IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2025] SMCDT 4

Between

Singapore Medical Council

And

Dr Wong Yoke Meng

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension from Register of Medical Practitioners

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Singapore Medical Council
v
Dr Wong Yoke Meng

[2025] SMCDT 4

Disciplinary Tribunal — DT Inquiry No. 4 of 2025
A/Prof Roy Joseph (Chairman), Dr Chan Wai Lim William and Mr Kessler Soh (Judicial Service Officer)
14-16, 19-22 September 2022
21-23 March, 11-13 September 2023
28 March, 14 August, 23 September 2024
14 March 2025

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension from Register of Medical Practitioners

29 August 2025

GROUNDS OF DECISION

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

INTRODUCTION

1. The Respondent Dr Wong Yoke Meng is a registered medical practitioner. He has a clinic at the Paragon Medical Centre (the "**Clinic**").

2. In 2014 and 2015, officers from the Ministry of Health ("**MOH**") carried out pre-licensing inspections at his Clinic. On 10 April 2015, MOH sent a letter to the Singapore Medical Council ("**SMC**") raising concerns about his prescribing practice of hormone replacement therapy ("**HRT**").

3. Following an investigation into the matter, a Notice of Complaint was served on him on 12 August 2015. A Notice of Inquiry was subsequently issued by the SMC on 15 January 2021 and the present Disciplinary Tribunal ("**DT**") was convened to inquire into the matter.

4. The Respondent faced 40 charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) (the "**MRA**").

   a. These charges related to repeated breaches of various provisions of the 2002 Edition of the SMC Ethical Code and Ethical Guidelines ("**2002 ECEG**").

      i. 18 charges related to inappropriate prescriptions of HRT for 18 patients (the "**Prescription Charges**").

      ii. 22 charges related to inadequate keeping of medical records of these 18 patients and four other patients (the "**Record-Keeping Charges**").

   b. For each charge, it was alleged that the Respondent's conduct was "an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency" [the "**Principal Charge(s)**"]. Alternatively, it was alleged that the conduct was "such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner" [the "**Alternative Charge(s)**"].

5. The Respondent contested all 40 charges, and evidence was led over 13 days, followed by submissions, from September 2022 to March 2025 at the disciplinary inquiry before the DT (the "**Inquiry**").

6. The expert witness for the SMC was Dr PW1 (PW1, the "**SMC Expert**"), who prepared an expert report (the "**SMC Expert Report**"[1]). The crux of the SMC's case was as follows:

[1] *Expert Opinion of Dr PW1*: Agreed Bundle (Volume I) dated 13 September 2022 ("**1AB**") pp 161-406 (Tab 2).

a. For the Prescription Charges, the Respondent failed to provide appropriate care, management and treatment of his patients by inappropriately prescribing medications to them. For each medication listed in each Prescription Charge, the prescription was inappropriate because:

   i. there were no specific symptoms or indications that warranted the prescription;

   ii. the hormones levels of the patient were within the normal range; and

   iii. relevant physical examinations of the patient were not done.

b. For the Record-Keeping Charges, the Respondent failed to keep medical records of each patient that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient; the medical records did not document sufficient details of what was advised and explained to the patient, including treatment options, risks and the patient's informed consent.

c. The Respondent's conduct in respect of each charge was sufficiently egregious to amount to professional misconduct.

7. The Respondent did not dispute that hormones are to be prescribed for treating specific symptoms. His defence was that he was not treating his patients for specific symptoms. Rather, his practice centred around optimising the hormone levels of his patients to prevent or slow down the deterioration of their health and wellbeing. This practice of "functional medicine", or anti-aging or preventative medicine, involved giving low doses of hormone to push the patient's relevant hormone level from the lower third to the upper third of the reference range. He asserted that the medical records that he kept would have been sufficient for a doctor trained in functional medicine to take over the management of his patients. Two experts were called to testify in his defence:

a. Dr RW3 (RW3), who submitted an expert report ("**Dr RW3's Expert Report**"[2]); and

b. Dr RW4 (RW4), who submitted an expert report ("**Dr RW4's Expert Report**"[3]).

Expert reports were also tendered by another local doctor, Dr E, who did not testify at the Inquiry.

8. Having considered the totality of the evidence, including the voluminous patient medical records and the medical literature tendered in evidence by the SMC and the Respondent, we accepted the evidence of the SMC Expert and rejected the Respondent's defence, and we found that the SMC had proven the Principal Charges beyond a reasonable doubt:

a. For the Prescription Charges, the Respondent had inappropriately prescribed medications to the 18 patients. For each patient: (a) there were no specific signs or symptoms[4] that warranted the prescription; (b) the hormone levels of the patient were within the normal range; and (c) relevant physical examinations of the patient were not done. The Respondent's approach of prescribing medications for the purpose of hormone optimisation was not based on clear medical grounds as it was not grounded on established medical practice, was not evidence-based, and was highly inappropriate.

b. For the Record-Keeping Charges, the Respondent did not keep medical records of the 22 patients that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient; the medical records did not document sufficient details of what was advised and

[2] *Expert Report* dated 8 July 2022 (marked "**R2**").
[3] *Expert Report* dated 18 July 2022 (marked "**R3**"); *Supplementary Expert Report* dated 8 September 2023 (marked "**R8**").
[4] "Signs" refer to objective observations that may be made by a doctor, for example, from a physical examination; "symptoms" refer to subjective experiences reported by the patient, such as fatigue. In the evidence tendered before the DT, expressions such as "signs", "symptoms" and "indications" (which refer both to signs *and* symptoms) appear to have been used interchangeably. In the Grounds of Decision, for ease of reference and to minimise repetition, these expressions are used interchangeably; and the expression "**symptoms**" (which is used in the Prescription Charges) refer to signs, symptoms, or both signs and symptoms.

explained to the patient, including treatment options, risks and the patient's informed consent.

c. The Respondent's conduct in each charge constituted "an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency" and he was guilty of professional misconduct for all the charges.

9. As for the sentence, the SMC submitted that the Respondent ought to be suspended for the maximum duration of 36 months. The Respondent submitted for a much shorter period of suspension of one year and 20 weeks. We accepted the submission of the SMC that the maximum period of suspension of 36 months would be appropriate and order accordingly. That said, given the very egregious nature of the Respondent's misconduct in the present charges, as well as other instances of professional misconduct that he had been found guilty of, we were of the opinion that a striking off could also have been considered.

10. We explain the grounds of our decision in detail below. For ease of reference:

a. The abbreviations used in the Grounds of Decision are set out at **Annex A**.

b. The charges are set out at **Annex B**.

c. A summary list of the (anonymised) patients, charges and medications involved are set out at **Annex C**.

BACKGROUND AND BRIEF CHRONOLOGY

11. The following table provides a brief chronology of the main events leading up to the Inquiry before this DT:

S/n	Date	Event
1.	28 July 2014; 9 February 2015	Officers from the MOH carried out pre-licensing inspections on the Clinic.
2.	3 March 2015	MOH letter to the Respondent providing feedback on the areas found to be lacking in the Respondent's practice during the pre-licensing inspections.[5]
3.	10 April 2015	MOH sent a letter to the SMC providing feedback on the Respondent's inappropriate prescribing practice of HRT at the Clinic (the "**MOH Letter**").[6]
4.	30 April 2015	SMC referred a complaint to the Chairman of the Complaints Panel under s 39(3)(*a*) of the MRA (the "**Complaint**").[7]
5.	12 August 2015	SMC Investigation Unit served a "**Notice of Complaint**" on the Respondent.[8]
6.	29 September 2015	The Respondent submitted his written explanation to the Complaint (the "**Respondent's Explanation**").[9] (The Respondent subsequently provided various clarifications and documents as requested by the SMC Investigation Unit.)
7.	13 March 2017	Following an investigation, the Complaints Committee ("**CC**") informed the Respondent of its decision to refer the Complaint to a DT for a formal inquiry.

[5] 1AB pp 450-451 (Tab 5).
[6] 1AB p 409 (Tab 3).
[7] 1AB p 408 (Tab 3).
[8] 1AB pp 411-414 (Tab 4).
[9] 1AB pp 416-453 (Tab 5).

S/n	Date	Event
8.	15 January 2021	The SMC issued the initial Notice of Inquiry. (Various amendments were subsequently made to the Notice of Inquiry.)
9.	1 June 2021 4 January 2022 4 May 2022 7 August 2023	Pre-Inquiry Conferences conducted before the DT, in preparation for the hearing.
10.	14-16, 19-22 September 2022; 21-23 March, 11-13 September 2023	Hearing of evidence before the DT
11.	28 March, 14 August, 23 September 2024; 14 March 2025	Submissions before the DT

TRIAL

Charges

12. At the Inquiry, the Respondent faced a total of 40 charges relating to 22 patients:

    a. 18 Prescription Charges, for failing to provide appropriate care, management and treatment by inappropriately prescribing medications to 18 patients; and

    b. 22 Record-Keeping Charges, for failing to keep medical records that were clear, accurate, legible and of sufficient detail for 22 patients.

13. The charges were set out in a Notice of Inquiry, which underwent various amendments during the Inquiry. The latest amendments were made on 13 September 2023 after the

evidence of the final witness had been heard. The amendments were made on the application of SMC and was not objected to by the Respondent. The particulars of the 40 charges in this latest Notice of Inquiry dated 13 September 2023 (the "**NOI**", marked "**P1B**") are set out at **Annex B**.

Relevant ECEG provisions

14. The charges related to breaches of various provisions of the 2002 Edition of the SMC Ethical Code and Ethical Guidelines ("**2002 ECEG**"). The 2002 ECEG was in force from 2002 to 31 December 2016 and were the relevant guidelines in force at the material times.

15. Guideline 4.1.3 of the 2002 ECEG (which was relevant to the Prescription Charges) stated:

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

16. Also relevant was Guideline 4.1.4 of the 2002 ECEG:

> "**4.1.4 <u>Untested practices and clinical trials</u>**
> *A doctor shall treat patients according to generally accepted methods and use only licensed drugs for appropriate indications. A doctor shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial.*
>
> A doctor who participates in clinical research must put the care and safety of patients first. If a doctor wishes to enter a patient into a clinical trial, he must ensure that the trial is approved by an ethics committee and conforms to the Good Clinical Practice Guidelines. In addition, informed consent must be obtained from the patient.

> It is not acceptable to experiment or authorise experiments or research which are not part of a formal clinical trial and which are not primarily part of treatment or in the best interest of the patient, or which could cause undue suffering or threat to the life of a patient."
>
> (*Emphasis* added)

17. Guideline 4.1.2 of the 2002 ECEG set out the relevant principles and standards for keeping medical records (which was relevant to the Record-Keeping Charges):

> "Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented."

Respondent's objections to the charges

18. As a preliminary point, we first address the objections raised by the Respondent to the charges. These objections were not raised at the start of the Inquiry, but only after the hearing of evidence had concluded and at the stage of closing submissions.

19. The Respondent's objections were as follows:

    a. For the Prescription Charges, an issue before the DT was whether the Respondent had performed relevant *medical examinations* before prescribing HRT. The Respondent submitted that any failure to perform medical examinations fell outside the remit of the Inquiry.[10] It was submitted that the DT's inquiry powers were limited to the scope of the Complaint only. The DT must only inquire into the question asked in the Complaint, which was the Respondent's prescription of HRT. In the MOH Letter, MOH's concerns were the Respondent's HRT prescriptions and the indications and assessments done for these prescriptions. When the SMC referred the information to the Chairman of the Complaints Panel, the concern related to the Respondent's prescription of HRT and the indications for the prescriptions. The issues identified in the subsequent Notice of Complaint for the Respondent to respond to were all related to his HRT prescriptions. It was submitted that, accordingly, the DT could not make any determination on any matters falling

[10] *Respondent's Reply Submissions* dated 15 January 2024 ("**RRS**") at [111]-[116].

outside the Respondent's HRT prescriptions, including general examinations or examinations for any other unrelated purposes.

b. In relation to the Record-Keeping Charges, it was submitted that the charges exceeded the scope of the Inquiry.[11] The focus of the MOH Letter was the Respondent's HRT prescriptions and the indications and assessments done for these prescriptions. The gravamen of the MOH's complaint against the Respondent's record-keeping practice was the lack of "documentation of the assessment done and indications were non-specific". At best, only the documentation of the indications and assessments done were in issue. In the Notice of Complaint, the Respondent was not asked to address any complaint of his failure to document his advice and explanation, including the discussion of treatment options, risks, and patients' informed consent. The SMC had exceeded its power of prosecution by framing the Record-Keeping Charges against the Respondent that was beyond the scope of the Complaint. Particular (c) of each Record-Keeping Charge stated that the medical record for the patient "*did not document sufficient details, including what [the Respondent] had advised and explained to the Patient if any such advice and/or explanation had been given, including but not limited to the discussion of treatment options, risks and the Patient's informed consent*". This did not form the gravamen of the Complaint. The DT could not to make any determination of the matters falling outside of the Respondent's record-keeping practice, including Particular (c).

20. We found the Respondent's objections to the charges to be without merit.

21. In relation to the Prescription Charges, whether the Respondent had performed relevant *medical examinations* before prescribing HRT was clearly within the scope of the Complaint.

a. The SMC's Complaint stated that "MOH expressed concerns over Dr Wong's practices following a review of the Patient Medical Records and based on expert opinion".[12] The Complaint enclosed the MOH Letter, which set out MOH's concerns following their pre-licensing inspections of the Respondent's Clinic. The

[11] RRS at [240]-[247], [306]-[311].
[12] 1AB p 408 (Tab 3) at [2].

MOH Letter expressed concern over the Respondent's prescribing practice in relation to HRT, for which expert opinion had been sought from the Academy of Medicine, Singapore ("**AMS**"):

> "[…] Dr Wong Yoke Meng has been prescribing HRT even when there was no documentation of the indications and laboratory results were within normal levels […]
>
> 2 Dr Wong was found to be prescribing HRT to numerous (more than 12) patients repeatedly, even when the hormone levels were noted to be within normal range and without further referral to a specialist. […] AMS has opined that the HRT was prescribed in an indiscriminate manner without due diligence and unproven therapies for non-specific complaints. In addition, there was no documentation of the assessment done and indications were non-specific […].
>
> 3 MOH is concerned over the prescribing practice of Dr Wong Yoke Meng in relation to HRT.[13]"

b. In the Notice of Complaint served by the SMC on the Respondent, the Respondent was asked (among other things) to "Provide justification for the use of Hormone Replacement Therapy" (at para 3(b)). In the Respondent's Explanation, he explained, among other things, his general approach to "wellness and preventative medicine"; that he would, during his consultations, "rule out any contraindications"; and he would "take a systematic approach to [his] patient's overall health by monitoring the health of their major organs such as the heart, lungs, breast, liver, kidneys etc". In short, the Respondent was made aware that his prescribing practice in relation to HRT was being called into question, and he was given an opportunity to explain and justify his prescribing practice.

c. An inquiry into this "prescribing practice" must necessarily entail a consideration of whether the necessary assessments and physical examinations had been done before his prescription of HRT. Such assessments or physical examinations must precede and form part of the medical grounds for the prescription. Under Guideline 4.1.3 of the 2002 ECEG (reproduced above, at [15]), a doctor shall prescribe, dispense or supply medicines only "on clear medical grounds" and "following an adequate personal consultation and relevant investigations". The gravamen of each Prescription Charge was a failure by the Respondent to provide care, management

[13] 1AB p 409 (Tab 3) at [1]-[3].

and treatment to the patient by way of the inappropriate prescription of HRT, in breach of Guideline 4.1.3. The particulars asserting his failure to conduct the relevant examinations for the patient were well within the scope of the Complaint and were relevant issues for the DT to consider at the Inquiry.

22. In relation to the Record-Keeping Charges, the issues of documentation of discussions on treatment options, risks, informed consent were part and parcel of the Respondent's prescribing practice for HRT, and well within the scope of this Inquiry.

a. The MOH had written to the Respondent on 3 March 2015 to provide feedback on the areas that they had found to be lacking in his practice during the pre-licensing inspections. The letter stated, among other things, that "Proper documentation on the indications, risks and benefits, and the evidence or lack of evidence for them, must be clearly explained to patients and documented in the patients' case notes". This letter was referred to in the Respondent's Explanation and enclosed at Annex 5 of the Respondent's Explanation.

b. When the Respondent received the Notice of Complaint on 12 August 2015, he would have been aware that the MOH had concerns about his documentation, including documentation of his discussions with his patients on the attendant risks and benefits. Hence, in the Respondent's Explanation on 29 September 2015, he explained that he carried out with each patient "a very thorough initial consultation lasting 45-60 minutes during which [he] rule out any contraindications (e.g. breast cancer, raised PSA, prostate cancer)" and he "take[s] into consideration each patient's age, symptoms, lab results and patient objectives" before he prescribes HRT.

c. The Record-Keeping Charges asserted that the Respondent had failed to keep medical records that were clear, accurate, legible and of sufficient detail. His failure to document discussions of treatment options, risks and informed consent was one of the particulars included by the SMC to support the insufficiency of his medical records, and was relevant for the DT to consider at this Inquiry.

23. The Respondent thus had ample notice of the relevant issues both in the Prescription Charges and the Record-Keeping Charges. He was given full opportunity to address these issues before the DT. It was thus somewhat surprising that the Respondent chose to raise these objections to the charges only at the stage of closing submissions. Such objections should have been raised at the start of the Inquiry.

a. The Respondent gave no indication at all at the start of the Inquiry and throughout the hearing of his objections to the charges. After the evidence of the final witness was concluded on 13 September 2023, the Respondent had more than three months to prepare and submit closing submissions. Yet, even in the closing submissions exchanged in December 2023, the Respondent did not raise the objections to the charges. It was only in the Respondent's Reply Submissions in January 2024 that the objections were made.

b. Under Regulation 34(4) of the Medical Registration Regulations 2010 ("**MRR**"), which sets out the procedure for the DT inquiry, objections on a point of law should be made at the start of the inquiry, after the charges are read out to the medical practitioner. The rationale of having the objections to the charges raised at this early stage is so that "if any such objection is upheld, no further proceedings shall be taken on the charge to which the objection relates": Reg 34(4)(b). If the charges fell on a preliminary point of law, it would obviate the need for evidence to be adduced by either side, resulting in substantial savings of time and costs.

Respondent's challenge of SMC Expert's evidence

24. The SMC Expert, Dr PW1, was a specialist and Senior Consultant at the Division of Obstetrics and Gynaecology in Institution A, Singapore.

25. The Respondent challenged the expertise and evidence of Dr PW1.[14]

[14] *Respondent's Closing Submissions* dated 15 December 2023 ("**RCS**") at [33]-[101].

a. It was asserted that Dr PW1 lacked the requisite expertise and clinical experience to provide reliable opinions on the subject matter in issue:

   i. His experience in urological and dysfunction issues was limited and outdated. Much of his clinical experience was based on his clinical practice at Institution A, which was not a full-serviced hospital. Its clinical services were focused largely on women and children. There were doubts as to the extent of clinical experience that Dr PW1 would have gained in managing male patients and clinical issues peculiar to male patients. His experience in managing patients with urological and dysfunction issues was from when he had practised at Institution B, which had ceased to operate sometime in 1997. His formal training as an O&G specialist and at medical school did not translate to knowledge gained from personally managing and treating patients. He lacked personal clinical experience with HRT, especially for male patients. He had obtained his MRCOG (London) qualification in 1991 and his training was outdated.

   ii. Dr PW1's clinical experience was limited to public healthcare institutions, where resources were more constrained. This coloured the various criticisms he made based on costs. Such criticisms were not as compelling in the context of private practice, where healthcare was provided with far less strain on government resources and at the patient's own cost, should they deem the cost worthwhile.

   iii. Dr PW1's expertise did not extend to the subject matter in issue. It was based solely on his reading of literature in abstract, not first-hand clinical experience.

b. It was also asserted that Dr PW1 lacked objectivity and was not impartial, that he displayed bias and an overzealousness to prop up the SMC's cause; that his evidence was internally inconsistent and inconsistent with the extrinsic facts (other medical literature).

26. We found the Respondent's criticism of Dr PW1's expertise or evidence to be without merit.

a. We accepted the submission of the SMC that Dr PW1 clearly had the relevant qualifications and expertise to give expert evidence on the issues arising at this Inquiry. He was a Senior Consultant of the Division of Obstetrics and Gynaecology in Institution A. He had been in practice in Singapore for close to four decades. He had broad training and experience in using hormones in metabolic, reproductive and general health in patients. He had an active clinical practice and had also conducted many clinics to deal with the issues of menopause, male fertility and andrology management, and he continued to conduct two general clinic sessions per week at Institution A. He had also published papers on HRT. He had substantial clinical experience not only in gynaecological issues but also male infertility and andrology management, and frequently attended meetings relating not only to O&G but also menopause and andropause.[15] He had active teaching appointments at Duke-NUS Medical School (where he was also<designation redacted>), NUS Yong Loo Lin School of Medicine and the NTU Lee Kong Chian School of Medicine. We accepted that Dr PW1 was well-equipped to opine on issues relating to fundamental principles such as assessment, diagnosis and documentation, which would have been part and parcel of every doctor's training and practice.

b. We also found Dr PW1's expert evidence to be objective and impartial. It was supported by medical literature and was credible. The Respondent's assertion that Dr PW1 displayed bias, or that his evidence was internally or externally consistent, were entirely without basis. In fact, as will be seen later, Dr PW1's objective evidence was largely supported by the evidence of the Respondent's local expert, Dr RW3.

27. Having examined the medical literature adduced at the Inquiry by the SMC and the Respondent, we found the expert evidence of Dr PW1 to be cogent and supported by the medical literature. Specifically, we accepted the evidence of Dr PW1 on the applicable standards in the prescription of HRT.

[15] CV of Dr PW1: SMC Expert Report, Annex A (1AB pp 189-190).

Prescription Charges

Medications prescribed

28. The table below sets outs the hormones and medications prescribed by the Respondent in the Prescription Charges.

Hormones	**Prescriptions**	**Patients**
Testosterone	(a) Nebido (injection) (b) Sustanon (injection) (c) Testoviron (injection) (Nebido, Sustanon, Testoviron are "intramuscular testosterone") (d) Testosterone cream	Male: Patients 2, 3, 4, 7, 10, 12, 13, 16, 17, 20, 21 Female: Patients 1, 5, 6, 8
Progesterone	(e) Progesterone cream	Male: Patients 3, 12, 16 Female: Patient 6
Estradiol	(f) Estrogen cream	Patient 6
Thyroxine	(g) Eltroxin (tablet)	Patients 3, 5, 9, 10, 20
Human growth hormone	(h) Norditropin (injection)	Patients 3, 7, 12, 13, 16, 18, 22
	(i) Secretagogues (tablet) (Secretagogues are not a hormone, but a supplement of amino acids which can promote the production of growth hormones)	Patient 8

29. We found that the Respondent had failed to provide appropriate care, management and treatment of his patients by inappropriately prescribing the medications to them. For each medication listed in each Prescription Charge, the prescription was inappropriate for three main reasons:

a. There was no evidence that the patient had specific signs or symptoms that warranted the prescription;

b. the hormones levels of the patient were within the normal range; and

c. relevant physical examinations of the patient were not done.

30. As will be elaborated below, the Respondent prescribed HRT without due diligence and in an indiscriminate and arbitrary manner. His HRT practice was not evidence-based and was an egregious departure from the applicable standards and amounted to professional misconduct.

Testosterone Replacement Therapy (TRT) for males

31. The key considerations in Testosterone Replacement Therapy ("**TRT**") for males are set out in the table below.

Symptoms	Late Onset Hypogonadism ("**LOH**")
Hormone Levels	Normal testosterone range for males: 241 – 827 ng/dl (8.4 – 28.7 nmol/L) Free testosterone: 22.9 – 104.1 pmol/L
Examinations	Digital Rectal Examination ("**DRE**", also referred to as a digital prostate examination) Heart examination Other examinations (lung, abdomen)

32. *Symptoms*. TRT is indicated for males with LOH. A diagnosis of LOH was based on: (a) the presence of clinical symptoms; and (b) persistent low serum testosterone level.[16] The Singapore Urological Association's *Guidelines on Late Onset Hypogonadism* (2010)[17] stated that relevant clinical symptoms included sexual dysfunction, low libido, erectile dysfunction, decreased drive and mood, osteoporosis and visceral fat.[18]

[16] SMC Expert Report at [10], [18] (1AB pp 163-164).
[17] SMC Expert Report at Annex E (1AB pp 231-245).
[18] 1AB pp 236-237.

33. *Hormone Levels*. The Society for Men's Health (Singapore) ("**SMHS**") issued the *Testosterone Deficiency Syndrome (TDS) Guidelines 2013* (the "**SMHS Guidelines**").[19] Under the SMHS Guidelines, the starting point for testing would be the *total testosterone level*:

> "Currently, there is no arbitrary value of total testosterone or free testosterone level below which to start TRT. However, there is the general agreement that total testosterone level above 12 nmol/l (350 ng/dl) does not require TRT. There is also consensus that patients with serum total testosterone below 8 nmol/l (230 ng/dl) will usually benefit from TRT.[20]"

34. If the patient's total testosterone level was within the range of 230 ng/dl to 350 ng/dl (the "grey zone", as described by Dr PW1), a further test of the patient's *free testosterone level* would be warranted to confirm whether the patient was suffering from true androgen deficiency. This was because a free testosterone test would be more precise than the total testosterone test: if the free testosterone level was within the reference range, TRT should not be offered to the patient.[21]

35. It was also recommended that there be a repeat testing of the testosterone levels in the morning. For example, the Endocrine Society Clinical Practical Guideline ("**ESCPG**") on *Testosterone Therapy in Men with Androgen Deficiency Syndromes* [2010] ("**ESCPG on Testosterone Therapy in Men**")[22] recommended that testosterone therapy be offered to older men "with low testosterone levels *on more than one occasion* and clinically significant symptoms of androgen deficiency, after explicit discussion of the uncertainty about the risks and benefits of testosterone therapy".[23] As explained by Dr PW1, this is to account for the variation in testosterone levels by about 20% depending on the time of the day, due to the diurnal rhythms of the body. Generally, testosterone levels would be higher in the morning and lower in the afternoon or evening.[24]

[19] SMC Expert Report at Annex G (1AB pp 271-296).
[20] 1AB p 281.
[21] Dr PW1: Transcript 16 September 2022, 219:2-4 (p 219 lines 2-4); 223:22–224:6.
[22] SMC Expert Report at Annex F (1AB pp 246-270).
[23] 1AB pp 249-250.
[24] Dr PW1: Transcript 14 September 2022, 78:8-23.

36. *Examinations*. Various guidelines recommended that a DRE be carried out for male patients before starting them on TRT. This was to exclude prostate cancers and tumours which would be a contraindication to TRT.

a. For example, the ESCPG on Testosterone Therapy in Men:

> "In men 40 [years] of age or older who have a baseline PSA [Prostate-Specific Antigen] greater than 0.6 ng/ml, we recommend digital examination of the prostate and PSA measurement before initiating treatment, at 3 to 6 months, and then in accordance with evidence-based guidelines for prostate cancer screening, depending on the age and race of the patient.[25]"

b. SMHS Guidelines:

> "Prior to starting TRT, Digital Rectal Examination (DRE) and a PSA level should be performed to detect prostate cancer.[26]"

c. The International Society for The Study of the Aging Male ("**ISSAM**"): *Investigation, treatment and monitoring of late-onset hypogonadism in males: Official Recommendations of ISSAM* (2002) (the "**ISSAM Guidelines**")[27]:

> "The suspicion of prostate cancer is […] an absolute contra-indication for androgen therapy.[28]"

37. It would also be appropriate to carry out a *heart examination* before initiating TRT, for haematocrit (the concentration of red cells in the blood) and for signs of cardiovascular disease.[29] The ESCPG on Testosterone Therapy in Men recommended against testosterone therapy "in patients with hematocrit above 50%, […] or uncontrolled or poorly controlled heart failure […]".[30] Dr RW3 explained:

> "Because when you treat with testosterone, you can increase certain blood parameters like haematocrit, which can make the blood thicker. And if he has got a coronary narrowing, you could predispose him to coronary thrombosis. Or he has got a narrowing in the blood vessels to the brain. You can predispose him to a stroke. So because of that, we

[25] 1AB p 255.
[26] 1AB p 283.
[27] SMC Expert Report at Annex D (1AB pp 217-230).
[28] 1AB p 226.
[29] Dr PW1: Transcript 16 September 2022, 106:14-25.
[30] 1AB p 255.

> expect the practitioner to do at least a baseline monitoring because the man is more prone than woman. So you should be checking on it.[31]"

38. Other physical examinations included *lung examinations* (in some cases) and *abdominal examinations*, which would form part of the typical physical examinations for a patient.[32]

39. We found the Respondent's prescriptions of testosterone to the male patients concerned (Patients 2, 3, 4, 7, 10, 12, 13, 16, 17, 20, 21) to be inappropriate:

    a. None of the patients showed specific symptoms of LOH;

    b. Their testosterone levels were within the normal range for males (or above the normal range in some cases); and

    c. The relevant physical examinations were not done.

    (These points are elaborated later for each patient.)

TRT for females

40. The key considerations in TRT for females are set out in the table below:

Symptoms	Hypoactive Sexual Desire Disorder ("**HSDD**")
Hormone Levels	Normal testosterone range for females: 14 – 76 ng/dl (0.5 – 2.6 nmol/L)
Examinations	Breast, abdominal and pelvic examinations

41. *Symptoms*. In *Androgen Therapy in Women: A Reappraisal: An Endocrine Society Clinical Practice Guideline* [2014] ("**ESCPG on Androgen Therapy in Women**")[33], it was recommended that TRT should not be prescribed to women except for those with

[31] Dr RW3: Transcript 23 March 2023 (Part 1), 61:2195–62:2200.
[32] Dr PW1: Transcript 14 September 2022, 87:2-12; 16 September 2022, 197:13–198:1.
[33] SMC Expert Report at Annex C (1AB pp 194-216).

a specific diagnosis of HSDD.[34] There was a lack of research into the treatment of low testosterone in women, and many doctors were more concerned if testosterone levels in women were too high, rather than too low.[35]

42. The diagnostic criteria for HSDD were set out in the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* ("**DSM IV**"):[36] (a) persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity, taking into account factors that affect sexual functioning, such as age and the context of the person's life; (b) the disturbance caused marked distress or interpersonal difficulty; (c) the sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance or a general medical condition.[37]

43. *Hormone levels*. The normal range of testosterone levels for females was 14–76 ng/dl (0.5–2.6 nmol/L).

44. *Examinations*. Relevant physical examinations for females were breast, abdominal and pelvic examinations.[38]

45. We found the Respondent's prescriptions of testosterone to the female patients concerned (Patients 1, 5, 6, 8) to be inappropriate:

    a. None of the patients showed specific symptoms of HSDD;

    b. Their testosterone levels were within the normal range for females; and

    c. The relevant physical examinations were not done.

    (These points are elaborated later for each patient.)

[34] 1AB p 196.
[35] SMC Expert Report at [19] (1AB pp 164-165).
[36] The relevant excerpt from the DSM IV is reproduced in the Prosecution's Bundle of Medical Literature ("**PBML**") at pp 36-41 (Tab 6).
[37] PBML p 41.
[38] SMC Expert Report at [28], [77], [96] (1AB pp 166, 172, 174).

Progesterone Replacement Therapy (PRT) for males

46. Progesterone Replacement Therapy ("**PRT**") was *not* indicated for males.

Symptoms	(Not indicated for males)
Hormone Levels	Normal progesterone range for males: 0.00 – 4.11 nmol/L
Examinations	-

47. There was no evidence-based indication for prescribing progesterone therapy to men.[39] No medical literature was produced by the Respondent to support his practice of PRT for men. Dr RW3 said that he did not prescribe progesterone in men and declined to comment on it.[40]

48. Given that progesterone therapy was not indicated for men, we found the Respondent's prescriptions of PRT for his male patients (Patients 3, 12, 16) to be inappropriate.

Progesterone and Estradiol Replacement Therapy for females

49. The key considerations in Progesterone and Estradiol Replacement Therapy for females are set out in the table below.

Symptoms	Menopausal symptoms
Hormone Levels	Normal female progesterone range (post-menopausal): 0.00 – 1.24 nmol/L Normal female estradiol range (post-menopausal): Non-detectable – 32.2 pg/ml
Examinations	Breast, abdominal and pelvic examinations

50. *Symptoms*. A woman in menopause may exhibit one or more of the following symptoms: hot flushes, vaginal dryness, psychological issues. HRT can be prescribed for patients showing menopausal symptoms, as recommended by the Royal College of

[39] SMC Expert Report at [22] (1AB p 165).
[40] Dr RW3: Transcript 23 March 2023 (Part 1), 14:500–15:525.

Obstetricians & Gynaecologists,[41] now set out in guidelines issued by the UK National Institute for Health and Care Excellence ("**NICE**").[42]

51. Dr PW1 explained that estrogen was indicated for women having menopause, especially those having hot flushes or dry vagina. Progesterone was also prescribed to protect the uterus lining from the estrogenic effect, so as not to predispose the patient to hyperplasia of the endometrium (thickening of the lining of the uterus) which might lead to cancer. That was why estrogen and progesterone were given together.[43]

52. However, the results of clinical trials from the Women's Health Initiative ("**WHI**") demonstrated that the use of estrogen and progestin hormone after menopause increased the risk for heart disease, blood clot, breast cancer and dementia.[44] One study found that there was an increase in the risk of cognitive decline, which might bring on conditions like dementia.[45] Another study found that the use of estrogen and progesterone increased the risk of ischemic strokes in generally healthy post-menopausal women.[46] In light of the studies showing that the prescription of estrogen and progesterone might increase the risk of adverse events in post-menopausal women, practitioners now only used estrogen and progesterone for indicated purposes (for example, to treat hot flushes) *for short duration*. This practice of prescribing estrogen and progesterone together and in limited circumstances was reflected by the *Global Consensus Statement on Menopausal Hormone Therapy* which was led by the International Menopause Society.[47]

53. *Examinations*. The relevant physical examinations were breast, abdominal and pelvic examinations.[48]

[41] Dr PW1: Transcript 15 September 2022, 65:11-19; 66:21–67:6; 73:11-15; 74:3-9.
[42] Exh P11: NICE Guideline on *Menopause: diagnosis and management* (12 November 2015). Dr PW1: Transcript 16 September 2022, 2:8-10.
[43] Dr PW1: Transcript 14 September 2022, 96:5-10; 208:23-25; 209:10-18.
[44] Exhs P5–P10. Dr PW1: Transcript 16 September 2022, 6:6-16.
[45] Exh P7: "Effect of estrogen plus progestin on global cognitive function in postmenopausal women: the Women's Health Initiative Memory Study: a randomized controlled trial". Dr PW1: Transcript 16 September 2022, 17:10-20:7.
[46] Exh P8: "Effect of estrogen plus progestin on stroke in postmenopausal women: the Women's Health Initiative: a randomized trial". Dr PW1: Transcript 16 September 2022, 20:14-19.
[47] Exh P12. Dr PW1: Transcript 16 September 2022, 6:21-7:7.
[48] SMC Expert Report at [77] (1AB p 172).

54. The Respondent prescribed progesterone and estradiol to one patient (Patient 6, a 70-year-old woman). We found the prescription to be inappropriate as there was no evidence of any menopausal symptoms in the patient. (This point is elaborated later.)

Thyroxine Replacement Therapy

55. The key considerations in Thyroxine Replacement Therapy are set out in the table below.

Symptoms	Hypothyroidism
Hormone Levels	Normal thyroxine ranges (for males and females): T3 (Triiodothyronine): 60 – 181 ng/dl T4 (Free Thyroxine): 0.71 – 1.85 ng/dl TSH (Thyroid Stimulating Hormone): 0.55 – 4.78 uIU/ml
Examinations	Thyroid examinations

56. *Symptoms*. Thyroxine should only be prescribed to patients suffering from hypothyroidism. (Hypothyroidism is a condition where the thyroid gland does not produce sufficient hormones.) Symptoms of hypothyroidism included, for example, weakness, hoarseness of voice, weight gain, fatigue, increased sensitivity to cold, puffy face and depression. Some of the symptoms were non-specific and blood tests had to be done to confirm the diagnosis of hypothyroidism.[49]

57. *Hormone Levels*. To diagnose hypothyroidism accurately, the blood test results for the Triiodothyronine ("**T3**"), Free Thyroxine ("**T4**") and Thyroid Stimulating Hormone ("**TSH**") levels were the best reference source. Hypothyroidism was defined by low T3 or T4 levels that were below the normal thyroxine ranges. One must also look to the TSH levels as the TSH was a pituitary hormone produced by the pituitary gland that stimulated the thyroid gland to produce thyroxine, and thus could signal for any pituitary

[49] Excerpt from Mayo Clinic website (PBML pp 134-135). European Association of Urology Guidelines on "Investigation, Treatment, and Monitoring of Late-Onset Hypogonadism in Males: ISA, ISSAM, EAU, EAA, and ASA Recommendations": SMC Expert Report at Annex H (1AB pp 297-307). Dr PW1: Transcript 14 September 2022, 101:18–102:2; 115:7-11.

problems. Even if a patient's T3 and T4 levels were low, it would still be necessary to check the patient's TSH levels to see if it was within the normal range. [50]

a. If the T3 and T4 levels were low (*i.e.*, *below* the normal range) while the TSH level was normal, the patient would be considered hypothyroid.[51]

b. If the T3 and T4 levels were low and the TSH level was low, it would indicate that the patient might be suffering from pituitary gland issues.

58. *Examinations*. Thyroid examinations were necessary and should be conducted before prescribing thyroxine. As was explained by Dr RW3:

> "Then the tenets of which medicine is built is a good history, a good physical examination, simple, laboratory test, imaging and so forth and so forth. Now, symptoms you got. Then you examine. Examine the neck. Examine the neck. But how do you examine the neck? Look, see, feel. So you look. You can see the patient come in with a big neck. It's clear, prima facie evidence, no need to do anything anymore. It's staring at you. But there are people with a big neck with hypothyroidism. There are people with big neck with hyperthyroidism. So you still have to see what type of thyroid condition it is. And some people with totally normal neck, with hyper or hypothyroidism. So physical examination is not the prima facie evidence alone. But if it's already there, you already got your diagnosis.[52]"

59. We found the Respondent's prescriptions of thyroxine to the patients concerned (Patients 3, 5, 9, 10, 20) to be inappropriate:

a. None of the patients showed a combination of low T3, T4 and high TSH levels suggestive of hypothyroidism;

b. Their thyroxine levels were within the normal range; and

c. The relevant physical examinations were not done.

(These points are elaborated later for each patient.)

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[50] SMC Expert Report at [13], [20] (1AB pp 163, 165). Dr PW1: Transcript 14 September 2022, 103:1-12.
[51] Dr PW1: Transcript 15 September 2022, 211:1-10.
[52] Dr RW3: Transcript 23 March 2023 (Part 3), 34:1210–35:1219.

Growth Hormone Replacement Therapy

60. The key considerations in Growth Hormone Replacement Therapy are set out in the table below.

Symptoms	Growth Hormone Deficiency Specific diseases, for example, tumour on the pituitary gland
Hormone Levels	Normal IGF-1 (Insulin-like Growth Factor-1) ranges: 36-40 years: 109 – 284 ng/ml 41-45 years: 101 – 267 ng/ml 46-50 years: 94 – 252 ng/ml 51-55 years: 87 – 238 ng/ml 56-60 years: 81 – 225 ng/ml 61-65 years: 75 – 212 ng/ml 66-70 years: 69 – 200 ng/ml 71-75 years: 64 – 188 ng/ml Normal IGFBP-3 (Insulin-like Growth Factor Binding Protein 3) ranges: 51-55 years: 3.4 – 6.8 ug/ml 56-60 years: 3.4 – 6.9 ug/ml 61-65 years: 3.2 – 6.6 ug/ml
Examinations	-

61. *Symptoms*. Growth Hormones ("**GH**") should be prescribed only as a treatment for some medical conditions, such as Growth Hormone Deficiency ("**GHD**") caused by a tumour on the pituitary gland.[53] Under the guidance issued by NICE on "Human growth hormone (somatropin) in adult with growth hormone deficiency" (27 August 2003) ("**NICE Guidance on GH**"),[54] GH treatment was recommended for the treatment of adults with GH deficiency only if the following three criteria were fulfilled:[55]

a. they have severe GHD;

[53] SMC Expert Report at [21] (1AB p 165).
[54] PBML pp 42-83 (Tab 7).
[55] PBML p 46.

b. they have a perceived impairment of quality of life; and

c. they are already receiving treatment for any other pituitary hormone deficiencies as required.

62. For the first requirement (severe GHD), the ESCPG on *Evaluation and Treatment of Adult Growth Hormone Deficiency: An Endocrine Society Clinical Practice Guideline* [2011] ("**ESCPG on GH**")[56] stated that "[i]diopathic GHD in adults is very rare, and stringent criteria are necessary to make this diagnosis".[57] Symptoms of GHD included increased body fat, reduced muscle bulk, reduced strength and physical fitness, thin and dry skin, depressed mood and reduced vitality and energy. However, these symptoms were non-specific, and careful investigations including the patient's history would be warranted, including a blood test.[58]

63. *Hormone Levels*. The normal Insulin-like Growth Factor-1 ("**IGF-1**") ranges for various age groups are set out in the table at [60] above.

64. We found the Respondent's prescriptions of GH (to Patients 3, 7, 12, 13, 16, 18, 22) and Secretagogues (to Patient 8) to be inappropriate:

a. None of the patients showed indications of GHD (or specific diseases that would justify starting the prescriptions); and

b. Their hormone (IGF-1) levels were within the normal range (or above the normal range in some cases).

(These points are elaborated later for each patient.)

[56] PBML pp 109-132 (Tab 12).
[57] PBML p 110 at [1.3].
[58] *The Use of Growth Hormone in Children and Adults: Quick Reference for Healthcare Providers (Malaysia)*: PBML pp 84-92 (Tab 8) at p 90; *Adult Growth Hormone Deficiency* (Cedars Sinai website): PBML pp 93-98 (Tab 9) at pp 94-95; ESCPG on GH: PBML pp 109-132 (Tab 12) at p 114.

Polypharmacy in HRT

65. Ten patients had been prescribed with more than one hormone (Patient 3, 5, 6, 7, 8, 10, 12, 13, 16, 20). Such polypharmacy of multiple hormones was inappropriate. A rare instance where hormones could be prescribed together was estrogen with progesterone, as described at [51] to [52] above. As Dr PW1 explained, polypharmacy was inappropriate because the interaction of the medications was uncertain and could cause undesirable side effects that were detrimental to the patient; and it would be unclear which medication was the causative agent. If HRT for various hormones were carried out concurrently, it would be difficult to ascertain the effectiveness of each treatment.[59]

Conclusion

66. In short, we found that the prescriptions referred to in each Prescription Charge did not meet the applicable standards for the diagnosis and treatment of hormone deficiency, and this amounted to egregious professional misconduct.

Record-Keeping Charges

67. We found that, for the 22 patients in this Inquiry, the Respondent had not kept Patient Medical Records ("**PMRs**") that were clear, legible, accurate and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

Medical records were not clear and legible

68. Having perused the case notes in the PMRs, we found that the Respondent's handwritten notes were not clear and legible.

    a. In his oral testimony, the Respondent conceded that his handwriting was "not legible to all".[60]

    b. After MOH's initial inspections of his Clinic, the MOH asked for his illegible handwriting in the medical records to be transcribed. The transcriptions were carried

[59] Dr PW1: Transcript 14 September 2022, 87:23-89:4.
[60] Respondent: Transcript 19 September 2022, 200:10-22; 20 September 2022, 142:16-23.

out by two of his nurses, and they wrote the transcriptions on the original records. The nurses had to consult him occasionally during the transcriptions.[61]

c. Even so, there were instances where the Respondent's handwriting was misread and wrongly transcribed. For example, "skin" was wrongly transcribed as "sleep";[62] "blood test review" was wrongly transcribed as "blood test results".[63]

d. There were also instances when the Respondent could not read his own handwriting. For example, for Patient 6, the Respondent read his case note as stating fogginess in the "head", and later corrected himself that it should be "brain" and not "head".[64] For Patient 11, a word that the Respondent read as "knees" was later corrected to "Korea".[65]

69. The case notes were illegible and very difficult to read. Any doctor taking over the management of the patient would have difficulty trying to read and understand them.

Medical records were not accurate and of sufficient detail

70. We also found that the PMRs were not accurate and of sufficient detail.

71. For the prescription of HRT, there ought to have been clear, accurate and sufficient documentation, including of the following details:[66]

a. The patient's symptoms and history, relevant negative findings, physical examinations done, and indications for treatment;

b. What was advised and explained to the patient and discussed with the patient, including management plans, treatment options, the use and risks of hormones, and the patient's informed consent to undergo HRT;

[61] Respondent: Transcript 20 September 2022, 3:21–4:21.
[62] 1BPMR p 4. Transcript 20 September 2022, 121:9-18.
[63] 1BPMR p 276; and stated as such in the Statement of Dr Wong Yoke Meng dated 21 July 2022 (the "**Respondent's Statement**", marked R1) at [161] (p 47). This is discussed further at [128.b] below.
[64] 1BPMR p 170. Transcript 20 September 2022, 193:2-7.
[65] 1BPMR p 327. Transcript 21 March 2023 (Part 2), 24:863-864; 26:919-920; 27:982–28:1002.
[66] SMC Expert Report at [12], [185]-[188] (1AB pp 163, 185-186).

c. A list of appropriate medical prescriptions;

d. Monitoring and review of the patient at regular intervals.

72. The Respondent's Statement stated that he routinely discussed HRT with his patients, including attendant risks, before initiating it.[67] There was, however, no contemporaneous record of any such discussions in the PMRs. Some PMRs were incomplete as there were missing records. The records that were available were bare and lacking in details. We agreed with the SMC Expert that the case notes were "scant in details and confusing to read".[68]

73. At the Inquiry, the Respondent claimed to be able to recall undocumented details of the patients' symptoms and discussions from memory. We accepted the submission of the SMC that this was *not credible* given the many patients that he was treating with HRT and the many years that had passed since then. In any event, proper documentation was vital for the benefit of any doctor taking over treatment of the patient. Insufficient details would make it difficult for the next doctor to take over the management of the patient.[69]

74. We agreed with the opinion of the SMC Expert that the Respondent's record-keeping for the 22 patients in this Inquiry was not adequate to meet the applicable standards:[70]

a. The documentation of patient history, physical examination and counselling was poor in all the case records.

b. All the notes contained hardly any or no details of discussion of risks and benefits and treatment options.

c. Legibility was an issue as well.

[67] R1 at [66] (p 26).
[68] SMC Expert Report at [187] (1AB p 186).
[69] SMC Expert Report at [189] (1AB p 186).
[70] SMC Expert Report at [186] (1AB pp 185-186).

75. All these would make it difficult for any other doctor taking over management of the patient to understand the patient's history and treatment. The Respondent's failure to maintain clear, legible, accurate and sufficiently detailed medical records for his patients was in clear breach of Guideline 4.1.2 of the 2002 ECEG (at [17] above). It was sufficiently egregious to amount to professional misconduct.

76. (These points are elaborated later for each patient.)

Findings relating to each patient and each charge

Patient 1 (F/48) (Charges 1 and 2)

Patient 1	Female, 48 years old (as of 5 October 2013), from Russia	
Prescription	Medication	Date
	Sustanon (testosterone)	7 November 2013
Medical Records	5 October 2013 – 3 January 2014 (1BPMR Tab 1, pp 3-17A)	

Prescription Charge (Charge 1)

77. We found the prescription of Sustanon to be inappropriate.

a. *First, there was no evidence that Patient 1 displayed symptoms suggestive of HSDD.*

i. She first consulted the Respondent on 5 October 2013. No symptoms of HSDD were documented in the case notes.[71] There was no indication that she faced any issues with low sexual libido, which was one of the symptoms of HSDD in women. There was also no such indication at her next consultation on 7 November 2013.[72]

[71] 1BPMR p 4.
[72] 1BPMR p 5.

ii. In the Respondent's Statement he stated that it was conveyed to him that Patient 1 had "a lack of sex drive".[73] He said in his oral testimony that this issue was only raised by the patient's husband in a casual conversation after a consultation; but this conversation was not recorded in the case notes.[74] In our opinion, such a casual remark, even if made by the patient's husband, could not form the basis of a diagnosis of the patient's condition. The Respondent ought to have verified with Patient 1 if she was experiencing any decrease in sexual libido.[75]

b. *Second, Patient 1's testosterone levels were in the normal range*.

i. A blood test around 7 November 2013 showed the testosterone level to be 20 ng/dl (0.7 nmol/L), which was in the normal range.[76]

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*. The Respondent said that another doctor who referred Patient 1 to him had recently done a check-up of the patient.[77] This was, however, a bare assertion and the results of those checks were not documented in the case notes.

78. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 1 by inappropriately prescribing Sustanon to her. His conduct as set out in Charge 1 was sufficiently egregious to amount to professional misconduct.

<u>Record-Keeping Charge (Charge 2)</u>

79. We found that the Respondent had not kept medical records for Patient 1 between 5 October 2013 and 3 January 2014 that were clear, accurate, legible and of sufficient

[73] R1 at [75] (p 29).
[74] Respondent: Transcript 20 September 2022, 122:6-23.
[75] Respondent: Transcript 20 September 2022, 123:18-21.
[76] 1BPMR p 15.
[77] Respondent: Transcript 20 September 2022, 127:22–128:11.

detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

80. Some additional observations:

a. In the 5 October 2013 case notes, there was a notation "Thyroid – taking hormones 3 ago"[78]. The Respondent explained that Patient 1 had been taking thyroid hormones for three years before the consultation on 5 October 2013. However, he could not provide more information about Patient 1's history of thyroxine replacement therapy and whether she was still on such therapy, as these were not recorded in the case notes.[79]

b. In the 5 October 2013 case notes, there was also a notation, "put on one year programme in HK/Moscow"[80], which was unclear. The Respondent explained that given that Patient 1 was not always in Singapore, he *suggested* to put her on a one-year programme in Hong Kong (where he was a registered doctor and had a clinic) and Moscow (where he knew of a doctor who could see her).[81] However, in the absence of this explanation from the Respondent, the notation could have been easily misread to mean that Patient 1 was already on a programme back in Hong Kong/Moscow. Such information would have been relevant for a doctor taking over management of the case, to understand the key milestones in the patient's history of HRT.

[78] 1BPMR p 4.
[79] Respondent: Transcript 20 September 2022, 118:4-19; 119:14-17.
[80] 1BPMR p 4 (as transcribed).
[81] Respondent: Transcript 20 September 2022, 116:22–118:3.

81. We found that the Respondent's record-keeping for Patient 1 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 2 was sufficiently egregious to amount to professional misconduct.

Patient 2 (M/48) (Charges 3 and 4)

Patient 2	Male, 48 years old (as of 31 August 2012), from Malaysia	
Prescriptions	Medications	Dates
	Testosterone cream	1 February 2013
	Sustanon (testosterone)	14 January 2014
Medical Records	1 February 2013 – 14 January 2014 (1BPMR Tab 2, pp 18-36T)	

<u>Prescription Charge (Charge 3)</u>

82. We found the prescriptions of testosterone (testosterone cream, Sustanon) to be inappropriate.

a. *First, there was no evidence that Patient 2 displayed symptoms suggestive of LOH.*

i. No relevant complaints were reflected in the case notes.

ii. In the Respondent's Explanation, it was stated that Patient 2 was started on TRT for being "symptomatic".[82] This was, however, contradicted in the Respondent's Statement where he stated that Patient 2 had "no specific medical complaints and/or illness".[83]

b. *Second, Patient 2's testosterone levels were in the normal range.*

i. A blood test around 5 April 2012 showed the testosterone level to be 359 ng/dl (12.5 nmol/L), which was in the normal range.[84]

[82] 1AB p 427.
[83] R1 at [77] (pp 29-30).
[84] 1BPMR p 35.

ii. A blood test around 27 November 2012 showed the testosterone level to be 564 ng/dl (19.6 nmol/L), which was in the normal range.[85]

iii. The Respondent said that he had asked Patient 2 to do a blood test in Malaysia in 2013. This was not documented in the case notes, and there was no record of whether the patient did the blood test and the blood test results.86

iv. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not conduct a DRE or heart examination for Patient 2 before prescribing testosterone.

83. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 2 by inappropriately prescribing testosterone (testosterone cream and Sustanon) to him. The Respondent's conduct as set out in Charge 3 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 4)

84. We found that the Respondent had not kept medical records for Patient 2 between 1 February 2013 and 14 January 2014 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

[85] 1BPMR p 32.
[86] Respondent: Transcript 21 March 2023 (Part 1), 25:892–26:931.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

85. Some additional observations:

a. Patient 2 was first started on TRT on 17 May 2012. The case notes for 17 May 2012 recorded that Patient 2 was prescribed testosterone ("**Andriol Testocap**").[87] But there were no records of any complaints by Patient 2 – it was simply a list of prescriptions. The Respondent said that he was not at the Clinic and he discussed with the patient over the phone; but there was no record of such a phone call in the case notes. Moreover, this prescription was made at a time when the Respondent was *suspended* from practice.[88]

b. The Respondent said that Patient 2 was mainly monitored by his own doctors in Kuala Lumpur, not only testosterone but his general health.[89] However, there was a lack of documentation of any information from Patient 2's Malaysian doctors.

86. We found that the Respondent's record-keeping for Patient 2 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 4 was sufficiently egregious to amount to professional misconduct.

[87] 1BPMR p 18L.
[88] Respondent: Transcript 21 March 2023 (Part 1), 6:190–7:253.
[89] Respondent: Transcript 21 March 2023 (Part 1), 14:489-502.

Patient 3 (M/57) (Charges 5 and 6)

Patient 3	Male, 57 years old (as of 11 September 2013)	
Prescriptions	Medications	Dates
	Nebido (testosterone)	29 April 2014 25 June 2014
	Sustanon (testosterone)	31 October 2013 2 December 2013 7 July 2015 5 August 2015
	Testosterone cream	29 May 2014
	Progesterone cream	19 February 2014 19 March 2014
	Norditropin (growth hormone)	29 May 2014
	Eltroxin (thyroxine)	29 May 2014
Medical Records	11 September 2013 – 5 August 2015 (1BPMR Tab 3, pp 37-91P)	

Prescription Charge (Charge 5)

87. We found the prescriptions of testosterone (Nebido, Sustanon, testosterone cream) to be inappropriate.

a. *First, there was no evidence that Patient 3 displayed symptoms suggestive of LOH.* There was no diagnosis of LOH in the case notes. The case notes for 11 September 2013 recorded certain symptoms which were not necessarily LOH.[90]

b. *Second, Patient 3's testosterone levels were in the normal range* (or above the normal range).

[90] 1BPMR p 38. Respondent: Transcript 21 September 2022, 126:14–127:6.

i. A blood test around 12 September 2013 showed the testosterone level to be 404 ng/dl (14.0 nmol/L), which was in the normal range.[91]

ii. A blood test around 5 February 2014 showed the testosterone level to be 443 ng/dl (15.4 nmol/L), which was in the normal range. The free testosterone level was 51.9 pmol/L, which was in the normal range.92

iii. A blood test around 29 April 2014 showed the testosterone level to be 763 ng/dl (26.5 nmol/L), which was in the normal range. The free testosterone level was 82.2 pmol/L, which was in the normal range.93

iv. A blood test around 29 August 2014 showed the testosterone level to be 1,159 ng/dl (40.2 nmol/L).94 This was above the normal range.

v. A blood test around 30 December 2014 showed the testosterone level to be 740 ng/dl (25.7 nmol/L), which was in the normal range. The free testosterone level was 89.72 pmol/L, which was in the normal range.95

vi. A blood test around 5 May 2015 showed the testosterone level to be 448 ng/dl (15.5 nmol/L), which was in the normal range.96

vii. There was no relevant blood test that showed the testosterone level to be below the normal range.

viii. The Respondent conceded that Patient 3 could have had an "overdosage" of testosterone. He was ultimately unable to stabilise or regulate Patient 3's testosterone levels, and he referred the patient to a urologist or endocrinologist.[97]

c. *Third, relevant physical examinations were not done*.

[91] 1BPMR p 66.
[92] 1BPMR pp 68, 70.
[93] 1BPMR pp 73, 75.
[94] 1BPMR p 83.
[95] 1BPMR pp 85, 87.
[96] 1BPMR p 89.
[97] Respondent: Transcript 21 September 2022, 150:17-25; 156:13-15; 163:7-13; 163:24-164:3.

The Respondent did not carry out a DRE for Patient 3; it was not part of his practice to do a DRE before prescribing testosterone.[98] There were also no heart or abdominal examinations.

88. We found the prescriptions of progesterone cream to be inappropriate.

a. *First, PRT was not indicated for males* (see [46]-[47] above).

b. *Second, Patient 3's progesterone levels were in the normal range*.

i. A blood test around 5 February 2014 showed the progesterone level to be 2.6 nmol/L, which was in the normal range for males.[99]

ii. A blood test around 29 April 2014 showed the progesterone level to be 2.3 nmol/L, which was in the normal range. [100]

iii. There was no relevant blood test that showed the progesterone level to be below the normal range.

89. We found the prescription of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 3 displayed symptoms suggestive of GHD.* The case notes did not contain such a diagnosis.

b. *Second, Patient 3's IGF-1 levels were in the normal range*.

i. A blood test around 29 April 2014 showed the IGF-1 level to be 142 ng/ml, which was in the normal range for his age group (56-60 years).[101]

[98] Respondent: Transcript 21 September 2022, 131:19-22, 136:20-24.
[99] 1BPMR p 68.
[100] 1BPMR p 73.
[101] 1BPMR p 73.

ii. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

90. We found the prescription of Eltroxin to be inappropriate.

a. *First, there was no evidence that Patient 3 displayed symptoms suggestive of hypothyroidism*. The case notes did not contain such a diagnosis.

b. *Second, Patient 3's thyroxine levels were in the normal range*.

i. A blood test around 29 April 2014 showed the T3 level to be 75 ng/dl, T4 level 0.97 ng/dl, TSH level 1.16 uIU/ml, which were in the normal range.[102]

ii. There was no relevant blood test that showed the thyroxine level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

Thyroid examinations were not done.

91. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 3 by inappropriately prescribing testosterone (Nebido, Sustanon, testosterone cream), progesterone cream, Norditropin and Eltroxin to him. It was particularly reckless to prescribe, on the same day (29 May 2014), three types of hormones (testosterone cream, Norditropin, Eltroxin). The Respondent's conduct as set out in Charge 5 was sufficiently egregious to amount to professional misconduct.

<u>Record-Keeping Charge (Charge 6)</u>

92. We found that the Respondent had not kept medical records for Patient 3 between 11 September 2013 and 5 August 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

[102] 1BPMR p 72.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

93. Some additional observations:

a. The Respondent did not have a complete set of Patient 3's case notes. In the Respondent's Explanation it was stated that Patient 3's case notes prior to 2014 were "not available".[103] No reason was offered for why the notes could not be located.

b. The Respondent had switched between prescribing Sustanon and testosterone cream (which were short-acting) and Nebido (which was long-acting) on various occasions, but the reasons were not recorded in the case notes.[104] The reasons for switching medication were important and ought to have been documented.

94. We found that the Respondent's record-keeping for Patient 3 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 6 was sufficiently egregious to amount to professional misconduct.

Patient 4 (M/57) (Charges 7 and 8)

Patient 4	Male, 57 years old (as of 12 June 2014)	
Prescriptions	Medications	Dates
	Nebido (testosterone)	12 June 2014
	testosterone cream	2 February 2015
Medical Records	5 November 2012 – 10 July 2015 (1BPMR Tab 4, pp 92-122)	

[103] 1AB p 428.
[104] Respondent: Transcript 21 September 2022, 155:8-19.

Prescription Charge (Charge 7)

95. We found the prescriptions of testosterone (Nebido, testosterone cream) to be inappropriate.

a. *First, there was no evidence that Patient 4 displayed symptoms suggestive of LOH.*

There was no record of any symptoms in the case notes at the time of the prescriptions.

b. *Second, Patient 4's testosterone levels were in the normal range*.

i. A blood test around 21 March 2013 showed the testosterone level to be 514 ng/dl (17.8 nmol/L), which was in the normal range.[105]

ii. A blood test around 12 June 2014 showed the testosterone level to be 440 ng/dl (15.3 nmol/L), which was in the normal range.[106]

iii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out any DRE or heart examinations before prescribing testosterone.

96. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 4 by inappropriately prescribing testosterone (Nebido, testosterone cream) to him. The Respondent's conduct as set out in Charge 7 was sufficiently egregious to amount to professional misconduct.

[105] 1BPMR p 117.
[106] 1BPMR p 120.

Record-Keeping Charge (Charge 8)

97. We found that the Respondent had not kept medical records for Patient 4 between 5 November 2012 and 10 July 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

98. Some additional observations:

a. The Respondent said that Patient 4 was not very keen on testosterone replacement and asked to wait until the blood test results came back; and it was the patient's wife who insisted that he received the hormone treatment. But there was no record of this in the case notes.[107]

b. In the Respondent's Explanation, it was stated that Patient 4 voluntarily stopped HRT in 2013; he said that Patient 4 "had it a few times and then he stopped".[108] However, the times when Patient 4 was on or off HRT, and the rationale for stopping and resuming each time, were not recorded in the case notes.

c. In the Respondent's Statement and in his oral testimony, he said that Patient 4 "ultimately did not use" the testosterone cream; but this point was not recorded in the case notes.[109] If the patient did not use the medication, it was significant to his therapy and ought to have been documented in the case notes.

[107] Respondent: Transcript 22 September 2022, 85:13–86:8.
[108] 1AB p 430. Respondent: Transcript 22 September 2022, 84:15-16.
[109] R1 at [110] (p 37). Respondent: Transcript 22 September 2022, 88:21–89:8.

d. The Respondent said that a doctor taking over after 2015 would not have faced the question of HRT anymore as Patient 4 had stopped HRT by then. The cessation of HRT (as well as what was discussed in relation to the cessation) was not documented in the case notes.[110]

99. We found that the Respondent's record-keeping for Patient 4 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 8 was sufficiently egregious to amount to professional misconduct.

Patient 5 (F/42) (Charges 9 and 10)

Patient 5	Female, 42 years old (as of 19 January 2013)	
Prescriptions	Medications	Dates
	Testosterone cream	19 January 2013 10 June 2013 1 July 2013 22 July 2013 14 September 2013 8 November 2013 17 December 2013 1 April 2014 29 April 2014 23 May 2014
	Eltroxin (thyroxine)	13 March 2013
Medical Records	14 January 2013 – 18 September 2015 (1BPMR Tab 5, pp 123-168C)	

Prescription Charge (Charge 9)

100. We found the prescriptions of testosterone cream to be inappropriate.

a. *First, there was no evidence that Patient 5 displayed symptoms suggestive of HSDD.*

[110] Respondent: Transcript 22 September 2022, 90:9–91:14.

There were no indications of HSDD in the case notes for any of the dates on which testosterone cream was prescribed.

b. *Second, Patient 5's testosterone levels were in the normal range*.

i. A blood test around 15 January 2013 showed the testosterone level to be 20 ng/dl (0.7 nmol/L), which was in the normal range for females.[111]

ii. In the Respondent's Explanation, it was stated that Patient 5's hormone levels were "checked regularly".[112] There were, however, no blood tests which included testosterone levels since 15 January 2013 in the case file; the Respondent acknowledged that the testosterone levels for the patient had not been monitored adequately.[113]

iii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*. The Respondent said that he would not usually carry out physical examinations for patients with no complaints.[114] However, prescribing TRT to a patient without having done such examinations was an inappropriate practice.

101. We found the prescription of Eltroxin to be inappropriate.

a. *First, there was no evidence that Patient 5 displayed symptoms suggestive of hypothyroidism*. The case notes did not contain such a diagnosis. The Respondent said that he gave Eltroxin for the patient's "morning fatigue".[115] However, fatigue was a non-specific symptom that did not necessarily indicate hypothyroidism.

b. *Second, Patient 5's thyroxine levels were in the normal range*.

[111] 1BPMR p 154.
[112] 1AB p 432.
[113] Respondent: Transcript 20 September 2022, 171:12–173:7.
[114] Respondent: Transcript 20 September 2022, 160:22-25.
[115] Respondent: Transcript 20 September 2022, 145:22-25.

i. A blood test around 15 January 2013 showed the T3 level to be 95 ng/dl, T4 level 1.10 ng/dl, TSH level 3.33 uIU/ml, which were in the normal range. [116]

ii. There was no relevant blood test that showed the thyroxine level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

No thyroid examination was carried out. The Respondent said that he had observed that there was no swelling of the thyroid but did not palpate it; he conceded that it was insufficient, and he also did not document his observations in the case notes.[117]

102. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 5 by inappropriately prescribing testosterone cream and Eltroxin to her. The Respondent's conduct as set out in Charge 9 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 10)

103. We found that the Respondent had not kept medical records for Patient 5 between 14 January 2013 and 18 September 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

104. Some additional observations:

[116] 1BPMR p 152.
[117] Respondent: Transcript 20 September 2022, 189:22–190:16.

a. The Respondent said that Patient 5's main complaint was that she missed her period for three months. This was told to him by her husband, and later by her as well. Testosterone was given for her "low sex drive" which her husband had confided in him, and which he later verified with the patient. However, these were not written down in the case notes.[118]

(The notation "[decreased] sex drive" that appears in the "Initial Assessment" Form[119] was not a contemporaneous record. The entry, dated July 2013, was made only in 2015 and backdated,[120] when the Respondent introduced new template documents following the MOH audit.)

b. In the Respondent's Explanation it was stated that Patient 5 "has been referred to her own doctor in Chengdu for follow up and monitoring when she cannot come to Singapore".[121] This was, however, not recorded in the case notes. There were no details of the follow up and monitoring that the patient was undergoing in China.

c. The Respondent said that while he did not monitor the blood test results of the patient, he did monitor her for the side effects and the results and the effectiveness of treatment.[122] There were, however, no case notes documenting these.

105. We found that the Respondent's record-keeping for Patient 5 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 10 was sufficiently egregious to amount to professional misconduct.

[118] Respondent: Transcript 20 September 2022, 146:2-21; 152:23–154:10.
[119] 1BPMR p 123C.
[120] Respondent: Transcript 20 September 2022, 177:16-23.
[121] 1AB p 432.
[122] Respondent: Transcript 20 September 2022, 173:15-19; 175:5-7.

Patient 6 (F/70) (Charges 11 and 12)

Patient 6	Female, 70 years old (as of 6 June 2014)	
Prescriptions	Medications	Dates
	Testosterone cream	6 June 2014 29 August 2014
	Estrogen cream	6 June 2014
	Progesterone cream	6 June 2014 29 August 2014 26 September 2014 5 December 2014 3 January 2015 12 February 2015
Medical Records	29 January 2013 – 12 February 2015 (1BPMR Tab 6, pp 169-191)	

Prescription Charge (Charge 11)

106. We found the prescriptions of testosterone cream to be inappropriate.

a. *First, there was no evidence that Patient 6 displayed symptoms suggestive of HSDD.* There were no specific symptoms of HSDD recorded in the case notes. In the Respondent's Statement, he stated that HRT was given to Patient 6 "to alleviate apparent hyposexual symptoms".[123] However, there were no records of hyposexual symptoms in the case notes. Only non-specific symptoms like fatigue and foggy thinking were documented.[124]

b. *Second, Patient 6's testosterone levels were in the normal range*.

i. A blood test around 29 May 2014 showed the testosterone level to be 20 ng/dl (0.7 nmol/L), which was in the normal range for females.[125]

[123] R1 at [128] (p 40).
[124] SMC Expert Report at [76] (1AB p 172).
[125] 1BPMR p 184.

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

107. We found the prescriptions of estrogen cream *and* progesterone cream on 6 June 2014 to be inappropriate.

a. First, Patient 6 did not exhibit menopausal symptoms. In the Respondent's Explanation, it was stated that he had started Patient 6 on HRT for treatment of her menopause.[126] However, there were no notations of any specific menopausal symptoms. The symptoms that were documented, such as fatigue and foggy thinking, were non-specific to menopause.[127]

b. *Second, Patient 6's estradiol and progesterone levels were in the normal range*.

i. A blood test around 29 May 2014 showed the estradiol level to be 18.3 pg/ml and progesterone level to be less than 0.7 nmol/L, both of which were in the normal range for post-menopausal women.[128]

ii. There was no relevant blood test that showed the estradiol or progesterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent had not carried out the requisite breast, abdominal and pelvic examinations. He said that he did not conduct physical examinations for Patient 6 as she was being seen by other doctors in Dubai and London and he thus expected them to carry out such examinations. He acknowledged that it was his responsibility as the prescribing doctor to conduct a physical examination before prescribing HRT to the patient, but said that Patient 6 was "a bit anxious" and she said that she did

[126] 1AB p 436.
[127] SMC Expert Report at [77] (1AB p 172).
[128] 1BPMR p 183.

not want any examination.[129] There was, however, no documentation in the case notes of the patient's refusal to undergo the examinations.

108. We found the prescriptions of progesterone cream *alone* (without the accompanying estrogen cream) from 29 August 2014 to 12 February 2015 to be inappropriate.

a. *First, it was inappropriate to prescribe progesterone cream without the accompanying estrogen cream*. Estrogen is meant to treat menopausal symptoms while progesterone is added to protect the uterus lining (as explained at [51] above). The Respondent said that he had stopped the estrogen due to Patient 6's complaints of weight gain.[130] However, there was no record of this in the case notes.

b. *Second, Patient 6's progesterone levels were in the normal range* (or above the normal range).

i. A blood test around 29 May 2014 showed the progesterone level to be less than 0.7 nmol/L, which was in the normal range for post-menopausal women.[131]

ii. A blood test around 10 February 2015 showed the progesterone level to be 5.3 nmol/L, which far exceeded the upper end of the normal range for post-menopausal women (which was 1.24 nmol/L).132

iii. There was no relevant blood test that showed the progesterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

109. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 6 by inappropriately prescribing testosterone cream, estrogen cream

[129] Respondent: Transcript 20 September 2022, 227:3-20.
[130] Respondent: Transcript 20 September 2022, 212:1–214:4.
[131] 1BPMR p 183.
[132] 1BPMR p 190.

and progesterone cream to her. The Respondent's conduct as set out in Charge 11 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 12)

110. We found that the Respondent had not kept medical records for Patient 6 between 29 January 2013 and 12 February 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

111. Some additional observations:

a. There was a lack of notes in respect of Patient 6's panic attacks, which may or may not have been connected to her recurring complaints of hand tremors. The Respondent said that Patient 6 may have concurrently consulted with a psychiatrist or other doctor, but this was not recorded.[133] This would have been a relevant detail for any other doctor taking over, so that the doctor would be made aware of how Patient 6's complaints of panic attacks were being managed, and to ascertain whether the complaints of hand tremors which were still recurring as of 2015 were linked to the panic attacks.

b. The Respondent failed to document the follow-up to a test of Patient 6's T3 and T4 levels, which was apparently to check on whether there had been excessive thyroid replacement therapy.[134] It would not be clear to any other doctor taking over as to whether the test was indeed carried out and, if so, the results of the test.

[133] Respondent: Transcript 20 September 2022, 219:15-24.
[134] Respondent: Transcript 20 September 2022, 220:1–221:3.

c. The Respondent said that Patient 6 was concurrently being managed by doctors in Dubai and London. However, this was not documented anywhere in the case notes, including what treatments (if any) that Patient 6 was undergoing alongside the Respondent's HRT programme. This would have been pertinent information for a doctor taking over Patient 6's case, and the case notes were inadequate in this regard.

112. We found that the Respondent's record-keeping for Patient 6 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 12 was sufficiently egregious to amount to professional misconduct.

Patient 7 (M/64) (Charges 13 and 14)

Patient 7	Male, 64 years old (as of 19 September 2013), from India/UAE	
Prescriptions	Medications	Dates
	Sustanon (testosterone)	19 September 2013 25 July 2014 19 September 2014
	Testoviron (testosterone)	4 December 2013 28 February 2014
	Nebido (testosterone)	19 March 2015
	Norditropin (growth hormone)	19 September 2013 20 September 2013 4 December 2013 28 February 2014 25 July 2014 20 September 2014
Medical Records	19 September 2013 – 19 September 2015 (1BPMR Tab 7, pp 192-241)	

Prescription Charge (Charge 13)

113. We found the prescriptions of testosterone (Sustanon, Testoviron, Nebido) to be inappropriate.

a. *First, there was no evidence that Patient 7 displayed symptoms suggestive of LOH*. The case notes did not contain details of Patient 7's symptoms. There were two instances where some symptoms were noted down, but these were non-specific.[135]

b. *Second, Patient 7's testosterone levels were generally high or in the normal range*.

i. A blood test around 24 September 2012 showed the testosterone level to be 1,096 ng/dl (38.0 nmol/L), which exceeded the upper end of the normal range.[136]

ii. A blood test around 20 September 2013 showed the testosterone level to be 2,653 ng/dl (92.1 nmol/L), which *far exceeded* the upper end of the normal range.[137]

iii. A blood test around 16 April 2014 showed the testosterone level to be 215 ng/dl (7.5 nmol/L), which was *below* the normal range.[138]

iv. A blood test around 19 March 2015 showed the testosterone level to be 333 ng/dl (11.6 nmol/L), which was in the normal range.[139]

c. *Third, relevant physical examinations were not done*. The Respondent did not conduct a DRE or heart examination for Patient 7 before starting him on TRT.

114. We found the prescriptions of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 7 displayed symptoms suggestive of GHD*.

[135] 1BPMR p 193 ("sleep ↓"); 1BPMR p 194 ("Stress +++").
[136] 1BPMR p 219.
[137] 1BPMR p 227.
[138] 1BPMR p 234.
[139] 1BPMR p 240.

When the Respondent started Patient 7 on Norditropin on 19 September 2013, the only symptom recorded was non-specific and not conclusive of GHD.[140] There were no specific symptoms of GHD in the case notes.

b. *Second, Patient 7's IGF-1 levels were in the normal range* (or above the normal range).

i. A blood test around 26 April 2011 showed the IGF-1 level to be 192 ng/ml, which was in the normal range for his age group (61-65 years).[141]

ii. A blood test around 24 September 2012 showed the IGF-1 level to be 180 ng/ml, which was in the normal range for his age group.[142]

iii. A blood test around 16 April 2014 showed the IGF-1 level to be 306 ng/ml, which was above the normal range for his age group. [143] (It was in the range of the 31-35 years age group.)

iv. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

115. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 7 by inappropriately prescribing testosterone (Sustanon, Testoviron and Nebido) and Norditropin to him. The Respondent's conduct as set out in Charge 13 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 14)

116. We found that the Respondent had not kept medical records for Patient 7 between 19 September 2013 and 19 September 2015 that were clear, accurate, legible and of

[140] 1BPMR p 193 ("sleep ↓").
[141] 1BPMR p 208.
[142] 1BPMR p 219.
[143] 1BPMR p 234.

sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

117. Some additional observations:

a. Several years of notes were missing from Patient 7's case file. There were laboratory reports dating back to 27 April 2011;[144] however, there were no case notes until 19 September 2013.[145] In the Respondent's Explanation it was stated that Patient 7 had been under his "follow up care for more than 5 years" (as of September 2015).[146] The Respondent had not been able to find those notes from the earlier years.[147] Thus, the available medical records did not give a full picture of Patient 7's consultations with the Respondent.

b. In the Respondent's Explanation and Respondent's Statement, he stated that Patient 7 was receiving TRT from his doctors in Dubai.[148] In his oral testimony, the Respondent said that Patient 7 was seeing "three doctors for hormonal therapy" and he was receiving therapy in *India* as well. However, he did not record the patient's history of HRT in Dubai or India; and there was no way to know (from the medical records) all the hormonal therapies that the patient was on.[149] In our opinion, it was plainly inadequate to know only about the HRT programme that Patient 7 was receiving from the Respondent. The details of the patient's ongoing HRT overseas

[144] 1BPMR pp 207-209.
[145] 1BPMR p 193.
[146] 1AB p 444.
[147] Respondent: Transcript 21 September 2022, 26:5-7.
[148] 1AB p 444; R1 at [139] (p 42).
[149] Respondent: Transcript 21 September 2022, 30:7–32:3.

would impact the management of the HRT to be given to him; the Respondent ought to have made the necessary inquiries and documented them.

c. In the Respondent's Statement, he stated that Patient 7 was under the care of a gastroenterologist and a cardiologist.[150] He also said that there was a cardiologist and family physician in Dubai, and another cardiologist and family physician in India.[151] There were, however, no case notes showing the Respondent's advice and follow-up on the care that Patient 7 was receiving. Given that heart issues would be relevant for a male patient being prescribed TRT, the Respondent ought to have sought more details and documented them in the medical record.

d. In the Respondent's Statement, he stated that Patient 7 was "knowledgeable on the subject of HRT" and during consultations "there would be in-depth discussions on the effectiveness of the HRT that he was on, and to check whether there were any side effects of his HRT".[152] However, the case notes contained no record of any of these discussions.

e. Patient 7 was prescribed different forms of intramuscular testosterone across various consultations (Sustanon on 19 September 2013; Testoviron on 4 December 2013 and 28 February 2014; back to Sustanon on 25 July 2014 and 19 September 2014; and then to a long-acting depot, Nebido, on 19 March 2015). The case notes did not, however, explain why these changes were made. A doctor taking over the case would be hard-pressed to discern the reasons for the changes at the different points in time.

f. The Respondent said that there was a discussion between him and Patient 7 that took place at a hotel in Hong Kong, where "by mutual agreement" Patient 7 would try Norditropin to optimise his IGF-1 levels.[153] However, this discussion was not documented anywhere in the case notes. (There was also no mention in the

[150] R1 at [139] (p 42).
[151] Respondent: Transcript 21 September 2022, 29:7-13.
[152] R1 at [140] (p 42).
[153] Respondent: Transcript 21 September 2022, 61:14–62:15; 63:8-11.

Respondent's Explanation or Respondent's Statement. In any event, it was inappropriate for the Respondent to prescribe Norditropin on that basis.)

118. We found that the Respondent's record-keeping for Patient 7 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 14 was sufficiently egregious to amount to professional misconduct.

Patient 8 (F/47) (Charges 15 and 16)

Patient 8	Female, 47 years old (as of 6 May 2013), from Indonesia	
Prescriptions	Medications	Dates
	Testosterone cream	6 May 2013 13 August 2013
	Secretagogues	26 December 2013
Medical Records	31 December 2012 – 4 February 2015 (1BPMR Tab 8, pp 241A-273D)	

119. We found the prescriptions of testosterone cream to be inappropriate.

a. *First, there was no evidence that Patient 8 displayed symptoms suggestive of HSDD.*

In the Respondent's Statement he stated that the patient might be experiencing symptoms such as fatigue.[154] Such symptoms, however, were non-specific, and could be due to many other reasons.[155]

b. *Second, Patient 8's testosterone levels were in the normal range.*

i. A blood test around 31 December 2012 showed the testosterone level to be 24 ng/dl (0.8 nmol/L), which was in the normal range.[156]

[154] R1 at [152] (p 44).
[155] SMC Expert Report at [97] (1AB p 174).
[156] 1BPMR p 266.

ii. A blood test around 7 November 2013 showed the testosterone level to be 74 ng/dl (2.6 nmol/L), which was in the normal range.[157]

iii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

There were no breast, abdominal and pelvic examinations done prior to the prescriptions.

120. We found the prescription of secretagogues to be inappropriate.

a. *First, there was no evidence that Patient 8 displayed symptoms suggestive of GHD*. The Respondent said that Patient 8 was having "sleep problems", among other things.[158] However, poor sleep was a non-specific symptom.

b. *Second, Patient 8's IGF-1 levels were in the normal range*.

i. A blood test around 7 November 2013 showed the IGF-1 level to be 145 ng/ml, which was in the normal range for her age group (46-50 years).[159]

ii. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

121. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 8 by inappropriately prescribing testosterone cream and secretagogues to her. The Respondent's conduct as set out in Charge 15 was sufficiently egregious to amount to professional misconduct.

[157] 1BPMR p 273.
[158] Respondent: Transcript 21 September 2022, 19:8-20.
[159] 1BPMR p 273.

Record-Keeping Charge (Charge 16)

122. We found that the Respondent had not kept medical records for Patient 8 between 31 December 2012 and 4 February 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

123. Some additional observations:

a. There were missing case notes between March 2012 (the earliest laboratory report) and May 2012 (the earliest entry in the case notes).[160] The case notes around this time could have been important for a doctor taking over the case to understand why Patient 8 was eventually started on TRT in May 2013.

b. The Respondent had a system of pasting a sticker to record the registration date. The system appeared, however, to be inaccurate and unreliable. For Patient 8, the earliest laboratory report was in March 2012 and the earliest case notes were dated May 2012. However, the registration date on the sticker was stated to be 1 October 2012. The Respondent was unable to explain this discrepancy.[161]

c. There was no documentation of any discussions or symptoms to justify the prescription of Utrogestan (progesterone) and Estrogel on 31 December 2012; or Utrogestan on 25 March 2013, 6 May 2013 and 13 August 2013.[162] While Patient 8 was of a menopausal age at the time, it would be unclear to a doctor taking over

[160] 1BPMR pp 254-260; 1BPMR p 243. Respondent: Transcript 21 September 2022, 3:11-20.
[161] Respondent: Transcript 21 September 2022, 3:21–4:11.
[162] 1BPMR pp 244-246.

management of the case as to what symptoms she might have been experiencing or the reasons that the Respondent had made the prescriptions.

124. We found that the Respondent's record-keeping for Patient 8 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 16 was sufficiently egregious to amount to professional misconduct.

Patient 9 (M/43) (Charges 17 and 18)

Patient 9	Male, 43 years old (as of 20 January 2014), from Malaysia	
Prescription	Medication	Date
	Eltroxin (thyroxine)	20 January 2014
Medical Records	24 December 2013 – 8 April 2014 (1BPMR Tab 9, pp 274-286)	

Prescription Charge (Charge 17)

125. We found the prescription of Eltroxin to be inappropriate.

a. *First, there was no evidence that Patient 9 displayed symptoms suggestive of hypothyroidism*. In the Respondent's Explanation, it was stated that the patient's thyroid function was "normal"; he also confirmed in his oral testimony that there were no concerns with the patient's thyroid function.[163]

b. *Second, Patient 9's thyroxine levels were in the normal range*.

i. A blood test around 24 December 2013 showed the T3 level to be 121 ng/dl, T4 level 1.22 ng/dl, TSH level 2.52 uIU/ml, which were in the normal range.[164]

ii. There was no relevant blood test that showed the thyroxine level to be below the normal range.

[163] 1AB p 423. Respondent: Transcript 22 September 2022, 63:5-10.
[164] 1BPMR p 280.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out a thyroid examination of Patient 9.

126. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 9 by inappropriately prescribing Eltroxin to him. The Respondent's conduct as set out in Charge 17 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 18)

127. We found that the Respondent had not kept medical records for Patient 9 between 24 December 2013 and 8 April 2014 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

128. Some additional observations:

a. As was noted by Dr PW1, the case records were very lacking in details. For each visit, "there was a list of prescription items and investigations but hardly any history and no physical examination details. The case records are scant and confusing and many words are hard to read and decipher."[165]

b. The following was a stark example of the illegibility of the case notes that led to it being misread, even by the Respondent himself. The Respondent made an entry in the case notes of 20 January 2014 which was meant to read, "take after blood test

[165] SMC Expert Report at [105] (1AB p 175).

review". The was incorrectly transcribed (by the Respondent's nurses) as "take after blood test results".[166] In the Respondent's Statement, he also wrongly stated it as such when explaining his treatment plan for the patient.[167] It was also initially misread by the Respondent's Counsel and Dr PW1 as "take after food, test results".[168] This was but one illustration of the difficulty in deciphering the Respondent's notes and understanding his therapy.

c. Further, as was noted by Dr PW1, adding to the confusion was that there were "duplicate entries for same date and time – 24 Dec 2013 (10am) with slightly different details entered, both scanty and quite illegible."[169]

129. We found that the Respondent's record-keeping for Patient 9 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 18 was sufficiently egregious to amount to professional misconduct.

Patient 10 (M/45) (Charges 19 and 20)

Patient 10	Male, 45 years old (as of 18 October 2014), from China	
Prescriptions	Medications	Dates
	Testosterone cream	18 October 2014
	Eltroxin (thyroxine)	18 October 2014
Medical Records	16 April 2014 – 23 March 2015 (1BPMR Tab 10, pp 287-303E)	

Prescription Charge (Charge 19)

130. We found the prescription of testosterone cream to be inappropriate.

a. *First, there was no evidence that Patient 10 displayed symptoms suggestive of LOH.*

[166] 1BPMR p 276. Respondent: Transcript 22 September 2022, 64:19–65:4.
[167] R1 at [161] (p 47).
[168] Dr PW1: Transcript 15 September 2022, 186:3-25.
[169] SMC Expert Report at [105] (1AB p 175); 1BPMR p 275.

In the Respondent's Explanation it was stated that Patient 10 was "symptomatic".[170] But there was no documentation of any symptoms in the case notes. There were no complaints relating to libido or low sex drive.[171]

b. *Second, Patient 10's testosterone levels were in the normal range*.

i. A blood test around 16 April 2014 showed the testosterone level to be 333 ng/dl (11.6 nmol/L), which was "in the lower end of the normal range for males".[172] This was in the "grey zone" (explained at [34] above) for which a free testosterone test should have been carried out to verify whether TRT would be appropriate for the patient. Such a test was not done. A repeat morning test (explained at [35] above) was also not done.

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out a DRE for Patient 10.

131. We found the prescription of Eltroxin to be inappropriate.

a. *First, there was no evidence that Patient 10 displayed symptoms suggestive of hypothyroidism*. In the Respondent's Explanation, it was stated that Patient 10 was "symptomatic".[173] But there was no documentation of any symptoms in the case notes. The Respondent said that Eltroxin was given to the patient "to try to improve his energy a little bit".[174] Poor energy levels, however, were non-specific and were not a sufficient justification to prescribe Eltroxin.

b. *Second, Patient 10's thyroxine levels were in the normal range*.

[170] 1AB p 424.
[171] Respondent: Transcript 22 September 2022, 55:5-8.
[172] 1BPMR p 298. R1 at [166] (p 48).
[173] 1AB p 424.
[174] Respondent: Transcript 22 September 2022, 56:19–57:16.

i. A blood test around 16 April 2014 showed the T3 level to be 91 ng/dl, T4 level 1.26 ng/dl, TSH level 3.57 uIU/ml, which were in the normal range.[175]

ii. There was no relevant blood test that showed the thyroxine level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out a thyroid examination for Patient 10 before the prescription.

132. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 10 by inappropriately prescribing testosterone cream and Eltroxin to him. The Respondent's conduct as set out in Charge 19 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 20)

133. We found that the Respondent had not kept medical records for Patient 10 between 16 April 2014 and 23 March 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

134. Some additional observations:

[175] 1BPMR p 296.

a. In the Respondent's Statement, he stated that Patient 10 was "also being managed by doctors in China and Canada, including regular physical check-ups in Vancouver", and that in order to facilitate co-management he had provided Patient 10 with a copy of results of blood tests planned by him and the list of prescriptions made by him for the patient to take back to his doctors in China and Canada.[176] There was, however, no documentation of any details of Patient 10's treatment, test results and prescriptions from his doctors in China and Canada in the medical records, which would be important for the (co-)management of the patient.

b. In the Respondent's Statement, he stated that he had an "in-depth discussion" with Patient 10 in which TRT was discussed, and the patient "consented to undergo TRT".[177] There was, however, no documentation of this discussion or consent in the medical records. (There was also no mention in the Respondent's Explanation.[178])

c. In the Respondent's Explanation, it was stated that the complaints presented by Patient 10 on 16 April 2014 were "lack of energy & sexual frequency".[179] In his oral testimony he acknowledged that this was inaccurate and there was no record of a complaint regarding "sexual frequency" in the case notes.[180]

135. We found that the Respondent's record-keeping for Patient 10 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 20 was sufficiently egregious to amount to professional misconduct.

Patient 11 (M/58) (Charge 21)

Patient 11	Male, 58 years old (as of 9 January 2013)
Medical Records	9 January 2013 – 14 August 2015 (1BPMR Tab 11, pp 304-372)

[176] R1 at [164] (p 47).
[177] R1 at [166] (p 48).
[178] 1AB p 424.
[179] 1AB p 424.
[180] Respondent: Transcript 22 September 2022, 55:12-17. 1BPMR p 288.

Record-Keeping Charge (Charge 21)

136. We found that the Respondent had not kept medical records for Patient 11 between 9 January 2013 and 14 August 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

137. Some additional observations:

a. Even though the Respondent had been treating Patient 11 for 12 years, he was only able to produce case notes from the most recent four years. He said that the older notes before 2012 were no longer in his computer system or in his physical possession as his team had "disposed of" these older notes; and the symptoms that prompted the prescription of TRT for Patient 11 were "in the missing pages that have been thrown away". Such records would be highly relevant to any other doctor taking over management of the patient. Without such records, a doctor taking over treatment of the patient would not know the patient's history before 2012. It was unacceptable for the older notes to have been disposed of since Patient 11 was still seeing the Respondent for treatment.[181]

b. The Respondent said that Patient 11 had complaints of erectile dysfunction ("**ED**"). The symptoms later improved and the patient did not have subsequent complaints of ED. The Respondent presumed that TRT had been helpful to the patient; however, he did not document any such improvement in the patient's complaint of ED. He

[181] Respondent: Transcript 21 March 2023 (Part 2), 1:14–5:152.

conceded that another doctor would think that no specific action for ED was being considered due to the ongoing HRT, and not that the ED complaints had stopped.[182]

c. The Respondent said that Patient 11's stressful divorce was the reason for the prescription of dexamethasone; however, this reason was not recorded.[183]

d. The Respondent said that he had prescribed Viagra to Patient 11 on 28 November 2014 due to the patient's complaint of mild ED and stress from the patient's ongoing divorce. However, these were not recorded down, and only the patient's "anxiety" was recorded in the case notes for that day.[184]

e. The Respondent acknowledged that there were "deficiencies in the recording".[185]

138. We found that the Respondent's record-keeping for Patient 11 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 21 was sufficiently egregious to amount to professional misconduct.

[182] Respondent: Transcript 21 March 2023 (Part 2), 21:762–22:788.
[183] 1BPMR p 307. Respondent: Transcript 21 March 2023 (Part 2), 22:791–24:860.
[184] 1BPMR p 330. Respondent: Transcript 21 March 2023 (Part 2), 30:1066-1083.
[185] Respondent: Transcript 21 March 2023 (Part 2), 35:1273-1280.

Patient 12 (M/57) (Charges 22 and 23)

Patient 12	Male, 57 years old (as of 14 March 2013)	
Prescriptions	Medications	Dates
	Intramuscular testosterone	14 March 2013 9 April 2013 26 September 2013 27 October 2013 11 December 2013 8 January 2014 24 March 2014 8 May 2014 13 August 2014 26 November 2014
	Testosterone cream	3 August 2015
	Progesterone cream	10 May 2013 7 June 2013 16 July 2013
	Norditropin (growth hormone)	10 May 2013 18 October 2014 23 January 2015
Medical Records	5 March 2013 – 17 August 2015 (2BPMR Tab 12, pp 373-441)	

<u>Prescription Charge (Charge 22)</u>

139. We found the prescriptions of testosterone (intramuscular testosterone, testosterone cream) to be inappropriate.

a. *First, there was no evidence that Patient 12 displayed symptoms suggestive of LOH.*

In the Respondent's Statement, he stated that on 5 March 2013 the patient reported "sleep issues, a decrease in vitality".[186] These considerations, however, did not justify the prescription of TRT.

b. *Second, Patient 12's testosterone levels were in the normal range*.

i. A blood test around 5 March 2013 showed the testosterone level to be 347 ng/dl (12 nmol/L), which was in the normal range.[187] This was in the "grey zone" (explained at [34] above) for which a free testosterone test should have been carried out to verify whether TRT would be appropriate for the patient. Such a test was not done. A repeat morning test (explained at [35] above) was also not done.

ii. A blood test around 8 January 2014 showed the testosterone level to be 563 ng/dl, which was in the normal range.[188]

iii. A blood test around 6 July 2015 showed the testosterone level to be 353 ng/dl (12.2 nmol/L), which was in the normal range. The free testosterone level was 36.03 pmol/L, which was in the normal range.[189] (The testosterone level was just out of the "grey zone" (explained at [34] above); a repeat morning test (explained at [35] above) was not done.)

iv. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

Relevant physical examinations (DRE, heart, lung examinations) were not done for Patient 12 before starting TRT for him.

[186] R1 at [178] (p 50).
[187] 2BPMR p 419.
[188] 2BPMR p 425.
[189] 2BPMR pp 439, 441.

140. We found the prescriptions of progesterone cream to be inappropriate.

a. *First, PRT was not indicated for males* (see [46]-[48] above).

b. *Second, Patient 12's progesterone levels were in the normal range*.

i. A blood test around 5 March 2013 showed the progesterone level to be 0.7 nmol/L, which was in the normal range for males.[190]

ii. There was no relevant blood test that showed the progesterone level to be below the normal range.

141. We found the prescriptions of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 3 displayed symptoms suggestive of GHD*. The case notes did not contain such a diagnosis. In the case notes for 18 October 2014, there were notations of "UTI symptoms" and "superficial burns",[191] but these were not relevant to a diagnosis of GHD.

b. *Second, Patient 12's IGF-1 levels were in the normal range*.

i. A blood test around 5 March 2013 showed the IGF-1 level to be 133 ng/ml, which was in the normal range for his age group (56-60 years).[192]

ii. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

142. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 12 by inappropriately prescribing intramuscular testosterone, testosterone cream, progesterone cream and Norditropin to him. The Respondent's conduct as set out in Charge 22 was sufficiently egregious to amount to professional misconduct.

[190] 2BPMR p 419.
[191] 2BPMR p 392.
[192] 2BPMR p 419.

Record-Keeping Charge (Charge 23)

143. We found that the Respondent had not kept medical records for Patient 12 between 5 March 2013 and 17 August 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

144. Some additional observations:

a. In the Respondent's Explanation, it was stated that Patient 12 had been under his care "for the last 10 years" (as of 2015); although in the Respondent's Statement, he stated that Patient 12 first attended at the Clinic "in around 2010".[193] No case notes before March 2013 were produced and he was "not absolutely sure" whether the patient was started on hormonal therapy before that.[194] A doctor taking over Patient 12's care would not have the full picture of the patient's treatment history.

b. In the Respondent's Statement he stated that during the period that Patient 12 was under his care, the patient underwent "routine health check-ups under an arrangement with his company, and was being concurrently managed by other doctors".[195] This information was important but was not recorded in the case notes.

c. In the Respondent's Statement, he stated that Patient 12 attended at the Clinic on 10 May 2013 and there was a detailed discussion about GH replacement therapy and the patient agreed to such therapy, and Norditropin was given to the patient. In his

[193] 1AB p 431. R1 at [177] (p 50).
[194] Respondent: Transcript 21 September 2022, 191:15–192:10.
[195] R1 at [177] (p 50).

oral testimony, however, he said that there was "no clinical review" that day and what he had stated in the Respondent's Statement could have been a mistake. He said that the discussion could have happened before that date, but he could not recall the date on which the discussion took place, as it was not documented in the case notes.[196] The case notes were thus inadequate and unclear, and could not be relied upon by a doctor taking over Patient 12's case.

145. We found that the Respondent's record-keeping for Patient 12 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 23 was sufficiently egregious to amount to professional misconduct.

Patient 13 (M/39) (Charges 24 and 25)

Patient 13	Male, 39 years old (as of 7 November 2013), from Russia	
Prescriptions	Medications	Dates
	Sustanon (testosterone)	7 November 2013
	Norditropin (growth hormone)	14 January 2014
Medical Records	7 November 2013 – 22 January 2015 (2BPMR Tab 13, pp 442-454E)	

Prescription Charge (Charge 24)

146. We found the prescription of Sustanon to be inappropriate.

a. *First, there was no evidence that Patient 13 displayed symptoms suggestive of LOH.*

The Respondent said that the prescription was based on his assessment that day and the patient's complaints (of poor sleep, fatigue, decreased sex drive).[197] However, these alone were an insufficient basis to prescribe TRT.

[196] R1 at [181] (p 51). Respondent: Transcript 21 September 2022, 200:13–201:10; 205:3-7.
[197] Respondent: Transcript 21 September 2022, 83:7-15.

b. *Second, Patient 13's testosterone levels were in the normal range*.

i. A blood test around 7 November 2013 showed the testosterone level to be 247 ng/dl (8.6 nmol/L), which was in the normal range.[198] This was in the "grey zone" (explained at [34] above) for which a free testosterone test should have been carried out to verify whether TRT would be appropriate for the patient. Such a test was not done. A repeat morning test (explained at [35] above) was also not done.

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out the relevant physical examinations (DRE, heart, lung examinations) before prescribing TRT.

147. We found the prescription of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 13 displayed symptoms suggestive of GHD*. In the Respondent's Statement it was stated that Norditropin was prescribed for complaints of "poor sleep, fatigue, decreased sex drive".[199] These symptoms were, however, non-specific to GHD.

b. *Second, Patient 13's IGF-1 levels were in the normal range*.

i. A blood test around 7 November 2013 showed the IGF-1 level to be 119 ng/ml, which was in the normal range for his age group (36-40 years).[200]

ii. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

[198] 2BPMR p 454.
[199] 1AB p 433.
[200] 2BPMR p 454.

148. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 13 by inappropriately prescribing Sustanon and Norditropin. The Respondent's conduct as set out in Charge 24 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 25)

149. We found that the Respondent had not kept medical records for Patient 13 between 7 November 2013 and 22 January 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

150. Some additional observations:

a. In the Respondent's Statement, he stated that on 9 November 2013 he had discussed with Patient 13 the results of a blood test performed around 7 November 2013.[201] However, the blood test results were not reported until 13 November 2013.[202] When questioned about this discrepancy, the Respondent said that he had called the laboratory and asked for the results. However, neither the call nor the results were recorded in the case notes. If what the Respondent said was true, it should have been recorded down.[203]

b. In respect of his prescription of Norditropin, the Respondent said that he had discussed Patient 13's IGF-1 results. He said that he made some notations on the lab

[201] R1 at [208] (p 56).
[202] 2BPMR p 452.
[203] Respondent: Transcript 21 September 2022, 84:8-23; 85:15-20.

test result *where he circled to show and explain to the patient* that his hormone level was on the low side.[204] However, it transpired that the handwritten notations were *not* made contemporaneously when he was discussing with the patient, but only in 2015, when he made the notations for his own reference when preparing his explanation to MOH and SMC.[205] He eventually conceded that he did *not* make the notations when discussing with Patient 13.[206]

151. We found that the Respondent's record-keeping for Patient 13 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 25 was sufficiently egregious to amount to professional misconduct.

Patient 14 (F/61) (Charge 26)

Patient 14	Female, 61 years old (as of 7 September 2012)
Medical Records	7 February 2013 – 22 June 2015 (2BPMR Tab 14, pp 455-471E)

Record-Keeping Charge (Charge 26)

152. We found that the Respondent had not kept medical records for Patient 14 between 7 February 2013 and 22 June 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

[204] 2BPMR p 454. Respondent: Transcript 21 September 2022, 88:3-11; 88:24–89:4; 90:3-13.
[205] Compare Exh P13 p 158 (the copy provided to MOH) with 2BPMR p 454 (the copy provided to SMC). Respondent: Transcript 21 September 2022, 90:14–92:12.
[206] Respondent: Transcript 21 September 2022, 92:20-24.

153. Some additional observations:

a. Although laboratory tests were conducted for Patient 14 between March 2010 and May 2012,[207] there were no notes of any consultations with the patient during this period. The case notes for 7 September 2012 had a notation "repeat meds",[208] which would suggest that Patient 14 had been prescribed medication by the Respondent before this date, but there was no record of what these medications were.

b. The Respondent said that the prescription of Norditropin (growth hormone) on 7 September 2012 was "probably based on the test done in 2010".[209] There was, however, no reference in the case notes that the Respondent was referring to these test results to support his prescription.[210] It would not be obvious to a doctor taking over the case that the Respondent was relying on the 2010 test results (when a more recent test ought to have been carried out before prescribing Norditropin).

c. As to why Norditropin was prescribed that day, the Respondent said that the patient was very frail and having osteoporosis, and the collagenous tissues on the face and body were drooping significantly. This was not recorded in the case notes, and the notes were missing.[211] A doctor taking over management of Patient 14 would not be able to understand the patient history and prescriptions from the case notes.

d. The Respondent said that on 28 March 2013 there was an annual check-up for Patient 14: "pap smear, ultrasound, pelvic". However, the results of these examinations were not recorded in the case notes.[212]

e. Patient 14 continued to see the Respondent between 2012 and 2015. The Respondent said that he had asked Patient 14's husband, a doctor, to follow up with Patient 14's annual blood test, including hormones. However, the Respondent did not have copies of the patient's annual blood tests, and he did not notate any of the blood test

[207] 2BPMR pp 465A-465L.
[208] 2BPMR p 456.
[209] 2BPMR p 465C. Respondent: Transcript 21 March 2023 (Part 3), 4:116-122.
[210] 2BPMR p 456.
[211] Respondent: Transcript 21 March 2023 (Part 3), 7:228-251.
[212] Respondent: Transcript 21 March 2023 (Part 3), 11:385–12:406. 2BPMR p 457.

results that had been ordered by the patient's husband. He did not follow up and monitor the patient's blood test results.[213]

f. When asked about how he would know whether Patient 14 was benefitting from his treatment, the Respondent said that it could be implied as the patient saw him regularly and did not have any symptoms or complaints and was willing to continue the treatment.[214] However, these "negative findings" were not documented. A doctor taking over the management of Patient 14 would not have any information to determine whether the patient had benefitted from the Respondent's treatment.

154. We found that the Respondent's record-keeping for Patient 14 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 26 was sufficiently egregious to amount to professional misconduct.

Patient 15 (F/56) (Charge 27)

Patient 15	Female, 56 years old (as of 6 April 2013)
Medical Records	6 July 2013 – 1 August 2015 (2BPMR Tab 15, pp 472-509H)

Record-Keeping Charge (Charge 27)

155. We found that the Respondent had not kept medical records for Patient 15 between 6 July 2013 and 1 August 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

[213] Respondent: Transcript 21 March 2023 (Part 3), 13:467–15:529.
[214] Respondent: Transcript 21 March 2023 (Part 3), 15:532–16:564.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

156. Some additional observations:

a. The case notes from 29 September 2012 to 18 January 2014[215] only contained lists of prescriptions. Only on 3 May 2014 were there notations relating to the history that was taken at that visit.[216] We found these records to be inadequate considering that the Respondent was prescribing hormones such as Estrogel (estrogen) and Utrogestan (progesterone) during this period.[217] The rationale for the prescriptions, discussions with the patient as well as the patient's consent should have been noted down, but were not done.[218]

b. In the Respondent's Explanation, it was stated that Patient 15 was started on estradiol and progesterone replacement therapy "for her menopause",[219] but no menopausal symptoms were recorded in the case notes.

c. In the Respondent's Explanation, it was stated that Patient 15 discontinued her HRT treatment in December 2013 and restarted in December 2014.[220] (This was not borne out by the case notes, which showed that the HRT treatment restarted in June 2014.) The Respondent could not remember why Patient 15 decided to stop the treatment on 14 December 2013, and he said that "probably" it "could be" that she already had supplies of the medication. The treatment was restarted in June 2014; he did not document the reasons for restarting the treatment and was unable to recall the reason. The treatment stopped again on 19 June 2015, and the reason for discontinuing the treatment was also not recorded in the case notes.[221] The reasons for stopping and restarting the treatment were important for the management of the patient. The

[215] 2BPMR pp 473-477.
[216] 2BPMR p 479.
[217] *Eg*, on 31 August 2013 (2BPMR p 476).
[218] Respondent: Transcript 21 March 2023 (Part 3), 22:775-779.
[219] 1AB p 435.
[220] 1AB p 435.
[221] Respondent: Transcript 21 March 2023 (Part 3), 22:782-786; 22:801–23:810; 24:855–26:933; 27:954-961; 28:1017-1021; 31:1114–32:1142; 40:1440-1454.

reasons, as well as any discussions between doctor and patient relating to the stopping or restarting of the therapy, ought to have been recorded in the case notes. This would enable any doctor taking over the management of the patient to appreciate the full picture of the patient's treatment.

157. We found that the Respondent's record-keeping for Patient 15 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 27 was sufficiently egregious to amount to professional misconduct.

Patient 16 (M/51) (Charges 28 and 29)

Patient 16	Male, 51 years old (as of 22 September 2012)	
Prescriptions	Medications	Dates
	Nebido (testosterone)	3 October 2012
	Norditropin (growth hormone)	22 September 2012 3 November 2012 16 March 2013 4 April 2013 4 May 2013 18 October 2013 30 December 2013 5 May 2014 15 September 2014 19 November 2014
	Progesterone cream	15 September 2014
Medical Records	22 September 2012 – 5 August 2015 (2BPMR Tab 16, pp 510-544)	

<u>Prescription Charge (Charge 28)</u>

158. We found the prescription of Nebido to be inappropriate.

a. *First, there was no evidence that Patient 16 displayed symptoms suggestive of LOH.*

No such symptoms were recorded in the case notes for 3 October 2012 when the medication was prescribed.[222]

b. *Second, Patient 16's testosterone levels were in the normal range*.

i. A blood test around 19 January 2012 showed the testosterone level to be 456 ng/dl (15.8 nmol/L), which was in the normal range.[223] The Respondent agreed that it was "not a concern".[224]

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

The Respondent did not carry out a DRE for Patient 16. In the Respondent's Statement it was stated that Patient 16 was "not keen to undergo a repeat rectal examination" after going through annual check-ups with another doctor.[225] There was, however, no record in the case notes to show that the patient had declined a DRE. The Respondent also had no copies of the results of Patient 16's various annual check-ups. In the absence of such results, the Respondent ought to have carried out a physical examination to ascertain that Patient 16 was a suitable candidate for testosterone therapy.

159. We found the prescriptions of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 16 displayed symptoms suggestive of GHD*.

The case notes for the dates on which the prescriptions were made contained a list of prescriptions, but no relevant symptoms were recorded. Only non-specific

[222] 2BPMR p 512.
[223] 2BPMR p 534.
[224] Respondent: Transcript 21 September 2022, 102:22–103:6.
[225] R1 at [221] (p 59).

symptoms had been recorded, such as on 18 May 2013 ("stressed", "sleep erratic").[226]

b. *Second, Patient 16's IGF-1 (and IGFBP-3) levels were in the normal range* (or above the normal range).

i. A blood test around 19 January 2012 showed the IGF-1 level to be 289 ng/ml, which was above the normal range for his age group (51-55 years).[227]

ii. A blood test around 28 June 2013 showed the IGFBP-3 level to be 5.1 ug/ml, which was in the normal range for his age group.[228]

iii. A blood test around 11 February 2014 showed the IGF-1 level to be 227 ng/ml, which was in the normal range for his age group.[229]

iv. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

160. We found the prescription of progesterone cream to be inappropriate.

a. *First, PRT was not indicated for males* (see [46]-[48] above).

b. *Second, Patient 16's progesterone levels were in the normal range*.

i. A blood test around 28 June 2013 showed the progesterone level to be 0.7 nmol/L, which was in the normal range for males.[230]

ii. There was no relevant blood test that showed the progesterone level to be below the normal range.

[226] 2BPMR p 516.
[227] 2BPMR p 534.
[228] 2BPMR p 541.
[229] 2BPMR p 544.
[230] 2BPMR p 541.

161. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 16 by inappropriately prescribing Nebido, Norditropin and progesterone cream to him. The Respondent's conduct as set out in Charge 28 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 29)

162. We found that the Respondent had not kept medical records for Patient 16 between 22 September 2012 and 5 August 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

163. Some additional observations:

a. Several years of medical records were missing from Patient 16's case files. In the Respondent's Explanation, it was stated that Patient 16 had been under his care "for more than 10 years" (as of 2015). [231] The earliest medical record was in January 2012,[232] and the records from 2006 to 2011 were missing. The Respondent said that he was unable to find the original notes, and computerised versions of the notes up to 2011 were no longer available due to technical issues with a software upgrade. The original case file containing the notes from 2012 to 2015 (which were in issue in this Inquiry) were also missing.[233] With such incomplete, scanty and missing notes, it would be difficult for a doctor taking over the management of Patient 16 to

[231] 1AB p 437.
[232] Laboratory report at 2BPMR p 529.
[233] Respondent: Transcript 21 September 2022, 101:11-17; 105:22–106:7; 108:12-23.

ascertain his history and prescriptions over the years. This was especially important as Patient 16 appeared to be on a long-term HRT programme with the Respondent.

b. The Respondent admitted that he had not recorded sufficient details of Patient 16's medical history that would be relevant to the treatment; he also did not record discussions and explanations to the patient. He said, however, that he had nevertheless discussed each item with the patient "in quite detail".[234] Patient 16, who was called as a witness (RW2) by the Respondent, said that he had provided the Respondent with information including: (a) his medical history, health history, family history, (b) clinical symptoms, and (c) details of overseas treatment (such as previous blood work, protocols, monitoring and rationale); and he had discussed the side effects of HRT with the Respondent. Patient 16 said that he had been diagnosed with hypogonadism and adult growth hormone deficiency, and that he suffered from mild benign prostate hyperplasia; and that he was on HRT concurrently with various doctors overseas.[235] The Respondent ought to have documented these details. Without such details, a doctor taking over treatment of Patient 16 would not have the full picture of the patient's treatments.

c. There were two separate entries recorded on the same date of 18 May 2013.[236] The Respondent could not explain why there were two different entries for the same date, and he acknowledged that he would have only referred to one the entries if the other entry had not been pointed out to him, and that it would have added to the confusion for a doctor taking over Patient 16's case.[237]

164. We found that the Respondent's record-keeping for Patient 16 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 29 was sufficiently egregious to amount to professional misconduct.

[234] Respondent: Transcript 21 September 2022, 119:21–120:5; 123:23–124:8.
[235] Patient 16 (RW2): Transcript 22 March 2023, 5:149-152; 8:279–9:299; 10:333-338; 25:887-898; 27:956-968.
[236] 2BPMR pp 512, 516.
[237] Respondent: Transcript 21 September 2022, 111:24–112:24; 116:12-24.

Patient 17 (M/48) (Charges 30 and 31)

Patient 17	Male, 48 years old (as of 19 February 2014)	
Prescriptions	Medications	Dates
	Sustanon (testosterone)	19 February 2014
	Nebido (testosterone)	26 February 2014
Medical Records	19 – 26 February 2014 (2BPMR Tab 17, pp 545-554A)	

Prescription Charge (Charge 30)

165. We found the prescriptions of testosterone (Sustanon and Nebido) to be inappropriate.

a. *First, there was no evidence that Patient 17 displayed symptoms suggestive of LOH.*

No such complaints were recorded in the case notes. The Respondent confirmed that Patient 17 "did not complain of any lack of libido or sex".[238]

b. *Second, Patient 17's testosterone levels were in the normal range*.

i. A blood test around 19 February 2014 showed the testosterone level to be 268 ng/dl (9.3 nmol/L), which was in the normal range.[239] This was in the "grey zone" (explained at [34] above) for which a free testosterone test should have been carried out to verify whether TRT would be appropriate for the patient. Such a test was not done. A repeat morning test (explained at [35] above) was also not done.

ii. There was no relevant blood test that showed the testosterone level to be below the normal range.

[238] Respondent: Transcript 22 September 2022, 71:5-9.
[239] 2BPMR p 554.

c. *Third, relevant physical examinations were not done*. The Respondent did not carry out a DRE for Patient 17.

166. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 17 by inappropriately prescribing Sustanon and Nebido to him. The Respondent's conduct as set out in Charge 30 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 31)

167. We found that the Respondent had not kept medical records for Patient 17 between 19 and 26 February 2014 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

168. Some additional observations:

a. The reason for the change in prescription from Sustanon on 19 February 2014 to Nebido on 26 February 2014 was not documented. The Respondent said that Patient 17 was the personal bodyguard of a politician, who would be returning to< country redacted >; so he decided to give the patient a "long acting depot so that it will last longer than the 2 weeks". This reasoning was not recorded in the case notes.[240] Such information would have been relevant for a doctor taking over management of the patient, to understand the history of his testosterone prescriptions and the rationale behind them.

[240] Respondent: Transcript 22 September 2022, 72:20–73:13. 2BPMR p 547.

b. The Respondent prepared a medical report for Patient 17, but the report made no mention of the patient's ongoing TRT with the Respondent, including the types of TRT that he had received and the rationale.[241] The report was insufficient and lacking in important details. (It was also not dated correctly.)[242]

169. We found that the Respondent's record-keeping for Patient 17 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 31 was sufficiently egregious to amount to professional misconduct.

Patient 18 (M/61) (Charges 32 and 33)

Patient 18	Male, 61 years old (as of 11 December 2012)	
Prescriptions	Medication	Dates
	Norditropin (growth hormone)	11 December 2012 28 February 2013 4 April 2013 24 April 2014 14 June 2014 5 August 2014 17 September 2014 4 December 2014 10 February 2015
Medical Records	11 December 2012 – 10 February 2015 (2BPMR Tab 18, pp 555-603E)	

<u>Prescription Charge (Charge 32)</u>

170. We found the prescriptions of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 18 displayed symptoms suggestive of GHD.*

[241] Respondent: Transcript 22 September 2022, 74:4-6. 2BPMR p 554A.
[242] Respondent: Transcript 22 September 2022, 79:15-25.

Most of the case notes only contained a list of prescriptions, and the symptoms noted down during this period were positive. It was unclear what symptoms Patient 18 had been facing to justify GH replacement therapy. This was not stated in the Respondent's Explanation or in the Respondent's Statement.[243] The Respondent was unable to say what Patient 18's symptoms were and whether they were suggestive of GHD.[244]

b. *Second, Patient 18's IGF-1 (and IGFBP-3) levels were in the normal range* (or above the normal range).

i. A blood test around 8 December 2012 showed the IGF-1 level to be 205 ng/ml, which was in the normal range for his age group (61-65 years).[245]

ii. A blood test around 2 October 2013 showed the IGFBP-3 level to be 4.9 ug/ml, which was in the normal range for his age group.[246]

iii. A blood test around 9 June 2014 showed the IGF-1 level to be 346 ng/ml, which was *above* the normal range for his age group.[247]

iv. A blood test around 10 February 2015 showed the IGF-1 level to be 221 ng/ml, which was above the normal range for his age group. [248]

v. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

171. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 18 by inappropriately prescribing Norditropin to him. The Respondent's conduct as set out in Charge 32 was sufficiently egregious to amount to professional misconduct.

[243] 1AB p 439. R1 pp 64-66.
[244] Respondent: Transcript 21 September 2022, 228:9-12.
[245] 2BPMR p 580.
[246] 2BPMR p 588.
[247] 2BPMR p 595.
[248] 2BPMR p 603.

Record-Keeping Charge (Charge 33)

172. We found that the Respondent had not kept medical records for Patient 18 between 11 December 2012 and 10 February 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

173. Some additional observations:

a. In the Respondent's Explanation it was stated that Patient 18 had been under the Respondent's care "for more than 10 years" and was still on a hormone replacement therapy programme at the Clinic.[249] There were, however, very little case notes available.

b. There were no notes available on the rationale and discussions pertaining to the prescription of GH replacement therapy. The Respondent was unable to say whether Patient 18's symptoms were suggestive of GHD.[250]

c. The Respondent did not note down details of his efforts to reduce and calibrate Patient 18's Norditropin dosage. He said that the initial prescription was for the patient to inject himself six times a week, but this was not recorded in the case notes.[251] Any other doctor looking at the later prescriptions of injections (three times a week) would not know that the weekly dosage had been halved or the reason for the reduction in dosage.

[249] 1AB p 439.
[250] Respondent: Transcript 21 September 2022, 228:3-12.
[251] Respondent: Transcript 21 September 2022, 230:23–231:6.

174. We found that the Respondent's record-keeping for Patient 18 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 33 was sufficiently egregious to amount to professional misconduct.

Patient 19 (F/56) (Charge 34)

Patient 19	Female, 56 years old (as of 9 December 2013), from Taiwan
Medical Records	9 December 2013 – 7 October 2014 (2BPMR Tab 19, pp 604-630)

Record-Keeping Charge (Charge 34)

175. We found that the Respondent had not kept medical records for Patient 19 between 9 December 2013 and 7 October 2014 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

176. Some additional observations:

a. The case notes from the initial consultation on 9 December 2013 showed a list of "medication" at the bottom of the page; there was a notation that the medication was "given to [patient] by Taiwan [doctors]".[252] This was a notation added by one of his nurses (and was not a transcription of any of the Respondent's handwriting).[253] Without the notation, another doctor taking over would not know whether the list of

[252] 2BPMR p 605.
[253] Respondent: Transcript 21 March 2023 (Part 3), 45:1633–46:1669.

medication was the patient's own existing medication or whether it had been prescribed by the Respondent at the initial consultation.

b. In the Respondent's Explanation, it was stated that Patient 19 had consulted him for "symptoms of menopause". In his oral testimony he said that he was not treating her just for menopause; he was "optimizing all her hormones".[254] There was no record of this in the case notes. Any other doctor taking over Patient 19's case would not have been able to discern why the patient had been started on HRT.

c. There was also no record of what HRT was started, what was stopped and what was given and not used.[255] For example, Patient 19 stopped using estradiol (biest); however, the Respondent did not document the patient's decision to stop and the reasons for doing so.[256]

177. We found that the Respondent's record-keeping for Patient 19 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 34 was sufficiently egregious to amount to professional misconduct.

[254] 1AB p 440.
[255] Respondent: Transcript 21 March 2023 (Part 3), 49:1788-1791; 57:2054-2060.
[256] Respondent: Transcript 21 March 2023 (Part 3), 54:1973–55:1992; 56:2037-2047.

Patient 20 (M/64) (Charges 35 and 36)

Patient 20	Male, 64 years old (as of 25 July 2011)	
Prescriptions	Medications	Dates
	Intramuscular testosterone	25 July 2011 22 December 2012 25 March 2013 8 May 2013 14 June 2013 28 December 2013 8 February 2014 23 March 2014 18 August 2014 28 October 2014
	Testosterone cream	25 March 2013 3 May 2013 14 June 2013 31 July 2013 18 September 2013 9 November 2013 28 December 2013 20 May 2014 18 August 2014 28 October 2014
	Eltroxin (thyroxine)	10 November 2012 22 December 2012 8 February 2013 25 March 2013 3 May 2013 14 June 2013 31 July 2013 18 September 2013 9 November 2013 28 December 2013 3 January 2014 8 February 2014 23 March 2014 20 May 2014 18 August 2014 28 October 2014
Medical Records	25 July – September 2011; September 2012 – 28 October 2014 (2BPMR Tab 20, pp 631-687X)	

Prescription Charge (Charge 35)

178. We found the prescriptions of testosterone (intramuscular testosterone and testosterone cream) to be inappropriate.

a. *First, there was no clear evidence that Patient 20 displayed symptoms suggestive of LOH.*

The symptoms recorded on 11 July 2011 included decreased libido and decreased performance.[257] These were relevant to assessing whether Patient 20 had LOH but were alone insufficient to point to such a diagnosis.

b. *Second, Patient 20's testosterone levels were in the normal range*.

i. A blood test around 11 July 2011 showed the testosterone level to be 288 ng/dl (10.0 nmol/L), which was in the normal range.[258] This was in the "grey zone" (explained at [34] above) for which a free testosterone test should have been carried out to verify whether TRT would be appropriate for the patient. Such a test was not done. A repeat morning test (explained at [35] above) was also not done.

ii. A blood test around 7 January 2012 showed the testosterone level to be 688 ng/dl (23.9 nmol/L), which was in the normal range.[259]

iii. A blood test around 4 May 2012 showed the testosterone level to be 588 ng/dl (20.4 nmol/L), which was in the normal range.[260]

iv. A blood test around 25 March 2013 showed the testosterone level to be 420 ng/dl (14.6 nmol/L), which was in the normal range.[261]

[257] 2BPMR p 632.
[258] 2BPMR p 660G.
[259] 2BPMR p 662.
[260] 2BPMR p 665.
[261] 2 BPMR p 672.

v. A blood test around 28 October 2014 showed the testosterone level to be 329 ng/dl (11.4 nmol/L), which was in the normal range. The free testosterone level was 27.65 pmol/L, which was in the normal range.[262] (The testosterone level was in the "grey zone" (explained at [34] above); a repeat morning test (explained at [35] above) was not done.)

vi. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*. The Respondent did not carry out a DRE for Patient 20.[263]

i. It was noted on 11 July 2011 that Patient 20 had "BHP" (which was meant to refer to "**BPH**" or "benign prostatic hypertrophy", a condition in men in which the prostate gland was enlarged). An enlarged prostate was one of the contraindications for TRT. However, the Respondent did not seek any further information from Patient 20 or the doctor treating his prostate issues.[264] Given that Patient 20 was having BPH, a physical examination ought to have been carried out.

ii. It was also noted on 11 July 2011 that Patient 20 had a history of chronic heart problems, where he had two stents inserted following a heart attack. The ESCPG on Testosterone Therapy in Men recommended against the prescription of TRT in people with raised haematocrit, or uncontrolled or poorly controlled heart failure (discussed at [37] above). The Respondent had not spoken to the patient's cardiologist and was not aware of what the cardiologist had done for the patient.[265] In our opinion, special care should have been taken to ensure that Patient 20 was in a condition to be treated with TRT. There should have been more thorough investigations into the patient's symptoms and medical condition before starting the patient on TRT.

[262] 2BPMR pp 679, 681.
[263] Respondent: Transcript 22 September 2022, 6:16-19.
[264] 2BPMR p 632. Respondent: Transcript 22 September 2022, 5:13–6:10; 6:20-23.
[265] 2BPMR p 632. Respondent: Transcript 22 September 2022, 2:4–3:14; 25:20-24.

179. We found the prescriptions of Eltroxin to be inappropriate.

a. *First, there was no evidence that Patient 20 displayed symptoms suggestive of hypothyroidism*.

The case notes did not document specific symptoms indicative of hypothyroidism.

b. *Second, Patient 20's thyroxine levels did not support a finding of hypothyroidism,* and suggested that an investigation into pituitary issues should have been done.

i. A blood test around 4 May 2012 showed the T3 level to be 82 ng/dl; T4 level 1.05 ng/dl; TSH level 0.54 uIU/ml.[266] While the T3 level was at the lower end of the normal range, the TSH level was low (below the normal range). As was explained by Dr PW1, a case of hypothyroidism can be seen from low T3 levels and raised TSH level; on the contrary, low TSH levels would indicate problems relating to the pituitary gland (explained at [57] above).

ii. A blood test around 25 March 2013 showed the T3 level to be 98 ng/dl; T4 level 1.13 ng/dl; TSH level 0.25 uIU/ml.[267] The TSH levels remained low, which suggested that there might be issues with the pituitary gland, as opposed to a case of hypothyroidism.

iii. A blood test around 28 October 2014 showed the T3 level to be 59 ng/dl; T4 level 0.99 ng/dl; TSH level 0.98 uIU/ml.[268] While the T3 level was below the normal range, the TSH level was now at the lower end of the normal range. Considering the fluctuations in the TSH levels, the appropriate course of action was to exclude issues relating to the pituitary gland first, before prescribing Eltroxin.

c. *Third, relevant physical examinations were not done*.

[266] 2BPMR p 665.
[267] 2BPMR p 668.
[268] 2BPMR p 678.

The Respondent said that he observed no swelling of the neck and no palpation was done for Patient 20.[269] A visual observation alone, however, would not be sufficient (as explained at [58] above).

180. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 20 by inappropriately prescribing testosterone (intramuscular testosterone and testosterone cream) and Eltroxin to him. The Respondent's conduct as set out in Charge 35 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 36)

181. We found that the Respondent had not kept medical records for Patient 20 between 25 July 2011 and September 2011, and between September 2012 and 28 October 2014 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

182. Some additional observations:

a. A blood test around 28 December 2013 showed raised levels of inflammation markers. The patient's hs-CRP level was 6.4 mg/L, which was in the high range.[270] The Homocysteine level had increased from 16.4 umol/L (which was above the normal range) in January 2012, to 19.3 umol/L around 28 December 2013.[271] The Respondent said that he had a discussion with Patient 20 as he recognised that there were many values from the blood test results that were out of the normal range, and it would be of concern to him. However, the case notes did not contain any record

[269] Respondent: Transcript 22 September 2022, 47:12-19.
[270] 2BPMR p 676.
[271] 2BPMR pp 661, 674.

of such a discussion or confirmation of Patient 20's consent to continue with TRT. The Respondent continued to prescribe TRT to Patient 20 after that.[272] Without any notation in the case notes, it would be difficult for a doctor taking over to understand that there were such concerns which had then been discussed with the patient.

b. The Respondent had changed the prescriptions for intramuscular testosterone over the course of Patient 20's TRT, but the reasons were not documented.

   i. After the prescription of Sustanon on 28 October 2014, Patient 20 was prescribed Nebido at the next visit. The Respondent said that Patient 20 had suffered from various side effects such as "sweating over the body and the head", "irritable", "sexual energy was not good".[273] These side effects appeared to have been recorded but were barely legible. It was unclear from the case notes that these side effects were related to the Sustanon prescription (as opposed to the Eltroxin prescription) and thus prompted the change in the formulation given.

   ii. Patient 20 was also prescribed Nebido at the visit on 13 January 2014. (The initial notation of "Sustanon" was struck out and replaced with "Nebido".) The Respondent said that Patient 20 worked on an oil rig and he was sometimes away three months or more and that it was the patient who had requested for something that was more convenient that he did not need to apply every day or inject every month. So Nebido (a long-acting form of testosterone) was given.[274] The reason for this change was not recorded in the case notes.

c. In the Respondent's Statement he stated that throughout the period that Patient 20 was under his care, the patient was "also being concurrently managed by other doctors, including attending annual health check-ups and examinations through his company".[275] However, the results from these annual health check-ups were not documented in the case notes.

[272] Respondent: Transcript 22 September 2022, 24:14-22; 26:1–27:21; 28:4-8, 19-23.
[273] 2BPMR p 649. Respondent: Transcript 22 September 2022, 30:10-19.
[274] 2BPMR p 650. Respondent: Transcript 22 September 2022, 29:13-21.
[275] R1 at [263] (p 67).

183. We found that the Respondent's record-keeping for Patient 20 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 36 was sufficiently egregious to amount to professional misconduct.

Patient 21 (M/56) (Charges 37 and 38)

Patient 21	Male, 56 years old (as of 12 November 2013)	
Prescriptions	Medications	Dates
	Intramuscular testosterone	12 November 2013 9 December 2013 4 September 2014
	Testosterone cream	9 December 2013 19 February 2014 14 March 2014 4 September 2014
Medical Records	20 September 2013 – 23 July 2015 (2BPMR Tab 21, pp 687Y-726J)	

Prescription Charge (Charge 37)

184. We found the prescriptions of testosterone (intramuscular testosterone, testosterone cream) to be inappropriate.

a. *First, there was no evidence that Patient 21 displayed symptoms suggestive of LOH.*

b. *Second, Patient 21's testosterone levels were in the normal range*.

i. A blood test around 28 September 2013 showed the testosterone level to be 313 ng/dl (10.9 nmol/L), which was in the normal range. The free testosterone level was 25.3 pmol/L, which was in the normal range.[276] (The testosterone level was in the "grey zone" (explained at [34] above); a repeat morning test (explained at [35] above) was not done.)

[276] 2BPMR pp 703, 701G.

ii. A blood test around 27 January 2014 showed the testosterone level to be 474 ng/dl, which was in the normal range. The free testosterone level was 62.6 pmol/L, which was in the normal range. [277]

iii. A blood test around 29 August 2014 showed the testosterone level to be 409 ng/dl, which was in the normal range.[278]

iv. There was no relevant blood test that showed the testosterone level to be below the normal range.

c. *Third, relevant physical examinations were not done*.

i. Patient 21 had a family history of stroke, cancer and diabetes.[279] It was important for the Respondent to have cleared him of cancer risks before starting him on HRT. The Respondent had carried out a prostate examination on 14 October 2013 and found a "slight enlarge prostate, nodular". He agreed that where an enlarged prostate nodule was found, there was generally a need to investigate and exclude the possibility of prostate cancer. However, he did not do any investigations (including an ultrasound scan) before starting the TRT.[280]

ii. Patient 21 had previously undergone a PET/CT study which showed that he had a "right lung nodule with calcifications for evaluation" with "mild low-grade activity".[281] The patient also complained of "sinus and cough often" and "flu increase"[282] (which might be lung-related symptoms). But there was no evidence that the Respondent carried out any chest examinations for the patient.

185. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 21 by inappropriately prescribing testosterone (intramuscular

[277] 2BPMR pp 709, 710.
[278] 2BPMR p 717.
[279] 2BPMR p 688. Respondent: Transcript 21 March 2023 (Part 1), 47:1707–48:1737.
[280] 2BPMR p 688. Respondent: Transcript 21 March 2023 (Part 1), 41:1492–42:1512; 61:2193-2205.
[281] 2BPMR pp 701A-701B.
[282] 2BPMR p 688.

testosterone, testosterone cream) to him. The Respondent's conduct as set out in Charge 37 was sufficiently egregious to amount to professional misconduct.

Record-Keeping Charge (Charge 38)

186. We found that the Respondent had not kept medical records for Patient 21 between 20 September 2013 and 23 July 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

187. Some additional observations:

a. The case notes were lacking in details of the extent of the investigations into Patient 21's lung condition and enlarged prostate findings. There was also no record of the Respondent's reasoning or discussion with the patient on his prostate issues or the decision to continue TRT.

b. The Respondent ordered an abdomen and prostate ultrasound for Patient 21 on 27 January 2014. He was unable, however, to recall why he had ordered the ultrasound test at that time, and the reasoning was not found in the case notes.[283] There was also no record of whether the test was carried out and the results of the test.

188. We found that the Respondent's record-keeping for Patient 21 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 38 was sufficiently egregious to amount to professional misconduct.

[283] 2BPMR p 692. Respondent: Transcript 21 March 2023 (Part 1), 55:2009–57:2075.

Patient 22 (M/74) (Charges 39 and 40)

Patient 22	Male, 73 years old (as of 2 February 2015), from Indonesia	
Prescription	Medication	Date
	Norditropin (growth hormone)	2 February 2015
Medical Records	9 November 2013 – 14 July 2015 (2BPMR Tab 22, pp 727-765I)	

Prescription Charge (Charge 39)

189. We found the prescription of Norditropin to be inappropriate.

a. *First, there was no evidence that Patient 22 displayed symptoms suggestive of GHD.*

b. *Second, Patient 22's IGF-1 levels were in the normal range.*

i. A blood test around 30 August 2014 showed the IGF-1 level to be 127 ng/ml, which was in the normal range for his age group (71-75 years).[284]

ii. A blood test around 2 February 2015 showed the IGF-1 level to be 132 ng/ml, which was in the normal range for his age group.[285]

iii. There was no relevant blood test that showed the IGF-1 level to be below the normal range.

190. We found that the Respondent had failed to provide appropriate care, management and treatment to Patient 22 by inappropriately prescribing Norditropin to him. The Respondent's conduct as set out in Charge 39 was sufficiently egregious to amount to professional misconduct.

[284] 2BPMR p 754.
[285] 2BPMR p 761.

Record-Keeping Charge (Charge 40)

191. We found that the Respondent had not kept medical records for Patient 22 between 9 November 2013 and 14 July 2015 that were clear, accurate, legible and of sufficient detail so that any other doctor reading them would be able to take over the management of the patient.

a. There was no documentation of the patient's symptoms and indications for treatment.

b. There was no documentation of what was advised and explained to the patient, including the discussion of treatment options, risks and the patient's informed consent to the treatment.

192. Some additional observations:

a. Patient 22 had been under the Respondent's care "for more than 10 years", but several years' worth of case notes were missing.[286] Crucial details, including Patient 22's previous history of HRT, were lacking from the case notes.

b. The Respondent said that Patient 22 was already being treated with Norditropin in Indonesia, but this background information was not recorded in the case notes; and he could not remember any of the details of the patient's history of GH replacement therapy.[287]

c. In a medical report prepared by the Respondent, the patient was instructed to "continue on [his] current BHRT replacement program".[288] However, the details of the "BHRT replacement program" were unclear and it was unclear what hormones were involved.

[286] 1AB p 443. Respondent: Transcript 21 September 2022, 233:1-6.
[287] Respondent: Transcript 21 September 2022, 235:19–236:6; 241:12-24.
[288] 2BPMR p 765I.

193. We found that the Respondent's record-keeping for Patient 22 did not meet the standards expected of him as a medical practitioner. His conduct as set out in Charge 40 was sufficiently egregious to amount to professional misconduct.

Respondent's defence

194. We next explain, briefly, why we did not accept the Respondent's defence.

195. The Respondent was a registered specialist in Obstetrics and Gynaecology. His clinic specialised in "Preventive Medicine" and "Functional Medicine". His focus on preventive medicine was to promote or optimise the health and well-being of his patients, and to prevent or slow down the onset of diseases, disabilities, early death, other adverse effects on the quality of life.[289] His practice of functional medicine centred around the optimisation of hormone levels for the purpose of bringing about potential physiological benefits and preventing potential deterioration of his patients' health and wellbeing. In doing so, he did not aim to treat diseases, but rather, to prevent them.[290]

Prescription Charges

196. The Respondent saw his practice of prescribing hormones for the optimisation of hormone levels as different from the concept of hormonal replacement solely for the treatment of symptoms. He submitted that his prescriptions were consistent with accepted medical practice. He sought to argue that *besides* the use of hormones to treat diseases as described by the SMC Expert, prescriptions of hormones were appropriate where patients exhibited relevant symptoms or serum levels were not in the optimal range, including for the purposes of "optimising" the patient's functions and wellness.[291]

197. He had generally sought to base his practice on the guidelines and literature provided by, among others, the American Academy of Anti-Aging Medicine (the A4M), the World Anti-Aging Medicine Society (European), and the International Hormone Society. He had also studied various textbooks and other literature, [292] including the *Guide to Anti-Aging & Regenerative Medicine* (2013-2018 Ed, American Academy of

[289] Respondent's Statement at [16].
[290] RCS at [4].
[291] Respondent's Statement at [27]-[44].
[292] Respondent's Statement at [23]-[24].

Anti-Aging Medicine) (the "**AAM Guide**");[293] *The Hormone Handbook* (2nd Edition) by Dr Thierry Hertoghe (the "**Hertoghe Handbook**");[294] and various guidelines on *Evidence-Based Hormone Therapies* published by the International Hormone Society.[295]

198. The Respondent submitted that there were no clear local guidelines expressly *proscribing* the prescription of hormones for age-related issues. Patient preferences and values should be taken into account when applying the guidelines, and that the need to apply the guidelines was not absolute. One of the patients (Patient 16) had testified and confirmed that the Respondent had taken his medical history and provided advice and explanations (including information like treatment options and risks).

199. It was also submitted that there was at least reasonable doubt as to whether the Respondent's conduct crossed the disciplinary threshold. Not every departure from the relevant standard constituted professional misconduct. Any departure from standards prescribed in the 2002 ECEG did not in and of itself lead to the conclusion that there was professional misconduct. Mere negligence or incompetence would not suffice; the critical inquiry was whether the conduct would be regarded as falling so far short of expectations as to warrant the imposition of sanctions: *SMC v Lim Lian Arn* [2019] 5 SLR 739 ("***Lim Lian Arn***") at [33]-[34], [37]-[38]. The Respondent had not acted out of indifference to his patients' welfare, or in disregard of the applicable standards.

Record-Keeping Charges

200. The Respondent stated that he routinely recorded down relevant details of history, presenting complaints and symptoms; he also made careful notes of the treatments and supplements which were given to the patients.[296]

201. It was submitted that the Respondent's records would sufficiently allow his patients' HRT to be taken over by another doctor *with the relevant expertise*. Dr RW3 and Dr Dr RW4, both of whom had years of experience in HRT, did not have any issues gleaning

[293] Excerpts at RBML pp 107-147 (Tab 2).
[294] Excerpts at RBML pp 9-105 (Tab 1).
[295] Excerpts at RBML pp 168-178 (Tab 4).
[296] Respondent's Statement at [61].

the patient's profile and treatment plan, despite issues with the legibility of the medical notes.

a. Dr RW3 stated that although the Respondent's record-keeping for each patient was brief, "an experienced anti-aging medicine and functional medicine practitioner" should be able to take over the management of the patient.[297]

b. Dr RW4 stated that he found "no difficulty in taking over the management" of the patients and any doctor trained in preventive or anti-aging medicine could easily take over management of the patients.[298]

202. It was submitted that there was a reasonable doubt as to whether the medical records would not adequately allow a medical practitioner *with the relevant expertise* to take over the management of the patients.

203. It was submitted, in the alternative, that the Respondent's record-keeping practice did not cross the disciplinary threshold. No harm was occasioned by any lapse in the record-keeping. Where patients were being co-managed or managed subsequently by another doctor, the doctor would not rely on the treating doctor's medical records but would take detailed history and do the relevant examination afresh.

Respondent's HRT practice was not evidence-based and he failed to keep proper records

204. We found no clear medical evidence to support the Respondent's practice of prescribing hormones for the purposes of anti-aging and wellness.

205. The Respondent started his patients on HRT when he considered their hormone levels to be at suboptimal levels. Even where a patient's hormone level was within the normal range, he considered it to be suboptimal if the level was in the lower one-third of the normal range.[299] We found this cut-off of *one-third* to be arbitrary and unsupported by any credible medical literature. None of the medical literature furnished by the

[297] For example, Dr RW3's Expert Report at [35] (in respect of Charge 2); at [72] (in respect of Charge 6).
[298] For example, Dr RW4's Expert Report at [24] (in respect of Charge 2); at [34] (in respect of Charge 4).
[299] Respondent's Statement at [20] and, for example, at [75], [87], [96], [113], [126], [151], [152], [159], [165], [206], [232], [235], [241], [266], [275], [281].

Respondent justified such a practice of prescribing hormones when the hormone levels were at the lower one-third of the normal range.

a. The Respondent relied on the Hertoghe Handbook and the AAM Guide as his "textbooks" to justify his HRT practice.[300] These publications, however, did not support the prescription of hormones for *wellness* purposes. For example, the Hertoghe Handbook merely stated a normal (testosterone) range of 300-1,000 ng/dl for young men[301] (which was much higher than the levels found in other literature) and did not state that TRT should be prescribed where levels fell to the lower one-third level. The references cited in the Hertoghe Handbook[302] dealt with the use of hormones *as part of therapeutic treatment* and not for the purposes of anti-aging.

b. As was submitted by the SMC, the Respondent's approach to prescribing hormones for wellness purposes was unsupported by any local guidelines (such as those by the SMHS) or international guidelines (such as those by the Endocrine Society). None of the medical literature tendered by the Respondent supported his approach to HRT and his prescription of HRT for wellness and anti-aging purposes.

c. The Respondent's use of HRT in "functional medicine" did not accord with the conventional understanding of functional medicine. The conventional understanding of functional medicine was lifestyle intervention such as exercise, diet, and not smoking.[303] Such an understanding of functional medicine was also supported by the Respondent's own medical literature: *The Textbook of Functional Medicine* (2010 Ed)[304] described functional medicine as including "efficient and effective *nutrition intervention strategies* aimed at preventing and delaying the progression of common chronic diseases" and "the integration of extensive epidemiological research with the discoveries being made in nutrigenomics will give rise to a new personalized medicine *using diet, lifestyle and environment* as

[300] Respondent: Transcript 20 September 2022, 75:7–76:8.
[301] RBML p 48.
[302] RBML pp 130-144.
[303] Dr PW1: Transcript 19 September 2022, 144:10-19.
[304] Excerpts at RBML pp 149-166 (Tab 3).

principal tools in both prevention and treatment of specific chronic diseases" (emphases added).[305]

206. Prescribing hormones for anti-ageing or wellness was simply not an accepted practice in Singapore. Even today, there is no general medical consensus as to the practice and benefits of anti-aging medicine.

a. The Respondent's local expert, Dr RW3, a specialist in urology and trained in endocrinology, was the founder and a former President of the SMHS. Dr RW3 described anti-aging medicine as a "relatively new entrant into the medical field" and one that was still "in its infancy". They were "not so well organized" and "don't have all these guidelines". He accepted that until there were such guidelines, *practitioners carrying out hormonal therapy had to abide by the established guidelines.* [306]

b. Dr RW3's evidence, therefore, did not lend support to the Respondent's HRT practice as it did not comply with the existing guidelines.

207. The Respondent's foreign expert, Dr RW4, had a doctorate in Endocrinology, Biology and Sports Medicine from the University of Montpellier and was the founder of Institution B. He testified via videolink and gave evidence in support of the Respondent's HRT practice. But his evidence had to be treated with caution.

208. Of greatest concern was that Dr RW4's testimony appeared to be tainted with bias and lacking in independence and objectivity.

a. The fact that there had been a business relationship between Dr RW4 and the Respondent was not disclosed. In cross-examination, Dr RW4 initially denied any association between his Institution B in Hong Kong and the Respondent's clinic in Singapore.[307] It was only after he was confronted with the fact that the Respondent's clinic in Hong Kong had the *same address* as his clinic that he admitted that he and

[305] RBML pp 151-152.
[306] Dr RW3: Transcript 23 March 2023 (Part 3), 2:42-55; 3:71-82.
[307] Dr RW4: Transcript 11 September 2023, 24:5-10.

the Respondent had been in talks for the Respondent's clinic to join his clinic in Hong Kong.[308] Neither Dr RW4 nor the Respondent, however, had disclosed this relationship. That Dr RW4 tried to conceal it cast serious doubt on his independence, impartiality and objectivity, and the credibility of his testimony.

b. His lack of impartiality and objectivity was apparent during his testimony. On many occasions, he did not answer questions directly, but gave convoluted, irrelevant and sometimes *speculative* answers. For example, when asked for his opinion on whether the Respondent, before prescribing TRT to female patients, ought to have recorded in detail the patients' symptoms, Dr RW4 did not answer the question directly but speculated that the Respondent would have had long consultations with his patients to ascertain their clinical symptoms.[309] In relation to Patient 3, he initially gave his opinion that at a testosterone level of 763 ng/dl "of course we don't give any more testosterone";[310] however, when told that the Respondent had in fact prescribed testosterone to the patient, he changed his evidence and speculated that the prescription was probably because the patient "expressed a mood a little bit imbalance. And always sexual disorder".[311]

c. At times he gave rambling responses that did not answer the questions put to him, and even when no question had been asked; he persisted despite being asked to stop.[312] Even after being reminded by the DT that his primary duty was to assist the DT by responding precisely to the questions put to him,[313] he continued to give responses that did not directly answer the questions put to him.[314]

209. Dr RW4's testimony was also unhelpful in other ways.

a. His testimony on the appropriateness of the Respondent's HRT practice was not backed by medical literature. In his expert report, he merely included extracts of the

[308] Dr RW4: Transcript 11 September 2023, 24:11–25:7. Cf Exh P14 (Clinic B) p 3 and Exh 15 (Respondent's clinic) p 9 which both list the same address in Hong Kong.
[309] Dr RW4: Transcript 11 September 2023, 125:8–127:22.
[310] Dr RW4: Transcript 11 September 2023, 72:11-14.
[311] Dr RW4: Transcript 11 September 2023, 74:23–75:9.
[312] Dr RW4: Transcript 11 September 2023, 102:5–104:21.
[313] Dr RW4: Transcript 13 September 2023, 2:10-13.
[314] For example, Dr RW4: Transcript 13 September 2023, 20:13–23:6; 39:19–41:18.

bibliography from the Hertoghe Handbook,[315] without producing any guidelines or other literature in full. He claimed that it was not necessary to refer to any of the articles as the questions asked of him were "relatively simple to answer" and he was very familiar with all the questions.[316] When asked, for example, about what medical literature he had to offer to support his opinion that progesterone replacement therapy for men was justified for the purpose of wellness and anti-ageing, he did not answer directly and claimed that there were "hundred and hundred of articles" and "we cannot have a battle of articles".[317] As it turned out, he did not refer to any article to support his opinion. His bare opinion, unsupported by any medical literature, was unhelpful and carried very little weight.

b. His evidence of the practice in France was not relevant. According to him, anti-aging medicine was a specialty in France, with guidelines from the French government, and it was a university post-graduate specialty course.[318] There were, however, no guidelines for the practice of anti-aging medicine in Singapore; the practice in France did not apply in Singapore.

c. He had limited current clinical experience as he was no longer in active practice. In his current role as the CEO of Clinic B, he was involved in managing the company such as recruiting doctors and staff and designing the services offered. He was "managing the company only" and did not see any patients.[319]

210. The Respondent was thus unable to adduce any credible evidence that his use of HRT for preventive medicine, functional medicine, anti-aging was an accepted practice in Singapore. He submitted that there were no clear guidelines against the prescription of hormones for age-related issues, and an injustice would result if he was convicted on the charges.[320] This assertion was plainly incorrect as there were in fact such guidelines (as explained at [28]-[66] above).

[315] Dr RW4's Expert Report (R3) at Annex C (pp 71-122).
[316] Dr RW4: Transcript 11 September 2023, 33:18–34:6.
[317] Dr RW4: Transcript 11 September 2023, 108:24–110:12.
[318] Dr RW4: Transcript 11 September 2023, 27:22-24; 29:1-6.
[319] Dr RW4: Transcript 11 September 2023, 20:11-14; 21:1-2.
[320] RCS at [125]-[134].

211. The general approach towards HRT in Singapore is well-established: hormone therapy is limited to the context of treating disease. As explained by the SMC Expert:

> "Hormone replacement therapy for men and women should be evidence based as hormones are drugs which can have significant side effects and serious adverse effects. They should be prescribed using evidence-based guidelines and with proper history, examination, investigations, counselling of possible treatments, discussion of suitability, benefits and risks and with close follow up and monitoring. If prescribing outside evidence-based guidelines, e.g., off label use, these therapies should be performed or studied only under proper research basis or trials.[321]"

212. The Respondent's HRT practice was inconsistent with this established evidence-based practice and an egregious departure from the applicable standards. As explained by the SMC Expert:

> "[The Respondent] had been prescribing hormone therapy without due diligence, and in an indiscriminate liberal manner, basing his prescriptions on unproven therapies for non-specific complaints. This is tantamount to an abuse of hormones for hormonal replacement therapy.[322]"

213. The Respondent knew that his HRT practice was "controversial", and that many doctors in Singapore would stick to practising "so-called safe medicine according to the guidelines" and that "[m]any doctors will not agree with [him]" and would say "it's wrong".[323] Thus the Respondent was aware that his HRT practice did not comply with the applicable guidelines. He was also aware that his HRT practice was not generally accepted by the medical profession. Yet he persisted in prescribing hormones to his patients indiscriminately as part of anti-aging and wellness programmes. Each prescription was thus an *intentional and deliberate act* in breach of his duty to provide evidence-based care under Guideline 4.1.4 of the 2002 ECEG (reproduced at [16] above).

214. As for the Record-Keeping Charges, despite the Respondent's assertions that he routinely recorded down relevant details of history, presenting complaints and symptoms, and made careful notes of the treatments and supplements which were given to the patients, this was plainly false and not borne out by the patient medical records

[321] SMC Expert Report at [7]. Dr PW1: Transcript 14 September 2022, 71:22–72:20.
[322] SMC Expert Report at [190] (1AB p 187).
[323] Respondent: Transcript 19 September 2022, 193:17–194:7, 206:7-15.

presented at the Inquiry. For each patient, there was no clear, accurate and sufficient documentation of information such as the patient's history, symptoms, blood tests, physical examinations, diagnosis of any hormone deficiency or illness, as ought to have been recorded in the patient's medical records. Whatever notes that were available were largely illegible and difficult for another doctor to read and understand. A doctor who might need to take over the management of the patient would find it difficult to rationalize, from the sparse details recorded, the treatment that had been offered and to continue with management of the patient.

Verdict of the Tribunal

215. Accordingly, we found that the SMC had proven the Prescription Charges and Record-Keeping Charges beyond a reasonable doubt. We found the Respondent guilty of professional misconduct on all the charges, and his conduct in each charge constituted "an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency". His conduct clearly fell so far short of expectations that the imposition of sanctions would be warranted: *Lim Lian Arn* at [38].

SENTENCE

216. We next considered the appropriate orders to be made in the sentencing of the Respondent.

Overview of parties' sentencing submissions

217. The broad sentencing positions of the parties were as follows.

218. The SMC sought a global sentence of 72 months' suspension (subject to the statutory cap of 36 months' suspension set out in the MRA).[324]

a. For the Prescription Charges, it was submitted that the defendant's culpability was high, and the harm in each case was slight to moderate, and that periods of suspension of 14 to 32 months be imposed for each charge.

b. For the Record-Keeping Charges, a suspension period of five months for each charge.

c. The sentences in four charges to run consecutively (two Prescription Charges and two Record-Keeping Charges), and the remaining to run concurrently.

219. The Respondent submitted that the appropriate sentence should not be more than a suspension of one year and 20 weeks.[325]

a. For the Prescription Charges, it was submitted that there was medium culpability and slight harm for each case, and that periods of suspension of one month to seven weeks be imposed for each charge (after reducing each sentence on account of delay in prosecution).

b. For the Record-Keeping Charges, a suspension period of one to three weeks for each charge (after reducing each sentence on account of delay in prosecution).

c. For the sentences in 16 charges to run consecutively (six Prescription Charges and ten Record-Keeping Charges), and the remaining to run concurrently.

[324] *Prosecution's Sentencing Submissions* dated 16 May 2024 (marked "**PSS**"); *Prosecution's Reply Sentencing Submissions* dated 13 June 2024 (marked "**PRSS**"); *Prosecution's Further Submissions (Sentencing)* dated 2 January 2025 (marked "**PFSS**").
[325] *Respondent's Sentencing Submissions* dated 16 May 2024 (marked "**RSS**"); *Respondent's Reply Sentencing Submissions* dated 27 June 2024 (marked "**RRSS**"); *Respondent's Further Submissions* [Sentencing] dated 2 January 2025 (marked "**RFSS**").

220. The sentencing positions of the SMC and the Respondent are summarised in the table at [256] below.

General sentencing approach

221. In deciding on the sentence, we were guided by the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* published on 15 July 2020 (the "**Sentencing Guidelines**").

222. The Sentencing Guidelines emphasise (at [9]-[11]) that public interest considerations are paramount in medical disciplinary proceedings. These include upholding the reputation of and confidence in the medical profession, and the protection of the health, safety and well-being of the public. Other sentencing considerations also apply, such as general deterrence, specific deterrence, retribution and rehabilitation.

223. Given the multiple charges, we adopted a two-step sentencing approach (Sentencing Guidelines, at [73]-[78]): (a) first, we determined the appropriate individual sentence for each charge; (b) second, we determined and calibrated the overall sentence to ensure proportionality.

224. Finally, we considered whether the sentence ought to be reduced on account of delay in the prosecuting of the matter.

Sentencing for Prescription Charges

225. In deciding on the sentence for the Prescription Charges, we applied the sentencing framework laid down by the High Court (the Court of Three Judges) in *Wong Meng Hang v SMC* [2018] 3 SLR 526 ("***Wong Meng Hang***"). *Wong Meng Hang* laid down a four-step sentencing framework and a "harm-culpability matrix", the application of which was elaborated in the Sentencing Guidelines. The four steps were:

a. Step 1 – Evaluate the seriousness of the offence with reference to harm and culpability;

b. Step 2 – Identify the applicable indicative sentencing range using the harm-culpability matrix;

c. Step 3 – Identify the appropriate starting point within the indicative sentencing range; and

d. Step 4 – Adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

Step 1 – Evaluating harm and culpability

226. *Harm*. "Harm" refers to "the type and gravity of the harm or injury that was caused to the patient and society by the commission of the offence": (Sentencing Guidelines, at [47]). Apart from actual harm, the potential harm that could have resulted from the breach, even if such harm did not actually materialise on the given facts, should be considered. When assessing potential harm, both (i) the seriousness of the harm risked, and (ii) the likelihood of the harm arising should be considered. Potential harm should be taken into account only if there was a *sufficient likelihood* of the harm arising. (Sentencing Guidelines, at [50])

227. We accepted the submission of the SMC that in relation to seven patients (Patients 3, 5, 6, 7, 12, 16, 20) (the "**seven patients**") there was *moderate* harm. The harm could be categorised as *moderate* for the following reasons:

a. The Respondent had made numerous prescriptions of different hormones for each of the seven patients. The sheer number of prescriptions and the polypharmacy increased the potential and likelihood of harm to the patients. This was compounded by the fact that the prescriptions were made without relevant blood tests and physical examinations to ensure that the prescriptions were appropriate and to exclude contraindications. All this heightened the risk of harm to the patients. As explained by Dr PW1, "when you give hormones together, there is a lot of interactions, side effects, and it can be quite detrimental to do that."[326]

[326] Dr PW1: Transcript 14 September 2022, 88:4-6.

b. Two of the patients (Patients 7, 16) were concurrently being seen and prescribed HRT by other doctors in other countries, without the Respondent having the relevant information about these other HRT treatments. This would have exposed the patients to a greater likelihood of harm in the form of overdosage and side effects. Some of the patients were elderly (Patients 3, 6, 7, 12, 20) and more vulnerable and susceptible to harm from the inappropriate prescriptions.

c. There was evidence of actual harm to some of the patients. Patients 3 and 7 experienced supra-physiological levels after being given testosterone by the Respondent (see [87.b] and [113.b] above, respectively). Patient 6 suffered side effects such as hand tremors after being prescribed testosterone by the Respondent.[327]

d. We add that even if there was no direct evidence of harm for some of the patients, that did not diminish the very real risk of potential harm. Absence of evidence should not be construed as evidence of absence of harm.

228. For the remaining 11 patients (Patients 1, 2, 4, 8, 9, 10, 13, 17, 18, 21, 22), we accepted that the harm could be categorised as *slight* harm as these patients were prescribed only one hormone or were prescribed multiple hormones but on very few occasions.

229. Apart from the harm or potential harm to the patients in question, the Respondent's misconduct had the potential to cause grave harm and bring serious disrepute to the medical profession. Persons who were otherwise healthy were misled by the Respondent into thinking that they had hormone levels that were low (lower third of the reference range) and given false hopes that they could benefit from a life-long programme of hormone supplementation. They were not informed that the proposed treatment was not a standard of care in Singapore; they were thus subject to unnecessary expenditure, investigations and treatment. Apart from wasting their money, the patients were subject to the unknown risks that might be associated with raising their hormone levels from the lower third to the upper third of the reference range on a long-term basis,

[327] Patient 6 was noted to have suffered from hand tremors on 18 July 2014, 29 August 2014 and 26 September 2014 (1BPMR pp 174, 176). Such harm occurred after the Respondent prescribed testosterone cream to her on 6 June and 29 August 2014.

which the Respondent sought to do. Such malpractice could erode public trust in the medical profession and tarnish Singapore's reputation as a centre of medical excellence.

230. We were unable to accept the submissions of the Respondent that there was only slight harm for all the 18 patients. Among other things, his submission that none of the 18 patients suffered any actual harm occasioned by the prescriptions simply ignored the evidence of actual harm that was caused to some patients, as explained above (at [227]). He sought to defend his actions by saying that because he used small doses, there would be no risk and hence it was alright to do so. This, however, ignored the fact that the hormone levels of some of his patients reached supra-physiological levels *even at low doses*.

231. *Culpability*. "Culpability" is a measure of the doctor's degree of blameworthiness (Sentencing Guidelines, at [53]). A list of non-exhaustive factors that may be considered when assessing the level of culpability is set out at [54] of the Sentencing Guidelines.

232. In the present case, we accepted the submission of the SMC that the Respondent's culpability in each case was *high*.

a. The Respondent had prescribed HRT to his patients when there was no proper, evidence-based clinical basis to do so. The patients had no symptoms requiring treatment and their hormone levels were within the normal range. He failed to carry out physical examinations. He did not take a proper history of each patient. In many instances he started them on HRT without even waiting for the blood test results to come in. In short, he failed to act as a competent doctor should in meeting the basic standard of care, management and treatment of his patients. For some patients he made numerous prescriptions of hormones and engaged in polypharmacy, which heightened the potential harm that the patients were exposed to.

b. His failure to comply with the applicable guidelines were intentional given his seniority and many years in practice. They were not the negligent acts of an inexperienced doctor. At all times, he was conscious of what the standard of practice was and he was aware that what he was doing was not the standard of practice in

Singapore. He was aware that his approach was controversial but he continued in such practice wilfully.

c. The Respondent was motivated by financial gain. As part of his "anti-aging" or "wellness and health" programme for his patients, he offered his patients an annual package of consultations for which they paid a sum of money for the whole year, and saw him regularly even though they were well – "just like joining a package for a gym or joining a package for beauty treatment". [328] For example, the package for Patient 2 was priced at $12,000 per year[329] and the package for Patient 5 was priced at $10,000 per year.[330] The steep amounts that he was charging his patients for these packages did not include the amounts they also had to pay for the medications which he prescribed to them as part of their "hormonal replacement and optimisation".[331] Given the unproven benefits of such therapy, it would seem that the only beneficiary of the Respondent's HRT practice was himself.

Step 2 – Identifying the applicable indicative sentencing range

233. In *Wong Meng Hang* at [33], the following indicative sentencing ranges were laid down with a harm-culpability matrix:

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

[328] Respondent: Transcript 20 September 2022, 62:7–63:3.
[329] 1BPMR p 18F.
[330] 1BPMR p 129.
[331] Respondent: Transcript 20 September 2022, 64:4-9.

234. We noted that the Sentencing Guidelines at [55] reproduced the harm-culpability matrix set out in *Wong Meng Hang*, with a slight modification. For moderate harm with low culpability, or slight harm with medium culpability, the indicative sentencing range was reflected as suspension "of up to 1 year". In our opinion, this must be read subject to s 53(2)(*b*) of the MRA, which provides that a DT may order a period of suspension of "not less than 3 months and not more than 3 years". Hence, if suspension is ordered by a DT, it must be for a period of at least three months and not for any shorter duration.

235. Applying the harm-culpability matrix:

a. For the seven patients where there was moderate harm (at [227] above), and with the Respondent's culpability assessed to be high, the indicative sentencing range would be a suspension of two to three years for each charge; and

b. For the other 11 patients where there was slight harm (at [228] above), and with the Respondent's culpability likewise assessed to be high, the indicative sentencing range would be a suspension of one to two years for each charge.

Step 3 – Identifying appropriate starting point within indicative sentencing range

236. We identified the appropriate starting points as follows:

a. For the seven patients where there was moderate harm (Patients 3, 5, 6, 7, 12, 16, 20), the appropriate starting point would be at least 24 months' suspension.

b. For the remaining 11 patients where there was slight harm (Patients 1, 2, 4, 8, 9, 10, 13, 17, 18, 21, 22), the appropriate starting point would be at least 12 months' suspension.

237. It was arguable that there were varying degrees of harm within each category that could justify starting points higher than 24 months and 12 months within each category of harm. This could depend, for example, on the number of HRT prescriptions and types of HRT prescribed, and evidence of actual harm. We did not consider it necessary,

however, to adopt such a granular approach. We considered that, given the large number of charges, and the number of sentences that would run consecutively, it would not have a material impact on the final sentence.

Step 4 – Taking into account offender-specific aggravating and mitigating factors

238. We accepted the submission of the SMC that there were two main aggravating factors.

a. *The Respondent's seniority*. The Respondent had over four decades of experience as a medical practitioner, and his patients would have reposed a high degree of trust and confidence in him. A doctor's seniority is an aggravating factor because the seniority "attracts a heightened sense of trust and confidence in the practitioner and the profession, and the negative impact on public confidence in the integrity of the medical profession is amplified when such an offender is convicted of professional misconduct." (Sentencing Guidelines at [69(b)])

b. *Antecedents*. There were relevant antecedents.

i. In March 2011, the Respondent was convicted by a Disciplinary Committee on four charges of professional misconduct under the MRA for offering, in advertisements for his clinic, various procedures that were not medically proven (stem cell treatment for cellular rejuvenation, chelation as "detox medicine", detoxification for heavy metals as "detox medicine" and face treatment using oxygen). The Disciplinary Committee ordered that he be fined $10,000 and censured: SMC Press Release dated 15 April 2011.[332]

ii. In April 2011, the Respondent was convicted after a trial before a Disciplinary Committee on 13 charges of professional misconduct under the MRA in respect of his treatment of four patients. He prescribed treatments that were not medically proven (intra-muscle and intra-thecal stem cell injections, colonic irrigation, coffee enema), and failed to obtain informed consent from his patients. The Disciplinary Committee ordered that he be suspended for a period

[332] PFSS at Tab C.

of 12 months, fined $10,000, and censured: *In the Matter of Dr Wong Yoke Meng* [2011] SMCDC 22.

These convictions in 2011, so far as they related to the offering of medically unproven treatments, were relevant to the present Prescription Charges. The convictions did not appear to have deterred the Respondent, for he engaged in similar misconduct shortly after, by prescribing HRT without clear medical grounds *from 2011* to 2014.

239. There were no mitigating factors. The Respondent had not shown any regret or remorse for his misconduct.

240. Taking into account the aggravating factors, we considered it appropriate to apply an uplift to the starting sentences, as follows:

a. For the seven patients where there was moderate harm (Patients 3, 5, 6, 7, 12, 16, 20), an uplift of four months per charge, to arrive at a suspension period of 28 months for each charge.

b. For the remaining 11 patients where there was slight harm (Patients 1, 2, 4, 8, 9, 10, 13, 17, 18, 21, 22), an uplift of two months per charge, to arrive at a suspension period of 14 months per charge.

241. The sentences thus imposed for the Prescription Charges are summarised in the table at [256] below.

Sentencing for Record-Keeping Charges

242. The SMC submitted that a suspension of five months be imposed for each Record-Keeping Charge.

243. We accepted the submission of the SMC that the Respondent's failure to keep proper medical records was a serious breach.

a. As explained by the High Court in *SMC v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 ("***Mohd Syamsul***") at [12]:

> "[T]he failure to keep adequate records ought not to be seen as a minor or technical breach. Properly kept medical records form the basis of good management of the patient and of sound communications pertaining to the care of the patient, and help ensure that the care of patients can be safely taken over by another doctor should the need arise."

b. The Respondent acted in blatant disregard of the duty to document, and his breach was particularly egregious. He failed to keep clear and accurate notes. He failed to document sufficient details, including the advice and explanation given by him such as the discussion of treatment options and risks, and the patient's informed consent. Whatever notes he kept were largely illegible, making it difficult for another doctor to read and understand the patients' medical history and to take over management of the patients.

244. The SMC also submitted that the Respondent had tried to cover up his inadequate documentation by introducing "New Documents" after the MOH audit; that some of these documents were backdated to give the impression that they were part of contemporaneous medical records, and that existing case notes were tampered with.[333] In our opinion, however, the evidence adduced was not sufficient to prove that the Respondent had acted dishonestly in that regard. His explanation that he was simply trying to improve his record-keeping following the MOH audit was plausible and we accepted that it was not necessarily an attempt to cover up.

245. In *Mohd Syamsul*, the court held that the failure to document essential details such as the symptoms presented by the patient, the physical findings and the likely diagnosis amounted to a grievous breach of the obligation to keep adequate medical records, and

[333] PSS at [77]-[81].

a term of three months' suspension was appropriate (at [7], [12]-[13]). We accepted the submission of the SMC that the Respondent's breaches in the present case were more egregious compared with *Mohd Syamsul* in that he persistently failed to maintain clear and accurate records with sufficient details, and his records were largely illegible.

246. In our opinion, it would be appropriate that a suspension of four months be imposed for each Record-Keeping Charge. This would be similar to the four-month suspension imposed in *In the Matter of Dr Wee Teong Boo* [2022] SMCDT 1 ("***Wee Teong Boo***") for one of the record-keeping charges where the medical records were bereft of details and did not properly document the patient's medical history, medical condition, the doctor's findings, diagnoses and reasons for his prescriptions, and the doctor's handwriting in the patient's medical records was largely illegible (*Wee Teong Boo* at [30]-[32]). The breaches by the Respondent were equally egregious and a similar period of suspension would be appropriate.

Aggregate sentence

247. As to the aggregate sentence:

a. The SMC submitted that the sentences in four charges should run consecutively (two Prescription Charges and two Record-Keeping Charges), with the sentences for the other charges to run concurrently. This would give an aggregate of 72 months' suspension, subject to the statutory cap of 36 months.[334]

b. The Respondent submitted for the sentences in 16 charges to run consecutively (six Prescription Charges and ten Record-Keeping Charges), with the sentences for the other charges to run concurrently. He also submitted for a 2/3 reduction on account of delay in the prosecution, to give an aggregate of one year and 20 weeks' suspension.[335]

248. In our judgment, it would be appropriate for the sentences in 10 charges to run consecutively (with the sentences for the other charges to run concurrently). This would

[334] PSS at [2]. This differed slightly from the submission at PSS at [91], but the difference is not material.
[335] RSS at [83].

reflect the overall gravity of the Respondent's breaches considering his high culpability and the level of harm in the Prescription Charges, as well as the egregious breaches in respect of the Record-Keeping Charges. The ten sentences to run consecutively would comprise the following:

a. Two Prescription Charges involving moderate harm (and high culpability) (Charges 5, 11): 28 months' suspension per charge;

b. Three Prescription Charges involving slight harm (and high culpability) (Charges 15, 32, 37): 14 months' suspension per charge; and

c. Five Record-Keeping Charges (Charges 6, 12, 14, 23, 36): 4 months' suspension per charge.

This would give a notional aggregate of 118 months' suspension, subject to the statutory cap of 36 months.

249. The sentencing positions of the SMC and the Respondent, and the sentences ordered by the DT, are summarised in the table at [256] below.

Whether there was inordinate delay to warrant a reduction of sentence

250. We considered whether there was any inordinate delay in the proceedings to warrant a reduction of sentence.

251. The following conditions must be met before a reduction of sentence may be warranted (*Ang Peng Tiam v SMC and another matter* [2017] 5 SLR 356 at [109]-[118]):

a. There was inordinate delay in the institution or prosecution of the proceedings;

b. The delay was not occasioned by the offender;

c. The offender has suffered prejudice by reason of the delay; and

d. There are no countervailing public interest considerations that offset or outweigh the mitigating weight of the inordinate delay.

252. A discount in sentence for any delay in prosecution is not automatic or routine, and all the circumstances must be scrutinised to determine whether the application of a discount is appropriate and will not trivialise or undermine the sanction being meted out: *SMC v Wee Teong Boo* [2023] 4 SLR 1328 at [74].

253. It is incumbent on the respondent doctor to show that the delay was not justifiable by good reasons, and a question to consider is whether the length of time taken to prosecute each case was warranted by its circumstances: *Ang Yong Guan v SMC* [2025] 3 SLR 135 at [68].

254. In the present case, the period between SMC's receipt of the MOH Letter on 10 April 2015 and the issuance of the initial Notice of Inquiry on 15 January 2021 was about 5 years and 9 months. In our opinion, there was no inordinate delay in the prosecution of this case. The case was complex, involving multiple patients (22 patients) and multiple charges brought against the Respondent eventually (40 charges). We accept that given the numerous patients and voluminous records, some of which was missing and much of which was illegible, it was necessary for time to be taken to peruse and understand the records and for expert opinion to be rendered before a decision was taken to institute disciplinary proceedings. The Respondent had not shown that there was any inordinate delay or that he suffered prejudice from any such delay.

255. Accordingly, we did not accept the submission of the Respondent that there ought to be a reduction in the sentence on account of delay in the prosecution of the case.

Summary of sentences

256. For ease of reference and comparison, the following table sets out the sentencing positions of parties and the sentences imposed by the DT.

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
<u>Charge 1</u> Patient 1 Prescription	High culpability Slight harm 14 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
<u>Charge 2</u> Patient 1 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
<u>Charge 3</u> Patient 2 Prescription	High culpability Slight harm 14 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
<u>Charge 4</u> Patient 2 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 5 Patient 3 Prescription	High culpability Moderate harm *32 months' suspension* (consecutive)	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm *28 months' suspension* (consecutive)
Charge 6 Patient 3 Record-Keeping	*5 months' suspension* (consecutive)	(2 months) *3 weeks' suspension* (consecutive)	*4 months' suspension* (consecutive)
Charge 7 Patient 4 Prescription	High culpability Slight harm 14 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
Charge 8 Patient 4 Record-Keeping	5 months' suspension	(One month) 1.5 weeks' suspension	4 months' suspension

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 9 Patient 5 Prescription	High culpability Moderate harm 28 months' suspension	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm 28 months' suspension
Charge 10 Patient 5 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension
Charge 11 Patient 6 Prescription	High culpability Moderate harm *30 months' suspension* (consecutive)	Medium culpability Slight harm (4 months) 5 weeks' suspension	High culpability Moderate harm *28 months' suspension* (consecutive)
Charge 12 Patient 6 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	*4 months' suspension* (consecutive)

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 13 Patient 7 Prescription	High culpability Moderate harm 30 months' suspension	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm 28 months' suspension
Charge 14 Patient 7 Record-Keeping	*5 months' suspension* (consecutive)	(One month) 1.5 weeks' suspension	*4 months' suspension* (consecutive)
Charge 15 Patient 8 Prescription	High culpability Slight harm 16 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm *14 months' suspension* (consecutive)
Charge 16 Patient 8 Record-Keeping	5 months' suspension	(One month) 1.5 weeks' suspension	4 months' suspension
Charge 17 Patient 9 Prescription	High culpability Slight harm 14 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 18 Patient 9 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Charge 19 Patient 10 Prescription	High culpability Slight harm 15 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
Charge 20 Patient 10 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Charge 21 Patient 11 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension
Charge 22 Patient 12 Prescription	High culpability Moderate harm 29 months' suspension	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm 28 months' suspension

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 23 Patient 12 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	*4 months' suspension* (consecutive)
Charge 24 Patient 13 Prescription	High culpability Slight harm 15 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
Charge 25 Patient 13 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Charge 26 Patient 14 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension
Charge 27 Patient 15 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 28 Patient 16 Prescription	High culpability Moderate harm 28 months' suspension	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm 28 months' suspension
Charge 29 Patient 16 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension
Charge 30 Patient 17 Prescription	High culpability Slight harm 15 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
Charge 31 Patient 17 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Charge 32 Patient 18 Prescription	High culpability Slight harm 17 months' suspension	Medium culpability Slight harm (4 months) 5 weeks' suspension	High culpability Slight harm *14 months' suspension* (consecutive)

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 33 Patient 18 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	4 months' suspension
Charge 34 Patient 19 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Charge 35 Patient 20 Prescription	High culpability Moderate harm 32 months' suspension	Medium culpability Slight harm (5 months) *7 weeks' suspension* (consecutive)	High culpability Moderate harm 28 months' suspension
Charge 36 Patient 20 Record-Keeping	5 months' suspension	(2 months) *3 weeks' suspension* (consecutive)	*4 months' suspension* (consecutive)
Charge 37 Patient 21 Prescription	High culpability Slight harm 16 months' suspension	Medium culpability Slight harm (4 months) 5 weeks' suspension	High culpability Slight harm *14 months' suspension* (consecutive)

Charge	**SMC's Submissions** No reduction for delay	**Respondent's Submissions** (Initial sentence) With 2/3 reduction for delay	**Sentence by DT** No reduction for delay
Charge 38 Patient 21 Record-Keeping	5 months' suspension	(One month) 1.5 weeks' suspension	4 months' suspension
Charge 39 Patient 22 Prescription	High culpability Slight harm 14 months' suspension	Medium culpability Slight harm (3 months) One month's suspension	High culpability Slight harm 14 months' suspension
Charge 40 Patient 22 Record-Keeping	5 months' suspension	(0.5 months) One week's suspension	4 months' suspension
Total	**36 months' suspension** (72 months, subject to statutory cap of 36 months)	**One year and 20 weeks' suspension**[336]	**36 months' suspension** (118 months, subject to statutory cap of 36 months)

Order of suspension

257. Accordingly, we order that the Respondent be suspended for a **period of 36 months**.

258. That said, given the very egregious nature of the Respondent's conduct and the number of patients involved, we considered this to be a case where a striking off could have been appropriate as well. We noted that, apart from his prior convictions in 2011 under

[336] (7 weeks x 6 Prescription Charges) + (3 weeks x 10 Record-Keeping Charges) = 72 weeks (or about one year and 20 weeks.

the MRA (which were considered as an offender-specific aggravating factor at [238] above), the Respondent had been convicted for other breaches. These included the following:

a. In 2001, he was found guilty under s 53(1)(*c*) MRA for allowing his clinic to be used for cosmetic skin treatment and programmes in breach of the conditions of the licence prescribed by the MOH, for which he was penalised $8,000.[337]

b. In May 2015, he pleaded guilty before a DT to a charge of bringing disrepute to the medical profession under s 53(1)(*c*) MRA by virtue of his earlier convictions in court for acting in breach of regulation 44 of the Private Hospital and Medical Clinics Regulations. He had pleaded guilty in court on 7 May 2010 to three charges (with a fourth similar charge taken into consideration for the purposes of sentencing) in relation to his collection of specimens and samples from his patients at his clinic and sending them to unaccredited foreign clinical laboratories, and sentenced by the court to a fine of $8,000 for each charge. For this breach, the DT ordered that he pay a total penalty of $24,000 and be censured: *In the Matter of Dr Wong Yoke Meng* [2015] SMCDT 3.

c. On 14 August 2024, after a trial before a DT, he was found guilty of two charges under s 53(1)(*c*) MRA for improper conduct which brought disrepute to the medical profession. These charges related to his conduct on two separate occasions: (a) false declarations made by him to the SMC when applying to renew his practising certificate in Singapore in 2015 and 2017, in that he failed to declare his convictions in the Hong Kong courts for having acted in contravention of Hong Kong's Dangerous Drugs Ordinance for which he was fined HKD 10,000 by a Hong Kong court (1st charge); and (b) failing to report to the Medical Council of Hong Kong ("**MCHK**") his various SMC disciplinary proceedings and criminal convictions in Singapore between 2010 and 2015, which resulted in a guilty finding by the Inquiry Panel of the MCHK against him for professional misconduct in 2020 (2nd charge). The DT suspended him for a period of six months in respect of the 1st charge and

[337] *In the Matter of Dr Wong Yoke Meng* [2015] SMCDT 3 at [16]-[17].

imposed a penalty of $36,000 in respect of the 2nd charge: *SMC v Dr Wong Yoke Meng* [2024] SMCDT 4.

259. Taken together, all these instances of professional misconduct painted a very disturbing picture of the Respondent's callous disregard for the laws, regulations and guidelines that govern the medical profession. He did not appear to have learnt from the disciplinary action taken against him in the past, which suggested that there was a high risk of such professional misconduct recurring and the consequent risks to more patients. His last conviction in 2024 showed a lack of honesty and truthfulness. The DT in that case found (at [53]) that he had "knowingly made the false declarations" to the SMC in respect of the 1st charge. Such dishonesty, coupled with his recurrent professional misconduct, was suggestive of a defect in character that called into question whether he was fit to practice. In our opinion, a striking off could have been considered if such a submission had been made by the SMC.

Other orders

260. Apart from a period of suspension, we also impose the "usual orders" (Sentencing Guidelines, at [19]) of a censure, a written undertaking by the Respondent to abstain from the conduct complained of, and the payment of costs by the Respondent.

Orders made by the Tribunal

261. In summary, the Tribunal ordered that:

a. the Respondent be suspended for a period of **36 months**;

b. the Respondent be censured;

c. the Respondent give a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct;

d. the Respondent pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Publication of Decision

262. We further order that the period of suspension is to commence 40 days after the date of this order, and that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of persons involved.

263. The hearing is hereby concluded.

A/Prof Roy Joseph Chairman	Dr Chan Wai Lim William	Mr Kessler Soh Judicial Service Officer

Ms Chang Man Phing, Ms Rebecca Goh and Mr Warren Tian
(M/s WongPartnership LLP)
For the Singapore Medical Council; and

Mr Christopher Chong, Ms Zoe Pittas and Ms Kuan Jin Yin
(M/s Dentons Rodyk & Davidson LLP)
For Dr Wong Yoke Meng

ANNEX A – ABBREVIATIONS

The following abbreviations are used in these Grounds of Decision.

Abbreviation	**Long form / Definition**	**Remarks**
1AB AB	*Agreed Bundle (Volume I)* dated 13 September 2022	Marked "1AB" or "AB" (There was only one Agreed Bundle)
1BPMR	Bundle of Patient Medical Records (Volume 1) Patients 1-11	Marked "1BPMR"
2BPMR	Bundle of Patient Medical Records (Volume 2) Patients 12-22	Marked "2BPMR"
2002 ECEG	SMC Ethical Code and Ethical Guidelines, 2002 Edition	
AAM Guide	*Guide to Anti-Aging & Regenerative Medicine* (2013-2018 Ed, American Academy of Anti-Aging Medicine)	Excerpts at RBML pp 107-147 (Tab 2)
AMS	Academy of Medicine, Singapore	
BPH	Benign prostatic hypertrophy	
CC	Complaints Committee	
Clinic	The Respondent's clinic at the Paragon Medical Centre	
Complaint	"Complaint Against Dr Wong Yoke Meng" sent by SMC to the Complaints Panel dated 30 April 2015	1AB p 408 (Tab 3)
Dr RW4	Dr RW4 (RW4)	A foreign expert called by the Respondent
Dr RW4's Expert Report	*Expert Report* dated 18 July 2022 *Supplementary Expert Report* dated 8 September 2023	Expert Report marked "R3" Supplementary Expert Report marked "R8"

Abbreviation	Long form / Definition	Remarks
DRE	Digital Rectal Examination	
DSM IV	*Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* (Published by the American Psychiatric Association)	
DT	Disciplinary Tribunal	
EAU	European Association of Urology	
ED	erectile dysfunction	
ESCPG	Endocrine Society Clinical Practical Guideline	
ESCPG on Androgen Therapy in Women	*Androgen Therapy in Women: A Reappraisal: An Endocrine Society Clinical Practice Guideline* [2014]	1AB pp 194-216
ESCPG on Testosterone Therapy in Men	*Testosterone Therapy in Men with Androgen Deficiency Syndromes*: *An Endocrine Society Clinical Practice Guideline* [2010]	1AB pp 246-270
ESCPG on GH	*Evaluation and Treatment of Adult Growth Hormone Deficiency: An Endocrine Society Clinical Practice Guideline* [2011]	PBML pp 109-132 (Tab 12)
GH	growth hormone	
GHD	Growth Hormone Deficiency	
Hertoghe Handbook	*The Hormone Handbook* (2nd Edition) by Dr Thierry Hertoghe	Excerpts at RBML pp 9-105 (Tab 1)
HRT	Hormone replacement therapy	

Abbreviation	Long form / Definition	Remarks
HSDD	Hypoactive Sexual Desire Disorder	
IGF-1	Insulin-like Growth Factor-1	
IGFBP-3	Insulin-like Growth Factor Binding Protein 3	
ISSAM	The International Society for The Study of the Aging Male	
ISSAM Guidelines	*Investigation, treatment and monitoring of late-onset hypogonadism in males: Official Recommendations of ISSAM* (2002)	1AB pp 217-230
Institution	Institution A	
LOH	Late Onset Hypogonadism	
MOH	Ministry of Health	
MOH Letter	Letter from MOH to SMC "Feedback on Dr Wong Yoke Meng – Inappropriate Prescription of Testosterone and Hormone Replacement Therapy (HRT)" dated 10 April 2015	1AB p 409 (Tab 3)
MRA	Medical Registration Act (Cap 174, Rev Ed 2004)	
MRR	Medical Registration Regulations 2010	
NICE	(UK) National Institute for Health and Care Excellence	
NICE Guidance on GH	NICE Guidance on "Human growth hormone (somatropin) in adult with growth hormone deficiency" (27 August 2003)	PBML pp 42-83 (Tab 7)
NOI	Notice of Inquiry dated 13 September 2023	Marked "P1B"

Abbreviation	Long form / Definition	Remarks
Notice of Complaint	"Notice of Complaint" sent by SMC Investigation Unit to the Respondent dated 12 August 2015	1AB pp 411-414 (Tab 4)
PBML	Prosecution's Bundle of Medical Literature	Marked "PBML"
PCS	*Prosecution's Closing Submissions* dated 14 December 2023	Marked "PCS"
PFS	*Prosecution's Further Submissions* dated 27 February 2024	Marked "PFS"
PFSS	*Prosecution's Further Submissions (Sentencing)* dated 2 January 2025	Marked "PFSS"
PMR(s)	Patient Medical Record(s)	
Dr RW3	Dr RW3 (RW3)	A local expert called by the Respondent
Dr RW3's Expert Report	*Expert Report for Singapore Medical Council Disciplinary Inquiry Against Dr Wong Yoke Meng* dated 8 July 2022	Marked "R2"
Dr PW1	Dr PW1 (PW1)	The SMC Expert
PRS	*Prosecution's Reply Closing Submissions* dated 12 January 2024	Marked "PRS"
PRT	Progesterone Replacement Therapy	
PSA	Prostate-Specific Antigen	
PRSS	*Prosecution's Reply Sentencing Submissions* dated 13 June 2024	Marked "PRSS"
PSS	*Prosecution's Sentencing Submissions* dated 16 May 2024	Marked "PSS"

Abbreviation	Long form / Definition	Remarks
RBML	Respondent's Bundle of Medical Literature	Marked "RBML"
RCS	*Respondent's Closing Submissions* dated 15 December 2023	Marked "RCS"
Respondent's Explanation	Letter of Explanation from the Respondent to the SMC Investigation Unit dated 29 September 2015	1AB Tab 5 (pp 415-453)
Respondent's Statement	Statement of Dr Wong Yoke Meng dated 21 July 2022	Marked "R1". This was the witness statement given by the Respondent for the purpose of this Inquiry.
RFSS	*Respondent's Further Submissions* [Sentencing] dated 2 January 2025	Marked "RFSS"
RRS	*Respondent's Reply Submissions* dated 15 January 2024	Marked "RRS"
RRSS	*Respondent's Reply Sentencing Submissions* dated 27 June 2024	Marked "RRSS"
RSS	*Respondent's Sentencing Submissions* dated 16 May 2024	Marked "RSS"
SMC	Singapore Medical Council	
SMC Expert Report	Expert Opinion of Dr PW1 (PW1)	1AB pp 161-406 (Tab 2)
SMHS	Society for Men's Health (Singapore)	
SMHS Guidelines	SMHS *Testosterone Deficiency Syndrome (TDS) Guidelines 2013*	1AB pp 271-296
T3	Triiodothyronine	
T4	Free Thyroxine	
TRT	Testosterone Replacement Therapy	

Abbreviation	Long form / Definition	Remarks
TSH	Thyroid Stimulating Hormone	
WHI	Women’s Health Initiative	

ANNEX B – CHARGES

Prescription Charges

1. The Prescription Charges were worded as follows:

CHARGE

That you, Dr Wong Yoke Meng, a registered practitioner under the Medical Registration Act are charged that you, *[period]*, whilst practising as a medical practitioner at [the Clinic], you had acted in breach of Guideline 4.1.3 of the [2002 ECEG] in that you failed to provide appropriate care, management and treatment to your patient, namely one *[Patient]*, by inappropriately prescribing *[medication(s)]* to the [patient], to wit:-

PARTICULARS

[Particulars]

and your aforesaid conduct constitutes an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency and that in relation to the facts alleged you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

ALTERNATIVE CHARGE

That you, Dr Wong Yoke Meng, a registered practitioner under the Medical Registration Act, are charged that you, *[period]*, whilst practising as a medical practitioner at [the Clinic], you had acted in breach of Guideline 4.1.3 of the [2002 ECEG] in that you failed to provide appropriate care, management and treatment to your patient, namely one *[Patient]*, by inappropriately prescribing *[medication(s)]* to the [patient], to wit:-

PARTICULARS

[Particulars]

and your aforesaid conduct constitutes such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner and that in relation to the facts alleged you are thereby

guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

2. The following table summarises the particulars of the Prescription Charges (with the names of the patients redacted):

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
1	on 7 November 2013 Patient 1	*Sustanon* (a) You prescribed and treated Patient 1 with Sustanon on 7 November 2013; (b) Patient 1's total testosterone level was 0.7 nmol/l on 7 November 2013, which was within the normal range; (c) Breast, abdominal and pelvic examinations were not done; and (d) There is no suggestion that Patient 1 displayed symptoms on 7 November 2013 suggestive of Hypoactive Sexual Desire Disorder
3	between 1 February 2013 and 14 January 2014 Patient 2	*Sustanon and testosterone cream* (a) You prescribed and treated Patient 2 with Sustanon on 14 January 2014; (b) There is no medical record of Patient 2's total testosterone level on 14 January 2014; (c) You prescribed and treated Patient 2 with testosterone cream on 1 February 2013; (d) There is no medical record of Patient 2's total testosterone level on 1 February 2013; (e) Patient 2's total testosterone levels were 359 ng/dl on 5 April 2012, 564 ng/dl on 27 November 2012 which were within the normal range; (f) There is no suggestion that Patient 2 displayed symptoms on 14 January 2014 and 1 February 2013 suggestive of Late Onset Hypogonadism; and (g) Heart (cardiovascular) and digital prostate examinations were not done

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
5	between 31 October 2013 and 5 August 2015 Patient 3	*Nebido, Sustanon, testosterone cream, progesterone cream, Norditropin and Eltroxin* (a) You prescribed and treated Patient 3 with Nebido on 29 April 2014 and 25 June 2014; (b) Patient 3's total testosterone level was 443 ng/dl (15.4 nmol/L) on 5 February 2014, which is within the normal range; (c) Patient 3's total testosterone level was 763 ng/dl (26.5 nmol/L) on 29 April 2014, which is within the normal range; (d) There is no medical record of Patient 3's total testosterone level on 25 June 2014; (e) You prescribed and treated Patient 3 with Sustanon on 31 October 2013, 2 December 2013, 7 July 2015 and 5 August 2015; (f) Patient 3's total testosterone level was 404 ng/dl (14.1 nmol/L) on 12 September 2013, which is within the normal range; (g) There is no medical record of Patient 3's total testosterone level on 31 October 2013, 2 December 2013, 7 July 2015 and 5 August 2015; (h) You prescribed and treated Patient 3 with testosterone cream on 29 May 2014; (i) There is no medical record of Patient 3's total testosterone level on 29 May 2014; (j) There is no medical record of Patient 3's symptoms on 31 October 2013, 2 December 2013, 29 April 2014, 29 May 2014, 25 June 2014, 7 July 2015, and 5 August 2015 suggestive of Late Onset Hypogonadism; (k) Heart (cardiovascular), abdominal and digital prostate examinations were not done; (l) You prescribed and treated Patient 3 with progesterone cream on 19 February 2014 and 19 March 2014; (m) Patient 3's progesterone level was 2.6nmol/L on 5 February 2014, which is within the normal range;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(n) There is no medical record of Patient 3's progesterone level on 19 February 2014 and 19 March 2014; (o) Patient 3's progesterone level was 2.3nmol/L on 29 April 2014, which is within the normal range; (p) Progesterone therapy is not indicated for men. There is no evidence-based indication for prescribing progesterone therapy to men; (q) You prescribed and treated Patient 3 with Norditropin on 29 May 2014; (r) There is no medical record of Patient 3's IGF level on 29 May 2014; (s) Patient 3's IGF-1 level was 142 ng/mol on 29 April 2014, which is within the normal range; There is no suggestion that Patient 3 displayed symptoms in May 2014 suggestive of growth hormone deficiency; (t) You prescribed and treated Patient 3 with Eltroxin on 29 May 2014; (u) There is no medical record of Patient 3's T3, T4 and TSH levels in May 2014; (v) Patient 3's T3 level was 75 ng/dl, T4 level was 0.97 ng/dl and TSH level was 1.16 uIU/ml on 29 April 2014, which is within the normal range; (w) There is no suggestion that Patient 3 displayed symptoms in May 2014 suggestive of hypothyroidism; and (x) Thyroid examinations were not done
7	between 12 June 2014 and 2 February 2015 Patient 4	*intramuscular testosterone and testosterone cream* (a) You prescribed and treated Patient 4 with intramuscular testosterone on 12 June 2014; (b) Patient 4's total testosterone level was 440 ng/dl (15.3 nmol/l) on 12 June 2014 which was within the normal range; (c) You prescribed and treated Patient 4 with testosterone cream on 2 February 2015; (d) There is no medical record of Patient 4's total testosterone levels on 2 February 2015;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(e) There is no suggestion that Patient 4 displayed symptoms on 12 June 2014 and 2 February 2015 suggestive of Late Onset Hypogonadism; and (f) Heart (cardiovascular) and digital prostate examinations were not done
9	between 19 January 2013 and 30 June 2014 Patient 5	*testosterone cream and Eltroxin* (a) You prescribed and treated Patient 5 with testosterone cream on 19 January 2013, 10 June 2013, 1 July 2013, 22 July 2013, 14 September 2013, 8 November 2013, 17 December 2013, 1 April 2014, 29 April 2014, 23 May 2014, and 30 June 2014; (b) There is no medical record of Patient 5's total testosterone level on 19 January 2013, 10 June 2013, 1 July 2013, 22 July 2013, 14 September 2013, 8 November 2013, 17 December 2013, 1 April 2014, 29 April 2014, 23 May 2014, and 30 June 2014; (c) Patient 5's total testosterone level was 20ng/dl (0.7 nmol/l) on 15 January 2013, which was within the normal range; (d) There is no suggestion that Patient 5 displayed symptoms on 19 January 2013, 10 June 2013, 1 July 2013, 22 July 2013, 14 September 2013, 8 November 2013, 17 December 2013, 1 April 2014, 29 April 2014, 23 May 2014, and 30 June 2014 suggestive of Hypoactive Sexual Desire Disorder; (e) You prescribed and treated Patient 5 with Eltroxin on 13 March 2013; (f) Patient 5's T3 level was 95 ng/dl, T4 level was 1.10 [ng]/dl and TSH level was 3.33 uIU/ml on 15 January 2013, which were within the normal range; (g) There is no suggestion that Patient 5 displayed symptoms in January 2013 suggestive of hypothyroidism; and (h) Thyroid examinations were not done
11	between 6 June 2014 and 12 February 2015 Patient 6	*testosterone cream, estrogen cream and progesterone cream* (a) You prescribed and treated Patient 6 with testosterone cream on 6 June 2014 and 29 August 2014;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(b) There is no medical record of Patient 6's total testosterone level on 6 June 2014 and 29 August 2014; (c) Patient 6's total testosterone level was 0.7 nmol/l on 29 May 2014, which was within the normal range; (d) There is no suggestion that Patient 6 displayed symptoms on 6 June 2014 and 29 August 2014 suggestive of Hypoactive Sexual Disorder; (e) The treatment with testosterone was inappropriate in view of her advanced age and female gender; (f) You prescribed and treated Patient 6 with estrogen cream on 6 June 2014; (g) There is no medical record of Patient 6's estradiol levels on 6 June 2014; (h) Patient 6's estradiol level was 18.3 pg/ml on 29 May 2014, which was within the normal range; (i) You prescribed and treated Patient 6 with progesterone cream on 6 June 2014, 29 August 2014, 26 September 2014, 5 December 2014, 3 January 2015 and 12 February 2015; (j) There is no medical record of Patient 6's progesterone levels on 6 June 2014, 29 August 2014, 26 September 2014, 5 December 2014, 3 January 2015 and 12 February 2015; (k) Patient 6's progesterone level was less than 0.7 nmol/L on 29 May 2014, which was within the normal range; (l) The treatment with estradiol and progesterone was inappropriate in view of her advanced age and lack of typical menopausal symptoms; and (m) Breast, abdominal and pelvic examinations were not done
13	between 19 September 2013 and 19 September 2014 Patient 7	*Sustanon, Testoviron, Nebido, and Norditropin* (a) You prescribed and treated Patient 7 with Sustanon on 19 September 2013, 25 July 2014, and 19 September 2014; (b) You prescribed and treated Patient 7 with Testoviron on 4 December 2013 and 28 February 2014; (c) You prescribed and treated Patient 7 with Nebido on 19 March 2015;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(d) There is no medical record of Patient 7's total testosterone level on 19 September 2013, 4 December 2013, 28 February 2014, 25 July 2014, and 19 September 2014; (e) There is no suggestion that Patient 7 displayed symptoms on 19 September 2013, 4 December 2013, 28 February 2014, 25 July 2014, 19 March 2015, and 19 September 2014 suggestive of Late Onset Hypogonadism; (f) Heart (cardiovascular) and digital prostate examinations were not done; (g) You prescribed and treated Patient 7 with Norditropin on 19 September 2013, 20 September 2013, 4 December 2013, 28 February 2014, 25 July 2014 and 20 September 2014; (h) There is no medical record of Patient 7's IGF levels on 19 September 2013, 20 September 2013, 4 December 2013, 28 February 2014, 25 July 2014 and 20 September 2014; (i) Patient 7's IGF level was 306 ng/ml on 16 April 2014, which was within the normal range; and (j) There is no suggestion that Patient 7 displayed symptoms on 19 September 2013, 20 September 2013, 4 December 2013, 28 February 2014, 25 July 2014 and 20 September 2014 suggestive of growth hormone deficiency
15	between 6 May 2013 and 13 August 2013 Patient 8	*testosterone cream and Secretagogues* (a) You prescribed and treated Patient 8 with testosterone cream on 6 May 2013 and 13 August 2013; (b) There is no medical record of Patient 8's total testosterone level on 6 May 2013 and 13 August 2013; (c) Patient 8's total testosterone level was 0.8 nmol/l on 31 December 2012 and 2.6 nmol/l on 7 November 2013, which were within the normal range; (d) There is no suggestion that Patient 8 displayed symptoms on 6 May 2013 and 13 August 2013 suggestive of Hypoactive Sexual Desire Disorder; (e) Breast, abdominal and pelvic examinations were not done; (f) You prescribed and treated Patient 8 with Secretagogues on 26 December 2013;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(g) Patient 8's IGF level was 202 ng/ml on 23 March 2012, 185 ng/ml on 31 December 2012 and 145 ng/ml on 7 November 2013, which were within the normal range; and; (h) There [was] no suggestion that Patient 8 displayed symptoms in December 2013 suggestive of growth hormone deficiency
17	On 20 January 2014 Patient 9	*Eltroxin* (a) You prescribed and treated Patient 9 with Eltroxin on 20 January 2014; (b) There is no medical record of Patient 9's T3, T4 and TSH levels on 20 January 2014; (c) Patient 9's T3 level was 121 ng/dl, T4 level was 1.22 ng/dl and TSH level was 2.52 uIU/ml on 24 December 2013, which were within the normal range; (d) There is no suggestion that Patient 9 displayed symptoms on 20 January 2014 suggestive of hypothyroidism; and (e) Thyroid examinations were not done
19	[on 18 October 2014][338] Patient 10	*testosterone cream and Eltroxin* (a) You prescribed and treated Patient 10 with testosterone cream on 18 October 2014; (b) Patient 10's total testosterone level was 333 ng/dl on 16 April 2014, which was within the normal range; (c) There is no suggestion that Patient 10 displayed symptoms on 18 October 2014 suggestive of Late Onset Hypogonadism; (d) Digital prostate examinations or repeat morning testosterone level checks were not done; (e) You prescribed and treated Patient 10 with Eltroxin on 18 October 2014; (f) There is no medical record of Patient 10's T3, T4 and TSH levels in October 2014; (g) Patient 10's T3 level was 91 ng/dl, T4 level was 1.26 ng/dl and TSH level was 3.57 uIU/ml on 16 April 2014, which were within the normal range;

[338] In the NOI, the period stated was "between 18 October 2014 and 25 May 2015". This was a typographical error: the only relevant prescriptions for Patient 10 were on 18 October 2014.

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(h) There is no suggestion that Patient 10 displayed symptoms in October 2014 suggestive of hypothyroidism; and (i) Thyroid examinations were not done
22	between 14 March 2013 and 23 January 2015 Patient 12	*intramuscular testosterone, testosterone cream, Norditropin and progesterone* (a) You prescribed and treated Patient 12 with intramuscular testosterone on 14 March 2013, 9 April 2013, 26 September 2013, 27 October 2013, 11 December 2013, 8 January 2014, 24 March 2014, 8 May 2014, 13 August 2014 and 26 November 2014; (b) You prescribed and treated Patient 12 with testosterone cream in August 2015; (c) Patient 12's total testosterone level was 347 ng/dl on 5 March 2013 and 353 ng/dl on 6 July 2015, which were within the normal range; (d) There is no medical record of Patient 12's total testosterone level on 14 March 2013, 9 April 2013, 26 September 2013, 27 October 2013, 11 December 2013, 24 March 2014, 8 May 2014, 13 August 2014 and 26 November 2014; (e) There is no suggestion that Patient 12 displayed symptoms on 14 March 2013, 9 April 2013, 26 September 2013, 27 October 2013, 11 December 2013, 8 January 2014, 24 March 2014, 8 May 2014, 13 August 2014 and 26 November 2014 suggestive of Late Onset Hypogonadism; (f) Heart (cardiovascular), lung, abdomen, digital prostate examinations or repeat morning testosterone level checks were not done; (g) You prescribed and treated Patient 12 with Norditropin on 10 May 2013, 18 October 2014 and 23 January 2015; (h) There is no medical record of Patient 12's IGF levels on 10 May 2013, 18 October 2014 and 23 January 2015; (i) Patient 12's IGF level was 133 ng/ml on 5 March 2013, which was within the normal range;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(j) There is no suggestion that Patient 12 displayed symptoms on 10 May 2013, 18 October 2014 and 23 January 2015 suggestive of growth hormone deficiency; (k) You prescribed and treated Patient 12 with progesterone on 10 May 2013, 7 June 2013 and 16 July 2013; (l) There is no medical record of Patient 12's progesterone levels on 10 May 2013, 7 June 2013 and 16 July 2013; (m) Patient 12's progesterone level was 0.7 nmol/l on 5 March 2013, which was within the normal range; and (n) Progesterone therapy is not indicated for men. There is no evidence-based indication for prescribing progesterone therapy to men
24	between 7 November 2013 and 14 January 2014 Patient 13	*intramuscular testosterone and Norditropin* (a) You prescribed and treated Patient 13 with intramuscular testosterone on 7 November 2013; (b) Patient 13's total testosterone level was 247 ng/dl on 7 November 2013, which was within the normal range; (c) There is no suggestion that Patient 13 displayed symptoms on 7 November 2013 suggestive of Late Onset Hypogonadism; (d) Heart (cardiovascular), lung (respiratory), digital prostate examinations or repeat morning testosterone level checks were not done; (e) You prescribed and treated Patient 13 with Norditropin on 14 January 2014; (f) There is no medical record of Patient 13's IGF levels on 14 January 2014; (g) Patient 13's IGF level was 119 ng/ml on 7 November 2013, which was within the normal range; and (h) There is no suggestion that Patient 13 displayed symptoms on 14 January 2014 suggestive of growth hormone deficiency
28	between 3 October 2012 and 19 November 2014 Patient 16	*Nebido, Norditropin and progesterone cream* (a) You prescribed and treated Patient 16 with Nebido on 3 October 2012;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(b) There is no medical record of Patient 16's testosterone levels on 3 October 2012; (c) Patient 16's total testosterone levels was 456 ng/dl on 19 January 2012, which was in the normal range; (d) There is no suggestion that Patient 16 displayed symptoms on 3 October 2012 suggestive of Late Onset Hypogonadism; (e) Digital prostate examinations or repeat morning testosterone level checks were not done; (f) You prescribed and treated Patient 16 with Norditropin on 3 November 2012, 22 September 2012, 16 March 2013, 4 April 2013, 4 May 2013, 18 October 2013, 30 December 2013, 5 May 2014, 15 September 2014, and 19 November 2014; (g) There is no medical record of Patient 16's IGF levels on 3 November 2012, 22 September 2012, 16 March 2013, 4 April 2013, 4 May 2013, 18 October 2013, 30 December 2013, 5 May 2014, 15 September 2014, and 19 November 2014; (h) Patient 16's IGF level was 289 ng/ml on 19 January 2012, 5.1 ug/ml on 28 June 2013, and 227 ng/ml on 11 February 2014, which were within the normal range; (i) There is no suggestion that Patient 16 displayed symptoms on 3 November 2012, 22 September 2012, 16 March 2013, 4 April 2013, 4 May 2013, 18 October 2013, 30 December 2013, 5 May 2014, 15 September 2014 and 19 November 2014 suggestive of growth hormone deficiency; (j) You prescribed and treated Patient 16 with progesterone cream on 15 September 2014; (k) Patient 16's progesterone level was 0.7 nmol/l on 28 June 2013, which was within the normal range; and (l) Progesterone therapy is not indicated for men. There is no evidence-based indication for prescribing progesterone therapy to men
30	between 19 February 2014 and 26 February 2014 Patient 17	*Nebido and Sustanon* (a) You prescribed and treated Patient 17 with Sustanon on 19 February 2014;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(b) Patient 17's total testosterone level was 268 ng/dl on 19 February 2014, which was in the normal range; (c) You prescribed and treated Patient 17 with Nebido on 26 February 2014; (d) There is no medical record of Patient 17's testosterone levels on 26 February 2014; (e) There is no suggestion that Patient 17 displayed symptoms on 19 February 2014 and 26 February 2014 suggestive of Late Onset Hypogonadism; (f) Digital prostate examinations or repeat morning testosterone level checks were not done;
32	between 11 December 2012 and 10 February 2015 Patient 18	*Norditropin* (a) You prescribed and treated Patient 18 with Norditropin on 11 December 2012, 28 February 2013, 4 April 2013, 24 April 2014, 14 June 2014, 5 August 2014, 17 September 2014, 4 December 2014, 10 February 2015; (b) Patient 18's IGF level was 205 ng/ml on 8 December 2012, which was within the normal range; (c) There is no medical record of Patient 18's IGF levels on 11 December 2012, 28 February 2013, 4 April 2013, 24 April 2014, 14 June 2014, 5 August 2014, 17 September 2014, 4 December 2014; and (d) There is no suggestion that Patient 18 displayed symptoms on 11 December 2012, 28 February 2013, 4 April 2013, 24 April 2014, 14 June 2014, 5 August 2014, 17 September 2014, 4 December 2014, 10 February 2015 suggestive of growth hormone deficiency
35	between 25 July 2011 and September 2011, and between September 2012 and 28 October 2014 Patient 20	*intramuscular testosterone, testosterone cream and Eltroxin* (a) You prescribed and treated Patient 20 with intramuscular testosterone on 25 July 2011, 22 December 2012, 25 March 2013, 8 May 2013, 14 June 2013, 18 September 2013, 28 December 2013, 8 February 2014, 23 March 2014, 18 August 2014, 28 October 2014;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(b) You prescribed and treated Patient 20 with testosterone cream on 25 March 2013, 3 May 2013, 14 June 2013, 31 July 2013, 18 September 2013, 9 November 2013, 28 December 2013, 23 March 2014, 20 May 2014, 18 August 2014, 28 October 2014; (c) Patient 20's total testosterone level was 688 ng/dl on 7 January 2012, 588 ng/dl on 4 May 2012, which were within the normal range; (d) There is no medical record of Patient 20's total testosterone level on 25 July 2011, 22 December 2012, 25 March 2013, 3 May 2013, 8 May 2013, 14 June 2013, 31 July 2013, 18 September 2013, 9 November 2013, 28 December 2013, 8 February 2014, 23 March 2014, 20 May 2014, 18 August 2014 and 28 October 2014; (e) There is no suggestion that Patient 20 displayed symptoms on 25 July 2011, 22 December 2012, 25 March 2013, 3 May 2013, 8 May 2013, 14 June 2013, 31 July 2013, 18 September 2013, 9 November 2013, 28 December 2013, 8 February 2014, 23 March 2014, 20 May 2014, 18 August 2014 and 28 October 2014 suggestive of Late Onset Hypogonadism; (f) Digital prostate examinations or repeat morning testosterone level checks were not done; (g) You prescribed and treated Patient 20 with Eltroxin on 10 November 2012, 22 December 2012, 8 February 2013, 25 March 2013, 3 May 2013, 14 June 2013, 31 July 2013, 18 September 2013, 9 November 2013, 28 December 2013, 3 January 2014, 8 February 2014, 23 March 2014, 20 May 2014, 18 August 2014, 28 October 2014; (h) There is no medical record of Patient 20's T3, T4 and TSH on 10 November 2012, 22 December 2012, 8 February 2013, 3 May 2013, 14 June 2013, 31 July 2013, 18 September 2013, 9 November 2013, 28 December 2013, 3 January 2014, 8 February 2014, 23 March 2014, 20 May 2014, 18 August 2014;

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
		(i) Patient 20's T3 level was 82 ng/dl, T4 level was 1.05 ng/dl and TSH level was 0.54 ulU/ml on 4 May 2012, which were within the normal range; (j) Patient 20's T3 level was 98 ng/dl, T4 level was 1.13 ng/dl and TSH level was 0.25 uIU/ml on 25 March 2013, which were within the normal range; (k) Patient 20's T3 level was 59 ng/dl, T4 level was 0.99 ng/dl and TSH level was 0.98 uIU/ml on 28 October 2014, which were within the normal range; (l) There is no suggestion that Patient 20 displayed symptoms in November 2012, December 2012, February 2013, May 2013, June 2013, July 2013, September 2013, November 2013, December 2013, January 2014, February 2014, March 2014, May 2014 and August 2014 suggestive of hypothyroidism; and (m) Thyroid examinations were not done
37	between 12 November 2013 and 4 September 2014 Patient 21	*intramuscular testosterone and testosterone cream* (a) You prescribed and treated Patient 21 with intramuscular testosterone on 12 November 2013, 9 December 2013 and 4 September 2014; (b) You prescribed and treated Patient 21 with testosterone cream on 9 December 2013, 19 February 2014, 14 March 2014 and 4 September 2014; (c) Patient 21's total testosterone level was 313 ng/dl on 28 September 2013, 474 ng/dl on 27 January 2014, 409 ng/dl on 29 August 2014, which was within the normal range; (d) There is no medical record of Patient 21's total testosterone level on 12 November 2013, 9 December 2013, 19 February 2014, 14 March 2014 and 4 September 2014; (e) There is no suggestion that Patient 21 displayed symptoms on 12 November 2013, 9 December 2013, 19 February 2014, 14 March 2014 and 4 September 2014 suggestive of Late Onset Hypogonadism; and (f) Chest/ abdominal examinations, digital prostate examinations or repeat morning testosterone level checks were not done

Charge	*[period], [Patient]*	*[medication(s)], [Particulars]*
39	on 2 February 2015 Patient 22	*Norditropin* (a) You prescribed and treated Patient 22 with Norditropin on 2 February 2015; (b) Patient 22's IGF level was 132ng/ml on 2 February 2015, which was in the normal range; and (c) There is no suggestion that Patient 22 displayed symptoms in February 2015 suggestive of growth hormone deficiency

Record-Keeping Charges

3. The Record-Keeping Charges were worded as follows:

CHARGE

That you, Dr Wong Yoke Meng, a registered practitioner under the Medical Registration Act, are charged that you *[period]*, whilst practising as a medical practitioner at [the Clinic], you had acted in breach of Guideline 4.1.2 of 2002 ECEG in that you failed to keep medical records of your patient, namely one *[Patient]*, that are clear, accurate, legible and of sufficient detail, to wit:

PARTICULARS

[Particulars]

and your aforesaid conduct constitutes an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency and that in relation to the facts alleged you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

ALTERNATIVE CHARGE

That you, Dr Wong Yoke Meng, a registered practitioner under the Medical Registration Act, are charged that you *[period]*, whilst practising as a medical practitioner at [the Clinic], you had acted in breach of Guideline 4.1.2 of 2002 ECEG in that you failed to keep medical records of your patient, namely one *[Patient]*, that are clear, accurate, legible and of sufficient detail, to wit:

PARTICULARS

[Particulars]

and your aforesaid conduct constitutes such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner and that in relation to the facts alleged you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

4. The Particulars of the Record-Keeping Charges were similarly worded:

(a) The medical records for *[Patient] [period]* were not clear, accurate and legible;

(b) The medical records for *[Patient] [period]* were not of sufficient detail so that any other doctor reading them would be able to take over the management of *[Patient]*; and

(c) The medical records for *[Patient] [period]* did not document sufficient details, including what you had advised and explained to the Patient if any such advice and/or explanation had been given, including but not limited to the discussion of treatment options, risks and the Patient's informed consent[.]

5. The following table summarises the patients and periods in relation to the Record-Keeping Charges (with the names of the patients redacted):

Charge	*[Patient]*	*[period]*
2	Patient 1	between 5 October 2013 and 3 January 2014
4	Patient 2	between 1 February 2013 and 14 January 2014
6	Patient 3	between 11 September 2013 and 5 August 2015
8	Patient 4	between 5 November 2012 and 10 July 2015
10	Patient 5	between 14 January 2013 and 18 September 2015
12	Patient 6	between 29 January 2013 and 12 February 2015
14	Patient 7	between 19 September 2013 and 19 September 2015

Charge	*[Patient]*	*[period]*
16	Patient 8	between 31 December 2012 and 4 February 2015
18	Patient 9	between 24 December 2013 and 8 April 2014
20	Patient 10	between 16 April 2014 and 23 March 2015
21	Patient 11	between 9 January 2013 and 14 August 2015
23	Patient 12	between 5 March 2013 and 17 August 2015
25	Patient 13	between 7 November 2013 and 22 January 2015
26	Patient 14	between 7 February 2013 and 22 June 2015
27	Patient 15	between 6 July 2013 and 1 August 2015
29	Patient 16	between 22 September 2012 and 5 August 2015
31	Patient 17	between 19 February 2014 and 26 February 2014
33	Patient 18	between 11 December 2012 and 10 February 2015
34	Patient 19	between 9 December 2013 and 7 October 2014
36	Patient 20	between 1 July 2011 and September 2011, and between 10 November 2012 and 21 September 2015
38	Patient 21	between 20 September 2013 and 23 July 2015
40	Patient 22	between 9 November 2013 and 14 July 2015

Annex C – Summary list of patients, charges, medications

Patient (Gender)	Charges	Medications
Patient 1 (F/48)	Charges 1 and 2	Sustanon
Patient 2 (M/48)	Charges 3 and 4	Sustanon, testosterone cream
Patient 3 (M/57)	Charges 5 and 6	Nebido, Sustanon, testosterone cream, progesterone cream, Norditropin, Eltroxin
Patient 4 (M/57)	Charges 7 and 8	Intramuscular testosterone (Nebido), testosterone cream
Patient 5 (F/42)	Charges 9 and 10	Testosterone cream, Eltroxin
Patient 6 (F/70)	Charges 11 and 12	testosterone cream, estrogen cream, progesterone cream
Patient 7 (M/64)	Charges 13 and 14	Sustanon, Testoviron, Nebido, Norditropin
Patient 8 (F/47)	Charges 15 and 16	Testosterone cream, secretagogues
Patient 9 (M/43)	Charges 17 and 18	Eltroxin
Patient 10 (M/45)	Charges 19 and 20	Testosterone cream, Eltroxin
Patient 11 (M/58)	Charge 21	-
Patient 12 (M/57)	Charges 22 and 23	Intramuscular testosterone, testosterone cream, progesterone cream, Norditropin
Patient 13 (M/39)	Charges 24 and 25	Intramuscular testosterone (Sustanon), Norditropin
Patient 14 (F/61)	Charge 26	-
Patient 15 (F/56)	Charge 27	-
Patient 16 (M/51)	Charges 28 and 29	Nebido, Norditropin, progesterone cream
Patient 17 (M/48)	Charges 30 and 31	Sustanon, Nebido
Patient 18 (M/61)	Charges 32 and 33	Norditropin
Patient 19 (F/56)	Charge 34	-
Patient 20 (M/64)	Charges 35 and 36	Intramuscular testosterone, testosterone cream, Eltroxin
Patient 21 (M/56)	Charges 37 and 38	Intramuscular testosterone, testosterone cream
Patient 22 (M/74)	Charges 39 and 40	Norditropin