IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2019] SMCDT 8

Between

Singapore Medical Council

And

Dr Tang Yen Ho Andrew

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension — Fine

Singapore Medical Council
v
Dr Tang Yen Ho Andrew

[2019] SMCDT 8

Disciplinary Tribunal — DT Inquiry No. 8 of 2019
Prof Ho Lai Yun (Chairman), Dr Siaw Tung Yeng and Mr Ng Choong Yeong Kevin (Legal Service Officer)

5 August 2019, 19 September 2019, 27 November 2019 and 13 December 2019

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension — Fine

17 February 2020

GROUNDS OF DECISION

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

INTRODUCTION

1. The Respondent, Dr Tang Yen Ho Andrew, is a registered medical practitioner. At all material times, the Respondent practised at Tang Medical & Surgery Pte Ltd, Blk 8 Jalan Batu, #01-11, Singapore 431008 ("**the Clinic**").

2. Following audit checks of the medical records of the Clinic by officers of the Ministry of Health ("**MOH**") on or about 30 October 2015, MOH sent a letter to the Singapore Medical Council ("**SMC**") on 17 November 2015. The letter expressed concern over the prescribing practices of the Respondent with respect to cough mixtures containing codeine. After an investigation by the SMC, and the repeated failure of the Respondent to respond to the investigation, SMC served the Notice of Inquiry on the Respondent on 19 February 2019.

BACKGROUND FACTS

The Charges

3. The Respondent faced 30 charges involving 10 patients, i.e. for each patient, there were the same three charges preferred against the Respondent. The three charges were:

   (a) The inappropriate prescription of cough mixtures containing codeine to the patient;
   (b) The failure to exercise competent and due care in his management of the medical condition(s) of the patient; and
   (c) The failure to keep proper medical records.

   All these amount to professional misconduct under section 53(1)(*d*) of the Medical Registration Act ("**MRA**"). The full set of charges are set out in the SMC's Bundle of Notice of Inquiry and Statement of Facts (marked "**PBN**") at Tab A, pages 1-28.

PRELIMINARY POINT – THE ABSENCE OF THE RESPONDENT THROUGHOUT THE PROCEEDINGS

4. The Notice of Inquiry ("**NOI**") was hand delivered to the residence of the Respondent on 19 February 2019. The domestic helper of the family received the NOI, and she signed an acknowledgement for it. The Respondent did not respond to the NOI. As the Pre-Inquiry Conference ("**PIC**") was fixed for 29 April 2019, the SMC secretariat and the SMC's Counsel initiated communication by way of letters, emails and telephone calls between 1 to 26 April 2019. There was no response from the Respondent, save for a telephone call by the SMC secretariat answered by the Respondent on 22 April 2019. The Respondent was asked to contact the SMC's Counsel in respect of whether he intended to represent himself or if he intended to engage a lawyer. The Respondent said he would do so, but he never did contact the SMC's Counsel.

5. At the PIC on 29 April 2019, the Respondent was absent. The DT was satisfied that the NOI was properly served on the Respondent in accordance with regulation 27 of the Medical Registration Regulations ("**MRR**"). The PIC therefore carried on in the absence of the Respondent.

6. Following the PIC, the DT issued the dates for the hearing, i.e. 5 to 7 August 2019 and other directions. The letter to inform the Respondent of the date of DT hearing and other directions was hand delivered to the Respondent's residence on 7 May 2019. A lady who identified herself as the Respondent's mother signed the acknowledgement of the letter. SMC's Counsel subsequently sent emails and a letter to the Respondent inviting him to respond and attend the hearing. Again, the Respondent failed to do so.

7. At the hearing on 5 August 2019, the Respondent again was absent. The DT was satisfied that due notice had been given to the Respondent, and the hearing commenced in the absence of the Respondent. Following a direction from the DT, the SMC's Counsel informed the DT that the Immigration and Checkpoint Authority had confirmed from its immigration records that the Respondent was in Singapore when the letters, emails and telephone calls were sent and made during the period from 1 to 26 April 2019. He was also in Singapore on 29 April 2019, the day of the PIC.

8. Following the completion of the hearing, the DT fixed the hearing date to deliver the verdict regarding the charges i.e. 19 September 2019. The SMC sent an email to the Respondent on the 15 August 2019, followed by a letter sent to his residential address informing him of the hearing date for the verdict. The Respondent was absent for the verdict on 19 September 2019, as was he on 27 November 2019 for the sentencing submissions, and the sentencing hearing on 13 December 2019. The Respondent was duly informed of all the relevant the dates, and the hearings all proceeded in his absence.

DISCIPLINARY TRIBUNAL INQUIRY

The Prosecution's Case

9. The whole case is based wholly on the medical records kept by the Respondent in relation to the 10 patients. They are referred to as Patient 1, Patient 2 etc. in this judgment, as set out in the Charges. SMC did not call any witnesses, other than its expert for the DT inquiry, Dr PE.

10. Relying on the expert report of Dr PE (PBN Tab B), the SMC set out the professional misconduct of the Respondent as follows:

    (a) The prescription of cough mixtures containing codeine to the 10 patients were inappropriate, and it demonstrated an intentional, deliberate departure from the standards of the medical profession (i.e. the first type of professional misconduct, or "the first limb", as set out in *Low Cze Hong v Singapore Medical Council [2008] 3 SLR (R) 612 ("Low Cze Hong"*)). In the alternative, that it amounted to such serious negligence that it portrays an abuse of the privileges which accompany registration of a medical practitioner (i.e. the second type of professional misconduct, or the "second limb", as set out in *Low Cze Hong*) (collectively the "**Inappropriate Prescription charges**");

    (b) The failure to exercise competent and due care in his management of the medical condition(s) of the 10 patients, such that it amounted to serious negligence under the second limb of *Low Cze Hong* (collectively the "**Competence and Care charges**"); and

(c) The failure to keep proper medical records of the 10 patients, such that it amounted to such serious negligence under the second limb of *Low Cze Hong* (collectively the "**Medical Records charges**").

11. The SMC further submitted that the case of *Singapore Medical Council v Lim Lian Arn [2019]* SGHC *172 ("Lim Lian Arn")* clarified the test for what constituted professional misconduct under *Low Cze Hong*. This was a three-stage inquiry where:

(a) the first stage was to establish the relevant benchmark standard applicable to the doctor;

(b) the second stage was to establish whether there has been a departure from the applicable standard; and

(c) the third stage was to determine whether the departure in question was sufficiently egregious as to amount to professional misconduct under the particular limb of *Low Cze Hong*.

For cases prosecuted under the first limb of *Low Cze Hong*, the question was whether the departure was an intentional and deliberate departure from the applicable standard. For cases under the second limb, the question was whether the negligent departure from the applicable standards was so serious that objectively, it portrays an abuse of the privileges of being registered as a medical practitioner.

Inappropriate Prescription Charges

12. Applying the three-stage *Lim Lian Arn* inquiry:

A. <u>The Relevant Benchmarks</u>

(a) The general benchmarks were guideline 4.1.3 of 2002 edition of the SMC Ethical Code and Ethical Guidelines ("**2002 ECEG**"), setting out the general responsibilities of a doctor when prescribing medicines;

(b) The more specific benchmark was the letter dated 9 October 2000 from the Ministry of Health to all doctors and pharmacists reminding them to limit the sale of cough mixtures containing codeine, such as limiting the amount prescribed to 240ml, and no sale to the same customer within four days, whenever possible (the "**MOH Letter**");

(c) The SMC's expert report also referred to the following:

(i) American College of Chest Physicians Clinical Practice Guidelines on the Diagnosis and Management of Coughs in Adults (2006) ("**ACCP Guidelines**");

(ii) British Thoracic Society Guidelines on Cough in Adults 2006 ("**BTS Guidelines**");

(iii) MOH 2008 Clinical Practice Guidelines on Management of Asthma ("**MOH Asthma Guidelines**"); and

(iv) Diagnostic and Statistical Manual of Mental Disorders 5th Edition ("**DSM 5**").

B. Whether there was a departure from the applicable benchmark

13. In essence, the SMC's case was that the Respondent had prescribed and sold 270ml of cough mixture containing codeine, more than the 240 ml quantity recommended by the MOH Letter, on multiple occasions to each of the 10 patients. The Respondent had, on several occasions, also prescribed and sold cough mixture containing codeine within 4 days of the last sale to the same patient in some of the cases without substantiating reasons. The expert report also stated that antitussive agents like cough mixtures containing codeine are recommended for short-term use (per the ACCP Guidelines) as they have an adverse profile (per the BTS Guidelines). Dr PE had testified that the Respondent had prescribed cough mixtures containing codeine beyond the recommended short-term use for such medication. Therefore, there was a departure from the applicable benchmarks.

C. Whether the departure sufficiently egregious

14. The MOH Letter was circulated to all doctors in Singapore. In any event, the Respondent was clearly aware of the standard he needed to observe, as he had been previously convicted by a Disciplinary Committee ("**DC**") on 9 May 2013. His conviction had been for the inappropriate prescription of hypnotic medication and cough mixtures containing codeine, his failure to exercise due care in the management of his patients, and his failure to keep proper medical records of his treatment of the patients. The DC had suspended the Respondent's registration for 6 months and fined him $10,000, amongst other orders. The SMC contended that the Respondent's intentional deliberate departure from the applicable standards contained in the MOH Letter, together with the antecedent conviction and the content of the expert report, was sufficiently egregious as to warrant a sanction. In the alternative, that there was serious negligence of the part on the part of the Respondent in repeatedly prescribing cough mixtures containing codeine to patients beyond their recommended short-term use, and that prescribing such cough mixtures was not recommended as it had an adverse profile according to the BTS Guidelines.

Competence and Care Charges

15. Applying the three-stage *Lim Lian Arn* inquiry:

A. The Relevant Benchmarks

The relevant standards for the management and care of patients were broadly set out in guideline 4.1.1.5 of the 2002 ECEG. The SMC also relied on paragraphs 8-10, 24-27 and 83-84 of the expert report, summarized as follows:

(a) A medical practitioner needs to conduct a proper diagnosis of the cause of the patient's cough symptoms; and subsequently

(b) Formulate an appropriate treatment plan to treat the cough symptoms of the patient.

B. Whether there was a departure from the applicable benchmark

16. The SMC contended that the treatment plan of the repeated long term prescription of codeine cough mixtures for the 10 patients were not appropriate, whether for the control of asthma, bronchitis or other upper respiratory tract infections. For example, Dr PE had testified that the cough mixture that the Respondent prescribed would not do anything for a patient's asthma control. There was thus a serious negligent departure from the applicable standards because the Respondent failed to rule out the actual cause of the cough symptoms of each patient, and failed then to formulate an appropriate treatment plan.

C. Whether the departure sufficiently egregious

17. In not formulating an appropriate treatment plan, the SMC argued that the underlying cause of the cough symptoms of the patients were not addressed and allowed to persist in the patients for periods spanning 1 month to 19 months. This serious negligent departure from the applicable standards showed a callous lack of concern for the 10 patients in question.

Medical Records Charges

18. Applying the three-stage *Lim Lian Arn* inquiry:

A. The Relevant Benchmarks

The relevant standards for the management and care of patients are broadly set out in guideline 4.1.2 of the 2002 ECEG. The SMC relied on paragraphs 18-23, 82 and 85 of

the expert report, where it set out that doctors were required to keep proper records of their patients in relation to the:

(a) Examination of the patient;

(b) Diagnosis of the medical problem of the patient;

(c) History of the symptoms of the patient;

(d) Advice of the medical practitioner to the patient of the risk of dependence on the use of medication containing codeine;

(e) Assessment of the patient by the medical practitioner as to whether the patient exhibited signs of codeine dependence; and

(f) Reasons of the medical practitioner for the repeated prescription of cough mixture containing codeine.

B. Whether there was a departure from the applicable benchmark

19. The SMC's expert report found that the medical records kept for each of the 10 patients were not up to standard. The notes were generally difficult to decipher and brief. There was no documentation as to any advice given on the risk of dependency of codeine based medications, no reasons for the repeated prescription of cough mixtures containing codeine, and a lack of any written treatment management plans.

C. Whether the departure was sufficiently egregious

20. The SMC submitted that the medical records were inadequate, compounded by the fact that the 10 patients were repeatedly prescribed cough mixture containing codeine, which had the well-known potential for dependency. In addition, good medical records would also assist in the proper monitoring the treatment and management of patients. All this would constitute a serious negligent departure from the applicable standards.

Adverse Inference

21. The Respondent has refused to participate in the inquiry, in spite of the many opportunities to do so. Citing *Took Leng How v Public Prosecutor [2006] 2 SLR (R)70,* the SMC's Counsel invited the DT to draw an adverse inference against the Respondent, in that the Respondent has no explanation for his conduct as particularised in the Charges, other than what was stated in his medical records.

DT DELIBERATION ON THE CHARGES

22. The DT undertook a comprehensive examination of the medical records of each of the 10 patients. The DT has set out below the records of each patient generally, for the purpose of looking at the context of the treatment given to each patient. The DT, as a specialist tribunal, also makes its own medical assessment of each patient, based solely on the medical records kept by the Respondent. The DT is mindful that any gaps in the evidence, existing because the Respondent has not participated in these proceedings, cannot and should not be filled in by the DT.

A. Patient 1

(a) The DT Summary – A 38-year-old asthmatic and known smoker. He was on Ventolin and a Seretide inhaler. In most of the visits, there was documented wheeze. The diagnosis was of bronchitis, VMR (i.e. vasomotor rhinitis), asthma and allergies. In most of the instances, on top of cough mixture containing codeine, the Respondent prescribed bronchodilators. In one episode on 18 July 2015, the Respondent treated Patient 1 with Ventolin nebulisation at the clinic. Essentially, the clinical impression of Patient 1 was that he had poorly controlled chronic asthma with hypersensitivities, and he was not compliant with the treatment. This required frequent visits to the doctor.

(b) The prescriptions of cough mixture with codeine – The Respondent prescribed 270ml of cough mixture containing codeine on 12 occasions to Patient 1. There were a total of 21 visits over a period of 8½ months where cough syrup containing codeine was prescribed. This equates to 2 to 3 visits a month on average.

(c) The DT's assessment of the standard of care rendered – The use of cough mixture containing codeine as a cough suppressant in Patient 1 is useful to suppress the cough, when used together with bronchodilators. It provides relief from troublesome coughs, and helps to minimize sleep disturbance arising from the cough. This synergistic combination of medications is a common practice amongst family physicians[1]. The management of this patient is within the competency of family physicians like the Respondent, and therefore did not require a referral to a specialist.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the standard Subjective Complaint, Objective Complaint, Assessment and Plan ("**SOAP**") structure generally used by doctors in medical record keeping. The SOAP structure is elaborated on at paragraph 28(a). The profile of Patient 1 is not of a codeine dependent patient. This is because of the treatment he received i.e.

[1] https://www.cfps.org.sg/publications/the-singapore-family-physician/article/755_pdf (Accessed 2 January 2020)

being on Ventolin, Seretide inhaler and bronchodilators etc. In the context of patients with co-morbid medical conditions i.e. a medical condition co-occurring with another, it would be rare for a family physician to document codeine dependency warnings in their medical records. All 10 patients in question had co-morbid conditions. As such, no medical notes regarding codeine dependency were strictly necessary.

B. Patient 2

(a) The DT Summary – A 37-year-old known asthmatic on a Ventolin Evohaler. Essentially, this was a patient with recurring episodes of cough. There was documentation of A&E hospital visits, where chest x-rays had been carried out on 5 May 2014 and 14 August 2014. Inhalers and bronchodilators were prescribed in several visits.

(b) The prescriptions of cough mixture with codeine – The Respondent prescribed 270ml of cough mixture containing codeine on 3 occasions (although there were a further 3 occasions where the quantity dispensed was not clear from the medical records). There was also 1 occasion when the Respondent prescribed cough mixture containing codeine within 4 days of the previous prescription. There were a total of 17 visits over a period of 16 months where cough syrup containing codeine was prescribed. This would average out to about 1 visit per month, although it is noted that Patient 2 did not visit every month.

(c) The DT's assessment of the standard of care rendered – The treatment instituted in all the visits were tailored to the presenting complaints, and the diagnosis by the Respondent were within his level of competency. There was no further need for a specialist referral. The use of cough mixture containing codeine as a cough suppressant in Patient 2 is useful to suppress the cough, when used together with bronchodilators. The reasons are as given for Patient 1 at paragraph 22A(c), and all the more for Patient 2 with his history of A&E visits.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. The patient was documented to have an allergy to nonsteroidal anti-inflammatory drugs ("**NSAIDS**") and had a history of spinal compression. In addition, he had sought A&E assistance and chest x-rays were carried out. Patient 2 thus did not fit the profile of a codeine dependent patient. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. As such, no medical notes regarding codeine dependency were necessary.

C. Patient 3

(a) The DT Summary – A 46-year-old with documented wheeze. Antibiotics were given to him at the first visit on 2 August 2015. He had a fever on the second

visit on 15 August 2015 and a chest x-ray was ordered. In addition to the cough mixture, the Respondent prescribed bronchodilators and antihistamines. From the medical records, diagnosis, investigations and medications prescribed, the impression here is a patient with chronic bronchitis.

(b) The prescriptions of cough mixture with codeine – The Respondent prescribed 270ml of cough mixture containing codeine on 9 occasions over a period of close to 3 months. This works out to be an average of 3 to 4 visits a month.

(c) The DT's assessment of the standard of care rendered – Cough mixture, together with the use of bronchodilators, is acceptable as a practice in treating the bronchitis. The reasons are as given for Patient 1 at paragraph 22A(c). The treatment given to Patient 3 (i.e. x-ray, antibiotics etc.) was appropriate because of his symptoms. Treatment of uncomplicated chronic bronchitis is within the competency of family physicians. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. With the investigations and treatment received i.e. x-rays, bronchodilators, antibiotics etc., the profile of Patient 3 is not of a codeine dependent patient. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency were needed.

D. Patient 4

(a) The DT Summary – A 38-year-old taxi driver on Becotide and Ventolin for his asthma. There is documented wheezing. In addition to the cough mixture, bronchodilators were also prescribed.

(b) The prescriptions of cough mixture with codeine – The Respondent prescribed 270ml of cough mixture containing codeine on 9 occasions. There were a total of 10 visits over roughly 3 months where cough syrup containing codeine was prescribed. This works out to an average of 3 to 4 visits a month.

(c) The DT's assessment of the standard of care rendered – Frequent wheezing and coughing episodes are not uncommon in mild to moderate asthmatics who are not compliant with the treatment plan. The treatment rendered to Patient 4 was not unacceptable. The reasons are as given for Patient 1 at paragraph 22A(c). Treatment of these asthmatics is within the competency of a family physician like the Respondent. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. In the context of an asthmatic like Patient 4, it is difficult to conclude that he had a codeine dependency due to the symptoms he presented. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency were needed.

E. Patient 5

(a) The DT Summary – A 42-year-old known smoker, with Chronic Obstructive Pulmonary Disease ("**COPD**") / Asthma. He was on Ventolin and Seretide Multi Dose Inhaler. In the early visits, he was mainly given cough mixture and told to continue with his own inhalers. From 15 June 2015 onwards, there was noticeable change to the management, in that bronchodilators were added. A chest x-ray was done on 26 August 2015. With the history, diagnosis, the investigations done and medicine prescribed for him, the clinical impression is that of a COPD patient with worsening symptoms over time. This was most likely aggravated by his smoking and non-compliance with the treatment, thus requiring frequent visits to the doctor.

(b) The prescriptions of cough mixture with codeine – The Respondent prescribed 270ml of cough mixture containing codeine on 14 occasions. There was also 1 occasion when the Respondent prescribed cough mixture containing codeine within 4 days of the previous prescription. Overall, there were 25 visits over 15 months where cough mixture containing codeine was prescribed. This works out to be an average of 1 to 2 visits a month, although it is noted that Patient 5 did not visit every month.

(c) The DT's assessment of the standard of care rendered – The use of cough suppressant in COPD patients are useful to suppress their cough, in addition to the use of bronchodilators. The treatment of Patient 5 was not unacceptable. The reasons are as given for Patient 1 at paragraph 22A(c). The management of this patient is definitely within the competency of family physicians like the Respondent. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – Patient 5 does not fit the profile of a codeine dependent patient, because of the symptoms, the investigations done and the treatment (i.e. chest x-ray, being on Ventolin, Seretide inhaler, and bronchodilators etc.). The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no notes regarding codeine dependency were required.

F. Patient 6

(a) The DT Summary – A 30-year-old with COPD / asthma using a Seritide inhaler. He was given cough mixture containing codeine, and it was reflected clearly in the medical notes that he was to continue with his own inhaler. Bronchodilators were given from 11 February 2015 onwards, together with the cough mixture. In addition, chest x rays were done 14 June 2014 and 26 August 2015. Fever was documented and treated on several visits.

(b) The prescriptions of cough mixture with codeine – The patient was prescribed 270ml of cough mixture containing codeine on 21 occasions. In total, there were 35 visits over 19 months where cough mixture containing codeine was prescribed. This works out to be an average of 2 visits a month where the cough mixture was prescribed.

(c) The DT's assessment of the standard of care rendered – The use of cough suppressant in COPD / asthmatic patients are useful to suppress their cough, in addition to the use of bronchodilators. The reasons are as given for Patient 1 at paragraph 22A(c). Chest x-rays and the use of bronchodilators were ordered or prescribed when necessary. The management of this patient is definitely within the competency of family physicians like the Respondent, and no specialist referral was necessary.

(d) The DT's assessment of the standard of the medical records – The notes were sufficiently clear and adequate for the purpose of the required SOAP structure. The profile of Patient 6 is of a patient with poorly controlled COPD / asthma, with multiple episodes of bronchitis or exacerbations i.e. a worsening of the condition. From the medical notes, the patient is a frequent traveller. All this does not fit the profile of a codeine dependant patient. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency were required.

G. Patient 7

(a) The DT Summary – Patient with a history of chronic bronchitis.

(b) The prescriptions of cough mixture with codeine – The patient was prescribed 270ml of cough mixture containing codeine on 7 occasions over a period of 3 months. This works out to be about 2 visits a month where the cough mixture was prescribed.

(c) The DT's assessment of the standard of care rendered – The use of cough mixture containing codeine would be necessary to treat and manage patients with bronchitis. Therefore, the treatment here was within the competency of the family physicians like the Respondent, and no specialist referral was necessary.

(d) The DT's assessment of the standard of the medical records – The notes were sufficiently clear and adequate for the purpose of the required SOAP structure. This does not fit the profile of a codeine dependant patient because of the history, diagnosis and medications prescribed. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency was required.

H. Patient 8

(a) The DT Summary – A 57-year-old taxi driver with a diagnosis of mainly bronchitis. Apart from cough mixture containing codeine, antibiotics and bronchodilators were also prescribed, together with chest x-rays. Fever was also documented on a several visits.

(b) The prescriptions of cough mixture with codeine – The patient was prescribed 270ml of cough mixture containing codeine on 14 occasions. In total, there were 17 visits over 4 to 5 months where cough mixture containing codeine was prescribed. This works out to be an average of 3 to 4 visits a month where the cough mixture was prescribed.

(c) The DT's assessment of the standard of care rendered – The use of cough mixture containing codeine, together with the use of bronchodilators, was appropriate. The reasons are as given for Patient 1 at paragraph 22A(c). The management of this patient is definitely within the competency of family physicians. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. The profile of Patient 8 is of a patient with chronic bronchitis. This does not fit the profile of a codeine dependant patient because of the history, diagnosis and mediation prescribed. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency was required.

I. Patient 9

(a) The DT Summary – A 44-year-old with a diagnosis of bronchitis. In all the 4 visits, other medications were prescribed, on top of the cough mixture containing codeine.

(b) The prescriptions of cough mixture with codeine – The patient was prescribed 270ml of cough mixture containing codeine on 4 occasions over 5 weeks.

However, for patients with bronchitis, the frequency of visits here was not medically unusual.

(c) The DT's assessment of the standard of care rendered – The management of this patient was not unacceptable, and was definitely within the competency of family physicians like the Respondent. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. The profile of Patient 9 is of a patient with bronchitis. There were insufficient visits for any suspicion of codeine dependency to be raised. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency was required.

J. Patient 10

(a) The DT Summary – A smoker with a diagnosis of mainly bronchitis. Besides cough mixture containing codeine, other medications including bronchodilators were prescribed.

(b) The prescriptions of cough mixture with codeine – The patient was prescribed 270ml of cough mixture containing codeine on 8 occasions over a 10-week period. This works out to be an average of 2 to 3 visits a month.

(c) The DT's assessment of the standard of care rendered – For patients with bronchitis, the frequency of visits was not medically unusual. The reasons are as given for Patient 1 at paragraph 22A(c). The management of this patient was not unacceptable and definitely within the competency of family physicians like the Respondent. There was no further need for a specialist referral.

(d) The DT's assessment of the standard of the medical records – To the DT, the notes were sufficiently clear and adequate for the purpose of the required SOAP structure. The profile of Patient 10 is of a patient with bronchitis. This does not fit the profile of a codeine dependant patient because of the history, diagnosis and medication prescribed e.g. bronchodilators etc. The other comments related to co-morbidity conditions, made with regard to the medical records of Patient 1 at paragraph 22A(d), are also applicable. Therefore, no medical notes regarding codeine dependency was required.

Inappropriate Prescription Charges

23. The DT finds as follows:

A. The Relevant Benchmarks

The DT agrees with the benchmarks as set out by the SMC in relation to the Inappropriate Prescription charges against the Respondent, in particular, the guidelines set out in the MOH Letter which was addressed to all doctors and pharmacists in Singapore.

B. Whether there was a departure from the applicable benchmark

24. The Respondent had prescribed 270ml of cough mixture containing codeine to each of the 10 patients on multiple occasions. This was more than the 240ml limit per patient per visit as advised in the MOH Letter. The number of times the Respondent "over-prescribed" the quantity of cough mixture containing codeine for each patient ranged from 4 to 21 times. The Respondent also prescribed cough mixture containing codeine within 4 days of the previous visit on 4 occasions, involving 4 of the patients.

C. Whether the departure was sufficiently egregious

25. The MOH Letter had been issued to all doctors and pharmacists in Singapore, as it had come to the attention of the National Pharmaceutical Administration that cough mixture containing codeine was being obtained with ease at medical clinics and pharmacies. This caution was deemed necessary as MOH was concerned that cough mixture containing codeine could be used by drug addicts in between their supply of illicit drugs. What makes the departure from the relevant benchmark particularly egregious is that the Respondent had a prior conviction by a Disciplinary Committee in May 2013 for, amongst other misconduct, being in breach of the MOH Letter for the inappropriate prescription of cough mixture containing codeine. The Respondent had also given a written undertaking dated 6 June 2013 ("**the Undertaking**") to the SMC that he would abide by the guidelines given for the prescription of codeine containing cough mixtures, and that he would not repeat the offence in the future. Therefore, the Respondent would certainly already be on notice to abide by the guidelines set out in the MOH Letter.

D. Finding

26. The DT finds that the Respondent did prescribe cough mixtures containing codeine to each of the 10 patients in quantities that were above the recommended guideline contained in the MOH Letter. As the Respondent has decided not to participate in these proceedings, the DT infers that he would have known what the recommended guideline quantity was, particularly because of his prior conviction and the Undertaking. It is therefore clear to the DT he had deliberately departed from those guidelines. The misconduct was sufficiently egregious to warrant a sanction, and the DT therefore finds the Respondent guilty of and convicts him on all 10 Inappropriate Prescription charges on the deliberate departure limb. As the DT convicts the Respondent on the deliberate

departure limb, it makes no findings against him on the alternate limb of serious negligence.

Competence and Care Charges

27. The DT finds as follows:

A. The Relevant Benchmarks

The DT agrees with the broad benchmarks set out in guideline 4.1.1.5 of the 2002 ECEG.

B. Whether there was a departure from the applicable benchmark

28. The DT has carefully reviewed the medical records of each of the patient, bearing in mind the context here of a family physician in private practice. Based on the review of these records as set out in paragraph 22 above, the DT finds that:

(a) The SOAP structure: There was SOAP structure reflected in the medical records of each patient. While details may be quite brief, the notes do consistently set out the (S)ubjective complaints of the patient like a cough; the (O)bjective complaints like a fever of, for example, 39.5 degrees Celsius, or signs of wheezing; the (A)ssesment of the patient like asthma, bronchitis, COPD; and (P)lan like prescribing chest x rays, bronchodilators, inhalers, other medications.

(b) Treatment plan and medication prescribed: Based on the medical records, the patients were all given medications other than just cough mixture containing codeine. Those who already had inhalers were typically told to continue with it. There were those who needed bronchodilators, antibiotics etc. and these were prescribed accordingly. Chest x-rays were also ordered when needed. Delving into more specific issues, the DT notes the following:

(i) Usefulness of cough mixture containing codeine: In relation specifically to the cough mixtures containing codeine, these are useful for suppressing coughs, particularly when prescribed in conjunction with inhalers, bronchodilators or other medications[2]. While there may be non-codeine based cough mixtures available, these may not be as effective in suppressing coughs. When asked by the DT if there was a better cough suppressant on the market, Dr PE testified that codeine cough mixture has not been proven to be the best (in suppressing coughs). Having said that, Dr PE did concede that Dhasedyl (a cough mixture containing codeine) was commonly prescribed for short term

[2] *Ibid*

cough relief. This indicates to the DT that centrally acting narcotics, i.e. cough mixtures containing codeine, are effective cough suppressants[3]. The question is what "short term" means in the medical context.

(ii) Issue of "short term" usage of cough mixture containing codeine: In relation to the suitability of cough mixture containing codeine for "short term" use only, the DT noted that the prescriptions were given to patients on an average of 3 to 4 times per month, or less. In some cases, like Patient 6, there was 35 prescriptions of codeine cough syrup over period of 19 months. This works out to be an average of 2 prescriptions per month, or 540ml per month. Patients 3, 4, 7, 9 and 10 all had 10 visits or less over a 2 to 3 months' period where cough mixture containing codeine was prescribed. It is noted that not all the patients had visits in consecutive months, which would affect the average per month visits. Having said that however, no evidence was led as to what "short term" use meant, and whether or not at beyond a certain level of consumption over a certain period, there was a risk of dependence.

(iii) The DT is of the view that "short term" usage would generally refer to a period of use for 2 months or less[4]. That being the case, it would be difficult to say that for Patients 3, 4, 7, 9 and 10 (all of whom had been seen by the Respondent for between 2 to 3 months, or less), that their treatment and care was inappropriate. In any event, all the 10 patients were prescribed other medications and treatments as part of their treatment plan. For patients 1, 2, 5, 6 and 8, who were being treated for a longer period of time, the important thing the DT noted was that they all had underlying medical conditions, of a moderate level of severity, which were not optimally controlled because of the non-compliance of the treatment by the patients. Their non-compliance could be seen through their frequent re-visits, and the exacerbation of their symptoms. They also had other medications and treatments prescribed by the Respondent. For example, although Patient 6 had been treated with cough mixture containing codeine for 19 months, the important factor the DT considered was the overall treatment which the Respondent had rendered to the patient. The treatment plan included Seretide inhalers, the use of bronchodilators, chest x-rays, etc. Patient 6 was also treated for fever. Thus, it was difficult to conclude that the Respondent did not afford Patient 6 competent care. Critically, none of the 10 patients were given solely cough mixture containing codeine. In this context, the treatment of the patients by the Respondent was not unacceptable.

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[3] *Ibid*

[4] http://www.smj.org.sg/article/approaching-chronic-cough (Accessed on 2 January 2020)

(iv) Issue of need to refer to a specialist because of level of severity of illness: Dr PE had testified that the 10 patients were in the range of mild to moderate severity of illness. The DT agrees with this assessment of the profile of the patients. The DT therefore is of the view that all the patients were within the competence of the Respondent to treat, and there was no need for the Respondent to have referred the patients for further management e.g. to a specialist.

(v) Issue of Patients 4 and 8 being taxi drivers: Dr PE and the SMC had highlighted that prescribing cough mixture containing codeine to taxi drivers was not acceptable, as that would potentially cause drowsiness and endanger themselves or other road users. The implicit assumption of Dr PE and SMC seemed to be that Patients 4 and 8 would drive, or would potentially drive, their taxis under the influence of the cough mixture containing codeine. As neither Patients 4 nor 8 were called as prosecution witnesses, this assumption could not be verified. It cannot be that taxi drivers, or for that matter pilots, surgeons or anyone requiring a degree of focus and skill, can never ever be prescribed cough mixtures containing codeine. Also, the potential danger or harm is also present for any person who uses, drives or rides any sort of vehicle, not just taxi drivers. Given the overall level of management of all the patients by the Respondent, the DT is of the view that it is unsafe to conclude the Respondent was acting particularly irresponsibly towards Patients 4 and 8, based on a generalised assumption.

(c) View of the DT: The use of cough mixture containing codeine, if taken in isolation and without reference to the overall context of each patient, may lead some to conclude that the prescriptions were excessive and inappropriate. However, once the overall context of the profile of the patients is taken into account, the low to moderate level of severity of their conditions, and the actual range of treatment afforded to each patient, the DT is unable to find that the Respondent failed to provide them with competent medical care. The prescription of cough mixture containing codeine was part of the overall treatment package for the 10 patients who were suffering from chronic obstructive airway diseases (e.g. chronic asthma, chronic bronchitis etc.). From the medical records, the actions of the Respondent did not appear to be blunderbuss. Clearly then, the views of the DT, based solely on the same medical records reviewed by Dr PE, differ from those of Dr PE.

C. Finding

29. In Singapore disciplinary proceedings, charges must be proven beyond a reasonable doubt. See *Wong Meng Hang* at [53]. In light of the standard of proof required, and the views of the DT above, the DT concludes that there is a reasonable doubt created as to

whether the Respondent had departed from the applicable benchmarks. The DT thereby acquits the Respondent of all 10 of the Competence and Care charges.

Medical Records Charges

30. The DT finds as follows:

A. The Relevant Benchmarks

The DT agrees with the broad benchmarks set out in guideline 4.1.2 of the 2002 ECEG.

B. Whether there was a departure from the applicable benchmark

(a) Issue of brief, incomprehensible notes: Although Dr PE stated that the medical notes were difficult to decipher and too brief for the use of another doctor taking over the care of the patient, the DT has, without much difficulty, set out above the summary of the medical records of each patient, the patient profile and treatment plan, all based on the medical records of the Respondent. While the level of documentation could have been better, in the view of the DT, it did fulfil the general criteria of being sufficient such that another doctor could take over the management of the patient. Having said that, it is noted that in the context of a family physician in private practice like the Respondent, there is less of a need for another doctor to take over the patients, unlike tertiary care facilities or multi-doctor practices.

(b) Issue of the lack of documentation on the dependency risks of codeine based medications; the lack of reasons for the repeated prescription of cough mixtures containing codeine; and a lack of any written treatment management plans: From the medical records, the DT was able to discern a profile of the patients without undue difficulty. The profiles did not indicate a risk of codeine dependency. Importantly, the prescription of cough mixture with codeine were all made in conjunction with other medication and treatment. The Respondent did not prescribe cough mixture containing codeine in isolation. The DT has already found that the Respondent's care and management of the patients to be not incompetent, even with the repeated prescriptions of cough mixtures containing codeine. Under the circumstances therefore, the apparent lack of documentation on the risk of dependency and the apparent lack of reasons for the repeated prescriptions of the cough mixture containing codeine were understandable. The medical records showed a SOAP structure. It was not the most comprehensive nor detailed. Nevertheless, it was sufficiently clear with the history, presenting complaint, diagnosis and a management plan (gleaned through the medications and treatment prescribed). The DT is of the view there were treatment plans present for each of the 10 patients contained in their respective medical records. While it is not the case of the SMC, the DT notes

for completeness, there is no evidence that the Respondent was selling cough mixture containing codeine to addicts for a profit.

C. Finding

31. From the above, the DT finds that there is reasonable doubt that the Respondent had failed to keep proper medical records and therefore departed from the applicable benchmark. The DT thereby acquits the Respondent of all 10 charges of the failure to keep proper medical records.

SUBMISSIONS ON SENTENCE

SMC's Submissions

32. For the 10 charges of Inappropriate Prescription that the Respondent was found guilty of, the SMC submitted that:

(a) The harm / culpability sentencing matrix as set out in *Wong Meng Hang v Singapore Medical Council [2018] SGHC 253* ("**the Wong Meng Hang sentencing matrix**") should be used;

(b) Using the *Wong Meng Hang* sentencing matrix, the harm level should fall within the "Moderate" range, and the culpability level in the lower end of the "High" range. This is due to the potential harm that could be caused to the patients should they develop a dependence on the codeine; and the fact the Respondent showed a recalcitrant disregard for the guidelines in the MOH Letter. Given this, the starting point for each charge should be a 24 months' suspension;

(c) Adjusting for the antecedent of the Respondent and his aggravating conduct of refusing to participate or respond to these proceedings, each charge should range from a 30 months to 36 months' suspension;

(d) Using the individual sentencing approach utilized in *Yip Man Hing Kevin v Singapore Medical Council and another matter [2019] SGHC 102 ("Kevin Yip")* and *Singapore Medical Council v Dr Tan Kok Jin [2019] SMCDT 3 ("Tan Kok Jin")*, the 3 most serious charges (i.e. Patients 4, 6 and 8) should each receive a suspension of 36 months, with the remaining 7 charges each receiving a 30 months' suspension;

(e) The 3 most serious charges should run concurrently, with the other charges running consecutively, giving an aggregate sentence of nine (9) years' suspension;

(f) As the DT is only empowered under the Medical Registration Act to impose a suspension of up to 3 years only, the Respondent should be struck off the register so as to properly reflect the severity of the Respondent's professional misconduct, with the usual other orders; and

(g) As there was no inordinate delay in this case, and any possible delay could be attributed to the non-cooperation of the Respondent, there was no justification for a discount in the sentencing.

DELIBERATION OF THE DT ON SENTENCING

Culpability / Harm Matrix

33. The DT adopts the Culpability / Harm sentencing matrix (set out below). As noted in *Wong Meng Hang*, the matrix has the intended effect of producing heavier sentencing tariffs compared to the more lenient sanctions in the past. The DT also utilises the *Wong Meng Hang* 4-step process in assessing the appropriate sentence.

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

Step 1 - Identifying the level of Harm

34. It is not the SMC's case that any actual harm occurred to any of the 10 patients. No such evidence was adduced. The SMC's case is that there was potential harm to the patients due to the possibility of dependence on codeine. The Court in *Wong Meng Hang* stated that "harm" would include potential harm. That Court also stated that *"…potential harm should only be taken into account if there was a sufficient likelihood of the harm arising; it would plainly not be appropriate to consider every remote possibility of harm for the purposes of sentencing."* (at [30]).

35. The DT acknowledges that consumption of cough mixture containing codeine beyond "short term" usage could lead to dependency issues. However, "short term" has not been defined by the SMC, and neither has the levels of codeine consumption that could lead to dependence. The DT believes that "short term" should be a period of 2 months

or less. In the present case, the duration of the prescriptions varies from 1 month to 19 months, and differing amounts were given to each patient. The effect of codeine would vary for individuals. Yet, all the patients appeared to be generalized by the SMC as being equally at risk of dependence. This makes it difficult for the DT to pinpoint the overall level of potential harm, and whether or not, per *Wong Meng Hang*, that there was a sufficient likelihood of the harm arising.

36. The SMC cited the two cases of *Singapore Medical Council v Chia Kiat Swan [2019] SMCDT 1 ("Chia Kiat Swan")* and *Tan Kok Jin*. Both these cases involved multiple charges of the inappropriate prescription of hypnotics, amongst other charges. The DT in *Tan Kok Jin* had also pointed out that the SMC had not, in that particular case, adduced evidence of actual harm caused to the patients. In that case, the duration of prescription for benzodiazepines ranged from 20 months to 33 months. These were far longer periods compared to the present case. Had there been evidence of actual harm, the DT in *Tan Kok Jin* stated that they might have been persuaded to classify the harm as Moderate. In the event, the DT classified the level of harm as Slight.

37. In *Chia Kiat Swan*, the doctor in that case had inappropriately prescribed benzodiazepines to patients for between over 6 years to nearly 12 years. Both Counsel mutually agreed in that case that the harm was Moderate, and the DT in that case concurred.

38. The DT is mindful not to downplay the potential harm that dependence on codeine could potentially bring to individuals. However, in the present case, the DT has found that the Respondent did not fail to provide competent care to his patients, and that the cough mixture containing codeine was prescribed as part of a treatment plan for each patient. The periods of prescription of the cough syrup containing codeine in this case was much shorter than in the *Tan Kok Jin* and *Chia Kiat Swan* cases. The DT would therefore assess the harm that could potentially be suffered by the patients to be Slight.

Step 2 - Identifying the level of Culpability

39. The DT notes that of the 10 patients, 4 of them had 10 visits or less in a 1 to 3-month period. The SMC highlighted that Patient 6 had 35 visits over 19 months, as an example of the high level of culpability of the Respondent. However, in all the visits by the 10 patients, the prescription of cough syrup containing codeine was in conjunction with other treatments and care, which the DT found to be not inadequate. Also, from a professional stand point, the DT's profile of Patient 6 was one who had poorly controlled asthma / COPD, repeated episodes of bronchitis and exacerbations, and thus required frequent visits. Regardless, the Respondent should still have needed to adhere to the MOH Letter guidelines regarding quantity i.e. 240ml, and frequency i.e. not within 4 days of last visit.

40. For *Chia Kiat Swan*, the culpability was assessed as between the lower end of High and the higher end of Medium, because the doctor had prescribed the benzodiazepine over a long period, of over 6 to nearly 12 years. In *Tan Kok Jin*, the culpability was assessed as Medium, given that the DT agreed with the joint recommendation of SMC and the Respondent's Counsel on this point. The prescription period in question in *Tan Kok Jin* was between 20 to 33 months.

41. Again, the periods of prescriptions were lower in the present case compared to *Chia Kiat Swan* and *Tan Kok Jin*. In the circumstances, the DT assesses the culpability of the Respondent to be the Low to mid-range of Medium.

Step 3- Indicative Sentencing Range and Appropriate Starting Point (1)

42. The indicative sentencing range in *Chia Kiat Swan* was between 1 to 3 years' suspension. The DT in that case was of the view that it should be a 2 years' suspension. With the discount for the inordinate delay, a final sentence of 16 months was imposed on the doctor in *Chia Kiat Swan*. This was based on a global basis, as *Chia Kiat Swan* pre-dated *Yip Man Hing Kevin v Singapore Medical Council and another matter [2019] SGHC 102* ("*Kevin Yip"*). In *Tan Kok Jin*, the DT used the individual sentence approach referred to in *Kevin Yip*. For the inappropriate prescription charges, the DT in that case decided that a 4 to 6 months' suspension for each inappropriate prescription charge was warranted. Ultimately, that DT decided that the 3 more serious inappropriate prescription charges should carry 6 months' suspensions, and those charges should run consecutively. Together with other charges, the total aggregate suspension was 2 years. There being an inordinate delay in this case as well, the final sentence was of 12 months' suspension. Therefore, in both cases using the *Wong Meng Hang* sentencing matrix, both the DTs in *Chia Kiat Swan* and *Tan Kok Jin*, using two different sentencing approaches, concluded that a suspension of 2 years was appropriate (before factoring in the inordinate delay sentencing discounts). Both *Chia Kiat Swan* and *Tan Kok Jin* were cases where the respective Respondent was convicted on multiple charges of differing types.

Sentencing Approach of the DT

43. The DT pauses here to consider the individual sentence approach taken by *Tan Kok Jin* and its effects. In that case, the DT felt it appropriate, in light of the comments made in the *Kevin Yip* case, to utilize the individual sentence approach, and move away from the more traditional global sentencing approach adopted by *Chia Kiat Swan* and earlier cases. In *Kevin Yip*, the Court was of the view that although the 3 charges related to the same type of failure by the doctor to his patient, the fact was that the doctor had a distinct duty on each of the separate occasions to assess the patient. The Court stated:

> "When dealing with a defendant convicted of multiple charges, whilst it may not always be necessary for the sentencing court or tribunal to

> explicitly state what the individual sentence is for each individual charge the defendant has been convicted of, this ought to have been done for the present case." [90]

44. In relation to the present case, there are 10 charges of inappropriate prescription of cough mixture containing codeine. Each charge is made up of multiple occasions where the Respondent made the inappropriate prescriptions. For example, in the charge with regard to Patient 1, there are 21 separate and distinct visits to the Respondent. As the SMC decided to charge the Respondent in such a manner, it may be difficult in this case to adopt the same principle behind the reasoning of preferring individual charges. In *Kevin Yip*, the charges were completely discrete and essentially involved one charge per occasion or visit.

45. When the DT in *Tan Kok Jin* utilized the individual sentence approach, it did lead to a situation where the SMC asked for a total suspension of between 3 years to 8 years, with 4 of the charges running consecutively. Under the MRA, a DT has powers to only order a suspension of 3 years. The DT in that case decided to sentence the Respondent to an aggregate of 2 years' suspension, with 5 charges running consecutively. Ultimately, due to a finding of an inordinate delay in the prosecution of the matter, the DT discounted the sentence and the final sanction was a 12 months' suspension.

46. The SMC in the present case had submitted for a starting point suspension of 2 years for each charge. Due to the aggravating factors present, i.e. the antecedent of the Respondent, and the fact he blatantly refused to attend any of the hearings or cooperate in any way with the investigations, the SMC submitted that the sentence for each charge should be 3 years for the most serious 3 charges (to run consecutively), and 30 months suspension for the remaining 7 charges (to run concurrently). This would add up to a total of 9 years' suspension. Had the DT convicted the Respondent of the other 20 charges as well, the aggregate sanction could well be higher. The SMC recognized this length of suspension was completely beyond the powers of the DT to order, and so further submitted that a striking out order would then be in order.

47. When queried by the DT that if the MRA, hypothetically, empowered the DT to impose a 10 years' suspension, would the SMC still ask for a striking out in this case? The SMC responded that in such a case, it would stand by the 9 years' suspension. However, since the DT did not have the powers to order that, and to reflect the severity of the Respondent's conduct in this case, SMC submitted that a striking out order was still justified. The DT observes that in essence, how the *Wong Meng Hang* sentencing matrix was used to establish the *global* starting point sentence in *Chia Kiat Swan*, is now being used as the starting point for *an individual charge*.

48. To the DT, this seems to be an unsatisfactory state of affairs. In the present case, it leads the DT to ask – Is the individual sentencing approach appropriate for the present case, where there are multiple occasions within a single charge where the doctor should have

assessed the patient? Would it lead to a situation, when used in conjunction with the *Wong Meng Hang* sentencing matrix in cases with multiple charges, where the aggregate sanctions would be so beyond the maximum allowable by the MRA, that the SMC would have to submit that a striking out order is the only sanction left? Would that offend the sentencing principle of totality, where a court or tribunal should be mindful that the overall sentence should not be "crushing"?

49. The individual sentencing approach is clearly suited for certain types of cases, where the charges relate to distinct or standalone events, e.g. *Kevin Yip*. It may be suitable for cases with multiple charges, where the charges are different in nature i.e. inappropriate prescription, failure to keep proper medical records charges and failure to refer the patient to a specialist, e.g. *Tan Kok Jin.* In the latter case, the appropriate sentence was achieved through a combination sentencing principles i.e. identifying the more serious charges and the use of consecutive and concurrent sentences.

50. In the present case, the DT notes that that the 10 charges in question relate to multiple events within each charge. Also, the 10 charges are similar in nature i.e. all relate to inappropriate prescriptions. Are these type of charges suitable to the individual sentencing approach? The DT is cautiously of the view that where there are many charges of a similar nature, with multiple events within each charge, the individual sentencing approach could be utilized, if the totality principle of sentencing is kept in mind.

51. The DT would also address the submission of the SMC that a striking off is called for in this case because the maximum suspension of 3 years is simply inadequate to reflect the severity of the Respondent's misconduct. To consider a striking off, the Court in *Wong Hang Meng* stated that question really is *"…whether the misconduct is so serious that it renders the doctor unfit to remain a member of the medical profession."* [66] A very brief review of cases where a doctor had been struck off the register would reveal the general type of cases where that sanction was imposed:

(a) Sexual misconduct in *Singapore Medical Council v Dr Tan Kok Leong [2019] SMCDT 4;*

(b) Dishonesty by the forgery of documents in *Singapore Medical* Council *v Dr Khoo Buk Kwong [2018] SMCDT 13*;

(c) Sexual misconduct and criminal behaviour in *Dr Ong Theng Kiat Disciplinary Tribunal Grounds of Decision dated 29 April 2015* and *Singapore Medical Council v Dr Lee Siew Boon Winston [2018] SMCDT 4*;

(d) Serious Negligence in *Wong Meng Hang [2018]*;

(e) Sale of cough syrup in large quantities (1907 litres) in a wholesale manner for substantial profit in *Dr Ho Thong Chew Disciplinary Tribunal Grounds of Decision dated 18 December 2014*; and

(f) Sale of hypnotics as a second time offender for a similar offence, being previously struck off for the first offence in *Dr AAN Disciplinary Inquiry Grounds of Decision dated 13 March 2009.*

52. From the cases where a doctor has been struck off, it is clear the misconduct has been so egregious that, in the words of the Court in *Wong Meng Hang, "…it leads to the conclusion that the doctor is permanently or indefinitely unfit to practice or remain a doctor."*

53. In the present case, the DT has expressly found that the Respondent did not act in an incompetent manner in the management of the 10 patients, and that the treatment of the patients and his medical record keeping were not inadequate. Pertinently, while the DT found the Respondent guilty of not adhering to the guidelines in the MOH Letter, it found overall that the treatment plan for each patient was not inappropriate given the medical context of the patient. The DT is unable to conclude, from the evidence before it, that the conduct of the Respondent is so egregious that he is permanently unfit to practise as a doctor. This view is, to an extent, is supported by the SMC. In response to a question by the DT, the SMC stated that had the DT been empowered to suspend the Respondent for 9 years (instead of just 3 years), it would not have asked for the Respondent to be struck off the register. This meant the Respondent's misconduct in the inappropriate prescription of cough mixture containing codeine was not in itself so serious at to warrant an immediate consideration of a striking off, even taking into account his antecedent and other aggravating factors.

54. The DT is of the view that a striking off is not warranted in light of the factors that need to be present to justify such a sanction. In addition, the DT does not agree with the SMC that just because the DT cannot impose any heavier suspension sanction than 3 years, a striking off is the only other option. That would violate the totality principle, where a striking off would be a crushing sentence on the Respondent in relation to the level of misconduct as found by the DT.

Step 3 - Indicative Sentencing Range and Appropriate Starting Point (2)

55. Returning to the indicative sentencing range, the DT assesses that the range for the sentence, with a finding of Slight Harm and Medium Culpability (in the low to mid-range), to be between 3 months to 1-year suspension for each charge. The DT assesses the starting point should be 5 to 7 months' suspension for each charge.

56. The DT is of the view that the more serious charges relate to Patients 5, 6 and 8. With these patients, the Respondent had not only breached the quantity guideline of not more

than 240ml per visit the most number of times, but also the frequency guideline of not prescribing cough mixture containing codeine within 4 days of the last prescription. Therefore, for Patients 5, 6 and 8, the upper range starting point sentence of 7 months should apply, and these sentences should run consecutively. For the remaining 7 charges, a 5 months' suspension would be imposed for each, with these charges all running concurrently. The total aggregate sentence therefore is a 21 months' suspension, before factoring in offender specific factors.

Step 4 - Adjustments for Offender Specific Factors

57. In May 2013, the Respondent had been found guilty, after a hearing by a Disciplinary Committee, on 17 charges of failing to exercise due care in the management of 17 patients, and 17 charges of failing to properly document sufficient clinical details in the medical records of the 17 patients. The 17 charges of failing to exercise due care included the inappropriate prescriptions of hypnotics and cough mixture containing codeine. The Respondent was sentenced to a suspension of 6 months, a fine of $10,000, a censure, a written undertaking to the SMC not to engage in similar conduct and the usual cost orders.

58. In the case of *Dr AWW Disciplinary Inquiry Grounds of Decision dated 10 September 2009*, the doctor faced 18 charges of failing to exercise due care in the management of his patients (the "**2009 matter**"). The failure included the inappropriate prescription of hypnotics and cough mixture containing codeine, insufficient documentation in the medical records of the patients, and the non-referral of the patients to specialists. Dr AWW had also been previously convicted and sentenced to a 6 months' suspension in another Disciplinary Committee Inquiry, related to a 2008 matter (the "**2008 matter**"). This conviction took place not long after he was notified of the 2009 matter, i.e. the disciplinary process for the 2008 matter was well underway when he committed the misconduct related to the 2009 matter. The Disciplinary Committee in the 2009 matter (the "**DC**") decided that although the conviction in the 2008 matter could not be regarded as an antecedent, it nevertheless was of the view the doctor should have been more vigilant in his conduct. The DC appeared in effect to give consideration to the 2008 matter, and imposed a heavier sentence of a 30 months' suspension and a $10,000 fine on the doctor.

59. The Respondent has shown a brazen disregard in breaching the guidelines of the MOH Letter for the second time, and in breaching the Undertaking he had given the SMC in 2013. The DT notes that although the Respondent had stated he would follow the guidelines for, amongst other things, codeine containing cough mixtures and not repeat the offence in the future, he in fact started dispensing that type of cough mixture in quantities over the MOH Letter guideline as early as June 2014, just a year after he gave the Undertaking.

60. For the whole disciplinary process and nearly the entire DT inquiry, the Respondent failed to communicate or respond to any emails, letters or phone calls by the SMC secretariat or SMC's Counsel (save for a brief telephone conversation the SMC secretariat on 22 April 2019). The Respondent has not at all participated in these proceedings to date. His conduct leads this DT to infer that the Respondent is deliberately refusing to participate in the proceedings, and that he is not remorseful nor contrite. The DT agrees with the SMC that all this ought to weigh as a seriously aggravating factor.

61. Medical practitioners are held to a higher standard than the ordinary citizen by virtue of the 2002 ECEG they subscribe too. Under the ECEG, a doctor in Singapore needs to, amongst other things:

    (a) Be dedicated to providing competent, compassionate and appropriate medical care to patients;

    (b) Be an advocate for patients' care and well-being and endeavour to ensure that patients suffer no harm;

    (c) Maintain the highest standards of moral integrity and intellectual honesty.

62. In this case, the Respondent has certainly has been wanting in his moral integrity and intellectual honesty. The DT agrees with the SMC that the effect of the antecedent of the Respondent, the aggravating factors of his brazen breach of his Undertaking, and his deliberate non-participation in these proceedings cannot be taken lightly.

63. In *Singapore Medical Council v Mohd Syamsul Alam bin Ismail SGHC [2019] 58*, the doctor had refused to participate in the proceedings, save for a few emails. The Court found that his blatant lack of remorse was seriously aggravating, and had been minded to increase the suspension by a further 6 months.

64. The DT agrees with the SMC that there was no inordinate delay in this case that would warrant a discount on the sentence. Any delay that may have prolonged these proceedings were due to either the lack of non-cooperation on the part of the Respondent, or the refusal of the Respondent to participate in the proceedings.

DT's DECISION

65. The Court in *Wong Meng Hang* made clear that the interest of the public is paramount. The need to protect society at large is a key sentencing consideration, as is the specific and general deterrent effect of the sentence.

66. Weighing the aggravating factors present in this case, the DT is inclined to firstly add a further 6 months to the initial starting point of 21 months' suspension for the

Respondent's refusal to participate in these proceedings. Secondly, to take into account the antecedent, the DT would increase the 27 months' suspension up to the maximum allowed under the MRA, i.e. 3 years, to account for the antecedent of the Respondent, and would further impose a significant fine on the Respondent.

67. The DT is of the view that the suspension and fine combination is a more appropriate upward calibration to the sanction. This would be instead of an outright striking off, which the DT had already stated would be not at all be appropriate, and would result in too crushing a sentence given the overall circumstances of this case.

68. The DT is also of the view that the suspension and fine combination would specifically and sufficiently deter the Respondent from such future conduct. In addition, it is to let doctors, in particular, primary care family physicians, know that whatever their treatment plan for their patient, they must follow the guidelines set out in the MOH Letter.

69. The DT sentences the Respondent as follows for the 10 Inappropriate Prescription charges:

(a) That he be suspended for a period of **three (3) years**;

(b) That he be fined **$25,000**;

(c) That he be censured;

(d) That he gives a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and

(e) That he pays the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

PUBLICATION OF DECISION

70. We order that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of persons involved.

71. The hearing is hereby concluded.

Prof Ho Lai Yun Dr Siaw Tung Yeng Mr Ng Choong Yeong Kevin
Chairman

Mr Burton Chen, Ms Junie Low and Mr Jeremy Marc Seah (M/s Tan Rajah and Cheah)
for Singapore Medical Council.