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

[2025] SGHC 17

Originating Application No 8 of 2023

Between

Dr Ang Yong Guan

… *Appellant*

And

Singapore Medical Council

… *Respondent*

Originating Application No 9 of 2023

Between

Singapore Medical Council

… *Appellant*

And

Dr Ang Yong Guan

… *Respondent*

JUDGMENT

[Professions — Medical profession and practice — Professional conduct]

Dr Ang Yong Guan
v
Singapore Medical Council

[2025] SGHC 17

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 October 2024

5 February 2025 Judgment reserved

Belinda Ang Saw Ean JCA (delivering the judgment of the court):

1 In *Singapore Medical Council v Dr Ang Yong Guan* [2023] SMCDT 2 (the "DT Decision"), a Disciplinary Tribunal ("DT") convened by the Singapore Medical Council (the "SMC") convicted Dr Ang Yong Guan ("Dr Ang") of three charges under s 53(1)(*e*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) (the "MRA") for failing to provide professional services of the quality which it was reasonable to expect of him under s 53(1)(*e*) of the MRA (the "professional services charges"), and acquitted him of three charges under s 53(1)(*d*) of the MRA for intentionally and deliberately departing from standards observed or approved by members of the profession of good repute and competency (the "professional misconduct charges"). Both Dr Ang and the SMC appealed against various aspects of the DT's decision.

2 In *Ang Yong Guan v Singapore Medical Council and another matter* [2024] 4 SLR 1364 (the "Liability Judgment"), we found Dr Ang liable for the three professional misconduct charges and set aside his conviction on the three professional services charges, which had been brought in the alternative. We heard parties on the appropriate sentence in respect of the professional misconduct charges on 16 October 2024. We now give our decision on sentence.

Facts

3 We begin with a brief summary of the facts relevant to our determination of the appropriate sanction to be imposed on Dr Ang in respect of the professional misconduct charges for which we found him liable. The full factual and procedural background of the present case may be found in the Liability Judgment.

4 Dr Ang is a senior medical practitioner, and a psychiatric specialist who has been practising for more than 36 years. His conduct which was the subject of the Liability Judgment occurred in the course of his treatment of the late Mr Quek Kiat Siong (the "Patient") over the period of 8 February 2010 to 4 August 2012, during which he issued numerous prescriptions which were not in compliance with the standards of treatment set out in the Ministry of Health ("MOH") guidelines that were applicable to him. In his last prescription to the Patient on 31 July 2012, Dr Ang had prescribed Mirtazapine and Zolpidem CR at a level that exceeded the maximum dosage limit as provided for in the product inserts.

5 On 4 August 2012, a few days after Dr Ang's last prescription to the Patient, the Patient passed away. The cause of the Patient's 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.

6 After these findings were released, the Patient's sister filed a suit against the Patient's insurers (the "Civil Proceedings"), in which the central issue 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. 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 Court of Appeal found that 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], and 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 [76], [111]–[113]).

7 On 11 April 2017, after the conclusion of the Civil Proceedings against the Patient's insurers on behalf of his estate, the Patient's sister filed a complaint against Dr Ang with the SMC, in relation to his treatment and care of the Patient. As noted above at [1], Dr Ang faced three charges for professional misconduct under s 53(1)(*d*) of the MRA, and three corresponding alternative charges under s 53(1)(*e*) of the MRA, with each pair of charges being brought on the basis of the same factual averments. The first pair of charges 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 of charges concerned Dr Ang's last prescription to

the Patient issued on 31 July 2012. The key factual elements of each pair of charges are summarised in the following table:

<table>
<tr><th>1st pair of charges</th><th>2nd pair of charges</th><th>3rd 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 12.5mg</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>

8 The DT convicted Dr Ang of the three professional services charges and imposed various sanctions on him, notably, a 24-month suspension from practice. Both Dr Ang and the SMC appealed against the DT's decision. We heard the appeals and in the Liability Judgment, we set aside the DT's decision and convicted Dr Ang of the three professional misconduct charges, save that not all the factual averments were found to be made out in relation to the first two professional misconduct charges. The key factual elements of each of the three professional misconduct charges for which we found Dr Ang to be liable (the "Charges") are summarised in the following table:

1st Charge	2nd Charge	3rd Charge
Concurrent prescription of two or more benzodiazepines to the Patient on various occasions		Prescribing a daily dosage of 60mg of Mirtazapine, in excess of the permitted maximum daily dosage of 45mg
Prescription of benzodiazepines despite being aware that the Patient was concurrently taking opioid analgesics		Prescribing a daily dosage of 25mg of Zolpidem CR, in excess of the permitted maximum daily dosage of 12.5mg

9 This leaves the question of the appropriate sanction to impose on Dr Ang. We will in our discussion below refer to salient paragraphs of the Liability Judgment that are important to the issue of sanction. Suffice to say for now that generally, in calibrating the level of harm in sentencing, one looks at the type of harm that the patient was being exposed to; and where a patient was exposed to very serious harm, like potential for death, then one calibrates the level of harm having regard to the potential harm that could happen. On culpability, one looks at the conduct that leads to the problem. There is a difference between a one-off improper treatment and the maintenance of improper treatment over a sustained period where a patient is exposed to damage and the physician fails to take that risk into account. Relatedly in sentencing, a relevant factor to look at in calibrating how we should classify the physician's culpability in a particular case is where the physician having considered the risk had in his mind thought that he was justified in deviating from the standard to treat his patient, but it turned out to be the wrong decision or that he did so without the patient's consent. Culpability will be high where objectively a physician knew that he

had deviated from the standard but could not mount a justification for it, and the inference is that he probably had no justification in so deviating.

The applicable legal principles in determining the appropriate sanction

10 The parties are in agreement that the principles relevant to the question of sentence are those set out in the SMC's Sentencing Guidelines for Singapore Medical Disciplinary Tribunals (June 2020 Edition) ("SMC Sentencing Guidelines"), which in turn is based on the sentencing framework for offences under the MRA in *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 ("*Wong Meng Hang*") at [30]–[44], (hereinafter referred to as the "*Wong Meng Hang* framework"). We accept that the *Wong Meng Hang* framework is applicable "to cases where deficiencies in a doctor's clinical care causes harm to a patient" such as the present (*Wong Meng Hang* at [36]) and begin by briefly summarising the steps of this framework.

11 The first of these steps entails evaluating the seriousness of the offence by ascertaining the levels of harm and culpability within which each case falls. The former is determined with reference to the type and gravity of the *actual* harm caused to the patient as a result of the offence, but, crucially, also includes *potential* harm of which there was a sufficient likelihood, even if no actual harm materialised (*Wong Meng Hang* at [30(a)]). Culpability refers to "the degree of blameworthiness disclosed by the misconduct", determined with reference to the offender's involvement in causing the harm; his or her state of mind when committing the offence; the extent to which the offending conduct departed from standards reasonably expected of a medical practitioner; and all other circumstances surrounding the commission of the offence (*Wong Meng Hang* at [30(b)]).

12 Next, the second step entails identification of the indicative sentencing range based on the identified levels of harm and culpability applicable in the instant case, in accordance with the matrix set out below (*Wong Meng Hang* at [33]):

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

13 The third step entails identification of the appropriate starting point *within* the range identified in the second step. This again turns on the level of harm and culpability in the case at hand and is simply a matter of granulating the facts of the case to identify a more precise point within that range and does not involve the double-counting of any factors (*Wong Meng Hang* at [42]).

14 Fourth, the indicative starting point may be further calibrated based on offender-specific factors which do not relate directly to the offence in question. A long unblemished track record, good professional standing, a timely plea of guilt, and in certain situations an undue delay in prosecution, may operate as potential mitigating factors warranting a downward adjustment in sentence. Conversely, a prior history of professional misconduct may amount to an aggravating factor warranting an upward adjustment to the sentence, especially

where that history demonstrates recalcitrance, lack of insight, or unwillingness to adhere to the values and ethos of the profession (*Wong Meng Hang* at [43]).

15 After the appropriate individual sentences for each of the charges are determined, the overall sentence should then be calibrated by applying the one-transaction rule and the totality principle (*Singapore Medical Council v Ling Chia Tien* [2024] SGHC 283 ("*Ling Chia Tien*") at [52] and [70]).

The parties' cases

16 It is not disputed that the *Wong Meng Hang* framework is in principle applicable to the question of the appropriate sanction. The parties' disagreement centres first on the levels of harm and culpability in respect of each of the Charges. They also disagree on the relevance of various offender-specific factors (both aggravating and mitigating), and the impact those factors should have on the final sentence. We thus set out the parties' cases below in brief and expand upon their arguments where necessary and appropriate in our discussion of each step of the *Wong Meng Hang* framework.

Dr Ang's case

17 Dr Ang's position is that the appropriate sentence would be a suspension of practice for three months, as well as a censure, and an order that he provide a written undertaking to refrain from engaging in the conduct complained of, or any similar conduct, in the future. A summary of Dr Ang's position applying the *Wong Meng Hang* framework is as follows:

Part of the framework	**For the offences in all three Charges**
Harm	Slight (lower end).

Culpability	Medium (lower end).
Applicable indicative sentencing range	Suspension of 3 months to 1 year.
Appropriate starting point	6 months each for the 1st and 2nd Charges, and 3 months for the 3rd Charge.
Mitigating factors	Cooperation with the SMC's investigations. Long, unblemished record and good professional standing. Inordinate delay in prosecution of some 3.5 years (which warrants a 50% discount on sentence). Dr Ang's remorse.
Adjusted starting point for each Charge	3 months for the 1st Charge. 3 months for the 2nd Charge. 1.5 months for the 3rd Charge.
Overall sentence	All three Charges should run concurrently because of the one-transaction rule, leading to global sentence of 3 months.

The SMC's case

18 The SMC's position as set out in its written submissions is that the appropriate sentence would be a suspension of 36 months from practice, as well as a censure, and that Dr Ang provide a written undertaking to refrain from engaging in the conduct complained of, or any similar conduct, in the future. A summary of the SMC's position applying the *Wong Meng Hang* framework is as follows:

Part of the framework	**For the offences in all three Charges**
Harm	Moderate (mid-range) for the 1st Charge.

	Moderate (lower end) for the 2nd Charge. Moderate (lower end) for the 3rd Charge.
Culpability	High (highest end) for the 1st Charge. High (highest end) for the 2nd Charge. High (highest end) for the 3rd Charge.
Applicable indicative sentencing range	Suspension of 24 to 36 months.
Appropriate starting point	28 to 30 months for the 1st Charge. 26 to 28 months for the 2nd Charge. 24 to 27 months for the 3rd Charge.
Aggravating factors	Dr Ang's high standing as an experienced and renowned specialist. Dr Ang's lack of genuine remorse and insight for his conduct. The overall severity of Dr Ang's conduct.
Mitigating factors	There was some prosecutorial delay.
Adjusted starting point for each Charge	18.7 to 20 months for the 1st Charge. 17.3 to 18.7 months for the 2nd Charge. 16 to 18 months for the 3rd Charge.
Overall sentence	The sentences under the 1st and 2nd Charges should run consecutively, with the sentence under the 3rd Charge to run concurrently.

Issues to be determined

19 Pursuant to the steps of the *Wong Meng Hang* framework, the following issues therefore arise for determination:

(a) what the appropriate level of harm for each of the Charges should be;

(b) what the appropriate level of culpability for each of the Charges should be;

(c) what the indicative range and starting point for each of the Charges should be;

(d) what offender-specific aggravating and mitigating factors should be considered; and

(e) whether the sentences for the Charges ought to run concurrently or consecutively.

What the appropriate level of harm for each of the Charges should be

20 We begin by considering what the appropriate level of harm for each of the Charges should be.

21 Counsel for Dr Ang, Mr Christopher Chong ("Mr Chong") says that the level of harm for each of the Charges should be at the lower end of the "Slight" category. This was on the basis that the present case only involved a *potential* risk of harm and not actual harm. Mr Chong emphasises in submissions that the SMC's case is not that Dr Ang's prescriptions caused the death of the Patient. He observes that in cases involving inappropriate prescriptions of benzodiazepines, severe harm is made out where patients lose their ability to function professionally, socially, or suffer long-term organ damage or death. Moderate harm is typically made out where there is either actual or high risk of addiction. On the other hand, where there is no evidence of actual harm, either in the form of addiction or physiological damage, precedents have typically found that the harm caused was slight, even where over ten patients were involved. The harm in such cases only increases where the inappropriate

prescription in question takes place over a prolonged period of time or where many patients were involved.

22 Mr Chong further submits that the present case did not give rise to any harm to public confidence in the medical profession and healthcare system. This was because his departures from the relevant guidelines were not the product of recklessness or wanton disregard for the Patient's welfare, but were part of a good faith attempt to manage the Patient's multiple, complex, and difficult psychiatric conditions. He also highlights the DT's observation that he had attempted to meet the standard of professional medical care expected of a reasonable and competent psychiatrist. Any harm to public confidence in the medical profession and healthcare system would be further attenuated by the fact that his breaches related only to a single patient with whom he had an "effective therapeutic relationship".

23 In contrast, counsel for the SMC, Mr Edmund Kronenburg ("Mr Kronenburg") says that the level of harm for the 1st Charge ought to be placed in the middle of the "Moderate" category, and in the lower end of the same category for the 2nd and 3rd Charges. This is primarily based on the considerable risks inherent in the concurrent prescription of multiple benzodiazepines, and concurrent prescription of benzodiazepines with opioid analgesics. However, as the 2nd Charge comprised fewer breaches than the 1st Charge, the harm associated with the former would be slightly lower than the latter. Thus, while both the 1st and 2nd Charges entail a moderate level of harm, the first falls within the middle of that range, while the second falls on the lower end. As for the level of harm associated with the 3rd Charge, Mr Kronenburg's submission is premised primarily on the significant extent to which Dr Ang exceeded the maximum daily dosages of Mirtazapine and Zolpidem CR. He also submits that Dr Ang's conduct gave rise to harm to public confidence in the

medical profession, given the large number of unjustified prescriptions and his status as a specialist.

The level of harm in relation to the 1st and 2nd Charge

24 As mentioned, Dr Ang's position in written submissions was to place the harm for all three Charges at the lower end of the "Slight" range. At the hearing, we questioned Mr Chong on his justification for this level of harm as opposed to another level. We do not accept Mr Chong's justification which is primarily based on guidance from some cases involving general practitioners, and in those cases the risks were materially different to those we are concerned with here (see [26] below). In our judgment, the level of harm associated with the 1st and 2nd Charges is closely linked to the severity of the potential harm which the Patient could have suffered because of Dr Ang's prescriptions. Even though the SMC's case against Dr Ang is predicated on the potential harm which the offending prescriptions might have caused the Patient – rather than any actual harm resulting therefrom – we find it difficult to ignore the fact that the level of potential harm associated with these prescriptions was *severe*. As we observed in the Liability Judgment, the prescription of multiple benzodiazepines entails risk of central nervous system ("CNS") depression, sedation, respiratory depression, and cardiovascular depression (at [110]). The risks inherent in the concurrent prescription of benzodiazepines with opioid analgesics are "of a similar nature, albeit of a greater magnitude", as they may disproportionately increase the CNS depressant effect of the respective medications and result in cardiorespiratory depression, hypotension, coma and death (Liability Judgment at [111]). Both Dr Ang's and the SMC's expert witnesses agreed that this was generally not advisable. Both parties' experts also cited literature from various United States regulatory bodies warning against such practices in the strongest terms, one of which expressed the view that the

expected utility of concurrent prescription of opioids and benzodiazepines was negative *except possibly in patients suffering from terminal illness* (Liability Judgment at [111]).

25 The severity of the potential harm which the Patient could suffer because of the offending prescriptions means that the level of harm for the 1st and 2nd Charge is, in our judgment, most appropriately placed in the middle of the "Moderate" level. This position is consistent with the SMC Sentencing Guidelines (at paras 50 and 52), which generally places cases involving substantial potential for serious personal injury at the "Moderate harm" level.

26 As for Dr Ang's reliance on numerous benzodiazepine-related precedents involving only potential harm to support his position that the level of harm in the present case would be most appropriately regarded as slight, these being *Singapore Medical Council v Dr Tan Kok Jin* [2019] SMCDT 3 ("*Tan Kok Jin*"), *Singapore Medical Council v Dr Eugene Ung* [2021] SMCDT 4 ("*Eugene Ung*"), and *Singapore Medical Council v Dr Ling Chia Tien* [2023] SMCDT 7 ("*Ling Chia Tien (DT)*"), those cases are all clearly distinguishable from the present case. While they had all involved potential rather than actual harm, the potential harm in those cases related to *tolerance, drug dependence, abuse, and/or addiction* (*Tan Kok Jin* at [43]; *Eugene Ung* at [52]; *Ling Chia Tien (DT)* at [192]). This was quite different from the risks involved in the present case (see [24] above), which were far graver in nature. As such, those cases could not be of assistance to Dr Ang, and could not be read as suggesting that cases involving only potential rather than actual harm would always or even generally fall within the lowest category of harm.

27 For completeness, this court had further explained in *Ling Chia Tien* (at [86]–[87]) that although Dr Ling had made concomitant prescriptions of two or

more benzodiazepines, or of one or more benzodiazepine with codeine (which is an opiate) to treat cough , and was unable to provide a satisfactory justification for such prescriptions, the SMC in that case had failed to discharge their burden of proving that such prescriptions would cause increased potential or actual harm. It was, therefore, because of the SMC's failure to establish the higher level of harm which it had asserted that the level of harm was ultimately found to be slight in *Ling Chia Tien*. This is not applicable in the present case because the SMC had established the high levels of potential harm which Dr Ang's prescriptions exposed the Patient to (see [24] above).

The level of harm in relation to the 3rd Charge

28 As for the level of harm in relation to the 3rd Charge, this is likewise to be determined based on the potential harm which the Patient could have suffered as a result of Dr Ang's last prescription. In our view, the gravity of the potential harm was severe. This is firstly reflected in Dr Ang's own concession in the Civil Proceedings, which we considered in the Liability Judgment at [145] (see below at [48]), that his prescription of 60mg of Mirtazapine per night went to the "edge of the killing range". Moreover, although it is not the SMC's case that Dr Ang had actually caused the Patient's death, and even though this was not averred in any of the charges (DT Decision at [79]), it remains open to the court to make logical inferences from the facts. For example, in *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 180 ("*Wee Teong Boo*"), the Agreed Facts did not contain any statement to the effect that certain patients suffered from drug dependency issues, and the respondent also did not mention in his Letter of Explanation that those patients were dependent on codeine or benzodiazepines. However, based on the frequency with which those patients had been prescribed the medications in question, and the fact the respondent had known *other* patients to be dependent, the court nonetheless drew an inference

that the respondent must have known that those patients were dependent on the medications in question and that his prescriptions were perpetuating their dependency (*Wee Teong Boo* at [49]–[50]).

29 In the present case, we find it difficult to ignore the fact that the Patient's cause of death had been certified as "multi-organ failure with pulmonary haemorrhage, *due to mixed drug intoxication* [emphasis added]" (Liability Judgment at [5]). Not only does this underscore the very real risk of very severe harm which was inherent in Dr Ang's prescriptions, we also cannot ignore the fact that the Patient's cause of death was found to have been the result of the combination of multiple drugs whose prescription Dr Ang was unable to justify. Thus, even though the SMC's case is not predicated on actual harm or a causal link between Dr Ang's prescriptions and the Patient's death, the fact of the Patient's death is something which this court is entitled and indeed obliged to take into account in assessing the risks inherent in the prescription which immediately preceded it.

30 In our view, the grave risks which Dr Ang's prescriptions entailed set this case apart from all the precedents upon which he sought to rely in support of his position on harm. As we have noted above at [26], the harm with which these cases were concerned largely entailed the risk of dependency and addiction, rather than death. Even the case of *Wee Teong Boo*, which for reasons discussed below at [44] involved a far more egregious level of culpability on the part of the respondent doctor, was arguably at least comparable in terms of the gravity of potential harm involved. At least among benzodiazepine-related precedents, in so far as potential harm is concerned, the present case stands alone in terms of the seriousness of the harm involved. Whilst Mr Chong adjusted Dr Ang's position on the appropriate level of harm from "Slight" to "Moderate" at the hearing before us, the SMC accepted that the harm associated

with the 3rd Charge could cross over into the most severe level. We are satisfied that the harm inherent in the 3rd Charge is most appropriately placed at the "Severe" level, albeit at the lowest end thereof.

Harm to public confidence in the medical profession

31 In relation to the harm caused to society by Dr Ang's misconduct (*ie*, harm to public confidence in the medical profession), we observe that, all else being equal, this is correlated with the actual or potential harm to the patient arising from the misconduct in question – naturally, the greater the actual or potential harm, the greater the harm would be to public confidence in the medical profession (SMC Sentencing Guidelines at para 51(f)). This being the case, we are of the view that the harm done to public confidence in the medical profession would largely mirror the levels of potential harm to the Patient which we have found to be appropriate in respect of each of the charges (see [25] and [29] above).

32 Finally, we do not think that any weight could be given to the DT's observation that Dr Ang had attempted to meet the standard of professional medical care expected of a reasonable and competent psychiatrist (see [22] above). That observation by the DT is not relevant to establishing a lower level of harm in the present case. At its very highest, it might militate against a finding of a heightened level of harm caused to public confidence in the medical profession.

What the appropriate level of culpability for each of the Charges should be

33 In relation to the appropriate level of culpability for each of the Charges, we first summarise the respective positions of the parties. Mr Chong says that

Dr Ang's culpability was at the lower end of the medium level for each. Although he accepts that an offence under s 53(1)(*d*) of the MRA is in principle associated with a higher degree of culpability than one under s 53(1)(*e*) of the MRA, he reiterates Dr Ang's position that he was trying his best to alleviate the Patient's suffering, and was motivated by genuine concern for the Patient. Mr Chong argues that Dr Ang's due diligence is evident from his documentation and treatment plans, his plan to eventually wean the Patient off the medications, and the improvements which the Patient experienced in his sleep, anxiety, mood, and daily functioning. Mr Chong also points out that the risks inherent in Dr Ang's prescriptions did not materialise. Finally, when compared to precedents in which culpability was found to be in the medium range, factors such as the limited number of patients and the shorter duration of the prescriptions likewise militate in favour of a finding of lower culpability.

34 Mr Chong also submits that there was no profit-motive operative in the present case which would militate in favour of a higher degree of culpability. He argues that it is entirely speculative to claim that Dr Ang "probably still made substantial profits", and points out that his invoices included those medications whose prescription were found in the Liability Judgment to have been justified. Mr Chong defends the DT's finding that financial gain was not Dr Ang's primary motive in departing from the relevant guidelines, and further submits that it was not a motive at all, and that in any event Dr Ang was not cross-examined on this point. The ultimate question is not simply the fact of profit, but whether the practitioner subjectively favoured their own interests over those of their patient, which was clearly not the case.

35 In this connection, Mr Chong says that it would not be correct to compare Dr Ang's case to that of *Wee Teong Boo*. He points out that the respondent in *Wee Teong Boo* had issued prescriptions the sole purpose of

which were to fuel his patients' addictions. This and other exceptional factors clearly set *Wee Teong Boo* apart from the present case, and there is no basis for claiming that Dr Ang's level of culpability was similar.

36 In contrast, the SMC's position is that Dr Ang's culpability in relation to all three Charges was at the apex of the high range. In relation to the 1st and 2nd Charges, Mr Kronenburg for the SMC focuses on the finding in the Liability Judgment that Dr Ang intentionally and deliberately departed from the applicable standard of conduct, and submits that it must follow that his culpability ought to be at the highest end of the spectrum. Mr Kronenburg further emphasises Dr Ang's failure to demonstrate clear medical grounds for departing from the applicable standards; the duration and frequency of his offending behaviour; and the abuse of trust and confidence which such behaviour would have entailed.

37 As for the 3rd Charge, Mr Kronenburg focuses on the finding in the Liability Judgment that Dr Ang had known of the applicable maximum dosage limits, the fact that he was exceeding them, and the high risks which doing so entailed. Mr Kronenburg also emphasises the significant extent to which Dr Ang exceeded the daily dosage limits of Mirtazapine and Zolpidem CR (*ie*, by 33% and 100% respectively).

38 Moreover, in relation to all the Charges, Mr Kronenburg argues that Dr Ang must have made some profit from those prescriptions which he remained unable to justify.

The level of culpability in relation to the 1st and 2nd Charges

39 On the question of Dr Ang's culpability, we will deal with the first two charges together. At the outset, we find Mr Chong's submission that Dr Ang

had carried out proper due diligence to be untenable. In the context of the 1st and 2nd Charge, we had found as follows (Liability Judgment at [112]–[114]):

> 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.
>
> [emphasis added in bold italics]

40 Dr Ang was convicted of the 1st and 2nd Charges precisely because he had failed to carry out proper due diligence. Having departed from established standards of treatment, he needed "to explain specifically why he chose to proceed in the manner he did, despite the significant risks" and needed to persuade the court that the prescriptions were "justified". However, as we had found, "the evidence did not even show that Dr Ang had applied his mind to these risks at the material time" (Liability Judgment at [112]). Neither was there any evidence of the effectiveness of the alleged protective measures Dr Ang had taken, such as "the extent to which they might negate the harm from [adverse drug-drug interactions occurring]". In fact, at times, the Patient was only monitored by Dr Ang via "telephone and outpatient consultations" (Liability Judgment at [114]). The times the Patient was an inpatient whilst being exposed to harm does not displace the fact that the Patient was still exposed to that harm which was still present. There was nothing which could be described as due diligence on Dr Ang's part, which might have gone towards reducing his culpability.

41 At the same time, and contrary to the SMC's submission, we do not think the mere fact that Dr Ang had been aware of the appliable guidelines and yet intentionally and deliberately departed from applicable standards of conduct must mean that his level of culpability necessarily falls on the highest end of the high range. As we held in the Liability Judgment (at [60]), where a treatment

does not conform to codified standards, an assumption of inappropriate treatment arises, and the evidential burden shifts to the defending medical practitioner to rebut this assumption by demonstrating that he had clear medical grounds. Crucially, the existence of clear medical grounds is foremost an *objective* inquiry, which involves a consideration of the *objective* risks and benefits of the treatment in question (Liability Judgment at [68]). If the practitioner fails to satisfy this test, as Dr Ang failed to do in respect of the offending prescriptions, then so long as he is found to have known of the standard of treatment in question and departed from it, it will necessarily follow that the departure will be considered intentional and deliberate.

42 However, because the nature of the inquiry into the existence of clear medical grounds is *objective*, it does not account for the distinction between a doctor who *subjectively* but erroneously believed that such grounds existed or that there was at least some legitimate reason for doing so, and a doctor who acted for reasons which are on their face illegitimate, such as to make a profit for himself from unnecessary treatment or unwarranted prescriptions. And although subjective intent or belief is not relevant to liability, the same does not hold true in the context of determining culpability for purposes of sentencing, which entails an assessment of the blameworthiness of the particular doctor and must depend at least in part on his or her subjective beliefs and thought processes. A doctor who prescribes medication in excess of generally accepted limits solely to enrich himself is self-evidently more blameworthy and culpable than one who does so because lower dosages have proven ineffectual in ameliorating his patient's condition, even if the objective benefits of doing so are eventually found to be dwarfed by the risks. It cannot be correct as a matter of principle to paint all doctors who intentionally depart from codified standards of treatment with the same brush in terms of their level of blameworthiness, regardless of their reasons for doing so. Indeed, as observed in *Wong Meng*

Hang, the culpability of an errant doctor depends not only on whether he intended to depart from accepted standards of care, but must take into account his motivations and overall state of mind when committing the offence (at [37]). Drawing on this observation from *Wong Meng Hang*, the SMC Sentencing Guidelines at para 54 observe that while an intentional and deliberate departure from standards will typically attract a higher degree of culpability than negligence or recklessness, a sentencing tribunal should:

> … carefully consider the circumstances of the case before them. For example, a doctor's intentional departure from medically-approved standards that was motivated by a genuine but mistaken concern for the patient's interest may be less culpable than a doctor who acted negligently but in blatant disregard of the patient's well-being.

43 In the present case, we did not see any basis to find that there was any profit-motive on Dr Ang's part, which may have warranted an increase in his level of culpability. Unless it can be shown that a doctor issued prescriptions or engaged in conduct with a *subjective* intent to solely enrich himself, the *objective* fact that a doctor may have made some profit from the medication prescribed is, without more, a neutral factor.

44 This is one significant basis which distinguishes the present case from those of *Wee Teong Boo* and *Singapore Medical Council v Dr Tham Ngiap Boo* [2023] SMCDT 4 ("*Tham Ngiap Boo*"), upon which the SMC sought to rely in support of its position on culpability. In *Wee Teong Boo*, this court found that the respondent not only knew that his patients were dependent on codeine-containing cough mixtures and benzodiazepines, but had also prescribed these medications for the sole purpose of allowing his patients to abuse them, effectively serving as a supplier of such drugs (at [56] and [66]). Similarly, in *Tham Ngiap Boo*, the DT found that the respondent "must have known that his excessive and prolonged prescriptions would contribute to his

patients' dependency, or cause his patients to become dependent, on the drugs" (at [12]). Moreover, the "huge quantity" of benzodiazepines and hypnotics prescribed led to the "irresistible inference" that they had been prescribed for monetary gain (*Tham Ngiap Boo* at [26(a)]). None of these illegitimate motives were present in Dr Ang's case.

45 With these observations in mind, the level of culpability for the 1st and 2nd Charges ought in our judgment to fall within the middle of the medium level. This recognises the fact that Dr Ang had not been acting in his own self-interest or from any patently illegitimate motive, but it also reflects his blameworthiness in failing to properly consider the risks of his treatment methods (see [39] above) or in obtaining consent from the Patient, and the fact that he ought to have known better as a specialist and senior medical practitioner. We explain.

46 As will be recalled, Dr Ang's case was that the severity and complexity of the Patient's condition made the concurrent prescription of multiple benzodiazepines and the concurrent prescription of benzodiazepines with opioid analgesics necessary, in order to relieve his psychiatric symptoms and for him to lead a normal life (Liability Judgment at [107]–[109]). Although Dr Ang was well-intentioned in this regard, his conduct is blameworthy because of two reasons. First, when deciding to engage in pharmacological practices which were in stark contravention of the standards of treatment set out in the guidelines, it was incumbent on Dr Ang to ensure that the risks thereof were *objectively* ameliorated to an extent that they would be outweighed by their benefits. If the risks outweighed the benefits, there would be no justification for embarking on such a course of treatment. As we had found in the Liability Judgment, Dr Ang was unable to objectively "justify these prescriptions in the light of the risks they entailed" (at [112]). This was aggravated by Dr Ang's

position as a specialist and senior medical practitioner. By virtue of his status, experience and training, he would have been expected to demonstrate a greater degree of competence in managing the risks associated with his prescriptions, as compared to a general practitioner. Yet as we observed in the Liability Judgment, not only did Dr Ang fail to demonstrate the availability and efficacy of protective measures which might have been deployed to counteract the adverse effects of any drug interactions while the Patient was being treated as an *inpatient*, there is very little which could conceivably have been done had such effects manifested during the substantial periods in which Dr Ang was treating the Patient as an *outpatient* (at [114]). In our view, these severe deficiencies in Dr Ang's risk management must be taken as increasing his culpability.

47 Second, and perhaps more importantly, even if we accept that Dr Ang genuinely believed it necessary to go outside the bounds of accepted standards of treatment if the Patient was to be able to live a normal life, it is difficult to excuse his failure to inform the Patient of the real and severe risk of the treatment possibly *ending* his life altogether. In our view, there is no "double counting" so to speak, when considering this factor in the assessment of culpability at the sentencing stage here. We will now explain. In certain cases, the failure to obtain consent alone may be a ground for action if the danger of harm was sufficiently grave (Liability Judgment at [76]-[82]). In these cases, since the failure to obtain consent would be an element of the charge made out against the doctor at the liability stage, it would not be appropriate to take this fact again to aggravate culpability at the sentencing stage – to avoid double-counting. However, in the present case, since lack of informed consent was not used as a basis for finding against Dr Ang for his misconduct (Liability Judgment at [98], [128]-[135]), it would be appropriate to account for this at sentencing. We had explained the significance of informed consent in the

Liability Judgment (at [76] and [82]) as so: in situations where a doctor wishes to depart from the relevant guidelines, "[w]here 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". It would have been incumbent on Dr Ang to ensure that the Patient was fully aware that while departing from established standards of treatment might relieve his undoubtedly severe and debilitating symptoms, they also carried a real risk of *death*, such that the Patient would have been in a position to decide whether this risk was worth undertaking and make a fully informed decision on the treatment options available to him. It is simply not for a doctor to dice with the life of a patient on the patient's behalf, especially where the risks inherent in a course of treatment are as significant as in the present case, no matter how well-intentioned or justifiable the doctor thinks that it is worth the gambit. Dr Ang's failure to inform the Patient of the relevant risks and obtain informed consent, while not the subject of a separate charge, thus increases his blameworthiness in the present case. The converse does not hold true. Had Dr Ang been able to demonstrate that he had in fact obtained the Patient's fully informed consent to this course of treatment (which was found to not be objectively justifiable), this would not have gone towards mitigating his culpability, it simply would not have been taken as an aggravating factor.

The level of culpability in relation to the 3rd Charge

48 In comparison to Dr Ang's conduct in relation to the 1st and 2nd Charges, we find his conduct here to be even more blameworthy. In the Liability Judgment, we had found as follows ([144]–[147]):

> 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.

49 Materially, the evidence had revealed that the prescription of Mirtazapine and Zolpidem CR above the limit set out in their product inserts was highly *dangerous*. In Dr Ang's own words, "his prescription of 60mg of Mirtazapine per night went to the 'edge of the killing range'", and "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" (Liability Judgment at [145]). Despite the highly dangerous nature of this prescription, and despite being aware of the risks it entailed, Dr Ang proceeded to increase the dosages of these medications without any good reasons for doing so, and without obtaining the Patient's informed consent (Liability Judgment at [146] and [148]). As we have explained earlier (see [46] and [47] above), this increases his culpability, and this blameworthiness was aggravated by his status as a specialist and senior medical practitioner.

50 Crucially, unlike the prescriptions underlying Dr Ang's conviction on the 1st and 2nd Charges, Dr Ang was not even able to explain "why he thought the risks to the Patient were worth taking" (Liability Judgment at [146]), or what steps he took which he subjectively believed would ameliorate the risks inherent in doing so. In the Liability Judgment (at [137]–[139]), we had rejected Dr Ang's explanation that "his prescription was made in order to keep the Patient's use of benzodiazepines low, especially through the use of Mirtazapine" as this was inconsistent with the actual history of prescriptions made to the Patient (Liability Judgment at [139]). Moreover, as we had observed in the Liability Judgment (at [144]), Dr Ang had not shown that he had considered the potential for drug interactions with the other drugs which the patient had been prescribed when increasing the dosages of Mirtazapine and Zolpidem CR so far beyond the limits set out in the package inserts. This apparent failure is of grave concern, given that the Patient was already being prescribed multiple benzodiazepines

and opioids at all material times, and the potential for drug interactions was therefore always present.

51 In our view, the lack of any explanation given for the increased dosages and the absence of thought given to how this might affect potential drug interactions is indicative that the last prescription could not even subjectively have been made with a genuine but mistaken concern for the Patient's interest. Instead, it suggested that there was no justification at all for the last prescription. The implication is that the last prescription was made with a lack of care and thought that mirrored a blatant disregard for the Patient's interest.

52 In our judgment, this calls for a higher level of culpability as compared to the 1st and 2nd Charge, and we thus find that the level of culpability for the 3rd Charge is appropriately situated at the low end of the high level.

The indicative range and starting point for each of the Charges based on the foregoing two factors

53 To summarise, we find that the levels of harm and culpability, the applicable indicative sentencing ranges, and the appropriate starting point for each of the Charges are as follows:

	1st Charge	**2nd Charge**	**3rd Charge**
Harm	Middle of moderate level	Middle of moderate level	Low end of severe level
Culpability	Middle of medium level	Middle of medium level	Low end of high level
Applicable indicative sentencing range	Suspension of 1 to 2 years	Suspension of 1 to 2 years	Suspension of 3 years or striking off
Appropriate starting point	18 months	15 months	36 months

54 On the difference in indicative starting points as between the 1st and 2nd Charges, we accept the SMC's submission, set out above at [23], that the level of potential harm associated with the 1st Charge ought to be regarded as higher than that associated with the 2nd Charge, due to the higher number of offending prescriptions and longer duration covered by the 1st Charge. As Mr Kronenburg explained, the duration of Dr Ang's misconduct under the 1st Charge was 22 months (inclusive of 38 occasions of concurrent prescription of multiple benzodiazepines and 50 occasions of concomitant prescriptions of benzodiazepines and opioid analgesics), and the duration under the 2nd Charge was seven months (inclusive of seven occasions of concurrent prescription of multiple benzodiazepines and four occasions of concomitant prescriptions of benzodiazepines and opioid analgesics).

55 In this regard, we note Mr Chong's suggestion that the only reason the first two charges were brought separately was because of a change in the guidelines. We do not see how this observation would have been of assistance

to Dr Ang. Had the SMC instead elected to bring a single charge in place of the first two charges, this single charge would logically have covered a longer period of treatment during which errant prescriptions had been made. This longer period would have invariably entailed a higher level of potential harm, warranting a higher indicative starting point. Indeed, the SMC's decision to bring two separate charges allows for the possibility that the sentences for these charges may be ordered to run concurrently rather than consecutively. We will discuss concurrent and consecutive sentences in the context of disciplinary proceedings below (at [80]-[81]).

The relevant offender-specific aggravating and mitigating factors that should be considered

56 Having established the indicative starting points for each of the charges, we turn next to the relevant offender-specific aggravating and mitigating factors which may be relevant in calibrating these starting points. As will be recalled, Dr Ang says that his cooperation with the SMC's investigations; unblemished record and good standing; the delay in prosecution of the present case; and his personal regret that his attempts to manage the Patient amounted to professional misconduct, are mitigating factors that should be counted in his favour. Although the SMC accepts that prosecutorial delay may warrant a downward calibration of the overall sentence, it also identifies Dr Ang's status as a psychiatric specialist, his lack of remorse and insight into his conduct, and the severity of his conduct as aggravating factors.

Dr Ang's status as a psychiatric specialist and his seniority

57 In our judgment, Dr Ang's status as a psychiatric specialist, his seniority in practice, and his standing within the medical community clearly constitute an aggravating factor. The rationale for this can be found in this court's holding in

Ang Peng Tiam v Singapore Medical Council and another matter [2017] 5 SLR 356 ("*Ang Peng Tiam*") at [93]:

> … in the specific context of disciplinary proceedings for professional misconduct, an offender's eminence and seniority is an aggravating factor. As stated at [89] above, one of the key functions that disciplinary proceedings serve is to uphold the standing of the medical profession in the eyes of the public. Seniority and eminence are characteristics that attract a heightened sense of trust and confidence, so that when a senior and eminent member of the profession is convicted of professional misconduct, the negative impact on public confidence in the integrity of the profession is correspondingly amplified.

Indeed, Dr Ang does not dispute that this can be considered an aggravating factor at this stage of the *Wong Meng Hang* framework.

58 Even though we found earlier that Dr Ang's status as a specialist increased his level of culpability (see [46] and [47] above), the present consideration of Dr Ang's seniority and specialist status as an aggravating factor does not amount to double counting, as the rationale behind the consideration of this factor at each stage of the analysis is different. In the context of culpability, Dr Ang is more culpable as a specialist because he possesses more experience and training – and thus a higher level of skill as compared to general practitioners and ought to have been more competent in knowing about and managing the risks associated with his prescriptions, and in obtaining informed consent from the risks that he was aware of. His failure to do so led to him being more culpable. On the other hand, since Dr Ang is held out as a person with special skill and expertise, it is inevitable that greater expectations will be placed on him, as compared to a general practitioner. This is accompanied by an enhanced level of professional accountability which must now be accounted for because Dr Ang had failed to meet the expectations placed on him. As for Dr Ang being a senior practitioner, his increased blameworthiness here stems from

his standing within the medical profession. This is twofold. First, when a senior practitioner such as Dr Ang misconducts himself, the harm to the profession is naturally much greater as compared to when an inexperienced junior doctor does so. Second, as Mr Kronenburg submitted at the hearing, Dr Ang's seniority lay not just with his number of years in the profession, but with his stature within the profession. Dr Ang held positions of prominence within the profession that included *inter alia* stints as "President of the Singapore Psychiatric Association", "Chairman of the Chapter of Psychiatrist Academy of Medicine" and "Chairman of the Psychiatric Committee for Mount E[lizabeth] Hospital". We agree with Mr Kronenburg that Dr Ang is no "ordinary senior doctor", but someone who is highly regarded in the profession, even when compared with other senior doctors. With great position comes great responsibility and we agree with Mr Kronenburg that there is greater erosion of public confidence in the medical profession when someone of Dr Ang's stature misconducts himself. The common thread running through both these factors is that they all "attract a heightened sense of trust and confidence" such that "the negative impact on public confidence… is correspondingly amplified" as a result of his misconduct (*Ang Peng Tiam* at [93]). This aggravating effect on the public disquiet caused by his status as a specialist and a senior practitioner is therefore appropriately accounted for at this stage.

59 In this connection, we did not accept that Dr Ang's good track record should be accorded any significant mitigatory weight. In this regard, we have little more to add to the observations we made in *Ang Peng Tiam* (at [104]):

> Therefore, it may be said, generally, that when a senior and eminent member of the medical profession is found guilty of professional misconduct, **any mitigating value that can be accorded on account of his good track record as a doctor will at best be modest**, especially when the offence committed is one that calls for general deterrence.

[emphasis added in bold]

Inordinate delay in prosecution

60 As noted above at [17]–[18], both Dr Ang and the SMC originally took the position in their written submissions that there was a delay which in principle warranted a discount of the overall sentence, with their disagreement being simply over the extent of the discount which would be appropriate in the present case. Dr Ang's position is that a discount of 50% would be appropriate. In this regard, he relies on the case of *Singapore Medical Council v Dr Chia Kiat Swan* [2019] SMCDT 1 for the proposition that there is a "benchmark period of 3 years that attracted a discount of 50% on the period of suspension in some past cases" (at [19]). He further relies on *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Jen Shek Wei*"), in which this court considered that the three year time period between the issuance of the Notice of Complaint and the Notice of Inquiry was "comparable to the delay in *Ang Peng Tiam*" such that the sentence should be reduced on account of inordinate delay (*Jen Shek Wei* at [169]). On the other hand, the SMC originally accepted that there had been some prosecutorial delay warranting a discount in sentence, and simply argued that Dr Ang should only be afforded a 30% discount in his sentence in view of the aggravating factors in the present case. However, at the oral hearing before us, Mr Kronenburg instead took the primary position that there was *no* inordinate delay, while maintaining that even if there was, the discount to be afforded to Dr Ang should not exceed one-third.

61 In our view, we do not think that any sentencing discount would be appropriate in the present case. It is trite that a discount in sentencing may be extended when there is a significant delay in investigation and/or prosecution, the underlying rationale for this being fairness to the offender. When there has been an inordinate delay in prosecution, "the sentence should reflect the fact

that the matter has been pending for some time, likely inflicting undue suffering that stems from the prolonged agony, suspense and uncertainty (*Ling Chia Tien* at [121] citing *Wong Poon Kay v Public Prosecutor* [2024] 4 SLR 453 ("*Wong Poon Kay*")). However, it is insufficient that there has been a delay, even if it is prolonged – the delay must also have been *inordinate*, in that it must be unusually long *and* inexplicable on reasonable grounds (*Ling Chia Tien* at [120] citing *Wong Poon Kay* at [68]). The delay must also be attributable to the Prosecution, or in the context of the MRA, to the SMC (*Wong Poon Kay* at [66]). The following cumulative conditions must therefore be satisfied before a court may decide to apply such a discount (*Ling Chia Tien* at [119], citing *Ang Peng Tiam* at [109] and *Wong Poon Kay* at [66]):

(a) there has been a significant delay in the investigation and/or prosecution of the matter;

(b) the delay has not been contributed to in any way by the offender; and

(c) the delay has resulted in real injustice or prejudice to the offender.

62 Moreover, it is trite that a party asserting a fact upon which he or she desires the court to give judgment has to prove the existence of that fact. As the party asserting that a delay was inordinate for purposes of a sentencing discount would invariably be the respondent doctor, the legal burden would fall upon the doctor to prove that there had been an inordinate delay. That said, once the doctor has made out a *prima facie* case of inordinate delay, perhaps by explaining why particular intervals during the proceedings were unnecessarily lengthy, the evidential burden may shift to the SMC to offer an explanation to the contrary. This is consistent with our past observations that it would promote

the expeditious conduct of proceedings if the SMC "provides information about matters that occurred some time ago in the past to the defendant and to the court or tribunal at an earlier stage of proceedings" (*Ling Chia Tien* at [120] citing *Wong Poon Kay* at [77] and *Ang Peng Tiam* at [117]).

63 We also take this opportunity to stress that the absolute length of a delay in and of itself *cannot* be taken as an indicator or proxy for whether the delay has been inordinate for purposes of sentencing discounts, and to the extent that past cases appear to suggest otherwise, we decline to follow them. As we have observed, the length of the delay must always be assessed in the context of the nature of investigations (*Wong Poon Kay* at [68] citing *Ang Peng Tiam* at [113]). More complex cases would necessarily require the SMC to spend a longer time before proceeding with the prosecution, making the inquiry into whether there has been an inordinate delay at its core highly fact-sensitive. Moreover, we have also observed that "it would be impracticable to refer only to the delay between the issuance of the notice of complaint and the notice of inquiry" (*Ling Chia Tien* at [122]). It would not be helpful to simply compare the length of delay in the present case against those of precedent cases to determine the appropriate discount (*Ling Chia Tien* at [123]). Instead, the correct approach would be to consider, amongst other things, "the reasons for the delay, whether the reasons proffered were defensible, and the effect that the delay would have had on the offender" (*Ling Chia Tien* at [123]).

64 This court's analysis in *Ling Chia Tien* serves as an example of this approach. There, this court first set out a detailed timeline of events, and then proceeded to consider the various exchanges between Dr Ling and the SMC, the appropriateness of their timelines, and the reasons (or lack thereof) for why certain processes which contributed to delays were required or repeated (*Ling Chia Tien* at [125]–[131]). For example, part of the reason why proceedings in

Ling Chia Tien had been unnecessarily prolonged was because of the appointment of two separate complaints committees, with each investigating the respondent's prescriptions of a different kind of medication (benzodiazepines and codeine) (at [8]–[11]). While the SMC's excuse for the delay was that the first complaints committee had no power to investigate codeine-related offences (which thus necessitated the appointment of a second complaints committee), both the DT and this court did not accept the excuse; they saw no reason why all the prescriptions could not have been investigated at one time (*Ling Chia Tien* at [129]). This being the case, drawing from the approach in *Ang Peng Tiam*, the court had found that there were insufficient reasons to explain the individual delays caused at three particular junctures (*Ling Chia Tien* at [132]). The court considered the circumstances in totality and noted the following delays (*Ling Chia Tien* at [134]):

> Taking the circumstances in the round, the following delays in this case were noted:
>
> (a) There was a gap of about 10 months between Dr Ling's First Letter of Explanation dated 23 April 2018 and the First CC informing him of a formal inquiry on 19 February 2019.
>
> (b) There was a gap of about 14 months between the Second Explanation on 3 February 2020 and the issuance of NOI(1) and NOI(2) on 13 April 2021. In full fairness, we acknowledged that this period coincided with the COVID-19 pandemic. On account of the delays caused by the pandemic, including the circuit breaker measures which kicked in from 7 April 2020 to 1 June 2020, we were prepared to treat those four months as neutral and they did not count towards our assessment of the overall delay. We were mindful that the complaints in this case pertained to a relatively small number of patients and the investigations were not all that complex. As such, we considered the delay of about ten months to be inexplicable.
>
> (c) There was also a gap of six months between the SMC's request on 28 September 2020 and Dr Eng's preparation of his second expert report by 19 March 2021.
>
> (d) The proceedings were delayed by about an additional two months due to the 69 amendments that the SMC sought to introduce during the second tranche of proceedings.

65 In view of the delays, this court was satisfied that "the cumulative delays were inordinate, that Dr Ling had not contributed to the delays, and that Dr Ling had been prejudiced by these delays". Therefore, this court upheld the DT's decision to apply a one-third discount to the sentence (*Ling Chia Tien* at [135]).

66 We would also observe that the decision in *Jen Shek Wei* can and must be understood in a manner which is consistent with these principles. The court there considered that after the SMC had sent a Notice of Complaint to Dr Jen on 17 July 2012, Dr Jen sent his response several weeks later on 2 August 2012. However, the SMC then subsequently took nearly three years to issue a Notice of Inquiry (*Jen Shek Wei* at [169]). The court found that there was no justification for it to have taken three years between "the date Dr Jen sent his Response to the Notice of Complaint and the date the Notice of Inquiry was issued against him". Although the court accepted that "it may take time to find and brief an expert witness given that the available pool of potential experts may be small and not every potential witness may be willing to testify", three years was found to be "overly lengthy by any reasonable measure". The delay "in this case was clearly unacceptable even if one factored in the time it might reasonably take to prepare the case" (*Jen Shek Wei* at [170]).

67 Moreover, the *nature* of the allegation against Dr Jen is another crucial factor relevant to the question of whether the delay in prosecution was inordinate. The charges against Dr Jen concerned his failure to conduct further evaluation and investigation of the patient's condition when such further assessment was warranted in the circumstances, and a failure to obtain informed consent from the patient before removing her left ovary. Crucially, all of the conduct with which the charge was concerned took place over a relatively short period of time. It did not involve a long history of treatment of the patient, numerous prescriptions, or voluminous documents, as in the present case, and

there was therefore no reason for it to have taken three years to issue the Notice of Inquiry. *Jen Shek Wei* cannot stand for a general principle that a sentencing discount will *always* be warranted so long as there has been a period of three or more years between the issuance of the Notice of Complaint and the Notice of Inquiry. Indeed, the court concluded by observing that "[e]ach case must obviously depend on its precise facts and circumstances" (*Jen Shek Wei* at [170]).

68 With the above principles in mind, we consider whether there has been an inordinate delay on the facts of this case. Although Dr Ang claims there has been a delay in the present case warranting 50% discount on his sentence, and notwithstanding the SMC's original position in its written submissions that there has been some delay warranting a discount of up to one-third, we are not persuaded that there has been an inordinate delay warranting a discount in sentencing. Dr Ang's position is predicated in a large part on the absolute length of the delay, and the fact that it exceeded the three-year mark. As we have explained earlier (see [63] above), reference to the absolute length of a delay without more is of no assistance to a defendant seeking a discount in sentence (and upon whom bears the legal burden of proving that the delay was inordinate). It was incumbent on Dr Ang to demonstrate, *inter alia*, that the delay was not justifiable by good reasons. To presume that a discount of 50% would be warranted so long as there has been a period of three years or longer between the issuance of the Notice of Complaint and the Notice of Inquiry (as in the present case) is wrong in principle. The critical question remains whether the length of time taken to prosecute each particular case is warranted by its circumstances.

69 In the present case, other than the absolute length of the delay and the SMC's concession, Dr Ang simply did not put any argument or evidence before

us which shed any light on the reasons why the present proceedings had taken as long as they did. In fairness, the absence of such evidence might have in part resulted from the fact that SMC had originally accepted the DT's finding that a discount was in principle appropriate, which implicitly entailed a concession that there *had* been an inordinate delay pursuant to the principles set out in *Ang Peng Thiam*. However, while a concession by the SMC that there has been prosecutorial delay warranting a discount may be evidence that a delay can be materially attributed to the SMC and may therefore be a *factor* supporting the finding that any such delay was inordinate, such a concession is not dispositive of the matter. It may simply be the case that the parties had misapprehended the legal principles. Ultimately, whether there has been an inordinate delay is for the defendant seeking a discount to prove, and is a legal conclusion reserved to the court, which must in every case examine the facts and satisfy itself that there has been an inordinate delay warranting a discount in sentencing. As Dr Ang has not offered any explanation as to how the SMC's conduct of the proceedings might have unduly and unreasonably prolonged their duration, he cannot discharge his burden of proving that any delay was inordinate.

70 For completeness, we note that the issue of whether there had been an inordinate delay at all *was* contested in proceedings before the DT, and in doing so, the parties examined the timeline of proceedings in greater detail than they did before us. In his submissions before the DT, Dr Ang highlighted the following intervals:

(a) the five months between the receipt of the complaint by the Patient's sister, and the issuance of the Notice of Complaint to Dr Ang;

(b) the one year and eight months from the receipt of Dr Ang's written explanation to the SMC's appointment of Mr Ng Boon Tat, the first of their expert witnesses;

(c) the two years and four months from the receipt of Dr Ang's written explanation to the finalisation of Dr Daniel Fung's expert report; and

(d) the three years and six months from the receipt of the complaint to the issuance of the Notice of Inquiry.

71 However, in the final analysis, Dr Ang's submission on this point before the DT suffers from the same flaw – he does not go further to explain *why* each of these periods ought to be considered inordinate in the specific circumstances of the case. On the contrary, as the SMC pointed out before the DT as well as at the hearing before us, between the complaint and Dr Ang's written explanation, the SMC had to review close to two thousand pages of material. To be sure, Dr Ang cannot be faulted for providing what he thought was the amount of information relevant to the present case. But the focus of the inquiry into whether the delay was inordinate is not whether the respondent doctor was at fault, but whether there was any unreasonable conduct on the part of the SMC which might have contributed to the prolonging of proceedings, such as to occasion unfairness to the respondent. In view of the nature of the complaint, it does not appear to us to be so.

72 Moreover, we also observe that the period between the issuance of the Notice of Complaint and the Notice of Inquiry covered the initial period of the COVID-19 outbreak in Singapore. The outbreak and associated restrictions caused unprecedented disruption to every aspect of Singaporean society, placing immense strain on the public healthcare system and healthcare

professionals. Before the DT, the SMC pointed out that this likely caused Dr Fung to require more time to finalise his report, given his concurrent and primary professional responsibilities in the Institute of Mental Health. We see no reason to doubt this, and also accept that the disruption to business operations across all sectors generally would have further added to the delays and disruptions caused to the proceedings.

73 Accordingly, while the absolute period between the receipt of the complaint and the issuance of the Notice of Inquiry might seem lengthy at first blush, in view of the factors above, as well as Dr Ang's failure to identify any fault or failing on the part of the SMC which might have unjustifiably prolonged any stage of the proceedings, we do not think it can be said that any of these intervals were unjustifiably long. It follows that any "delay" cannot be considered inordinate, and we therefore decline to grant him any discount in respect of his sentence.

74 However, for completeness, we are of the view that even *if* there had been any inordinate delay in the present proceedings which might have been attributable to the SMC, a discount in sentencing would still not have been appropriate. In *Wong Meng Hang*, the first respondent's actions were the "sole and direct cause of the patient's death", in the context of an elective aesthetic procedure in which death would not even have been contemplated by the patient. Given the gravity of this misconduct, the need to ensure fairness to the offender by affording a discount on account of delay was entirely overridden by the wider considerations of general deterrence and the need to uphold the standing of the medical profession (at [84] and [104]). As for the second respondent in *Wong Meng Hang*, while her actions were not as directly connected to the patient's death as the actions of the first respondent, they were nonetheless of a serious nature. The court similarly found that the inordinate

delay was overridden by the public interest in upholding public confidence in the medical profession, and did not afford her a discount on account of that delay (*Wong Meng Hang* at [112]).

75 While the gravity of the present case might not rise to the same level as in *Wong Meng Hang*, we repeat our observations that Dr Ang is a senior and well-respected specialist in the medical community. When such a figure exceeds the bounds of accepted treatment by such a degree, risks serious harm and even death to a patient in doing so, and remains unable even in hindsight to demonstrate that his actions were objectively defensible in terms of the risks and benefits that were entailed or that he even applied his mind to some of them, the impact on public trust and confidence in the medical profession will invariably be profound. In such a case, the need for general deterrence and to uphold trust and confidence in the medical profession would be paramount and take precedence over concerns regarding individual fairness. For these reasons, we are of the view that no discount in sentencing would have been appropriate, even if there had been an inordinate delay in the present case.

The other factors raised by parties

76 As regards Dr Ang's alleged lack of genuine remorse for and insight into his conduct, we do not accept the SMC's submission that Dr Ang's failure to plead guilty ought to be treated as an aggravating factor in the circumstances of this case. As a matter of principle, Dr Ang was entitled to defend himself before the DT and avail himself of his right of appeal. His exercise of that right simply meant that he would not benefit from the mitigatory weight of a plea of guilt (*Public Prosecutor v Jeffrey Pe* [2023] SGHC 313 ("*Jeffrey Pe*") at [280]). Moreover, Dr Ang's evidence that he had tried his best to treat the Patient and that the Patient's interest remained a paramount concern to him, cannot be taken

as a sign of a lack of remorse – Dr Ang cannot be penalised for simply stating his defence (see, for example, *Jeffrey Pe* at [272]–[277]).

77 The position Dr Ang took also did not show any lack of insight on his part. It was one that was based on his own subjective belief of his mindset whilst treating the Patient at the material time. It was not improper for him to make such an assertion even if we later found that his actions were not objectively justifiable.

78 As for Mr Chong's submission that Dr Ang's cooperation with the SMC's investigations ought to be considered another mitigating favour, we do not think that there is any evidence to support such a finding in the circumstances. In the same vein, we do not think that there is any evidence of personal regret on Dr Ang's part that would justify it being given significant weight as a mitigating factor.

Whether the sentences for the Charges ought to run concurrently or consecutively

79 Finally, we turn to consider how the sentences for each of the Charges ought to be run. Dr Ang submits that all the sentences ought to run concurrently, as the offending prescriptions were all ultimately directed towards treatment of a single patient's complex psychiatric condition, and hence ought to be considered as forming part of the same transaction. The SMC disagrees and contends that the sentences for the first two Charges ought to be made to run consecutively, as they are the most serious. SMC says that each prescription entailed a "fresh and distinct duty" to only prescribe, dispense, or supply medicines on clear medical grounds, and challenges Dr Ang's assertions that there was proximity of location and purpose as between the offending prescriptions covered by the 1st and 2nd Charges.

The sentences for the 1st and 3rd Charge ought to run consecutively, with the sentence for the 2nd Charge to run concurrently

80 In the context of disciplinary proceedings involving the medical profession, it is common for a Court of 3 Judges ("C3J") and the DT to impose consecutive periods of suspension where appropriate. However, the case law does not appear to have discussed the rationale behind why consecutive periods of suspension may be imposed. In our view, the starting point is the MRA. Sections 53(2)(*b*) and (*h*) provide the DT (and by extension, the C3J) with the discretion to make "such other order as the [DT] thinks fit" and that the DT may order the suspension of a doctor for a period of not less than 3 months and not more than 3 years. This suggests that in the appropriate case, the court (and the DT) may order consecutive periods of suspension. In *Ling Chia Tien* at [71] and [138], the C3J briefly explored the rationale behind consecutive periods of suspension and observed that it was related to the one-transaction rule and the totality principle. The C3J also observed that this approach was in line with the SMC Sentencing Guidelines (at paras 73-78) (*Ling Chia Tien* at [71]). In our view, the adoption of common law principles from criminal jurisprudence into disciplinary proceedings concerning the medical profession forms the basis for the court (and the DT) to impose consecutive periods of suspension where appropriate.

81 The adoption of common law principles from criminal jurisprudence has already been done in the context of disciplinary proceedings concerning the legal profession. In *Law Society of Singapore v Yap Bock Heng Christopher* [2014] 4 SLR 877 (at [35]-[41]), the court in considering whether it had the power to impose consecutive suspensions from practice observed that "consecutive sentences have always been permitted for criminal matters". By analogy from this common law principle, the court held that "a court exercising

its disciplinary jurisdiction has the power to impose consecutive periods of suspension". In determining the aggregate sentence, the court would view "the misconduct in totality and determine the appropriate sentence". We are of the view that the adoption of such common law principles from criminal jurisprudence would be appropriate in the context of disciplinary proceedings concerning the medical profession – such cases are after all quasi-criminal in nature (*Wee Teong Boo v Singapore Medical Council (Attorney-General intervener)* [2023] 3 SLR 705 at [41]; *Low Chai Ling v Singapore Medical Council* [2013] 1 SLR 83 ("*Low Chai Ling*") at [29]). As the court expressed in *Low Chai Ling* (at [29]), being quasi-criminal in nature, a disciplinary tribunal "has to adopt procedures and practices which ordinarily prevail in criminal trials".

82 In our judgment, we find it appropriate to run the sentences for the 1st and 2nd Charges concurrently and have the sentence for the 3rd Charge run consecutively. As concerns the first two Charges, we note that the factual averments and medications involved thereunder were ultimately identical. Moreover, while they appear to have been framed separately because of an update in one of the applicable relevant guidelines, the 2nd Charge was subsequently amended so as to delete reference to that guideline.

83 However, we are unable to agree with Dr Ang that the sentence for the 3rd Charge ought to run concurrently as well. As we have noted above at [52], the 3rd Charge was, in our view, the most serious of the Charges. It entailed a dramatic one-off increase in the prescriptions of Mirtazapine and Zolpidem CR well beyond the maximum dosage limits contained in the product inserts. There was no calibrated titration involved in the increase of the medications, and this occurred days before the Patient's death. By the conduct complained of in the 3rd Charge, Dr Ang had put the Patient in grave danger without any due

consideration of the benefits and risks of doing so. Dr Ang did not even appear to properly appreciate the gravity of so doing at the material time. This was completely unacceptable conduct that would harm public confidence in the medical profession. There is thus no basis for also running the sentence for the 3rd Charge concurrently.

84 Moreover, although we accept that the mischief with which all three Charges are concerned is broadly similar in the sense that they generally concerned the over-prescription of drugs and were part of Dr Ang's overall conduct of treating the Patient's psychiatric conditions, this does not necessarily mean that they must be considered as part of the same transaction. A doctor's overall treatment of a Patient may give rise to different kinds of misconduct such that the one-transaction rule does not apply. More importantly, the dramatic one-off increase in the prescriptions of Mirtazapine and Zolpidem CR with which the 3rd Charge is concerned is markedly different from the concurrent prescriptions of multiple benzodiazepines and benzodiazepines with opioid analgesics, which form the subject matter of the 1st and 2nd Charges. It would thus be more appropriate for the sentence in the 3rd Charge to run consecutively with the sentence in the 1st Charge.

Downward adjustment for proportionality

85 As a final step, we consider the totality principle, which entails "a broad-brushed 'last look' at all the facts and circumstances to ensure the overall proportionality of the aggregate sentence" (*Haliffie bin Mamat v Public Prosecutor and other appeals* [2016] 5 SLR 636 at [79]). This ensures that the overall sentence is neither excessive nor inadequate (*Gan Chai Bee Anne v Public Prosecutor* [2019] 4 SLR 838 at [20]) and could entail either an upwards or downwards adjustment of the sentence (*Seah Ming Yang Daryle v Public*

Prosecutor [2024] 4 SLR 1561 at [87] citing *Public Prosecutor v Su Jiqing Joel* [2021] 3 SLR 1232 at [126]). Thus, bearing the totality principle in mind along with the various aggravating factors which we have identified above, particularly Dr Ang's seniority and professional status, we adjust the sentences for the individual charges as follows:

	1st Charge	**2nd Charge**	**3rd Charge**
Appropriate starting point	18 months	15 months	36 months
Adjusted sentences	12 months	10 months	24 months

Conclusion

86 We thus set aside the sentence imposed by the DT and impose a suspension of 36 months on Dr Ang (see [82] and [84]). As to the date of commencement of the period of suspension, the parties are to write to this court with their respective proposal within 7 days of the release of this Judgment, failing which the court will stipulate the commencement date without further reference to the parties.

87 For avoidance of doubt, the other orders made by the DT are to stand, these being that Dr Ang is to be censured, and that he is to give a written undertaking to refrain from engaging in the conduct complained of, or any similar conduct in future.

88 On the issue of costs, Dr Ang submits that combined costs of $50,000 for this matter would be appropriate, arguing that there was a significant overlap of work *between the two originating applications before us* (*ie*, C3J/OA 8/2023

("OA 8") and C3J/OA 9/2023 ("OA 9")), and pointing out that he was found not liable for several of the factual averments underlying the 1st and 2nd Charges. The SMC submits for total costs of $147,000, arguing that there should be no apportionment of costs given the overlap in work done, by which it appears to refer to the overlap in work done in connection with the *professional misconduct* charges and the *professional services* charges.

89 We agree with the SMC that there should be no apportionment of costs. The professional services charges were brought as alternatives to the professional misconduct charges, and we eventually found Dr Ang liable of the primary and more severe charges. However, we take the view that some discount still ought to be afforded, not on the basis of any overlap in work done for OA 8 and OA 9, but because the SMC was unable to establish many of the factual averments underlying the first two charges. We also observe that the averments concerning discontinuation of antidepressants, for which Dr Ang was not found liable, involved close scrutiny of the individual justifications behind each discontinuation (see the Liability Judgment at [94]–[106]). This being the case, while we accept that the SMC's proposed figure closely approximates the appropriate figure of costs attributable to a proceeding of this nature and complexity, costs of $100,000 would be appropriate in the present case.

Sundaresh Menon
Chief Justice

Tay Yong Kwang
Justice of the Court of Appeal

Belinda Ang Saw Ean
Justice of the Court of Appeal

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