical notes and his evidence on the stand. On appeal, Dr Ang challenged the DT's decision on this issue principally on the basis that they were "not elements of the charge" and thus, the DT should not have directed its mind to this issue.

87 As we have explained earlier (at [76]–[83]), in determining whether a medical practitioner's departure from codified guidelines is justifiable in the circumstances, it may be necessary to consider whether the patient was informed of the departure and the risks this entails, and whether the patient consented to it. In situations where the likelihood and severity of the risks eventuating is high, without such consent, the departure will not ordinarily be considered appropriate. We say "ordinarily" because even in this context, there may be exceptional circumstances when it is perhaps not possible to obtain such consent. But the reason this is critical is that the medical practitioner is exposing the patient to serious risks or harm which the guidelines were designed to avoid or minimise. There is thus no basis for Dr Ang to challenge the DT's decision about the lack of informed consent on the basis that they were "not elements of the charge".

88 This being the case, we reiterate that the burden lies on Dr Ang to show that his conduct was justifiable in the circumstances, which in the context of departures from codified standards would in some instances entail demonstrating that the patient was informed of the fact of the departure and consented to this. While it is not necessarily the case that a doctor will always be found to have failed to properly advise a patient of the risks and benefits of a prescription or obtain their informed consent simply for want of documentation in the clinical record, bare assertions will not suffice for a medical practitioner to discharge the burden of proving that he did in fact do so. Similarly, expert evidence that doing so would be "usual practice" for a psychiatric specialist would also be of very little assistance, given that the inquiry is precisely whether the specific medical practitioner has met the standards expected of him. To put it bluntly, the question is whether the medical practitioner in question has complied with the "usual practice". Having regard to the arguments run in the proceedings below, we find that there is no basis for interfering with the DT's finding on this issue. Dr Ang himself conceded that the clinical record provided no evidence that he had considered the risks of the specific combinations of medicines which had been prescribed to the Patient, or that such risks had been explained to the Patient or his family. Moreover, Dr Ang's own account is that he simply explained the "possible side effects of the medications, including nausea, vomiting, unstable gait, drowsiness, and giddiness", and that he "warned [the Patient] that if he took more than the prescribed dose of medication, it may cause him to have difficulty breathing or to collapse". As the DT observed, this account conspicuously omits any mention of the considerable risks inherent in the concurrent prescription of multiple benzodiazepines *even in their prescribed amounts*, which we discuss in more detail at [110]–[111] below.

89 As for the other aspects of evaluating whether Dr Ang's departures from the Relevant Guidelines were justified, because the DT did not specifically consider whether Dr Ang's course of treatment was objectively appropriate, we will touch on this when we examine the facts and the evidence.

Application to the facts

90 It is not seriously disputed that Dr Ang's prescriptions were on their face inconsistent with the relevant codified standards of care applicable to him. The only remaining issue is whether he has discharged his burden of showing that these departures were justified, in the light of the principles that we have set out above (as summarised at [84]).

91 Dr Ang generally contends that the complex and evolving nature of the Patient's psychiatric condition was a factor that justified his prescriptions. Dr Fung agreed that the Patient's condition was "complex and difficult to manage". Although the SMC notes that such a claim is inconsistent with Dr Ang's own testimony during the Civil Proceedings that the Patient "was not a psychiatric case" and "was just suffering from stress related reactive depression", Dr Ang's testimony must be read in context. That testimony was given in response to questions pertaining to the Patient's *risk of suicide*. He had also explicitly defined a "psychiatric case" as "a person prone to schizophrenia, bipolar disorder, generalised anxiety disorder", or "more vulnerable to break down with … clear psychotic symptoms, hallucinations, delusions and loss of touch with reality". None of this is inconsistent with Dr Ang's position that the Patient was suffering from numerous other psychiatric conditions and was therefore a complicated and unusual case warranting departure from the standards codified in the Relevant Guidelines, or his claim to have believed this. However, in our judgment, the general complexity of the Patient's case did not, in and of itself,

permit Dr Ang to freely disregard the Relevant Guidelines or relieve him of the need to provide specific justifications in respect of individual departures therefrom. It would not have been open to Dr Ang to have proceeded on the basis that because the Patient presented a complex case, therefore, he was free to ignore or disregard the Relevant Guidelines.

92 We therefore turn to consider the various departures and the justification that Dr Ang attempted to advance for each of them. As set out above at [10], the First and Second charges both concern departures from the Relevant Guidelines of a similar nature, namely the discontinuation of antidepressants before four weeks, the concurrent prescription of two or more benzodiazepines, the concurrent prescription of benzodiazepines with opioid analgesics, and the prescription of benzodiazepines beyond the limits of short term and intermittent use. We note that each charge consists of multiple factual averments. While they all arise from the same broad factual matrix, each corresponds to a different guideline, and each of these is in turn undergirded by a different rationale and may be directed towards preventing or minimizing a different kind of risk or harm. We also note that not every departure from a relevant guideline will in and of itself be prohibited. It will therefore be necessary to assess each alleged departure. As explained earlier, the rationales are used as a point of reference because they are the reason why the standard exists. Therefore, if Dr Ang wished to justify his departure from the Relevant Guidelines, he would have to show that he addressed the dangers they were meant to prevent and explain how his conduct was objectively appropriate in the circumstances. It follows that a departure from one guideline and undertaking the risk to which it was directed may be justified on the facts, while a departure from a different guideline and undertaking the corresponding risk may not be. It would follow from this that Dr Ang may be able to justify some or all of the departures, but if he is found to be unable to justify any one of them, that would suffice, subject to

considerations of materiality, for the first two charges to be made out, in that to that extent, the prescriptions concerned would be considered inappropriate. Accordingly, we consider each of the departures in turn.

The first and second sets of charges

The discontinuation of antidepressants

93 As noted above at [10], the first professional misconduct charge and corresponding alternate charge aver that Dr Ang failed to continue various antidepressants for at least four to six weeks. In response, Dr Ang advances various justifications for each instance of premature discontinuation.

(1) Escitalopram, Paroxetine, Venlafaxine, and Agomelatine

94 Dr Ang claims that several antidepressants were discontinued earlier than the prescribed period of four to six weeks because they had caused the Patient to experience various side effects. Escitalopram was discontinued on 21 March 2010 after a single day's use, because it had caused the Patient to experience tiredness. Dr Ang points to an entry in his clinical notes made on that day, which recorded that the Patient had reported feeling "xian", which we understand to mean "unwell" or "lethargic", and in an entry made earlier the same day, the clinical notes also record that the Patient "feels tired this morning".

95 Similarly, Paroxetine was discontinued after eight days' use between 28 April 2010 and 5 May 2010, because its use had caused the Patient to experience tiredness and headaches; Venlafaxine was discontinued after three days' use between 14 to 16 May 2010 because it had caused the Patient to experience giddiness; and Agomelatine was discontinued after 23 days' use

from 1 to 23 March 2011 as it had caused a worsening of the Patient's headache, difficulties with sleeping, and poor mood.

96 In determining whether Dr Ang's explanations justify his actions, this must be weighed against the underlying *rationale* for the Guidelines. The rationale for the continuation of antidepressants for at least four to six weeks appears to be to afford the doctor sufficient time to determine whether the antidepressant is truly effective or ineffective. Since Dr Ang's departure from this guideline was occasioned by the side effects and not because he thought the drugs in question might be ineffective, it seems to us that to this point of the inquiry, Dr Ang's actions withstand scrutiny.

97 As for whether Dr Ang's conduct was objectively justifiable in the circumstances, it does not appear from the expert evidence that there was any danger or risk inherent in just the discontinuation of an antidepressant. In the circumstances, we accept Dr Ang's explanation that it cannot be sound medical practice to persist with an antidepressant where it is triggering adverse side effects and symptoms. As Dr BY Ng stated in his expert report, it may be necessary to switch antidepressants if a patient develops side effects, cannot tolerate the antidepressants, or if new symptoms emerge. Dr Fung likewise accepted that it would be "prudent to look at the medications" where there are side effects. Crucially, as we observed during the hearing, Dr Ang's clinical notes do record that the Patient had complained of the side effects which Dr Ang now identifies as the reasons for discontinuation and these entries coincide with the dates on which those medications were stopped. Accordingly, we find that Dr Ang has succeeded in discharging his burden of demonstrating that his discontinuation of Escitalopram, Paroxetine, Venlafaxine, and Agomelatine in less than four to six weeks was justified.

98 Lastly, given that Dr Ang's departure from the applicable guidelines in this context did not relate to the risks that these were meant to guard against, that is, to ensure that the doctor has sufficient time to determine whether the antidepressant is truly effective or ineffective, there was no need to further consider the issue of whether the departure from the relevant guideline had been discussed with the Patient or whether he had consented to such departure.

(2) Mirtazapine

99 On two occasions, Dr Ang discontinued the prescription of Mirtazapine after only one day's use. His reasons for the discontinuation on each occasion differ.

100 Dr Ang explains that the first discontinuation of Mirtazapine after a day's use on 1 April 2010 was because it was not helpful. While this would appear to be inconsistent with the rationale of the stipulation to continue antidepressants for a minimum of four weeks, Dr Ang testified before the DT that Mirtazapine (known also as Remeron) is not only an antidepressant, but also has sedative properties, and that it had been prescribed on 1 April 2010 in order to help the Patient sleep rather than as an antidepressant. Dr Fung also appears to have accepted that Mirtazapine could be used as a sedative rather than an antidepressant. Dr Ang explains that while a period of four to six weeks might be needed to ascertain Mirtazapine's efficacy as an antidepressant, its effectiveness as a sedative could be determined in a much shorter time. We agree with Dr Ang that where a medicine might be deployed to take advantage of *other* beneficial effects which it might have, those other effects will not necessarily take the same amount of time to manifest. This finds support in the fact that Dr Ang's decision to prescribe Dalmadorm on 2 April 2010 in place of

Mirtazapine *was* in fact recorded to have resulted in an improvement in the Patient's quality of sleep, after a single day.

101 The second instance on which Mirtazapine was discontinued after a day's use was on 4 June 2010. Dr Ang's explanation was that it was again being prescribed for its sedative rather than antidepressive properties, and that this was necessary because the Patient had reported being unable to sleep as he was troubled by an incident with another doctor. However, when Dr Ang visited the Patient the following day, he found the Patient sleeping. This led Dr Ang to conclude that Mirtazapine was not necessary and to discontinue it accordingly, as he did not want the Patient to be on too much medication. As with the side effects discussed above, these observations are likewise recorded in his clinical notes.

102 We are similarly inclined to accept this explanation. As with the first discontinuation, Dr Ang's rationale for the second had nothing to do with its apparent efficacy, or otherwise, as an antidepressant. Moreover, we accept that it is sound practice to discontinue the use of a medication that is deemed unnecessary. It would be unfair to fault Dr Ang for doing so, especially since the nub of the complaint against him in general is precisely that he prescribed too much medication when this was not necessary. We therefore find that Dr Ang has discharged his burden of showing his discontinuation of Mirtazapine on both occasions was supported by clear medical grounds.

(3) Duloxetine

103 There were numerous occasions on which Dr Ang prescribed Duloxetine and discontinued it before a period of four to six weeks had elapsed. This includes a prescription of 26 days between 2 to 27 April 2010, a prescription of 17 days from 30 April to 16 May 2010, a prescription of two

days from 1 to 2 August 2010, and a prescription of 17 days from 5 to 21 August 2010.

104 Dr Ang's explanation in respect of each discontinuance of Duloxetine was that he had wanted to assess the effectiveness of another antidepressant, and had discontinued Duloxetine while doing so in order to avoid having the Patient on too many different antidepressants simultaneously. Duloxetine was discontinued on 28 April 2010 so as to assess the effectiveness of Paroxetine, on 17 May 2010 to assess Venlafaxine, and on 3 August 2010 to assess Trittico (also known as Trazodone). However, as noted above at [95], Dr Ang was forced to discontinue Paroxetine and Venlafaxine owing to side effects. He also found it necessary to reduce the dosage of Trittico for similar reasons.

105 In this connection, it is material that Dr Ang had been using Duloxetine as the Patient's main antidepressant. Duloxetine had been the first antidepressant which Dr Ang prescribed to the Patient when the Patient first consulted him on 8 February 2010, and this first prescription of Duloxetine had been continued until 31 March 2010. The effectiveness of Duloxetine in treating the Patient was already known to Dr Ang. Thus, not only was the first early discontinuation on 28 April 2010 arguably just a technical breach, given that it had been discontinued just two days shy of the four-week period, it could be seen as part of a prescription stretching back continuously to 8 February 2010, save for a day's interruption on 1 April 2010.

106 In this light, we accept Dr Ang's explanation in respect of the various occasions on which Duloxetine was discontinued earlier than four to six weeks. Much like the other medications we have already discussed, the reason for the discontinuance was not its perceived ineffectiveness as an antidepressant. Rather, the discontinuations were to allow the testing of other antidepressants,

in the hope they might prove more effective than Duloxetine had been found to be. We accept that Dr Ang's ongoing attempts to calibrate the different medications which the Patient was taking were justified in the circumstances. There is no expert evidence suggesting otherwise. Further, it does not appear that the evidence or the submissions before the DT were directed to the question of possible adverse drug interactions, which we therefore do not consider.

The concurrent prescription of multiple benzodiazepines and benzodiazepines with opioid analgesics

107 Both the first and second pairs of charges also concern Dr Ang's concurrent prescription of multiple benzodiazepines to the Patient, and his prescription of benzodiazepines despite knowing that the Patient was also taking opioid analgesics which had been prescribed by another doctor for his chronic back pain. The first pair of charges concern such prescriptions issued between 8 February 2010 and 31 December 2011, and the second pair of charges pertain to those issued between 1 January 2012 and 31 July 2012. As Dr Ang's justifications for these practices and the rationale for the prohibition against them are similar, we deal with them together.

108 On the concurrent prescription of multiple benzodiazepines, Dr Ang's case is that different benzodiazepines are more effective in achieving different purposes. Dr Ang submits that the Patient had complex psychiatric or psychological conditions, which meant that two or more benzodiazepines were necessary for him. In his expert report, Dr BY Ng explained that some benzodiazepines are better at treating panic attacks, some are better at initiating sleep, and some are better at maintaining sleep and relieving anxiety during the daytime. An example of this in the present case would be the prescription of Alprazolam for the treatment of anxiety in the daytime, and the prescription of Dalmadorm to treat insomnia at night, which Dr BY Ng did not find excessive.

Dr Ang also highlights Dr Fung's concession under cross-examination, that multiple benzodiazepines could be prescribed if each was directed towards a different purpose. Moreover, although Dr Ang's clinical notes again did not explicitly record his reasons for the prescription of multiple benzodiazepines or what the purpose of each might have been, Dr Fung was apparently able to make logical inferences in this regard based on the objective facts that had been recorded.

109 As for the concurrent prescription of benzodiazepines with opioid analgesics, Dr Ang's explanation is simply that he had no choice. On one hand, the Patient's chronic back pain made the opioid analgesics necessary – indeed, both Dr Ang and the SMC agree that the Patient's lower back pain was a significant contributing factor to his psychiatric problems. On the other hand, the benzodiazepines were also necessary because if the Patient remained unable to sleep, this too would cause him more mental distress and worsen his psychiatric condition.

110 However, this is not the whole picture. As we have stated above, evaluating the justifiability of Dr Ang's departures requires an appreciation of the rationale behind the relevant prohibitions. On the prohibition against concurrent prescription of multiple benzodiazepines, Mr Ng Boon Tat's expert evidence was to the effect that although each individual medication which Dr Ang prescribed is relatively safe even in mild overdoses, the potential interactions which might occur when two or more drugs are concurrently prescribed give rise to significant safety concerns. The foremost of these risks are those of CNS depression, increased risks of sedation, respiratory depression, or cardiovascular depression. Dr Fung also observed that, while a common practice, the concurrent prescription of multiple medications of the same class, nonetheless remains controversial and can increase the likelihood of events such

as Serotonin Syndrome, Neuroleptic Malignant Syndrome, and benzodiazepine related respiratory depression. For these reasons, Dr Fung testified that it is nonetheless "probably not wise to do that", and while there may be reasons for prescribing multiple benzodiazepines and "it doesn't mean that you can't do it", "you would do it very carefully and you would have to watch".

111 The risks inherent in the concurrent prescription of benzodiazepines and opioid analgesics are of a similar nature, albeit of a greater magnitude. Although the dosages of opioid analgesics were within their approved daily dose ranges, the combination of opioid analgesics and psychiatric medications prescribed by Dr Ang has been well documented to further increase the risks of CNS depression and mortality. Mr Ng Boon Tat stated in his expert report that the package inserts and product monographs of opioids and benzodiazepines point out that the concurrent use of CNS depressants with opioids may "disproportionately" increase the CNS depressant effects of these medications and result in profound sedation, cardiorespiratory depression, hypotension, coma, and death. He also noted that the United States Food and Drug Administration published one of its strongest warnings on the concurrent use of opioids with benzodiazepines, as this combination had resulted in serious side effects, including slowed or difficult breathing and death. Similarly, Dr Fung cited literature suggesting that the chance of harm from concurrently prescribing opioids with benzodiazepines is greater than the chance of benefit, and that as a result, the expected utility of the opioid-benzodiazepine combination is negative, except possibly in patients suffering from terminal illness. Even Dr BY Ng expressed the opinion that he "would generally not recommend" concurrent prescription of benzodiazepines with opioid analgesics because of the increased risk of breathing suppression, and cited Guidelines for Prescribing Opioids for Chronic Pain issued by the United States' Centres for Disease

Control which recommend avoiding prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

112 In our judgment, Dr Ang's explanations set out at [108]–[109] above, do not suffice to justify these prescriptions in the light of the risks they entailed. General claims that the Patient had a complex psychiatric or psychological condition are not helpful in this context. What Dr Ang needed to do was to explain specifically why he chose to proceed in the manner he did, despite the significant risks which accompanied the prescription of two or more benzodiazepines, and the prescription of benzodiazepines while the Patient was on opioid analgesics. He needed to persuade us that the benefits of such prescriptions to the Patient justified taking the very material risks involved. A general claim that his conduct was reasonable "if the benefits outweighed the risks of concurrent use of the drugs" is unhelpful, without a proper evaluation or explanation of what those benefits were and how and why they outweighed the risks in this specific case. In this case, the evidence did not even show that Dr Ang had applied his mind to these risks at the material time.

113 In this connection, Dr Ang submits that the "close monitoring of the Patient" was a "significant factor showing that proper risk management measures were carried out … at the material time to ameliorate any associate risks (including from drug-to-drug interactions)". The experts diverge on the extent to which monitoring reduces the aforementioned risks, especially those inherent in the concurrent prescription of opioids and benzodiazepines. Although Dr BY Ng's view is that they could be ameliorated in an inpatient setting where medical staff can monitor the amount of medication taken as well as the patient's vital signs, Dr Fung took the opposite view.

114 Even if we were to accept that inpatient monitoring might have allowed for early detection of the onset of some of these risks and the administration of oxygen, cardiac stimulation, antidotes to the benzodiazepines or opioids, or other forms of emergency care, might have helped in the event severe and adverse drug interactions occurred, this somewhat misses the point. The first task for Dr Ang was to demonstrate that taking the risks inherent in the concurrent prescription of multiple benzodiazepines and benzodiazepines with opioid analgesics was warranted in the circumstances. In any event, Dr Ang did not provide any evidence as to the availability or efficacy of such protective measures, or the extent to which they might negate the harm from such interactions. More importantly, Dr Ang himself concedes that there were periods in which the Patient was concurrently taking multiple benzodiazepines, and benzodiazepines with opioid analgesics, *while being treated as an outpatient*, and where Dr Ang was monitoring him only by way of telephone and outpatient consultations. In this context, there would be no effective measures in place to detect the onset of adverse drug interactions, and almost certainly, there would have been nothing in the way of emergency care or support measures to enable anything to be done about it, had they materialised then.

115 Dr BY Ng's view that any unwanted drug interactions would "probably" have occurred while the Patient was being treated as an inpatient is also of little assistance to Dr Ang. Dr BY Ng did not provide any academic or scientific literature to support this assertion. Moreover, given the grave consequences of potential drug interactions, unless the risks thereof could have been mitigated very significantly, we do not see how Dr Ang's prescription of multiple benzodiazepines with opioid analgesics could have been objectively justified. It may also be noted that there is nothing in the evidence to suggest that the Patient was adequately apprised of these risks and consented to the course of treatment.

116 Accordingly, Dr Ang has failed to justify his concurrent prescription of multiple benzodiazepines and his prescription of benzodiazepines despite knowing that the Patient was also taking opioid analgesics. These factual elements of the first and second pairs of charges are thus made out.

The prescription of benzodiazepines beyond the limits of short-term and intermittent use

117 Both the first and second professional misconduct charges and their corresponding alternative charges also pertain to Dr Ang's prescription of benzodiazepines beyond the limits of short-term and intermittent use. Since the rationales for the directives against doing so are in essence the same, as are Dr Ang's justifications for departing from these directives, we deal with the two guidelines together.

118 The directives to limit the prescription of benzodiazepines to short-term relief and intermittent use are contained in Guideline 5.1.1 of the 2008 CPG (Benzodiazepines). Similarly, paragraph (f) of the 2008 Admin Guidelines (Benzodiazepines) directs that benzodiazepines should only be prescribed for intermittent use. The rationale for these directives is that long term use of benzodiazepines has been widely recognised to produce physical and/or psychological dependence, and even given rise to abuse of benzodiazepines. For these reasons, any long-term benzodiazepine prescription must be accompanied by appropriate clinical review, clear indications, and adequate documentation, failing which such a prescription would not be appropriate.

119 Dr Ang's case is that a short-term and intermittent prescription of benzodiazepines would not have been effective in dealing with the Patient's chronic insomnia, which would have been "agonising" and likely have exacerbated his psychiatric condition. He also claims to have applied his mind

to the risk of dependence, and more importantly, to have addressed it in various ways. First, Dr Ang claims that the Patient was monitored for signs of dependence and addiction, both while being treated inpatient, and through telephone and outpatient consultations. In the course of such monitoring, the Patient did not show obvious signs of dependency, addiction, or drug seeking behaviour, and proved himself to be responsible in his consumption of medications. Second, Dr Ang claimed that by giving the patient *other* medications with sleep-inducing properties, the Patient would be less likely to become dependent on benzodiazepines for sleep. Third, Dr Ang claims that he planned to wean the Patient off his medications by a course of detoxification in hospital, once the court case with his brother had concluded and his other primary stressors had been resolved.

120 We accept that Dr Ang had considered the risks of physical and/or psychological dependence accompanying long-term use of benzodiazepines, and that he had articulated a need for such use, which is supported by the numerous instances in which the Patient's inability to sleep was captured in the clinical record. We also accept that Dr Ang's long-term prescription of benzodiazepines in the present case was justified. Dr Fung implicitly agreed that long-term prescription of benzodiazepines was permissible if the Patient was monitored for dependence. Additionally, although we had previously found that outpatient and telephone monitoring did not sufficiently ameliorate the risks of drug interactions (at [113]–[115] above), the nature of the risk of drug dependency is quite different, in that the latter is not in itself immediately life threatening. Although there could be no absolute guarantee that the Patient would not develop drug dependency while being treated outpatient, the fact that the Patient had proven himself responsible in managing his medications ameliorated the chances of such harm. In the circumstances, we accept that Dr

Ang's prescription of benzodiazepines beyond the limits of intermittent and short-term use was necessary, and outweighed the relevant risks.

121 The issue then arises as to whether the risks of dependency accompanying the prescriptions of benzodiazepines beyond the limits of short-term and intermittent use were of a sufficient probability and magnitude that Dr Ang's conduct here can only be considered appropriate if he advised the Patient of the risks of the prescriptions and obtained his consent to this course. In this regard, we note that the SMC's case only goes so far as to demonstrate that Dr Ang's prescriptions were inconsistent with the Relevant Guidelines. It has not gone further to establish the likelihood of the Patient becoming dependent on the benzodiazepines; nor has it explained the severity of harm of such dependency on the Patient. On the contrary, the only evidence speaking to this is Dr Ang's account of the risk management measures that were put in place, his plans to wean the Patient off benzodiazepines, and his testimony that the Patient had on earlier occasions proven himself to be responsible and capable of handling his medications with the help of his family. This being the case, the absence of evidence as to the risks inherent in these departures means that we are unable, on the evidence that is before us, to find that Dr Ang was obliged to inform the Patient of the associated risks, or that the appropriateness of his prescriptions of benzodiazepines beyond the limits of intermittent and short-term use turns on whether he had done so. For the avoidance of doubt, we emphasise that it is not that we consider the risk of developing dependency or addiction to such medications to be not sufficiently serious or likely; rather, there was no evidence of this before us to enable us to come to a view of the potential dangers and risks in this case. In the circumstances, this factual element of the first and second pairs of charges is not made out.

The prescription of a six-month supply of benzodiazepines

122 The second professional misconduct charge and corresponding alternate charge also pertain to Dr Ang's issuance to the Patient of a six-month supply of benzodiazepines on 31 July 2012. The charges aver that in doing so, Dr Ang failed to prevent the long-term chronic use of benzodiazepines by the Patient, this presumably being a breach of the stipulations in the Relevant Guidelines that prescription of benzodiazepines should be limited to intermittent and short-term use.

123 Naturally, the relevant considerations in large part mirror those in respect of Dr Ang's prescription of benzodiazepines beyond the limits of intermittent and short-term use, as set out above at [117]–[119]. However, in respect of this specific incident, Dr Ang also explains that there had been an incident involving the Patient and another doctor, which had left the Patient traumatised and with a phobia of coming to a psychiatric clinic. Additionally, he also explains that the Patient was very busy owing to his work schedule, and wanted to minimise the number of visits he would have to make to collect medication.

124 In contrast, Dr Fung's evidence is that while a six-month supply of such medications may be acceptable with "stable and chronic" psychiatric patients, it was unusual to provide this immediately upon discharge. Even if the Patient was fearful of attending at psychiatric clinics, other arrangements could have been made to supply the requisite medication in smaller quantities – indeed, the Patient had in fact attended at Dr Ang's clinic on several occasions.

125 We accept Dr Ang's reason for his prescription of a six-month supply of benzodiazepines to the Patient. Dr Ang had explained why he had assessed that it was appropriate to provide a six-month supply to the Patient. Moreover, as

outlined above at [120], there were reasons for such a prescription to be made to the Patient. We also note that the Patient had already been on benzodiazepines for a significant duration, and appeared to have been assessed to be stable and could be said to fall within the category of "stable and chronic" psychiatric patients, of the sort for whom Dr Fung thought such a prescription would be appropriate.

126 Finally, for the same reasons discussed above at [121], the state of the evidence before us does not allow us to make a finding that Dr Ang was under an obligation to inform the Patient of the associated risks. Accordingly, we find that this factual element of the charge is not made out in this case.

Conclusion on the first and second pairs of charges

127 As we have set out earlier (at [10] above), there are multiple complaints against Dr Ang's various departures from the applicable standards of care that form the basis of the first and second pairs of charges. As we have found for Dr Ang on some grounds and against him on others, we consider below the extent to which these charges are made out.

(1) The first pair of charges

128 With respect to the first pair of charges, we have found (at [93]–[106] above) that Dr Ang has justified his discontinuation of anti-depressants before at least four weeks had passed. Accordingly, the first pair of charges are not made out in respect of these prescriptions by Dr Ang.

129 In relation to the concurrent prescription of multiple benzodiazepines and benzodiazepines with opioid analgesics, we have found (at [107]–[116] above) that Dr Ang had failed to justify his various prescriptions pertaining to

such conduct. As it is not disputed that Dr Ang had intentionally made such prescriptions, and that he was aware of the applicable guidelines, it would follow that he had intentionally and deliberately departed from the applicable standards of conduct, Dr Ang is guilty of professional misconduct under s 53(1)(*d*) MRA. As we have noted above at [51], the absence of malicious intent or financial motive, or even the presence of care and concern, are ultimately irrelevant to this question and the only question is whether the doctor knows of the applicable standard of conduct but chooses not to comply with it (*Jen Shek Wei* at [141]). We therefore convict him on the professional misconduct charge in respect of these prescriptions, and accordingly, his conviction on the alternative professional services charge in respect of these prescriptions falls away.

130 In relation to the prescription of benzodiazepines beyond the limits of short-term and intermittent use, we have found (at [117]–[121] above) that Dr Ang had considered the risk of the Patient developing a dependency posed by long-term use of benzodiazepines and had articulated a need for going ahead with his prescription. His decision was objectively reasonable in the circumstances. Moreover, given the absence of evidence about the probability of the Patient becoming dependent on the benzodiazepines, or the severity of harm of such dependency on the Patient (as at [121] above), there is some lack of clarity as to whether this was a material risk that Dr Ang should have discussed with the Patient and obtained the Patient's consent for, and whether the need for such discussion with the Patient is something that Dr Ang knew or ought to have known about. We therefore decline to find that this amounted to professional misconduct under s 53(1)(*d*) MRA. Similarly, we do not consider that this factual element on its own can give rise to a charge of failing to provide professional services of the quality which it is reasonable to expect of him under s 53(1)(*e*) MRA.

131 The first professional misconduct charge is thus made out against Dr Ang only to the extent set out at [129] above.

(2) The second pair of charges

132 With respect to the second pair of charges, we have accepted (at [122]–[125] above) Dr Ang's reason for why it was not inappropriate for him to prescribe a six-month supply of benzodiazepines to the Patient. This is because the Patient had already been on benzodiazepines for a significant duration, and had been reasonably assessed to be stable and was thus someone for whom such long-term prescriptions may be appropriate. Further, for the same reasons set out at [130] above, we find that this does not give rise to a breach of either s 53(1)(*d*) or s 53(1)(*e*) of the MRA. The second pair of charges are not made out in respect of these prescriptions by Dr Ang.

133 With respect to the second pair of charges relating to the prescription of benzodiazepines beyond the limits of short term and intermittent use, these facts are similar to the facts which formed the basis for the first pair of charges (as set out at [130] above). For the same reasons, the second pair of charges are not made out in respect of these prescriptions by Dr Ang.

134 As for the other parts of the second set of charges which relate to the concurrent prescription of multiple benzodiazepines and benzodiazepines with opioid analgesics, the facts are similar to the facts which formed the basis for the first pair of charges (at [129] above). For the same reasons, we find Dr Ang guilty of professional misconduct in respect of this factual element under s 53(1)(*d*) MRA, and his conviction on the alternative professional services charge under s 53(1)(*e*) MRA falls away. We therefore convict him on the second professional misconduct charge in respect of these prescriptions.

135 The second professional misconduct charge is thus made out against Dr Ang to this extent.

The third pair of charges

The prescriptions of Mirtazapine and Zolpidem CR beyond their respective maximum dosages

136 The third professional misconduct charge and corresponding alternate charge concerns Dr Ang's prescription of a daily dose of 60mg of Mirtazapine and 25mg of Zolpidem CR, in excess of their respective maximum dosages of 45mg and 12.5mg set out in their package inserts.

137 Dr Ang's testimony before the DT was that he was using Mirtazapine as a substitute for benzodiazepines, in order to keep the Patient's use of benzodiazepines under control. This is consistent with Dr Ang's claim to have prescribed other medicines along with benzodiazepines in order to reduce the risk of the Patient becoming dependent on the latter. He claims that in exceeding the recommended dosages of Mirtazapine and Zolpidem CR beyond the limit found in their package inserts, he had carefully and judiciously titrated the dosages over the course of his management of the Patient. His case is that his prescription was reasonable and appropriate in view of the Patient's "multiple complex conditions which include chronic pain, insomnia, anxiety, depression, PTSD and personality issues".

138 No further rationale was articulated as to the reasons behind the maximum dosage limits set out in the package inserts. The question then is whether it was justifiable for Dr Ang to have exceeded these limits as he did.

139 We are not persuaded that Dr Ang's prescription here was justified. As we have emphasised, general claims without proper explanation or evidence in

support are not helpful. Dr Ang would have had to go further to say whether he had considered the risks he was exposing the Patient to by this, and *why* he came to the conclusion that the benefits of prescribing Mirtazapine and Zolpidem CR above the limits set out in the product inserts outweighed the risks of doing so. He also had to explain why he decided to do so at the particular time the prescription was made, and not at an earlier or later time. Here, the foremost issue is *why* Dr Ang increased the dosages of Mirtazapine and Zolpidem CR in the way he did, when he did, and in the amount he did. In cross-examination before the DT, his explanation was that his prescription was made in order to keep the Patient's use of benzodiazepines low, especially through the use of Mirtazapine. However, this explanation only takes him so far. We accept that Dr Ang discontinued the Patient's prescription of Diazepam, which is a benzodiazepine, on 2 July 2012, the day on which the Patient's dose of Zolpidem CR was doubled from 12.5mg to 25mg and two days before Dr Ang doubled the Patient's dose of Mirtazapine to 60mg, but he was still taking 3mg of Bromazepam and 15mg of Midazolam, which are benzodiazepines. However, on 31 July 2012, the date of the Patient's final discharge, Dr Ang re-introduced 10mg of Diazepam into the Patient's prescription, while maintaining the Patient on 60mg of Mirtazapine and 25mg of Zolpidem. This makes it difficult to accept Dr Ang's explanation as to the purpose of the increased dosages with which the third professional misconduct charge is concerned.

140 Moreover, we are also not persuaded that the risks to the Patient were sufficiently ameliorated so as to negative the presumption of inappropriate treatment. We accept that the evidence available in the proceedings below showed that in general, a prescription of Mirtazapine or Zolpidem CR alone, in dosages beyond the limit stated in their product inserts, is not necessarily more unsafe. Mr Ng Boon Tat noted during his cross-examination that there was medical literature suggesting that Mirtazapine carried a risk of adverse drug

reactions at its normal dosing range. On the other hand, Mr Ng also conceded that there was no literature showing that dosages of Mirtazapine at 60mg or dosages of Zolpidem at 25mg were necessarily *more* unsafe, and in his own expert report, he notes that fatalities due to Mirtazapine alone are rare, and that even overdoses of over 120mg were "relatively benign and unlikely to cause major toxicity". Similarly, in Dr BY Ng's expert report, he points to *Clinical Pharmacology of Sleep* (S.R. Pandi-Perumal and J.M. Monti. Birkhauser Verlag), which suggests that some patients may need up to 90mg of Mirtazapine daily, and that dosages of 20 to 30mg of Zolpidem increase slow wave sleep. Additionally, Dr BY Ng cites *Schatzberg's Manual of Clinical Psychopharmacology* Ninth Edition (Alan F. Schatzberg, M.D., Charles DeBattista, D.M.H., M.D.), which states that:

> …Zolpidem is usually dosed at 5-10mg at night. Some patients seem to need 20 mg, although there is little evidence that this dose is much more effective than 10 mg. **But there is little evidence it presents more of a problem than smaller doses**.

141 In response, Mr Ng Boon Tat simply notes that the above sources cited by Dr Ng BY have "not been supported by consistent data from adequate randomised controlled trials", and that although the HSA has studied the effects of up to 75mg of Mirtazapine, "the HSA-approved package insert does not necessarily promote the use of these high doses", and it only recommends dosages of between 15 to 45mg. Thus, while absence of evidence is not evidence of absence, it does appear that the only medical literature speaking to the safety of the dosages Dr Ang prescribed suggests that such high dosages did *not* pose any exceptional danger beyond dosages remaining within the limits set out in their product inserts.

142 However, that dosages of Mirtazapine or Zolpidem CR in excess of the limit found in their product inserts are not *necessarily* more unsafe than dosages

within the limit when either is consumed *alone*, does not serve to exculpate Dr Ang. Materially, there is no evidence to show that such a prescription of Mirtazapine and Zolpidem CR past the limits set out in their product inserts, was in *this* case, safe for the Patient. It must be remembered that at this time, the Patient was on a variety of medications, not just Mirtazapine and Zolpidem CR. By the time the prescription of Mirtazapine and Zolpidem CR was increased to 60mg and 25mg respectively on 4 July 2012 and 2 July 2012 respectively, the Patient was also on another antidepressant (Duloxetine), other antipsychotics (Quetiapine and Olanzapine), and other benzodiazepines (Bromazepam and Midazolam).

143 This consideration of drug interactions is important because both Zolpidem CR and Mirtazapine have potential drug interactions with the other medications the Patient was already taking. In Dr Ng Boon Tat's expert medical report, he stated that:

> …the **package inserts and product monographs of opioids, benzodiazepines and zolpidem highlighted special precautions for the concomitant use of CNS depressants with opioids, as this combination may disproportionately increase the CNS depressant effects of these medications, which may result in profound sedation, cardiorespiratory depression, hypotension, coma and death.**
>
> [Emphasis in original]

Dr Ng also stated that:

> In addition, Mirtazapine may also increase the sedating effects of benzodiazepines and other sedating medications (including antipsychotics and opioids).

144 Given the number of different medications the Patient was on, the potential for drug interactions had to be accounted for when assessing whether Dr Ang's increase in the prescription of Mirtazapine and Zolpidem CR beyond

the limits stated in the package inserts was justified in the circumstances. Dr Ang has not shown that he had considered this at all.

145 Moreover, as the SMC points out, Dr Ang conceded during the Civil Proceedings that his prescription of 60mg of Mirtazapine per night went to the "edge of the killing range". According to Dr Ang, for patients "who had been on these four types of medicine for some time", a dangerous level of Mirtazapine to prescribe would be 45mg for "most patients". Some patients could tolerate 60mg. Dr Ang had further testified that "for most patients", the start of the "killing range" for a prescription of Mirtazapine started at 61mg. Dr Ang had also conceded in cross-examination below that "if someone were to take a look at the list of medicine at that point in time, 31st July, he will get a shock of his life". He went on to say that it was only if that person understood the "total big picture" that Dr Ang saw that said person would understand the prescriptions, but such generalities were not helpful.

146 From Dr Ang's own evidence in cross-examination, it is clear that his prescription of Mirtazapine and Zolpidem CR above the limits found in the product inserts was risky, and that he was aware of this. However, in his evidence, he did not explain *why* he thought the risks to the Patient were worth taking. The benefits of his prescription must outweigh or justify the risks taken on, and Dr Ang has not explained why this was so in this case. Dr Ang's general explanations that he wanted to reduce the Patient's use of benzodiazepines, and that he knew the "functioning of the patient" were insufficient. It was incumbent on him to go further and explain *why* he came to that conclusion, and provide evidence to support his reasoning. He has not done so.

147 As a final point, Dr Ang claims to have carefully and judiciously titrated the dosages over the course of his management of the Patient. This is untrue. Dr

Ang had consistently prescribed Mirtazapine and Zolpidem CR within the limits set out in the product inserts. It was only during the Patient's final admission to the hospital that Dr Ang prescribed Mirtazapine and Zolpidem CR above the limits set out in the product inserts. Indeed, Dr Ang confirmed in cross-examination that he had "only increased the Mirtazapine" in the "very last hospital stay" and that "Zolpidem also was increased on 25mg, only in the last hospital stay". The previous prescription of Mirtazapine and Zolpidem CR was only for 30mg and 12.5mg respectively. He had thus doubled the dosage for these drugs and taken the dosage well beyond the prescribed limits. This can hardly be described as a judicious or careful titration of the dosage.

148 Besides Dr Ang's failure to explain why it was reasonable for him to have done this, there is also the DT's finding that he failed to obtain the Patient's informed consent. The DT's finding is sound because if Dr Ang is unable to properly explain the basis of his prescription to this Court, it follows that he cannot possibly have informed the Patient of his reasons for departing from the limits set out in the product inserts. Therefore, Dr Ang is not able to show that these prescriptions were justified in the circumstances.

149 Finally, it is not contested that Dr Ang knew the applicable limits and knew he was exceeding them.

150 For these reasons, in our judgment, Dr Ang is guilty of professional misconduct under s 53(1)(*d*) MRA. The third professional misconduct charge is thus made out against Dr Ang, and the alternative professional services charge falls away.

Conclusion

151 For these reasons, we find that all three professional misconduct charges are made out, save that in respect of the first two charges, it is to the limited extent set out above. We will hear the parties on the question of the appropriate sanctions and, in due course, on costs.

Sundaresh Menon
Chief Justice

Tay Yong Kwang
Justice of the Court of Appeal

Belinda Ang Saw Ean
Justice of the Court of Appeal

Christopher Chong Fook Choy, Sim Mei Jun Andrey, Sia Tian Wa Jeremy Marc (Dentons Rodyk & Davidson LLP) and Chandra Mohan K Nair (Tan Rajah & Cheah LLP) for the appellant in OA 8 and the respondent in OA 9;
Kronenburg Edmund Jerome, Colin Wu Guolin, Nicole Lee Man Ruo and Chan Yu Jie (Braddell Brothers LLP) for the respondent in OA 8 and the appellant in OA 9.

Annex

CHARGES

1st professional misconduct charge

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

Particulars

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1st professional services charge

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

Particulars

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

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

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

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

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

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

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

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

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

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

(i) prescribe antidepressants to the Patient on numerous occasions, and in doing so, switch from one antidepressant to

another without ensuring that each antidepressant was continued for at least 4 to 6 weeks before such switching;

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

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

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

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

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

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

2nd professional misconduct charge

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

Particulars

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) At all material times, you knew, or ought to have known, that your prescription of the medicines was inappropriate and in breach of

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

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

2nd professional services charge

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

Particulars

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3rd professional misconduct charge

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

Particulars

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

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

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

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

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

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

3rd professional services charge

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

Particulars

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

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

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

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

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