IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2023] SMCDT 7

Between

Singapore Medical Council

And

Dr Ling Chia Tien

… *Respondent*

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Professional misconduct under section 53(1)(*d*) Medical Registration Act (Cap. 174, 2014 Rev Ed)

Medical Profession and Practice – Professional Conduct – Suspension

CONTENTS

Singapore Medical Council
v
Dr Ling Chia Tien

[2023] SMCDT 7

Disciplinary Tribunal – DT Inquiry No. 7 of 2023
A/Prof Siow Jin Keat (Chairman), Dr Siaw Tung Yeng, Ms Janice Wong (Judicial Service Officer)
7 to 10 February 2022, 29 to 30 August 2022, 7 to 8 September 2022, 14 and 16 November 2022, 18 April 2023, 6 December 2023 and 13 December 2023

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

14 December 2023

GROUNDS OF DECISION

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

INTRODUCTION

1. The Respondent, Dr Ling Chia Tien, is a registered medical practitioner. At all material times, he was practising as a general practitioner ("**GP**") at a clinic known as "Apex Medical Centre (Jurong) Pte Ltd" ("**the Clinic**").

2. The Singapore Medical Council ("**SMC**") brought 32 charges of professional misconduct against the Respondent under section 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("**MRA**") in respect of his management of 15 patients. There were:

(a) 15 charges pertaining to the Respondent's alleged failure to maintain adequate documentation ("**Documentation Charges**");

(b) Seven (7) charges pertaining to the Respondent's alleged inappropriate prescription of benzodiazepines ("**Benzodiazepine Prescription Charges**");

(c) Five (5) charges pertaining to the Respondent's failure to refer patients who had been prescribed benzodiazepines to a specialist ("**Benzodiazepine Referral Charges**"); and

(d) Five (5) charges pertaining to the Respondent's alleged inappropriate prescription of codeine-containing medications ("**Codeine Prescription Charges**").

3. The Respondent pleaded guilty to five (5) charges and claimed trial to 27 charges.

4. At the end of the inquiry, we convicted the Respondent on 29 charges and ordered, among other things, that he be suspended for a term of 19 months.

5. The grounds of our decision are set out below.

PROCEDURAL HISTORY

6. The Ministry of Health ("**MOH**") conducted an audit on the Clinic on 1 November 2016. During the audit, MOH obtained copies of certain Patients' Medical Records ("**PMRs**"). Two complaints were subsequently made by MOH to SMC against the Respondent. In the course of investigations, the Complaints Committee ("**CC**") requested the Respondent to provide them with typewritten transcripts of his PMRs. The transcripts were provided on 22 November 2017.

7. On 12 March 2018, the Respondent was served with a Notice of Complaint ("**NOC**") from the SMC in relation to his prescribing practices with respect to

benzodiazepines/hypnotics and his medical documentation for 16 patients. On 23 April 2018, the Respondent submitted his letter of explanation in response to the NOC.

8. On 12 December 2019, the Respondent was served with another NOC from the SMC in relation to his prescribing practices with respect to codeine-containing medications for five out of the 16 patients. On 3 February 2020, the Respondent submitted his letter of explanation in response to this NOC.

9. The Respondent was subsequently served with two Notices of Inquiry ("**NOI (1)**" and "**NOI (2)**") on 13 April 2021 containing a total of 32 charges. NOI (1) contained 27 charges, comprising the Documentation Charges, Benzodiazepine Prescription Charges and Benzodiazepine Referral Charges. NOI (2) contained five charges, which were the Codeine Prescription Charges. Following certain clarifications sought by the Respondent on the charges, the SMC made various amendments to NOI (1) and NOI (2) with the leave of the Disciplinary Tribunal ("**DT**") on 14 September 2021.

10. At the start of the DT inquiry on 7 February 2022, the Respondent pleaded guilty to 11 of the Documentation Charges. During the inquiry, the Respondent gave evidence that he had approved the sale of codeine-containing medicines by his clinic assistants to several patients on various occasions, and that some entries in the PMRs were made by the other doctors working in the Clinic, Dr F1 and Dr F2, as well as his clinic assistants. However, the typewritten transcripts that the Respondent had earlier provided to the CC did not distinguish between the entries he made and those made by the other doctors.

11. On 10 February 2022, we directed the Respondent to provide the SMC with amended and supplementary transcripts of the PMRs identifying the doctor or clinic assistant who wrote each entry, as well as indicating whether the patient was personally seen by a doctor on each occasion and, if so, who. The hearing was adjourned for the transcripts to be provided to SMC.

12. The SMC subsequently made various amendments to NOI (1) and NOI (2) based on the amended and supplementary transcripts. At the second tranche of the hearing on 29

August 2022, we granted leave to SMC to amend the NOIs. The Respondent retook his plea of guilt and pleaded guilty to five charges in relation to inadequate medical documentation. He claimed trial to the remaining 27 charges.

13. On 7 September 2022, the SMC applied to make further amendments to seven Schedules to the NOIs as there were missing entries from those Schedules. We allowed the amendments, and indicated that the Respondent should be given the opportunity to consider the amendments, including the opportunity to address the amendments by way of an additional witness statement. The Respondent subsequently submitted a further witness statement.

14. At the third tranche of the hearing on 14 November 2022 and 16 November 2022, the SMC sought leave to make further amendments to four of the Schedules to the NOIs. We allowed the amendments. The Respondent indicated that he was agreeable to the further amendments and did not seek leave to submit any further statements.

15. On 18 April 2023, which was the day scheduled for the DT to give its decision on whether the Respondent was guilty of the charges, we granted leave to the SMC to amend the particulars of three of the Benzodiazepine Prescription Charges. The particulars relate to the number of occasions the Respondent allegedly concomitantly prescribed benzodiazepines together with other drugs, and the amendments sought to reduce the number of such occasions set out in the charges. The Respondent did not object, save for the issue of costs. We allowed the amendments, as the amendments did not prejudice the Respondent's defence. We found the Respondent guilty of 29 charges of professional misconduct.

THE CHARGES

16. The Respondent faced 32 charges involving 15 patients. The charges can be classified into the following categories:

S/N	Category	Contested Charges	Charges that Respondent pleaded guilty to
(a)	Documentation Charges	5th Charge of NOI (1) (PAT 4)	2nd Charge of NOI (1) (PAT 3)
		16th Charge of NOI (1) (PAT 15)	8th Charge of NOI (1) (PAT 10)
		20th Charge of NOI (1) (PAT 1)	11th Charge of NOI (1) (PAT 13)
		21st Charge of NOI (1) (PAT 2)	13th Charge of NOI (1) (PAT 14)
		22nd Charge of NOI (1) (PAT 8)	18th Charge of NOI (1) (PAT 16)
		23rd Charge of NOI (1) (PAT 5)	
		24th Charge of NOI (1) (PAT 6)	
		25th Charge of NOI (1) (PAT 7)	
		26th Charge of NOI (1) (PAT 9)	
		27th Charge of NOI (1) (PAT 11)	
(b)	Benzodiazepine Prescription Charges	1st Charge of NOI (1) (PAT 3)	-
		4th Charge of NOI (1) (PAT 4)	
		7th Charge of NOI (1) (PAT 10)	
		10th Charge of NOI (1) (PAT 13)	
		12th Charge of NOI (1) (PAT 14)	
		15th Charge of NOI (1) (PAT 15)	
		17th Charge of NOI (1) (PAT 16)	
(c)	Benzodiazepine Referral Charges	3rd Charge of NOI (1) (PAT 3)	-
		6th Charge of NOI (1) (PAT 4)	
		9th Charge of NOI (1) (PAT 10)	
		14th Charge of NOI (1) (PAT 14)	
		19th Charge of NOI (1) (PAT 16)	
(d)	Codeine Prescription Charges	1st Charge of NOI (2) (PAT 5)	-
		2nd Charge of NOI (2) (PAT 6)	
		3rd Charge of NOI (2) (PAT 7)	
		4th Charge of NOI (2) (PAT 9)	

		5th Charge of NOI (2) (PAT 11)	

17. In respect of the Benzodiazepine Prescription Charges, Benzodiazepine Referral Charges and Codeine Prescription Charges, each charge comprises a main charge and an alternative charge, based on the two limbs of the test for professional misconduct as set out in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("***Low Cze Hong***"). Each main charge asserted that based on the facts set out in the charge, the Respondent was guilty of an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency. Each alternative charge asserted that based on the same facts as the main charge, the Respondent's conduct demonstrated such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

18. In respect of the Documentation Charges, the Respondent was charged with professional misconduct under the first limb of *Low Cze Hong*, *i.e.*, that based on the facts set out in the charge, the Respondent was guilty of an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

THE RELEVANT LEGAL PRINCIPLES

19. The test for professional misconduct requires the court or tribunal to engage in the following three-stage inquiry: *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 at [28].

    (a) The first stage is to establish the relevant benchmark standard that is applicable to the doctor.

    (b) The second stage is to establish whether there has been a departure from the applicable standard.

(c) The third stage is to determine whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limb of *Low Cze Hong* set out in the case against the doctor. In cases prosecuted under the first limb, the question is whether the departure was an intentional and deliberate departure from the applicable standard; while in cases prosecuted under the second limb, the question is whether the negligent departure from the applicable standard was so serious that objectively, it portrays an abuse of the privileges of being registered as a medical practitioner.

20. The SMC bears the burden of proving beyond a reasonable doubt that the elements of professional misconduct have been satisfied.

RESPONDENT'S PLEA OF GUILT

21. As indicated above, the Respondent pleaded guilty to five Documentation Charges.

22. The Respondent admitted that, in respect of the 2nd, 8th, 13th and 18th Charges of NOI (1), he had:[1]

(a) On the occasions when he saw the patient personally, failed to document adequately and/or at all, his patient's clinical history, diagnosis and findings for his patient's condition(s);

(b) On the occasions when he saw the patient personally or prescribed the medicines by approving the sale of the medicines by the clinic assistants, failed to document adequately and/or at all, the medical grounds for the prescription of medicines to his patient;

(c) On the occasions when he saw the patient personally or prescribed the medicines by approving the sale of the medicines by the clinic assistants, failed to document adequately and/or at all, the indication(s) and justification(s) for

[1] Agreed Statement of Facts (Amended) dated 15 July 2022 at [22].

the prescription or continuing the prescription of benzodiazepines at each clinical review;

(d) On the occasions when he saw the patient personally, failed to document if the patient suffered adverse effects from his prolonged and repeated benzodiazepine prescription;

(e) On the occasions when he saw the patient personally, failed to document any offer to refer his patient for a referral to a psychiatrist or other appropriate specialist for the management of his patient's condition;

and that he was thereby guilty of professional misconduct under section 53(1)(*d*) of the MRA in that his conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

23. In respect of the 11th Charge of NOI (1), the Respondent admitted that he had:[2]

(a) On the occasions when he saw the patient personally, failed to document adequately and/or at all, his patient's clinical history, diagnosis and findings for his patient's condition(s);

(b) On the occasions when he saw the patient personally or prescribed the medicines by approving the sale of the medicines by the clinic assistants, failed to document adequately and/or at all, the medical grounds for the prescription of medicines to his patient;

(c) On the occasions when he saw the patient personally or prescribed the medicines by approving the sale of the medicines by the clinic assistants, failed to document adequately and/or at all, the indication(s) and justification(s) for the prescription or continuing the prescription of benzodiazepines at each clinical review; and

[2] Agreed Statement of Facts (Amended) dated 15 July 2022 at [23].

(d) On the occasions when he saw the patient personally, failed to document if the patient suffered adverse effects from his prolonged and repeated benzodiazepine prescription;

and that he was thereby guilty of professional misconduct under section 53(1)(*d*) of the MRA in that his conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

THE CONTESTED CHARGES

24. To assist the DT in making the findings on the contested charges, the SMC called an expert witness, Dr PE. Dr PE is a GP working at Institution A. The Respondent gave evidence but did not call any other witnesses for the inquiry.

25. Before we address the contested charges, we deal with a preliminary point raised by the Respondent.

Preliminary point – SMC did not put its case to the Respondent

26. The Respondent submitted that the SMC did not put various matters to the Respondent during cross-examination. Applying the rule in *Browne v Dunn*, the Respondent submitted that the SMC ought to be taken to have accepted the truth of the Respondent's position in respect of those matters. While the Respondent acknowledged that tribunals are not bound to follow rules of evidence in disciplinary proceedings, the Respondent submitted that it appeared from the SMC's put questions to the Respondent that the SMC accepted that the rule in *Browne v Dunn* ought to be applicable, and that the rule ought to apply to this inquiry as a matter of procedural fairness.

27. With respect, we do not agree with the Respondent. Section 51(4) of the MRA provides that a DT is not bound to act in a formal manner and is not bound by the provisions of the Evidence Act 1893 or by any law relating to evidence but may inform itself on any

matter in such manner as it thinks fit. There is therefore no necessity for the SMC to put questions to the Respondent in order for the Respondent's evidence to be challenged. As the SMC pointed out, procedural fairness has been accorded to the Respondent as the relevant issues have been raised in cross-examination and the Respondent has had the opportunity to respond to the allegations.

28. We now turn to the contested charges.

Documentation Charges

29. The Documentation Charges against the Respondent alleged that he had failed to maintain medical records of sufficient detail. The Respondent faced 15 charges of this nature, ten (10) of which were contested. The Documentation Charges to which the Respondent claimed trial can be grouped into three categories: (a) inadequate documentation in respect of patients prescribed with benzodiazepines (referred to as the "**Benzodiazepine Documentation Charges**"); (b) inadequate documentation in respect of patients prescribed with codeine-containing medications (referred to as the "**Codeine Documentation Charges**"); and (c) inadequate documentation in respect of patients who were not prescribed with either benzodiazepines or codeine-containing medications (referred to as the "**General Documentation Charges**").

30. We deal first with the General Documentation Charges.

General Documentation Charges

The relevant benchmark standard

31. In relation to the standard of care, it was not disputed by the parties that guidelines 4.1.2 and 4.1.3 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines ("**2002 ECEG**") were applicable in relation to medical documentation. Guideline 4.1.2 provides that:

> 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.

32. Guideline 4.1.3 provides that a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patients' needs.

33. The SMC's expert witness, Dr PE, also opined on the components that have to be documented. Dr PE gave evidence that it was a basic standard for the following four key components to be documented:[3]

(a) The patient's chief complaint;

(b) The key points of a patient's medical history;

(c) The important details of physical examination conducted, including both positive and negative findings; and

(d) The plan, including investigations and therapeutics.

Dr PE testified that this was taught in medical school as well as to post-graduate students, and that these four components were similar to the "SOAP" format of documentation (*i.e.*, to record the subjective, objective, assessment and plan), which had become popular in recent years.

34. The Respondent's position was that Dr PE did not produce any documentation to demonstrate that such standards were taught in medical school, and even if such standards were taught, those were merely best practices which doctors should aspire towards. The Respondent's position was that it was unrealistic to apply such standards to GPs who practise in busy and fast-paced clinical settings.

35. The Respondent submitted instead that the applicable overall standard was that medical documentation should "fulfill the general criteria of being sufficient such that another

[3] Transcript of DT inquiry on 7 February 2022, pages 48 to 49.

doctor could take over the management of the patient": *Singapore Medical Council v Dr Tang Yen Ho Andrew* [2019] SMCDT 8 ("***Andrew Tang***") at [30(a)]. The Respondent also submitted that GPs were held to a lower standard of care in relation to medical documentation, as there was less of a need for another doctor to take over the patients of a family physician in private practice, as compared to tertiary care or multi-doctor practices.

36. While the SMC did not agree that GPs were held to a lower standard of care in relation to medical documentation, both parties agreed that in relation to documentation of medical records, one must be able to discern (a) the summary of medical records of each patient; (b) the patient profile; and (c) the treatment plan based on the medical records of each patient: *Andrew Tang* at [30(a)].

37. In our view, the parties' submissions as to the applicable standard were largely aligned. It was not disputed by the parties that guidelines 4.1.2 and 4.1.3 of the 2002 ECEG set out the applicable standard. It was not disputed that the case of *Andrew Tang* makes clear what has to be documented, particularly in the case of a GP. Further, in our view, the components of what should be documented, as set out by Dr PE, were not substantively different from the requirements set out in *Andrew Tang*. Both Dr PE and the DT in *Andrew Tang* indicated that there was a need to document a summary of the medical records, or the key points of a patient's medical history. Both indicated that there was a need to record the patient profile, which would include the patient's chief complaint and the important details of the physical examination conducted. Both indicated that there was a need to document the treatment plan.

38. While the Respondent submitted that GPs were held to a lower standard of documentation as compared to other doctors, we note that this was not actually stated in *Andrew Tang*, and it was not necessary for us to decide the point. Instead, the DT in *Andrew Tang* found that the medical documentation fulfilled the general criteria of being sufficient such that another doctor could take over the management of the patient, which we note was also a requirement set out in paragraph 4.1.2 of the 2002 ECEG. In our view, what was important was that in addition to fulfilling the requirements set out

at [37] above, the medical documentation should be such that another doctor would be able to take over the management of the patient.

39. A further issue raised by the parties was whether the standard of care was different in relation to the Respondent's prescription of medicines by approving the sale of medicines by his clinic assistants.

40. The SMC submitted that the requirements of documentation applied regardless of whether a doctor prescribed the medication after seeing the patient personally or if he simply approved it without seeing the patient. The SMC submitted that that duty was encapsulated in paragraph 4.1.1.4 of the 2002 ECEG, which provides that the doctor retains responsibility for the overall management of the patient when he delegates care. Dr PE's evidence was that prescription was the process of a doctor ordering his patient to take a medication or ordering his clinic assistants to dispense a medication to his patient, and the duty to document applied even when the doctor was approving the sale of medication over the counter.

41. The Respondent however submitted that the applicable standard of care would be lower for prescriptions by way of approving the sale of medicines over the counter. This was because in such a situation, the GP would not be in a position to note down details such as the chief complaint, important history, findings of physical examinations and plan for the patient. Instead, the GP would only be able to note down the medication requested by the patient and the medical grounds for allowing the sale. The medical grounds for each prescription could be discerned from the documentation made during earlier personal consultations.

42. While the duty to document would apply even when a doctor approves the sale of medication over the counter, for the reasons set out by the Respondent, we do not think that the standard of care in relation to prescriptions by way of approving the sale can be the same as the standard of care that applies when a doctor personally sees a patient. Because the doctor does not examine a patient when he approves the sale of medication over the counter, he would not be able to document details such as the chief complaint and details of physical examination conducted, which are only matters that he can

document after seeing the patient. We also do not think that it would be necessary in such circumstances to document the patient's medical history. Instead, it would suffice if the doctor documents the medication requested by the patient and the medical grounds for allowing the sale.

Whether there has been a departure from the applicable standard and whether the departure was sufficiently egregious to amount to professional misconduct

43. We next turn to examine whether there has been a departure from the applicable standard in relation to each of the General Documentation Charges, and whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limb of *Low Cze Hong.*

(1) 20th Charge of NOI (1) (PAT 1)

44. This charge spanned the period 23 August 2015 to 16 June 2016.

45. The SMC submitted that the Respondent breached the standards of documentation set out in the 2002 ECEG.[4] The SMC submitted that the Respondent had only recorded a brief notation of the patient's complaint and the medicines he prescribed. The SMC's main submissions are summarised below:

(a) In the entry dated 23 August 2015, the Respondent did not document the cause of the patient's arm pain, the severity of the pain, or what type of pain the patient was experiencing, and this was admitted by the Respondent. There was also no documentation of the medical grounds for the Respondent's clinical decision to prescribe Vimovo to the patient.

(b) For the entry on 28 February 2016, the Respondent only recorded bare notations. These were "sl painful (L) cx LN, reassured, KIV antibiotic if it gets worse".[5] The Respondent did not document any measurements or his

[4] See Joint Schedule of Positions on Charges at pages 21-23.
[5] Respondent's Bundle of Documents (Volume II) at page 6.

assessment of the size of the patient's lymph node, as well as his diagnosis, working diagnosis, or even a suspicion of the cause for the patient's condition.

(c) For the entry on 14 June 2016, the Respondent admitted that his handwriting was "scribbly".[6] The Respondent had explained that the two illegible notations in a circle meant that he had conducted a temperature check and "heart / lung" examination. However, such documentation was insufficient and could not be deciphered by another doctor without the Respondent's explanation.

(d) For the entry on 16 June 2016, the Respondent admitted that apart from a documentation of "VMR fever", there was nothing else notated on the patient's condition. The Respondent admitted that "there has been no diagnosis or the SOAP, which is the complaint, the subjective elements, the objective elements, … and no plan".[7] Further, the Respondent had not documented the chronicity of the patient's vasomotor rhinitis, which was relevant to determine the nature of the treatment that the patient required. The Respondent also did not document his findings or clinical thinking that led him to his diagnosis and conclusion of vasomotor rhinitis, such as how long the patient had been suffering from running nose.

46. In addition, the SMC submitted that the Respondent had tried to "pass off" other doctor's notes as his own. For example, the Respondent relied on Dr F2's 23 April 2015 entry to support his case that he had documented his diagnoses of the patient's conditions. Similarly, he had referred to the documentation of physical examinations by other doctors at his clinic to defend himself.

47. The Respondent submitted[8] that he had properly documented the clinical presentation, findings and diagnoses, and that the patient's profile and management plan could be gleaned from the PMR. For the visit on 28 February 2016, the Respondent noted that the patient had a painful cervical lymph node, which was not a cause of concern. There was therefore no need to document the size of the lymph node and any investigations

[6] Transcript of DT inquiry on 8 February 2022, page 171.
[7] Transcript of DT inquiry on 7 September 2022, page 72.
[8] See Joint Schedule of Positions on Charges at pages 21-22.

performed. For the visits on 14 and 16 June 2016, it was clear from the documentation that the patient had returned twice to see the Respondent as her symptoms persisted. Dr Ling's initial documented diagnosis was upper respiratory tract infection and the diagnosis was changed to chronic vasomotor rhinitis.

48. We agree with the SMC's submissions. Having reviewed the PMR, we note that the Respondent's entries consist largely of the complaint made by the patient and the medicines prescribed. The entries were lacking in detail. In respect of the 23 August 2015 entry, there were no details of the severity of the arm pain suffered by the patient or the type of pain that the patient was experiencing. In respect of the entry on 28 February 2016, the Respondent did not document any measurements or his assessment of the size of the lymph node, and did not indicate his diagnosis. In respect of the entry on 16 June 2016, there was no documentation of the Respondent's findings that led to his diagnosis of vasomotor rhinitis.

49. In addition, the medical records kept by the Respondent were extremely difficult to decipher. It would be difficult for another doctor looking at the PMR to understand what the Respondent had written and take over the management of the patient.

50. In our view, from the documentation, one could not sufficiently discern a summary of the patient's medical records, patient profile, or treatment plan. The Respondent had fallen short of the applicable standard. In our view, the Respondent was guilty of an intentional, deliberate departure from standards observed by members of the profession and his conduct was sufficiently egregious to amount to professional misconduct.

(2) 21st Charge of NOI (1) (PAT 2)

51. This charge spanned the period 11 March 2003 to 27 February 2016.

52. The SMC's submissions are summarised below:[9]

[9] See Joint Schedule of Positions on Charges at pages 23-24.

(a) As noted by Dr PE, no complete SOAP had been carried out for any of the visits, and there were also blind spots in the Respondent's case notes such that Dr PE was unable to decipher what the Respondent's diagnosis and medical grounds for his treatment were. For example, the Respondent stated that his diagnosis for the patient was allergic rhinitis, but this was not documented in the Respondent's PMRs. The Respondent also did not document the patient's clinical history, his assessment and findings.

(b) Further, the Respondent did not document any separate diagnoses which may share similar symptoms and conditions to what the patient was suffering but which may require different treatment. For example, as agreed by the Respondent, while the Respondent had documented the condition of "urticaria" on the patient's PMR, this did not necessarily point to a diagnosis of allergic rhinitis.

(c) While the Respondent asserted that he had made the diagnosis of allergic rhinitis since the patient was young and he had been treating the patient with medication for more than 20 years, there was no documentation of such a diagnosis. This clearly breached the documentation standards set out in the 2002 ECEG, as those standards applied regardless of the duration of the patient-doctor's relationship.

(d) The Respondent also attempted to rely on Dr F2's notes as his own.

53. The Respondent submitted that he had properly documented the patient's complaints and his prescriptions:[10]

(a) The Respondent submitted that the patient had a long history of cough due to allergic rhinitis, and she returned regularly to see the Respondent for her recurrent chronic cough. As the patient's symptoms and the treatment plans remained largely the same, the Respondent did not take detailed notes on the patient's repeat visits.

[10] See Joint Schedule of Positions on Charges at page 23.

(b) While the Respondent did not document the diagnosis of allergic rhinitis, the diagnosis would have been apparent based on the medicines prescribed (e.g. Dexamethasone and Esonide nasal spray) and the patient's history. The patient suffered from other conditions which were also likely to arise from atopy genes (eczema and urticaria).

54. We note that most of the entries in the PMR consist of the complaint by the patient and the medication given by the Respondent. For some of the entries, there was documentation of a physical examination conducted by the Respondent. There was however no documentation of the patient's medical history, and no documentation of the Respondent's diagnosis.

55. While the Respondent's position was that he did not take detailed notes on the patient's repeat visits, we note that even for the earlier visits, detailed notes were not taken, and there was no diagnosis of the patient's condition in the earlier visits.

56. The Respondent indicated in his witness statement[11] that his diagnosis for the patient was allergic rhinitis. The Respondent's evidence was that while he did not document this diagnosis of allergic rhinitis, such a diagnosis would have been apparent based on the medicines prescribed and the patient's history. In our view, that was not sufficient. What was documented in the PMRs was eczema and urticaria, which would not necessarily point to a diagnosis of allergic rhinitis. Another doctor reviewing the PMRs would not be able to discern the diagnosis of allergic rhinitis from the documentation and take over the management of the patient.

57. From the Respondent's documentation, we do not think that one would be able to glean the patient's profile and treatment plan. In our view, the Respondent had fallen short of the required standard. The Respondent was guilty of an intentional, deliberate departure from standards observed by members of the profession and his conduct was sufficiently egregious to amount to professional misconduct.

[11] Respondent's Statement of Evidence-in-Chief dated 10 December 2021 at [92].

(3) 22nd Charge of NOI (1) (PAT 8)

58. This charge spanned the period 10 March 2016 to 31 March 2016.

59. The SMC submitted that:[12]

(a) For this patient, the Respondent had only documented the date, name and quantity of medications, and had failed to document the condition that the patient came to the clinic for, the symptoms that the patient was showing, and the basis and justification for the prescriptions.

(b) The Respondent admitted that he did not apply his mind to whether the patient might require the particular medications that he asked for a repeat prescription of. Instead, the Respondent prescribed the medications based on "purely what the patient asked for".[13]

(c) Specifically, for his prescription of codeine-containing Codipront, the Respondent failed to, *inter alia*, include indication(s) and/or justification for prescribing or continuing codeine-containing cough medications.

(d) The Respondent had also failed to document the medical grounds for prescription where he had approved the sale of medications to the patient without seeing the patient personally.

60. The Respondent submitted that:[14]

(a) He did not personally see the patient at all and he had approved the sale of various medicines to the patient on four occasions (which had been earlier prescribed by Dr F2 during a personal consultation).

[12] See Joint Schedule of Positions on Charges at pages 24-25.
[13] Transcript of DT inquiry on 7 September 2022, page 125.
[14] See Joint Schedule of Positions on Charges at page 24.

(b) He documented the medications which the patient requested on each occasion. The medical grounds were documented by Dr F2 when she prescribed the medicines to the patient, and there was no need for the Respondent to rewrite such details.

61. We note that this charge pertains to the Respondent's failure to maintain medical records when he approved the sale of medicines to the patient without personally reviewing the patient on four occasions between 10 March 2016 to 31 October 2016.

62. We are of the view that the Respondent had failed to maintain adequate documentation. The Respondent had only indicated the date on which the medicines were prescribed to the patient and the medicines prescribed. There was no documentation as to the medical grounds for prescribing the medicines.

63. The Respondent's position was that the medical grounds were documented by Dr F2 when she personally saw the patient earlier and prescribed the medicines, and there was no need for the Respondent to rewrite the details. His position was that it was understood that the patient continued to suffer from the same symptoms which he complained of during his earlier consultation with Dr F2, and it was common for patients with chronic rhinitis (which the Respondent understood that the patient had) to have recurrent symptoms of cough, phlegm and sore throat.

64. We do not agree with the Respondent. Dr F2 saw the patient in February 2016, whereas the Respondent prescribed medicines to the patient on four occasions over a 7.5-month period thereafter, from 10 March 2016 to 31 October 2016. It was incumbent on the Respondent to indicate the medical grounds for prescribing the medicines, particularly when the Respondent's prescription was over an extended period of 7.5 months after the initial consultation. We do not agree that the Respondent's entries, read in conjunction with Dr F2's entries and the patients' medical history, reflect the patient's condition and the management plan for the patient.

65. In our view, the Respondent had fallen short of the required standards. The Respondent was guilty of an intentional, deliberate departure from standards observed by members

of the profession and his conduct was sufficiently egregious to amount to professional misconduct.

Benzodiazepine Documentation Charges

The relevant benchmark standard

66. It was not disputed that the applicable standards for documentation in relation to the General Documentation Charges apply to the Benzodiazepine Documentation Charges. In addition, it was not disputed that the MOH Administrative Guidelines on the Prescription of Benzodiazepines and other Hypnotics (dated 14 October 2008) ("**2008 Administrative Guidelines**") formed part of the applicable standards.

67. In this regard, paragraphs (c) and (d) of the 2008 Administrative Guidelines are relevant. These are set out below:

> (c) The following information *must* be documented in the medical record of *every* patient who is prescribed with benzodiazepines/ other hypnotics:
> (i) Comprehensive history, including psychosocial history and previous use of benzodiazepines or other hypnotics;
> (ii) Comprehensive physical examination findings, including evidence of misuse of benzodiazepines or other drugs; and
> (iii) Withdrawal symptoms to benzodiazepines/ other hypnotics previously experienced by the patient, if any.
>
> (d) The following information *must* be documented in the medical records of every patient *each time* he/she is prescribed benzodiazepines / other hypnotics either initially or as repeat prescriptions:
> (i) The prescribed type/name of benzodiazepine/hypnotic, its dosage and duration of use;
> (ii) Indication(s) and/or justification(s) for prescribing benzodiazepines/ other hypnotics; and
> (iii) Physical signs or evidence of tolerance, physical/psychological dependence or any illicit use or misuse of benzodiazepines or other drugs (eg. needle tracks on skin, inappropriate lethargy).
>
> [emphasis in original in italics]

Whether there has been a departure from the applicable standard and whether the departure was sufficiently egregious to amount to professional misconduct

68. We turn to examine each specific charge.

(1) 5th Charge of NOI (1) (PAT 4)

69. This charge spanned the period 12 September 2002 to 31 October 2016.

70. SMC submitted that there was a lack of documentation of the symptoms, investigations, medical grounds and referrals to a specialist. The patient was an elderly patient, and Dr PE's evidence was that an elderly patient's frailty should be addressed, documented and assessed. SMC also pointed out that the Respondent had admitted that on hindsight, he should have documented the patient's symptom of breathlessness on 13 March 2006, and that he did not document his warning to the patient that benzodiazepines may depress his breathing and cause sleep apnea.[15]

71. On the other hand, the Respondent submitted that he had properly documented the patient's history, diagnoses and indications for benzodiazepine. The Respondent also submitted that even though he had failed to document the patient's breathlessness and his refusal to visit the hospital on 13 March 2016, that did not affect the final treatment for the patient as he was only providing symptomatic relief to the patient. Further, while the Respondent admitted breaching the 2008 Administrative Guidelines by not documenting the indications for prescribing benzodiazepines, this was because the patient was the Respondent's last patient for the day and the Respondent was tired after a long session with the patient. The Respondent submitted that there was no intentional, deliberate breach of the guidelines.

72. We are of the view that there was insufficient documentation by the Respondent. There was no proper documentation of the Respondent's investigations or diagnosis of the patient. In the course of cross-examination, the Respondent testified that his diagnosis for the patient was benign vertigo,[16] but this was not stated in the Respondent's case notes. There was also no documentation of whether the patient suffered any adverse effects from the prescription of benzodiazepines.

73. Further, even though paragraph (d) of the 2008 Administrative Guidelines states that the indications and justifications for prescribing benzodiazepines must be documented

[15] Transcript of DT inquiry on 30 August 2022, page 193.
[16] Transcript of DT inquiry on 30 August 2022, page 175.

each time benzodiazepines are prescribed, that was not done. In relation to the consultations on 12 September 2002 and 14 April 2003, apart from indicating that the Respondent had "vertigo", there was no documentation of the Respondent's indications for prescribing benzodiazepines. In relation to the consultation on 13 March 2016, the Respondent admitted that he did not document the patient's breathlessness and his warning to the patient that benzodiazepines may depress his breathing and cause sleep apnea. It was no answer to say that that did not affect the final treatment for the patient, as the documentation of a patient's symptoms as well as the Respondent's advice to the patient would be important to enable any other doctor to take over the care of the patient.

74. We also note that the Respondent admitted that he did not document the indications for prescribing benzodiazepines on 13 March 2016. While the Respondent said that he was tired that night and there was no intentional, deliberate breach of the guidelines, the Respondent could have documented the indications the following day, or at any other time shortly thereafter. The failure to do so was a clear departure from the applicable standards. Given the clear requirements set out in the 2008 Administrative Guidelines, the Respondent's conduct demonstrated an intentional and deliberate departure from the applicable standards. We are of the view that the Respondent's misconduct was sufficiently egregious to amount to professional misconduct.

(2) 16th Charge of NOI (1) (PAT 15)

75. This charge was spanned the period 4 June 2016 to 26 July 2016. The patient had consulted the Respondent four times during this period.

76. The SMC submitted that the Respondent breached the applicable documentation standards for benzodiazepine prescription, given that the Respondent had consistently and repeatedly failed to document the patient's clinical history, his diagnosis and findings for the patient's condition; the medical grounds for the prescription of medicines to the patient; the indications and justifications for the prescriptions of benzodiazepines; and whether the patient suffered adverse effects from the repeated benzodiazepine prescriptions.

77. On the other hand, the Respondent submitted that he had properly documented his diagnoses and indications for the prescription of benzodiazepines. He had documented that the patient had "low mood" and "poor sleep" on 4 June 2016 and "anxiety disorder" on 8 June 2016. In addition, for the dates on which Ativan was prescribed, the Respondent had indicated that it was for the patient's sleep problem.

78. We are of the view that this charge is not made out. From a review of the PMR, we are satisfied that the patient's complaints were documented in detail. For example, as submitted by the Respondent, he had documented that the patient had "low mood" and "poor sleep" on 4 June 2016. The Respondent also documented the findings of his examination. For example, the Respondent recorded the patient's blood pressure at each of the four visits and the patient's heart rate on 8 June 2016. The diagnosis of anxiety disorder and the indications for the prescription of benzodiazepines were set out in the PMR. The treatment plan was also documented: the type of benzodiazepine, dosage and duration of use was stated in the PMR; the entry in the PMR on 4 June 2016 indicated that there should be a further review in three weeks' time; and the Respondent indicated on 27 June 2016 that there should be a "KIV ENT" referral, which indicated that the Respondent thought of referring the patient to a ear, nose and throat specialist.

79. In our view, the documentation was sufficient to enable another doctor to take over the management of the patient. Another doctor reviewing the PMR would be able to discern, amongst others, the patient's complaints, the examination findings, the indications for the prescription of benzodiazepines, the treatment considerations and treatment plan. In our view, the Respondent had not fallen short of the applicable standard.

Codeine Documentation Charges

80. Each of the five Codeine Documentation Charges against the Respondent alleges that the Respondent:

(a) Failed to document adequately and/or at all his patient's clinical history, diagnosis and findings on the occasions when he saw the patient personally;

(b) Failed to document adequately and/or at all, the medical grounds for the prescription of medicines on the occasions when he saw the patient personally; and

(c) Failed to document adequately and/or at all, the medical grounds for the prescription of medicines on the occasions when he prescribed the medicines by approving the sale of the medicines by the clinic assistants.

81. The Respondent admitted that he breached the charge particulars in relation to documentation on the occasions when he saw the patients personally. However, the Respondent denied that he failed to document the medical grounds of prescription on the occasions when he approved the sale of the medicines by the clinic assistants, *i.e.*, the Respondent denied [80(c)] in relation to each Codeine Documentation Charge.

The relevant benchmark standard

82. The SMC's position was that the applicable standards for documentation in relation to the General Documentation Charges applied to the Codeine Documentation Charges. The requirement of documentation was set out in the 2002 ECEG as well as in teaching. In addition, the SMC submitted that the specific requirements for the documentation of codeine prescription were set out in the MOH National Guidelines for the Safe Prescribing of Opioids 2021 ("**2021 Opioid Guidelines**"), and that the 2021 Opioid Guidelines represented the standards at the material time as the underlying principles taught in medical school had not changed for 20 years prior.

83. The SMC further submitted that the requirements of documentation applied regardless of whether the doctor prescribed the medication after seeing the patient personally or whether he simply approved the medication without seeing the patient.

84. On the other hand, the Respondent's position was that he did not have a duty to document the medical grounds of prescription on the occasions when he approved the sale of the medicines by the clinic assistants, as there were no guidelines at the material time which imposed a duty on doctors to document the indications for the supply of codeine-containing medicines.

85. In our view, the applicable standards for documentation in relation to the General Documentation Charges (see [37] and [38]) would apply to the Codeine Documentation Charges. These standards are of general applicability, and we see no reason why they should not apply when the medicines prescribed contain codeine.

86. We are further of the view that [42] above, in relation to the applicable standard of documentation for prescriptions by way of approving the sale of "general" medications, would similarly apply here. In other words, in relation to prescriptions by way of approving the sale of medicines, the standard of documentation expected of a doctor is lower as compared to a scenario where a patient is reviewed by the doctor. The doctor is nevertheless expected to document the medication requested by the patient and his medical grounds for allowing the sale.

Whether there has been a departure from the applicable standard and whether the departure was sufficiently egregious to amount to professional misconduct

87. As the Respondent admitted that he breached the charge particulars in relation to documentation on the occasions when he reviewed the patients personally, we will not elaborate on this issue, save to say that having reviewed the PMRs, we agree that the Respondent breached the applicable standard.

88. As for the occasions where the Respondent did not review the patients personally, having reviewed the PMRs, we note that generally, only the date, name and quantity of the medicines were recorded. In almost all instances, there was no documentation of the medical grounds for allowing the sale of the medications. For each charge, the number of instances where there was a lack of such documentation was fairly large, as set out below:

(a) 23rd Charge of NOI (1) (PAT 5) – 59 instances;

(b) 24th Charge of NOI (1) (PAT 6) – 26 instances;

(c) 25th Charge of NOI (1) (PAT 7) – 17 instances;

(d) 26th Charge of NOI (1) (PAT 9) – 4 instances; and

(e) 27th Charge of NOI (1) (PAT 11) – 65 instances.

89. In our view, the Respondent had breached the applicable standard for documentation. Given the number of instances where the documentation was lacking, we are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and that the Respondent's misconduct was sufficiently egregious to amount to professional misconduct.

Benzodiazepine Prescription Charges and Benzodiazepine Referral Charges

90. The Benzodiazepine Prescription Charges pertained to the Respondent's alleged inappropriate prescription of benzodiazepines, and the Benzodiazepine Referral Charges pertained to the Respondent's alleged failure to refer patients who had been prescribed benzodiazepines to a specialist.

91. For most of these charges, the time period involved was sometime between 2014 and 2016. For two of the charges, *viz*, the 4th and 6th Charges of NOI (1), there were two periods of time involved: 12 September 2002 to 14 April 2003, and 13 March 2016 to 31 October 2016.

The relevant benchmark standard for the Benzodiazepine Prescription Charges

92. It was not disputed that the 2008 Administrative Guidelines are applicable to the Benzodiazepine Prescription Charges.

93. The parties however disagreed on whether the 2002 MOH Guidelines for Prescribing of Benzodiazepines and other Hypnotics ("**2002 Guidelines**") and the MOH Clinical Practice Guidelines on Prescribing of Benzodiazepines (2/2008) ("**2008 CPG**") set out the relevant benchmark standard. SMC submitted that the 2002 Guidelines set out the applicable standard for the prescription of benzodiazepines until they were revised by the 2008 CPG, while the 2008 CPG still sets out the applicable standard for the prescription of benzodiazepines. The Respondent disagreed with this.

94. The SMC also submitted that there was no need to refer to international guidelines, given that MOH had issued specific guidelines in the form of both Clinical Practice Guidelines and the 2008 Administrative Guidelines, but SMC nevertheless submitted that the principles and rationales behind the Singapore guidelines are consistent with international guidelines. The Respondent's position was that significantly more weight should be placed on the recency of the guidelines at the material time rather than the source of the publication, and the Respondent submitted that the recommendations made in recent foreign international guidelines would supersede those made in the 2008 CPG.

2008 Administrative Guidelines

95. The 2008 Administrative Guidelines are applicable from 14 October 2008, which is the date of the guidelines. These guidelines set out the applicable standard for the prescription of benzodiazepines and, as indicated above, it was undisputed that they are applicable to the Benzodiazepine Prescription Charges. The relevant part of the guidelines is set out below for reference:

> **Use of benzodiazepines**
> (e) Medical practitioners are strongly discouraged from prescribing highly addictive benzodiazepines such as midazolam and nimetazepam (except for midazolam use in surgical procedures).
> (f) Benzodiazepines / other hypnotics, when used for treating insomnia, should be prescribed for intermittent use (eg. 1 night in 2 or 3 nights) and only when necessary.
> (g) Medical practitioners should *routinely* warn patients about rebound insomnia with the use of benzodiazepines and document such warning accordingly.
> (h) The dosage of benzodiazepine / other hypnotic used should be the lowest effective dose necessary to achieve symptomatic relief.

(i) The concurrent prescribing of two or more benzodiazepines should be avoided.
(j) Repeat prescriptions for benzodiazepines / other hypnotics should *not* be provided without a clinical review.
(k) Where there are doubts about dosage prescription or tapering of benzodiazepines/ other hypnotics, a psychiatrist or other specialists should be consulted.
(l) Care should be taken when prescribing benzodiazepines / other hypnotics to avoid excessive sedation (which may pose a risk to the patient who drives, operates heavy machinery, etc).
(m) Caution should be exercised when prescribing benzodiazepines for patients with a history or evidence of alcohol or other substance abuse.

[emphasis in original in italics]

Clinical Practice Guidelines and Royal Australian College of General Practitioners Guidelines

96. It was not disputed that the 2002 Guidelines set out the applicable standard for the prescription of benzodiazepines when they were in force. That was from 17 August 2002 to August 2008, after which the 2002 Guidelines were revised by the 2008 CPG. The 2008 CPG, published in September 2008, states that it is a revised version of the 2002 Guidelines.[17]

97. It was common ground that clinical practice guidelines published by the MOH are treated as withdrawn five years after publication. SMC's position however was that notwithstanding the fact that the 2008 CPG was treated as withdrawn, the recommendations in the 2008 CPG remained applicable during the material period. According to Dr PE, that was because the problems of benzodiazepine addiction, dependence and misuse still exist internationally and in Singapore. There is no breakthrough indicating that benzodiazepines are no longer addictive and there are no new developments in relation to benzodiazepines. The underlying principle that doctors have to be accountable and responsible in prescribing benzodiazepines is still true.[18] Specifically, the SMC submitted that pursuant to the 2002 Guidelines and the 2008 CPG, the recommended duration of use of benzodiazepines is two to four weeks.

[17] See the foreword to the 2008 CPG.
[18] Transcript of DT inquiry on 7 February 2022, pages 52-53.

98. In contrast, the Respondent submitted that Dr PE's assumption was misguided, as there have been many foreign clinical guidelines which have emerged based on new evidence on benzodiazepine use. The Respondent submitted that the articles cited by Dr PE were relatively outdated and from sources that might not be credible. After the expiry of the 2008 CPG, the recommendations made in recent foreign clinical guidelines, for example the *Prescribing drugs of dependence in general practice, Part B – Benzodiazepines* guidelines published by the Royal Australian College of General Practitioners in 2015 ("**2015 RACGP Guidelines**"), would supersede those made in the 2008 CPG.

99. Specifically, the Respondent submitted that the 2015 RACGP Guidelines acknowledge that the optimum duration of benzodiazepine therapy is one to four weeks. However, benzodiazepines may be used for longer than four weeks where it is clear that the benefits outweigh the risks or where a detailed individual assessment has been made. This would include cases where patients do not respond to or cannot tolerate numerous first-line therapies; the use is intermittent; and/or specialists make a recommendation for the therapy. The appropriate safeguards must be in place.

100. While we agree with the Respondent that the DT is entitled to find that foreign clinical guidelines are representative of the benchmark standards in Singapore, particularly where the 2008 CPG has been treated as withdrawn, in our view, the principles behind the 2008 CPG are consistent with the 2015 RACGP Guidelines, the guidelines that the Respondent relied on as setting out the applicable standards in Singapore. A close reading of the 2015 RACGP Guidelines shows that the 2015 RACGP Guidelines provide that:

(a) The optimum duration of benzodiazepine therapy is one to four weeks. Short-term therapy is generally advised to reduce the risk of dependence and withdrawal, as well as other potential harm such as cognitive impairment.[19]

[19] 2015 RACGP Guidelines at page 40.

(b) There are very few specific indications for the chronic use of benzodiazepines. The decision to prescribe benzodiazepines longer term should be uncommon and made with caution.[20]

(c) Benzodiazepines may be used for longer than four weeks in selected cases. These are where patients are terminally ill or severely handicapped, where it is clear that the benefits outweigh the risks and side effects, or where a detailed individual assessment has been made with a patient and their family or carers.[21]

(d) Benzodiazepines may be prescribed longer term where (i) patients do not respond to, or cannot tolerate numerous first-line therapies; (ii) use is intermittent; (iii) specialists make a recommendation and are able to provide a rationale for the therapy.[22]

101. In our view, the principles set out in the 2008 CPG are consistent with the 2015 RACGP Guidelines. Both sets of guidelines provide that benzodiazepines should be prescribed for a limited period, not beyond four weeks. While the 2015 RACGP Guidelines set out instances where long-term prescription of benzodiazepines can be given, the 2015 RACGP Guidelines state that there are very few specific indications for the chronic use of benzodiazepines, and the decision to prescribe benzodiazepines for a longer term should be uncommon and made with caution. This is consistent with the 2008 CPG, which provides that long-term chronic use of benzodiazepines is not recommended, and also states that "for any continued or repeat benzodiazepine prescription, there must be appropriate clinical review, clear indications and adequate documentation."[23] This suggests that even in the 2008 CPG, long-term use of benzodiazepines may be allowed in limited instances. In fact, Dr PE himself acknowledged that there is no absolute restriction on the long-term therapeutic use of benzodiazepines, and that most guidelines, including the 2008 CPG, allow for some clinical leeway for such a practice.[24]

[20] *Ibid.*
[21] *Ibid.*
[22] 2015 RACGP Guidelines at page 41.
[23] 2008 CPG at paragraph 5.1.
[24] Transcript of DT inquiry on 8 February 2022, page 10.

102. As the guidelines set out in the 2008 CPG are largely consistent with the 2015 RACGP Guidelines, we do not agree with the Respondent that the recommendations made in the 2015 RACGP Guidelines supersede those made in the 2008 CPG. The principles summarised in [101] are applicable and form part of the benchmark standard. We would add that we do not think it is necessary to set out precisely when the long-term use of benzodiazepines is permitted, because we agree with the SMC that, in any event, none of the Respondent's patients satisfy the criteria for long-term use as set out in the 2015 RACGP Guidelines, the guidelines relied on by the Respondent.

103. We also deal with other issues raised by the parties in relation to the applicable standard.

Concomitant prescriptions of benzodiazepines with other benzodiazepines/sedating drugs

104. The parties disagreed on the issue of whether concomitant prescriptions of benzodiazepines with other benzodiazepines and/or sedating drugs were permitted. The SMC submitted that that was not allowed, whilst the Respondent submitted that the various guidelines merely contained general warnings against concomitant prescriptions, but did not prohibit them, and that concomitant prescriptions would pose risks only when the upper range dosages of different benzodiazepines and/or other drugs were prescribed together.

105. In our view, the appliable standard is set out in the 2008 Administrative Guidelines. Paragraph (i) of the 2008 Administrative Guidelines provides that the concurrent prescribing of two or more benzodiazepines should be avoided. In addition, paragraph (l) of the 2008 Administrative Guidelines is relevant. This states that "[c]are should be taken when prescribing benzodiazepines / other hypnotics to avoid excessive sedation (which may pose a risk to the patient who drives, operates heavy machinery, etc)."

Treatment of vertigo

106. The parties disagreed on whether benzodiazepines were clinically indicated for vertigo. SMC's position was that the Respondent's prescription of benzodiazepines to treat PAT 4's vertigo was unsupported by any medical literature. The Respondent was charged

with the inappropriate prescription of benzodiazepines to PAT 4 in the 4th Charge of NOI (1). Dr PE gave evidence that the major indications for benzodiazepine usually do not include vertigo[25] and that the first-line treatment for vertigo should be antihistamines.[26] On the other hand, the Respondent relied on articles showing that both benzodiazepines and antihistamines have been used to treat vertigo by suppressing the vestibular system.

107. We agree with the SMC that benzodiazepines are not clinically indicated for vertigo. The Respondent did not refer to any peer reviewed medical literature or established guidelines that support the use of benzodiazepines for vertigo. An article relied on by the Respondent[27] to show that benzodiazepines were part of the variety of drugs that may be prescribed to treat vertigo was a generic article taken off the Internet. Subsequent medical literature tendered by the Respondent did not support his position:

(a) The "Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update)",[28] which was tendered by the Respondent, states that clinicians should not routinely treat benign paroxysmal positional vertigo with vestibular suppressant medications such as antihistamines and/or benzodiazepines.

(b) In "Efficacy of Benzodiazepines or Antihistamines for Patients with Acute Vertigo",[29] which involved a systematic review and meta-analysis on the efficacy of benzodiazepines or antihistamines for patients with acute vertigo, one of the key points of the study was that the use of benzodiazepines to treat acute vertigo should be discouraged.

[25] Transcript of DT inquiry on 7 February 2022, page 80.
[26] Transcript of DT inquiry on 7 February 2022, page 78.
[27] Anis Rehman, *Vertigo Treatments & Medications,* Singlecare (https://www.singlecare.com/conditions/vertigo-treatment-andmedications#vertigo-treatment-options), in Respondent's Bundle of Documents (Volume IV) at page 2.
[28] N Bhattacharyya *et al*, "Clinical Practice Guideline: Benign Paroxysmal Positional Vertigo (Update)", *Otolaryngology- Head and Neck Surgery* 2017, Vol. 156(3S) S1-S47. Exhibit R12.
[29] B R Hunter *et al*, "Efficacy of Benzodiazepines or Antihistamines for Patients with Acute Vertigo", *JAMA Neurol.* Published online July18, 2022. doi:10.1001/jamaneurol.2022.1858. Exhibit R11.

*Whether Selective Serotonin Reuptake Inhibitors ("**SSRIs**") or benzodiazepines should be prescribed as the first-line treatment for anxiety disorders*

108. The SMC's position was that SSRIs, rather than benzodiazepines, were recommended as the first-line treatment for anxiety disorders. In support of this, the SMC pointed to this being a Grade A recommendation with Level 1+ evidence in the MOH Clinical Practice Guidelines 1/2015 on Anxiety Disorders[30] ("**2015 Anxiety Disorders CPG**"). This was also a recommendation in the previous version of the MOH Clinical Practice Guidelines 7/2003 on Anxiety Disorders[31] ("**2003 Anxiety Disorders CPG**"). In addition, the SMC's position was that both guidelines state that benzodiazepines should not be used for the long term treatment of Generalised Anxiety Disorder.

109. In contrast, the Respondent submitted that it may be appropriate for benzodiazepines to be prescribed as first-line treatment for anxiety in certain cases, for example where patients may respond better to benzodiazepines or are less able to tolerate SSRIs, or where patients have severe and distressing anxiety symptoms. The Respondent submitted that recent medical literature[32] has found that benzodiazepines provide quick relief of anxiety and their efficacy is comparable to, if not better than, SSRIs. Also, SSRIs may not be safer than benzodiazepines, as SSRIs are associated with similar withdrawal symptoms at a similar incidence rate and numerous side effects. In contrast, benzodiazepines lead to less adverse effects compared to SSRIs.

110. In our view, the applicable standard is that SSRIs, rather than benzodiazepines, should be prescribed as the first-line treatment for anxiety disorders. We note that this is set out in both the 2015 Anxiety Disorders CPG and the 2003 Anxiety Disorders CPG, even though the latter has since been withdrawn. Given that MOH issued specific guidelines which deals with anxiety disorders, the applicable standard is set out in the recommendations in those guidelines, rather than the recommendations set out in foreign medical literature on this issue.

[30] At pages 5-6.
[31] At paragraph 5(b).
[32] See the articles and guidelines referred to at [144]-[145] of the Respondent's Closing Submissions dated 30 December 2022.

Prescriptions by way of approving the sale of benzodiazepines

111. The SMC submitted that even for over the counter sales of benzodiazepines where the Respondent had delegated the prescription of a medication to a clinic assistant, the Respondent would still remain responsible for the patient's overall care. This was pursuant to paragraph 4.1.1.4 of the 2002 ECEG, which states that the doctor retains responsibility for the overall management of the patient when he delegates care.

112. In contrast, the Respondent submitted that the applicable standard of care does not require doctors to see patients each time before making a repeat prescription of benzodiazepines. The Respondent relied on paragraph B5.5 of the SMC's Handbook on Medical Ethics (2016 Edition) ("**2016 SMC Handbook**") in this regard, which states that repeat prescriptions without consultations are allowed when (a) the patients have been very stable and require only replenishment of medicines needed for maintenance treatment; and (b) there is no evidence or information that the patients' clinical situations have changed. The Respondent also relied on paragraph B5.7 of the 2016 SMC Handbook, which he submitted allowed for repeat prescriptions of potentially addictive medicines to be made, provided that (a) the patient has a valid medical reason for obtaining such medicines; and (b) the reviewing doctor is sufficiently familiar with the patient to ensure that the repeat medicines would be safe for the patient.

113. We do not agree with the Respondent's submission. In our view, paragraph (j) of the 2008 Administrative Guidelines makes it clear that a doctor has to review a patient before making a repeat prescription of benzodiazepines. Paragraph (j) of the 2008 Administrative Guidelines deals specifically with the prescription of benzodiazepines, and states: "Repeat prescriptions for benzodiazepines / other hypnotics should not be provided without a clinical review." In contrast, the paragraphs cited by the Respondent in the 2016 SMC Handbook do not deal specifically with the prescription of benzodiazepines.

114. The Respondent argued that paragraph (j) of the 2008 Administrative Guidelines does not mention that a clinical review must be conducted *each time* repeat prescriptions are made. However, even without the inclusion of the words "each time" in paragraph (j),

paragraph (j) is sufficiently clear in indicating that a clinical review has to be carried out before repeat prescriptions of benzodiazepines are made. The Respondent had in fact conceded during the DT inquiry that he had breached paragraph (j).[33]

The relevant benchmark standard for the Benzodiazepine Referral Charges

115. The SMC's position on the relevant benchmark standard for the Benzodiazepine Referral Charges is set out below:

(a) The 2002 Guidelines state that medical practitioners should limit chronic benzodiazepine hypnotic prescription where possible and refer patients with refractory insomnia to psychiatrists for further management.[34]

(b) Similarly, the 2008 Administrative Guidelines provide at paragraph (n) for certain categories of patients to be referred to the appropriate specialist for further management.

(c) Paragraph 4.1.1.6 of the 2002 ECEG is also applicable. This provides that a doctor should practise within the limits of his own competence in managing a patient.

(d) While the SMC's primary position was that the Respondent, as a GP, ought to refer patients with psychiatric issues to specialists for management, SMC accepted that there were varying levels in the abilities of GPs to manage such conditions. Dr PE's evidence was that even experienced GPs, after exhausting the appropriate first-line treatments, should refer patients to psychiatrists if their problems persist after several months.

116. The Respondent submitted that the recommendations made in the more recent foreign clinical guidelines ought to supersede the outdated or expired local guidelines. The Respondent submitted that according to the 2015 RACGP Guidelines, patients at low

[33] Transcript of DT inquiry on 9 February, pages 185-186.
[34] Paragraph 4(4) of the 2002 Guidelines.

risks of benzodiazepine addiction, for example patients without past or current substance use disorders and/or mental illnesses, could be managed in primary care. Specialist referral would be warranted where the risks of addiction were high.

117. In our view, the relevant benchmark standard in relation to specialist referral is set out in paragraph (n) of the 2008 Administrative Guidelines. The 2008 Administrative Guidelines have not expired and are still applicable today. The 2008 Administrative Guidelines were issued by MOH, and there is no basis to say that the recommendations in foreign clinical guidelines should supersede the recommendations in the 2008 Administrative Guidelines. Paragraph (n) of the 2008 Administrative Guidelines provides that the following categories of patients should not be further prescribed with benzodiazepines or other hypnotics and must be referred to the appropriate specialist for further management:

(a) Patients who require or have been prescribed benzodiazepines/other hypnotics beyond a cumulative period of eight weeks;

(b) Patients who are already on high-dose and/or long-term benzodiazepines from their specialists or general hospitals. Where possible, these patients should be referred back to their respective specialists for further management until they are weaned off benzodiazepines/other hypnotics; and

(c) Patients who are non-compliant with professional advice or warning to reduce intake of benzodiazepines/other hypnotics.

118. In addition, the general guidelines set out at paragraph 4.1.1.6 of the 2002 ECCG are applicable. Paragraph 4.1.1.6 of the 2002 ECEG provides that a doctor should practise within the limits of his own competence in managing a patient, and where he believes that this is exceeded, he should offer to refer the patient to another doctor with the necessary expertise.

Whether there has been a departure from the applicable standard and whether the departure was sufficiently egregious to amount to professional misconduct

119. We next examine whether there has been a departure from the applicable standard in relation to each of the Benzodiazepine Prescription Charges and Benzodiazepine Referral Charges, and whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limb of *Low Cze Hong*.

120. The submissions of the SMC and the Respondent, as set out in the parties' Joint Schedule of Positions on Charges, are reproduced in their entirety in the Annex. We set out in the last column of the Annex the reasons for our decision on each charge. In our view, save for the 6th Charge of NOI (1) (PAT 4) and the 10th Charge of NOI (1) (PAT 13), there has been a departure from the applicable standard in relation to each charge, and the Respondent's conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency. The misconduct was sufficiently egregious to amount to professional misconduct.

Codeine Prescription Charges

121. The Respondent faced five charges pertaining to the inappropriate prescription of codeine-containing medications to five patients. The charges spanned a period from 8 December 2003 to 5 December 2016.

The relevant benchmark standard

122. We set out the parties' submissions as well as our views on the relevant benchmark standard.

2002 ECEG

123. The SMC submitted that the 2002 ECEG sets out the applicable standard for a practitioner's prescription practices for codeine-containing medications. The SMC

relied on paragraphs 4.1.1.1, 4.1.1.4, 4.1.1.6 and 4.1.3 of the 2002 ECEG, which are set out below:

> Paragraph 4.1.1.1 Adequate clinical evaluation of patients
>
> A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.
>
> If treatment is suggested or offered to a patient without such personal evaluation, the doctor must satisfy himself that he has sufficient information available and that the patient's best interest is being served. Such information could be transmitted by voice, electronic or other means by a referring doctor. Only in exceptional or emergency circumstances should a diagnosis or treatment be offered without personal contact and without the intermediation of a referring doctor.
>
> Paragraph 4.1.1.4 Delegation of duties
>
> A doctor may delegate another doctor, nurse, medical student or other health care worker to provide treatment or care on his behalf, but this person must be competent to carry out the care or procedure required. A doctor retains responsibility for the overall management of the patient when he delegates care. If the person delegated to is not duly registered as a practitioner, this must be in the context of a legitimate training programme and the doctor must exercise effective supervision over this person.
>
> Paragraph 4.1.1.6 Practise within competence and referral of patients
>
> A doctor should practise within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise. A doctor shall not persist in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having the required experience.
>
> … If a patient refuses to see a specialist, the doctor shall counsel the patient adequately and if he still refuses, it is allowable for that doctor to treat the patient in consultation with a specialist.
>
> Paragraph 4.1.3 Prescription of medicine
>
> A doctor may only prescribe medicines that are legally available in Singapore and must comply with all the statutory requirements governing their use.
>
> A doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. This includes prescription by a doctor for his own use. Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects.
>
> A doctor shall prescribe medicines only following an adequate personal consultation and relevant investigations. A decision to prescribe solely based on information provided by telephone or any electronic means is

> allowable for continuing care, or for exceptional situations where a patient's best interests are being served by doing so.

124. The above paragraphs of the 2002 ECEG were applicable at the time of the charges. While they do not deal specifically with the prescription of codeine-containing medications, they are of general applicability and are applicable to the Codeine Prescription Charges.

MOH Circular on the Sale and Supply of Cough Mixtures containing Codeine dated 9 October 2000

125. It was not disputed that the MOH Circular on the Sale and Supply of Cough Mixtures containing Codeine dated 9 October 2000 (the "**2000 Circular**") formed part of the applicable benchmark standard. The 2000 Circular reminds doctors and pharmacists not to prescribe more than 240 ml of codeine-containing cough mixture to a patient within four days, whenever possible. This is to prevent the potential abuse of codeine.[35]

2021 Opioid Guidelines

126. The SMC submitted that the applicable principles and standards for codeine-prescription practices in Singapore may also be found in the 2021 Opioid Guidelines. While the SMC recognised that the 2021 Opioid Guidelines came into force after the material codeine prescription periods in the proceedings and were not immediately applicable, Dr PE's evidence was that the 2021 Opioid Guidelines served to remind doctors of all the past existing good practices in terms of opioid use[36] and was a reinforcement of what had been taught to all doctors for the past decades.[37] In other words, it codified existing good practice as it stood.

127. The Respondent submitted that the 2021 Opioid Guidelines ought not to form part of the applicable standards for the inquiry, as the 2021 Opioid Guidelines were published in April 2021 and did not exist at the material time. The Respondent submitted that it would be unfair for guidelines to be applied retrospectively and for practitioners to be

[35] Paragraph 4 of the 2000 Circular.
[36] Transcript of DT inquiry on 29 August 2022, page 49.
[37] Transcript of DT inquiry on 29 August 2022, page 50.

held to standards set out in guidelines which did not exist as at the relevant charge period.

128. We consider that good practices do not amount to the benchmark standard required of a doctor. While Dr PE gave evidence that the 2021 Opioid Guidelines reinforces what was taught and reminds doctors of good practices, evidence was not given that those guidelines set out the standard required of a doctor at the material time, a breach of which would amount to professional misconduct. The 2021 Opioid Guidelines did not exist at the material time. A finding that the recommendations in the 2021 Opioid Guidelines set out the applicable standard at the material time must be based on clear evidence from the SMC. However, no such evidence was given.

International guidelines

129. The SMC argued that the restrictions in the 2000 Circular were consistent with 13 international guidelines dating from 2007 to 2020, which could be found at Annex B to Dr PE's Expert Report dated 19 March 2021 ("**Expert Report (2)**"). The SMC submitted that to that extent, reference could be made to the international guidelines to discern the standards that were practised by members of the medical profession. In Dr PE's expert view, there was a lack of medical evidence demonstrating that codeine was effective to treat cough beyond three weeks and more so if cough was beyond eight weeks,[38] as shown by the medical literature and guidelines listed in Annex A of Dr PE's Expert Report (2). Dr PE's view was that a reasonable and competent doctor in the Respondent's position would not repeatedly prescribe codeine for cough beyond three weeks and more so if cough was beyond eight weeks.[39]

130. Further, SMC submitted that the Classification of Cough as a Symptom in Adults and Management Algorithms, CHEST Guideline and Expert Panel Report (the "**CHEST Guidelines**") and the British Thoracic Society Guidelines on Recommendations for the management of cough in adults (the "**BTS Guidelines**") do not advocate the long-term use of codeine to treat cough. SMC submitted that these guidelines instead recommend

[38] Dr PE's Expert Report (2) at [35].
[39] Dr PE's Expert Report (2) at [37].

that investigations be carried out to determine the underlying cause of cough and that the underlying cause be treated.

131. In response, the Respondent pointed out that Dr PE had acknowledged in cross-examination that the articles he referred to actually showed that there was a particular section of patients who may benefit from long-term low-dose codeine therapy.[40] The Respondent also submitted that the articles that Dr PE referred to at Annex B of his Expert Report (2) did not support his position that codeine should not be prescribed to treat cough lasting beyond three weeks. In addition, the Respondent submitted that the specific sections in the CHEST Guidelines and BTS Guidelines referred to by SMC in its closing submissions were not referred to by Dr PE in his expert evidence and the SMC did not refer to them in the course of cross-examining the Respondent.

132. We can deal with the objections to the SMC's reliance on the CHEST guidelines and the BTS guidelines fairly quickly. We note that in Dr PE's first witness statement, he had indicated that his opinion on the Respondent's management and treatment of his patients was set out in the two expert reports he provided earlier.[41] The CHEST guidelines and the BTS guidelines were both referred to in Dr PE's Expert Report (2). As these guidelines had been referred to by Dr PE, there was no issue with the SMC referring to these guidelines or to specific sections of these guidelines in its closing submissions.

133. However, we agree with the Respondent that Dr PE had acknowledged that the articles he referred to actually show that there is a particular section of patients who may benefit from long-term low-dose codeine therapy.[42] Further, as pointed out by the Respondent in his submissions, not all the articles that Dr PE referred to at Annex B of his Expert Report (2) support his position.

134. In our view, the SMC has not established that there is a standard that codeine cannot be repeatedly prescribed for cough beyond three weeks and more so if the cough lasts

[40] Transcript of DT inquiry on 7 February 2022, page 163.
[41] Dr PE's witness statement dated 10 December 2021 at [2].
[42] Transcript of DT inquiry on 7 February 2022, page 163.

beyond eight weeks. We do not think that there is such an absolute rule. This was not borne out by Dr PE's evidence before the DT, or the articles that Dr PE relied on.

Management of chronic cough

135. The Respondent submitted that the applicable standard for the management of chronic cough was that set out in an article in the Singapore Medical Journal entitled "Approaching Chronic Cough".[43] According to the Respondent, the first step would be to diagnose the cause of chronic cough based on diagnostic clues for common causes of cough, the patient's history or a physical examination. If the diagnosis could not be confirmed, empirical treatment could be used. If the cause of cough still could not be identified, it would be appropriate to perform further investigations and/or refer the patient to an appropriate specialist. Specialist referral was not warranted if the cough was recurrent (*i.e.*, it responds to medication but returns when medication is stopped).[44]

136. A review of the article reveals that it sets out the following points:

(a) A careful history-taking and physical examination can provide a diagnosis in many patients.

(b) In healthcare settings where there is no easy access to specialist care, further investigations may be ordered where there are no diagnostic clues. An alternative approach is to try empirical treatment for the most common causes of chronic cough.

(c) In the local context, where the specialist referral system is more efficient, referral of the patient to a specialist is recommended where the cause of cough cannot be identified.

[43] Poulose V et al, *Approaching Chronic Cough*, Singapore Med J 2016; 57(2): 60 – 63, in Respondent's Bundle of Documents Tab 13.
[44] See Joint Schedule of Positions on Charges at pages 16-17, and Respondent's Statement of Evidence-in-Chief dated 10 December 2021 at [65]-[67], [71]-[72].

137. We note that the Respondent did not adduce expert evidence to support his submission that this article sets out the standard for the management of chronic cough at the material time. Further, the Respondent's submissions as to the applicable standard in relation to specialist referral are not supported by what is set out in the article. Contrary to the Respondent's submissions, the article does not indicate that specialist referral is not warranted if the cough is recurrent. The article in fact says that in the local context, the patient should be referred to a specialist where the cause of cough cannot be identified.

When codeine can be prescribed

138. Another point of contention between the parties was the applicable standard in relation to when codeine can be prescribed.

139. The Respondent's position was that codeine-containing medicines can be considered for symptomatic relief of refractory or unexplained cough. The Respondent referred to various articles in this regard. Further, the Respondent submitted that it is safe for codeine to be prescribed on a long-term basis for unexplained or refractory cough, provided that codeine use is intermittent and the appropriate safeguards are in place to prevent dependence.

140. In relation to the Respondent's submission that codeine-containing medicines can be considered for symptomatic relief of refractory cough, we agree with Dr PE's evidence given during cross-examination[45] that the articles relied upon by the Respondent for this submission[46] showed that a lock-step approach should be taken. As Dr PE indicated, the doctor should first make sure that the cough is chronic. Second, proper investigations should be carried out. Third, a low-dose trial of codeine can then be given.

141. Further, as pointed out by the Respondent,[47] Dr PE emphasised that a GP who sees a patient with chronic cough ought to investigate for common causes of cough (including

[45] Transcript of DT inquiry on 7 February 2022, page 152.
[46] Respondent's Closing Submissions dated 30 December 2022 at [227].
[47] Respondent's Closing Submissions dated 30 December 2022 at [229].

postnasal drip and gastroesophageal reflux). The next appropriate step would be to refer the patient to the relevant specialist (e.g. a respiratory physician, ear, nose and throat physician or gastroenterologist) for further investigations if required. If the patient is still coughing after the above steps have been carried out, it would be reasonable for the patient to be placed on two weeks' trial of codeine.[48] As for whether the patient should continue to be prescribed codeine after two weeks, Dr PE recognised that that was possible, but testified that he would ensure that the patient was adequately advised of the risks associated with opioid use and assess the patient for any risks of substance abuse or addiction. Dr PE testified that it was unlikely that a patient would opt to continue with long-term treatment with opioids after being advised of the risks.[49]

142. On a holistic review of the evidence given by both parties, our view is that the applicable standards in relation to the management of chronic cough and prescription of codeine are as follows:

(a) Investigations should be carried out and the underlying cause of the cough should be ascertained and treated. A doctor cannot simply prescribe codeine without any investigations as to the cause of the cough. This point does not appear to be controversial – Dr PE gave evidence that this step should be carried out, and the Respondent's position similarly was that the cause of chronic cough should be diagnosed (see [135] above).

(b) If the cough persists, the doctor should refer the patient to a specialist. We highlight that referral to a specialist is a step mentioned in the article "Approaching Chronic Cough" relied on by the Respondent (see [136] above).

(c) If the cough still persists, the patient may be placed on a trial of codeine. The point is that the doctor must reasonably come to a conclusion that codeine is justified before prescribing codeine, rather than simply prescribe codeine out of hand. While there is no absolute rule in relation to the duration for which codeine can be prescribed, if codeine is prescribed for a longer term, there

[48] Transcript of DT inquiry on 7 February 2022, pages 145-147.
[49] Transcript of DT inquiry on 7 February 2022, page 147.

should be justification for doing so given the potential for abuse, and there should be adequate safeguards in place to prevent dependence.

Prescriptions by way of approving the sale of codeine-containing medicines

143. Both parties agreed that the 2016 SMC Handbook was applicable. While this came into force only on 1 January 2017, both parties took the position that the standard indicated therein was representative of the applicable standard at the material time. Paragraph B5.5 of the 2016 SMC Handbook states that repeat prescriptions without consultations are allowed where (a) the patients have been very stable and require only replenishment of medicines needed for maintenance treatment; and (b) there is no evidence or information that the patients' clinical situations have changed. This is provided that repeat prescriptions do not go on indefinitely and clinical reviews are conducted at intervals appropriate to the patients' diagnoses and medical conditions.

Codeine in solid form

144. SMC's position was that codeine in solid form should be treated similarly to codeine in liquid form. Dr PE's evidence was that the active ingredient (*i.e.*, codeine) remained the same and the pharmacological effects of codeine were unchanged regardless of the form that the medication came in.[50]

145. The Respondent submitted that there were no applicable guidelines setting out any restrictions on codeine prescribed in solid form at the material time and that the limits on codeine in solid form in the Health Products (Therapeutic Productions) Regulations 2016 which came into effect on 1 October 2021 were not applicable.

146. We agree with the Respondent that there were no applicable guidelines at the material time setting out precise restrictions on the amount of codeine prescribed in solid form. While codeine in solid form may contain the same pharmacological effects as codeine in liquid form, there was no restriction at the material time on the precise quantity of solid codeine that could be prescribed, in the same way that there was for liquid codeine.

[50] Transcript of DT inquiry on 7 February 2022, page 118.

Whether there has been a departure from the applicable standard and whether the departure was sufficiently egregious to amount to professional misconduct

147. We next turn to consider whether there has been a departure from the applicable standard in relation to each of the Codeine Prescription Charges, and whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limb of *Low Cze Hong.*

148. The submissions of the SMC and the Respondent, as set out in the parties' Joint Schedule of Positions on Charges, are reproduced in their entirety in the Annex. The Annex also sets out the reasons for our decision on each charge. In our view, there has been a departure from the applicable standard in relation to each charge, and the Respondent's conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency. The misconduct was sufficiently egregious to amount to professional misconduct.

CONCLUSION ON LIABILITY

149. In conclusion, we found the Respondent guilty of all charges, save for the 6th Charge of NOI (1) (PAT 4), 10th Charge of NOI (1) (PAT 13) and 16th Charge of NOI (1) (PAT 15). The Respondent was therefore guilty of 29 charges of professional misconduct under s 53(1)(*d*) of the MRA, a breakdown of which is set out below:

(a) 14 Documentation Charges;

(b) Six (6) Benzodiazepine Prescription Charges;

(c) Four (4) Benzodiazepine Referral Charges; and

(d) Five (5) Codeine Prescription Charges.

SENTENCE

150. It was not in dispute that the four-step sentencing framework set out in *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("***Wong Meng Hang***"), which was subsequently explained and elaborated on in the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals ("**Sentencing Guidelines**") published by SMC on 15 July 2020, was applicable.

151. The first step entails an evaluation of the seriousness of the offence, having regard to the two principal parameters of harm and culpability: *Wong Meng Hang* at [30].

152. The second step is to identify the applicable indicative sentencing range based on the level of harm and culpability. The matrix below serves as a guide: *Wong Meng Hang* at [33].

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

153. The third step is to identify the appropriate starting point within the indicative sentencing range. The DT should have regard to the level of harm caused by the misconduct and the errant doctor's level of culpability as well as how the case at hand compares to other cases featuring broadly similar circumstances: *Wong Meng Hang* at [42].

154. The fourth step involves making adjustments to the starting point by taking into account offender-specific aggravating and mitigating factors: *Wong Meng Hang* at [43].

155. In both parties' submissions, both parties adopted an approach where the appropriate individual sentence for each charge was first determined, and thereafter, to ensure proportionality, the overall sentence was calibrated. This was in line with the approach set out at [78] of the Sentencing Guidelines, which states that for cases involving multiple offences, steps 1 – 4 of the sentencing framework should first be applied to determine the appropriate individual sentence for each charge, and to ensure proportionality, the overall sentence should then be calibrated by applying the one-transaction rule and the totality principle.

156. We set out the parties' submissions on sentencing, following by our decision.

SMC's Submissions on Sentence

Prescription and referral charges

157. In respect of the prescription and referral charges, SMC submitted that the Respondent's misconduct demonstrated a high degree of culpability and caused moderate harm to his patients.

158. SMC submitted that the Respondent's misconduct demonstrated a high degree of culpability because:

(a) The Respondent had failed in numerous aspects of the care, management and treatment of his patients.

(b) There was no clear clinical basis for the Respondent's prescriptions.

(c) The Respondent had prescribed benzodiazepine/codeine-containing medications over a long period of time.

(d) The Respondent had prescribed benzodiazepine/codeine-containing medications to multiple patients.

(e) The Respondent had breached MOH guidelines.

(f) The Respondent abused his position of trust and confidence.

159. SMC submitted that there was moderate harm for the following reasons:

(a) The Respondent prescribed benzodiazepine/codeine-containing medications for a long period of time.

(b) There was substantial potential for addiction to benzodiazepine or codeine.

(c) The patients were elderly and more vulnerable.

160. In relation to step 2 of the sentencing framework, SMC submitted that the applicable sentencing range would be a suspension of two to three years for each charge, as per the harm-culpability matrix set out at [152] above.

161. In relation to step 3 of the sentencing framework, SMC submitted that the precedent cases for inappropriate prescription of such egregious levels usually have a starting point of two years and above, and referred to *Singapore Medical Council v Dr Chia Kiat Swan* [2019] SMCDT 1 ("***Chia Kiat Swan***"). SMC submitted that the starting point for the Benzodiazepine Prescription Charges and Benzodiazepine Referral Charges should be 27 months as they fell in the middle of the range of moderate harm and high culpability, whereas the starting point for the Codeine Prescription Charges should be 24 months as they fell within the lower end of moderate harm and high culpability. This was because:

(a) Many of the benzodiazepine patients had multiple pre-existing conditions.

(b) The Respondent admitted to breaching the 2008 Administrative Guidelines which expressly prohibit the prescription of benzodiazepines beyond

intermittent use and without clinical review. In contrast, for the Codeine Prescription Charges, there was only one patient where the 2000 Circular was breached on limited occasions.

162. In relation to step 4 of the sentencing framework, SMC submitted that an aggravating factor was that the Respondent repeatedly embellished his evidence and gave an account of events that was not borne out by objective contemporaneous evidence. SMC submitted that an uplift of one month on each charge would be appropriate, and the appropriate sentence would therefore be:

(a) 28 months' suspension on each Benzodiazepine Prescription Charge;

(b) 28 months' suspension on each Benzodiazepine Referral Charge; and

(c) 25 months' suspension on each Codeine Prescription Charge.

Documentation Charges

163. In respect of the Documentation Charges, the SMC submitted that culpability was moderate and harm was slight.

164. The SMC submitted that the Respondent's culpability was moderate based on the following factors:

(a) The Respondent blatantly disregarded fundamental principles regarding the requirement of documentation.

(b) The Respondent disregarded the requirements of documentation, when he prescribed benzodiazepines and codeine-containing medications over the counter.

165. The SMC submitted that harm was slight based on the following factors:

(a) The Respondent's documentation was bereft of details.

(b) The Respondent practised in a group practice where other doctors saw the same patients.

166. In view of the above, the SMC submitted that the Respondent's misconduct fell within the range of a suspension period of three months to one year. The starting point was a suspension period of three months for each Documentation Charge, in line with the penalty imposed in *Singapore Medical Council v Mohd Syamsul Alam Bin Ismail* [2019] 4 SLR 1375 ("***Mohd Syamsul***").

167. The SMC submitted that the Respondent contested the charges when it was unmeritorious to do so, and that showed a lack of remorse. The SMC submitted that there should be an uplift of one month's suspension, and the appropriate sentence should be four months' suspension on each Documentation Charge.[51]

Totality principle

168. The SMC submitted that one Benzodiazepine Prescription Charge, one Benzodiazepine Referral Charge, one Codeine Prescription Charge and one Documentation Charge ought to be ordered to run consecutively. This would amount to a total sentence of 85 months' suspension. Given the statutory cap of 36 months' suspension in the MRA, SMC submitted that the Respondent should be suspended for 36 months. SMC submitted that this would adequately punish the Respondent for his misconduct, but not amount to a crushing sentence.

[51] The SMC initially submitted at [86] of the SMC's Sentencing Submissions dated 21 August 2023 that there should be an uplift of one month's suspension as the Respondent demonstrated a lack of remorse through his retraction of his plea of guilt for six of the Documentation Charges. However at the hearing on 6 December 2023, Counsel for the SMC clarified that SMC's submission was instead that there should be an uplift of one month's suspension as the Respondent contested the charges when it was unmeritorious to do so, and that showed a lack of remorse.

No inordinate delay to warrant any discount in sentence

169. SMC submitted that there was no inordinate delay to warrant any discount in sentence. The first NOC was issued on 12 March 2018. The second NOC was issued on 12 December 2019. Both NOIs were then issued together on 13 April 2021, which was a period of three years and one month from the date the first NOC was issued and a period of one year and five months from the date the second NOC was issued.

170. SMC submitted that the period of time was required for the CC in each case to complete its investigations. The first CC concluded its investigations on 19 February 2019, when they informed the Respondent that the matter would be referred to a formal inquiry. During the course of its investigations into the benzodiazepine-related charges, the first CC found that the Respondent had also prescribed codeine-containing medications, and submitted this information to SMC on 19 February 2019. This triggered an investigation into the Respondent's practice of prescribing codeine-containing medication by the second CC. The second CC concluded its investigations on 3 July 2020, when they informed the Respondent that the matter would be referred to a formal inquiry.

171. SMC submitted that the period of three years and one month from the date the first NOC was issued to the date the NOIs were issued was necessitated because there were two separate investigations into different aspects of the Respondent's practice. The first NOI could have been issued earlier, after the first CC concluded its investigations, but the SMC waited to issue the first and second NOIs together so that the Respondent had the option of a joint inquiry. This benefitted the Respondent. If SMC had issued the NOIs separately and conducted two separate inquiries, the Respondent would be liable to be sentenced separately for the two inquiries, for which the statutory cap of 36 months' suspension would have applied separately.

172. SMC submitted that no prejudice had been suffered by the Respondent, as the Respondent had been allowed to practise throughout this period. SMC also submitted that there were countervailing public interest considerations militating against granting a discount on account of the delay.

173. SMC submitted that the cumulation of the consecutive sentence it sought amounted to 85 months. Given the statutory cap in the MRA, the Respondent's global sentence would be limited to 36 months. This meant that the Respondent would effectively receive the benefit of a reduction of 49 months, which was a significant discount of almost 60%, and it would be disproportionate for the sentence to be discounted further on account of delay. However, if the DT were still minded to grant a discount, the discount should be no more than one-third.

Respondent's Submissions on Sentence

Prescription and referral charges

174. In respect of the prescription and referral charges, the Respondent submitted that the level of harm should be classified as slight. This was because:[52]

(a) There was no actual harm to the patients and no evidence that any of the patients developed physical dependence/addiction.

(b) The period of time over which inappropriate prescriptions were made was much lower as compared to the cases of *Chia Kiat Swan* and *Singapore Medical Council v Dr Tan Joong Piang* [2019] SMCDT 9 ("***Tan Joong Piang***") (where the level of harm was classified as moderate).

(c) The Respondent did not prescribe highly addictive benzodiazepines such as Dormicum or Erimin.

(d) The Respondent had in place various safeguards to prevent his patients from developing dependence to benzodiazepines and/or codeine-containing medications.

175. As for culpability, the Respondent submitted that the level of culpability should fall within the category of the lower range of "medium". This was because:

[52] Respondent's Reply Submissions on Sentencing dated 2 October 2023 at [24].

(a) The Respondent did not make inappropriate prescriptions for improper financial gain.

(b) The Respondent's prescriptions were part of a sincere attempt to help the patients concerned to continue to function in their respective lives.

(c) The Respondent had taken remedial steps after the audit and sought to wean his patients off benzodiazepines and codeine-containing medications.[53]

176. The Respondent submitted that the level of culpability ought not to be classified as high. This was because:

(a) The scale and extent of wrongdoing was significantly lower as compared to *Chia Kiat Swan* and *Tan Joong Piang*. The period of time over which inappropriate prescriptions were made was much lower compared to the two precedent cases.

(b) While the Respondent had approved the sale of benzodiazepines and/or codeine-containing medications by his clinic assistants on some occasions, such a practice was not as pervasive as compared to *Tan Joong Piang*.

(c) Unlike in *SMC v Wee Teong Boo* [2023] SGHC 180 ("***Wee Teong Boo***"), the Respondent had proper clinical basis for his prescriptions of benzodiazepines/codeine-containing medications. The Respondent had prescribed such medications to treat his patients' medical conditions.

(d) Unlike the respondent in *Wee Teong Boo*, the Respondent was aware that the 2000 Circular was in force at the material time. Save for three occasions in relation to the patient PAT 5, the Respondent had largely complied with the guidelines set out in the 2000 Circular when he prescribed codeine-containing cough mixtures to his patients.

[53] Respondent's Reply Submissions on Sentencing dated 2 October 2023 at [47].

177. In relation to step 2 of the sentencing framework, the Respondent submitted that based on the harm-culpability matrix, the applicable indicative sentencing range ought to be a suspension of three months to one year.

178. In relation to step 3 of the sentencing framework, the Respondent initially submitted that the appropriate starting point within the range for the Benzodiazepine Prescription Charges and the Codeine Prescription Charges ought to be a suspension of around four to six months. However in the Respondent's Reply Submissions on Sentencing,[54] the Respondent submitted that given that the Institution B medical reports for PAT 9 showed that the patient suffered no harm from the codeine-containing medications, and similarly, there was no evidence that any of the Respondent's other patients suffered harm, the starting point for the Codeine Prescription charges should be three months. For the Benzodiazepine Prescription Charges, the Respondent submitted that the starting point should be:

(a) Five months for the 1st Charge of NOI (1) (PAT 3) and 7th Charge of NOI (1) (PAT 10); and

(b) Four months for the 4th Charge of NOI (1) (PAT 4), 12th Charge of NOI (1) (PAT 14), 15th Charge of NOI (1) (PAT 15) and 17th Charge of NOI (1) (PAT 16).

179. As for the Benzodiazepine Referral Charges, the Respondent's submission was that the applicable sentencing period for each Benzodiazepine Referral Charge ought to be around 50% of the suspension period for the corresponding Benzodiazepine Prescription Charge. This was because it had been recognised in *Singapore Medical Council v Dr Tan Kok Jin* [2019] SMCDT 3 ("***Tan Kok Jin***") that a referral charge was less serious than a prescription charge. The Respondent therefore submitted that the starting point for the Benzodiazepine Referral Charges should be:

(a) 2.5 months for the 3rd Charge of NOI (1) (PAT 3) and the 9th Charge of NOI (1) (PAT 10); and

[54] See Respondent's Reply Submissions on Sentencing dated 2 October 2023 at [50].

(b) Two months for the 14th Charge of NOI (1) (PAT 14) and the 19th Charge of NOI (1) (PAT 16).

180. In relation to Step 4 of the sentencing framework, the Respondent submitted that there should be a reduction in the sentence for each charge on account of an inordinate delay in the prosecution. The Respondent submitted that:

(a) A 50% reduction in sentence ought to be applied for the NOI (1) charges, as NOI (1) was served on the Respondent on 13 April 2021, which was three years and one month after service of the NOC on 12 March 2018.

(b) A one-third reduction in sentence ought to be applied for the NOI (2) charges, as NOI (2) was served on the Respondent on 13 April 2021, which was one year and four months after service of the NOC on 12 December 2019.

181. The Respondent also submitted that he had suffered additional distress from the protraction of the DT inquiry. He submitted that the DT inquiry was protracted due to the following factors:[55]

(a) The CC did not request the Respondent to identify the entries made by him and the other doctors in his clinic when they asked for his typewritten transcripts on 22 November 2017. They had merely requested him to transcribe his clinic notes. The Prosecution erroneously assumed that all the entries had been made by the Respondent and proceeded to charge him on such a basis. As a result, the DT inquiry had to be adjourned by seven months for the Respondent to prepare amended and supplementary transcripts, the NOIs to be amended and both parties to address the amended NOIs.

(b) The SMC had mistakenly omitted 69 of the Respondents' entries from the Schedules to the NOIs. The DT inquiry had to be adjourned by another two

[55] Respondent's Mitigation Plea at [12].

months for the Schedules to the NOIs to be amended and the Respondent to address the amendments to the Schedules.

(c) The SMC had requested an extension of time for the parties to await the issuance of the grounds of decision of *Wee Teong Boo* before submitting their sentencing submissions. The deadline for the sentencing submissions, which was originally 16 May 2023, was eventually pushed back by three months to 21 August 2023.

182. Apart from the delay in prosecution, the Respondent submitted that the DT should take into account the following mitigating factors:

(a) The Respondent had a long unblemished track record for his entire medical career spanning almost 40 years.

(b) The Respondent had always been dedicated towards serving the community at large, and his clinic practice was predominantly a general practice with the bulk of his patients being residents in the HDB neighbourhood. He had been working tirelessly round the clock to provide comprehensive and continuing care to his patents, many of whom were his regular patients. He had acted out of genuine care and concern for his patients, rather than any selfish or malicious intention, and his main motivation had been to alleviate his patients' suffering as best as he could.

(c) The Respondent had shown remorse and insight and was unlikely to reoffend in the future. Following the MOH audit, he had taken more detailed clinic notes and taken steps to improve his prescription practices and exercised greater caution in prescribing benzodiazepines and/or codeine-containing medications.

183. Considering all the mitigating factors, a discount should be applied to the sentence for each charge. The Respondent's proposed sentencing for each charge, after taking the discount into account, was as follows:

(a) Benzodiazepine Prescription Charges – two months each (notional);

(b) Benzodiazepine Referral Charges – one month each (notional); and

(c) Codeine Prescription Charges – one month each (notional).

Documentation Charges

184. The Respondent submitted that the appropriate starting point for each Documentation Charge should be within the range of two to three months. This was because:

(a) Unlike in *Mohd Syamsul*, where the court imposed a suspension of three months for the doctor's failure to keep proper records, the Respondent's clinic was not part of a larger clinic group with rostered doctors. Instead, he worked in a clinic together with two other doctors, and he was the anchor doctor accounting for about 70% of the patients seen. The other doctors had no issues referring to the Respondent's clinical notes and managing the Respondent's patients when he was not on duty.

(b) Although the Respondent merely recorded his patient's symptoms and the medications prescribed, it was because his patients had returned for the same repeated problems for years, and he did not take detailed notes on their repeat visits given that the diagnoses and treatment plans remained the same. He had nevertheless documented the diagnoses, findings and treatment plans at least on the initial consultations with each patient.

185. The Respondent submitted that for the Benzodiazepine Documentation Charges, it would be appropriate to apply a starting point of three months' suspension for each charge. This should be reduced to a notional one month's suspension, taking into account the following factors:

(a) There was an inordinate delay in prosecution. There should be at least a 50% reduction in sentence for each Benzodiazepine Documentation Charge.

(b) The Respondent pleaded guilty to all the Benzodiazepine Documentation Charges save for the 5th Charge of NOI (1) (PAT 4). This ought to be considered as a mitigating factor in sentencing.

(c) The Respondent had shown some remorse and insight. He had sought to improve on his documentation practice following the MOH audit by maintaining more detailed documentation.

186. For each General Documentation Charge, the Respondent submitted that a starting point of two months' suspension would be appropriate. The starting point should be lower as compared to a Benzodiazepine Documentation Charge as there was a relatively lower level of harm and arguably a lower level of culpability. Taking into account the delay in prosecution and the Respondent's remorse and insight, the Respondent submitted that the appropriate sentence should be a notional one month's suspension.

187. With respect to the Codeine Documentation Charges, the Respondent submitted that a starting point of two months' suspension would be appropriate. The Respondent submitted that it was arguable that there was a lower level of culpability as compared to a Benzodiazepine Documentation Charge, given that there were no written guidelines setting out requirements on documentation in relation to prescriptions of codeine-containing medications. Taking into account the inordinate delay in prosecution and the Respondent's remorse and insight, the Respondent submitted that the appropriate sentence should be a notional one month's suspension.

Aggregate sentence

188. The Respondent submitted that the sentences for two Prescription Charges (*i.e.*, two months each), two Benzodiazepine Referral Charges (*i.e.*, one month each) and two Documentation Charges (*i.e.*, one month each) ought to run consecutively, such that the aggregate sentence ought to be a suspension period of eight months.

189. The Respondent also submitted that it was reasonable for the SMC to propose that the sentence for one Benzodiazepine Prescription Charge, one Codeine Prescription

Charge, one Benzodiazepine Referral Charge and one Documentation Charge ought to run consecutively.

190. The Respondent submitted that an aggregate sentence of eight months' suspension would be appropriate.

DT's Decision on the Appropriate Sentence

Prescription and referral charges

Step 1: Evaluate seriousness of offence with reference to harm and culpability

(1) Harm

191. We are of the view that the level of harm is slight, but at the upper range of the "slight" level. We set out our reasons below.

192. First, there was no actual harm. The harm in this case was the potential harm that could have resulted from the Respondent's breach. The potential harm to each patient was in the form of potential drug dependence, abuse and addiction. There was no evidence of actual harm, and no evidence adduced by SMC that any of the patients developed tolerance, dependence, or addiction to benzodiazepines and/or codeine-containing medications. Indeed, SMC stated that it was never their case that actual harm had materialised in the patients.[56]

193. Second, we considered the period of time over which the Respondent had inappropriately prescribed benzodiazepines and codeine-containing medications. This showed the extent of the Respondent's breaches and was a factor to be considered when assessing the level of harm. A summary of the duration of prescriptions and medications was set out by the Respondent in his sentencing submissions, which we reproduce below.[57]

[56] SMC's Reply Sentencing Submissions dated 2 October 2023 at [22].
[57] Respondent's Sentencing Submissions dated 21 August 2023 at [20], as clarified by the Respondent's letter dated 8 November 2023.

Patient	Duration (as per Schedules)	Prescription
PAT 3*	2 years 10 months	Benzodiazepines (Alprazolam)
PAT 4	1 year 3 months	Benzodiazepines (Diazepam, Lorazepam and Bromazepam)
PAT 10*	2 years 6 months	Benzodiazepines (Alprazolam)
PAT 14*	1 year 7 months	Benzodiazepines (Alprazolam)
PAT 15	2 months	Benzodiazepines (Lorazepam)
PAT 16*	1 year 9 months	Benzodiazepines (Lorazepam)
PAT 5	3 years 10 months	Various codeine-containing medications (Macrodine, Conkoff, Conkoff / Actifed, Codipront and Panaco)
PAT 6	7 years 1 month	Various codeine-containing medications (Actifed Co, Conkoff, Conkoff / Macrodine, Macrodine, Codipront and Panaco)
PAT 7	2 years 1 month	Codeine-containing medications (Actifed/Macrodine, Conkoff/Actifed)
PAT 9	3 years 8 months	Codeine-containing medication (Codipront)
PAT 11	1 year 5 months	Codeine-containing medication (Panaco)

*(Note: * = there is a corresponding Benzodiazepine Referral Charge for the same charge period)*

194. We note that the charge faced by the Respondent in respect of the patient PAT 5 spanned the period 8 December 2003 to 20 October 2016. However, as the Respondent pointed out,[58] the Schedule to that charge[59] indicates that the Respondent was charged for the inappropriate prescription of codeine-containing medications for three separate periods across that entire duration. This was (a) on 8 December 2003; (b) from 10 June 2005 to 16 October 2005; and (c) from 20 May 2013 to 20 October 2016. It would therefore not be accurate to characterise the duration of the Respondent's inappropriate prescriptions as one that took place over 13 years.

[58] Respondent's Reply Submissions on Sentencing dated 2 October 2023 at [7].
[59] 1st Charge of NOI (2) (PAT 5).

195. From the table set out above, it can be seen that the duration of inappropriate prescriptions for a majority of the patients was for a period of below three years. Out of the 11 patients involved, the duration of inappropriate prescriptions for eight of the patients ranged from two months to two years and ten months. There were only two codeine patients (PAT 5 and PAT 9) where the duration of prescriptions was more than three years (three years ten months and three years eight months respectively), and one codeine patient (PAT 6) where the duration of prescriptions was more than seven years.

196. We note that the period of time over which the Respondent inappropriately prescribed benzodiazepines and codeine-containing medications was much lower than the duration of the prescriptions in *Chia Kiat Swan* and *Tan Joong Piang*, where the level of harm was classified as moderate:

(a) In *Chia Kiat Swan*, the respondent pleaded guilty to four charges of inappropriate prescription of benzodiazepines to four patients, one charge of failing to refer a patient to a specialist and three charges of inadequate record-keeping. The duration of prescriptions ranged from over six years to nearly 12 years. The duration of prescriptions in that case far outweighed the present case, where the duration of prescriptions ranged from two months to seven years and one month. The potential harm arising from the risks of addiction and dependence was lower in the present case.

(b) In *Tan Joong Piang*, the respondent pleaded guilty to six charges of inappropriate prescription of hypnotics to six patients, six charges of failure to refer the patients to a specialist, and six charges of inadequate record-keeping. The duration of prescriptions ranged from ten years to 14 years and two months. Further, vulnerable patients were involved. All the patients were advanced in years, with the youngest being 57 years at the date of last prescription. Given the period of time over which hypnotics were prescribed in *Tan Joong Piang*, the potential harm arising from the risks of addiction and dependence was higher in that case.

197. While SMC submitted that the most relevant precedent was *Wee Teong Boo*, we agree with the Respondent that that case is distinguishable. The court in *Wee Teong Boo* found that the doctor's prescriptions for five of his patients were for the sole purpose of fuelling the patients' addictions, and not because of the patients' underlying medical condition. For another five of the patients, the court found that the doctor had known that they were dependent on codeine-containing cough mixtures and benzodiazepines and had knowingly perpetuated their addictions. Even if those patients had not suffered from drug dependency issues at the time of their first consultation, the patients had in fact developed such dependency though the doctor's improper prescriptions. *Wee Teong Boo* was clearly distinguishable from the present case, where there was no evidence that any of the patients had addiction or dependency issues. The prescriptions in the present case were clearly not for the purpose of fueling patients' addictions, and this was not a case where the Respondent had knowingly perpetuated his patients' addictions.

198. SMC also submitted that in both *Wee Teong Boo* and the present case, the respondent had diluted codeine mixtures or used admixtures. The court in *Wee Teong Boo* found that this increased the risk to patients and was not an appropriate treatment option, and SMC submitted that the use of admixtures was a similar aggravating factor in the present case as this would increase the risk to patients. However, there was insufficient evidence in the present case as to the composition of the admixtures and the effect of the admixtures on the patients. SMC has not demonstrated that the use of admixtures in the present case resulted in a higher level of harm.

199. We are however also aware that the period of time over which inappropriate prescriptions were made in the present case was higher than that in the following cases, where the level of harm was classified as slight:

(a) In *Singapore Medical Council v Dr Eugene Ung* [2021] SMCDT 4 ("***Eugene Ung***"), the respondent pleaded guilty to 13 charges of inappropriate prescription of benzodiazepines to 13 patients, and nine charges of keeping inadequate medical records. The duration of inappropriate prescriptions ranged from one year and seven months to three years and two months. In that case, there was no evidence of actual harm caused to any patient.

(b) In *Tan Kok Jin*, the respondent pleaded guilty to 11 charges of inappropriate prescription of benzodiazepines involving 11 patients, one charge of failure to refer a patient to a specialist, and two charges of failure to keep proper medical records. The duration of prescriptions ranged from one year and four months to two years and nine months. There was no evidence of actual harm caused to the patients.

(c) In *Andrew Tang*, the respondent was found guilty of ten charges of inappropriate prescription of codeine-containing medications to ten patients over periods of time that ranged from one month to 19 months. The respondent was acquitted of charges alleging a failure to exercise competent and due care in his management of the medical conditions of the patients, and charges of failure to keep medical records. However, *Andrew Tang* was not directly comparable to the present case, as the tribunal in *Andrew Tang* found that the respondent did not fail to provide competent care to his patients and the cough mixture containing codeine was prescribed as part of a treatment plan for each patient. The respondent in *Andrew Tang* was found guilty of the inappropriate prescription charges as he had prescribed codeine to his patients in breach of the 2000 Circular, by prescribing codeine beyond the 240 ml limit within four days. In contrast, in the present case, we found that many of the Respondent's prescriptions were made with no clear clinical basis.

200. In our view, the duration of prescriptions in the present case falls somewhere between the duration of prescriptions in the two groups of cases set out at [196] and [199] above, where harm was classified as moderate and slight respectively. Given however that in the present case, the majority of prescriptions were for a period not exceeding three years, and the fact that there was only one patient in respect of whom prescriptions were made for a period exceeding seven years, we are inclined to classify the harm as slight, although at the upper range.

201. Third, we agree with the Respondent that the present case was not one where highly addictive benzodiazepines were prescribed. As the Respondent pointed out, guideline (e) of the 2008 Administrative Guidelines provides that medical practitioners are

strongly discouraged from prescribing "highly addictive benzodiazepines" such as midadolam (Dormicum) and nimetazepam (Erimin). The risks of addiction and dependence are therefore lower in the present case.

202. Fourth, we agree with the Respondent that SMC had overstated the level of harm suffered by the Respondent's patients by reason of their age. SMC submitted that the patients were elderly and more vulnerable and that with the exception of PAT 6 and PAT 11, all the other patients were elderly patients in their 60s and 70s. SMC submitted that elderly patients were more susceptible to the inappropriate prescription of benzodiazepines and codeine-containing medications, and there was a particularly pertinent need to refer elderly patients to specialists as they were especially vulnerable. SMC also submitted that many of the benzodiazepine patients had multiple pre-existing conditions and were taking other kinds of medication, which made them even more susceptible to drug interactions and side effects.

203. However, as the Respondent pointed out, the SMC should refer to the ages of the patients at the material time when the prescriptions were made, rather than the current ages of the patients. The table below[60] sets out the patients' ages as at their first visit to the Respondent and as at 1 November 2016, the date of MOH's audit on the Respondent's clinic. As at 1 November 2016, there were four patients (rather than only two) who were not in their 60s and 70s.

Patient	**Date of First Visit**	**Age (as at First Visit)**	**Age (as at 1 November 2016)**
PAT 3	13 April 2006	67	77
PAT 4	12 September 2002	58	72
PAT 10	23 April 1990	55	81
PAT 14	16 May 1990	33	59
PAT 15	11 December 2012	57	61
PAT 16	22 September 2011	52	57
PAT 5	8 December 2003	63	76
PAT 6	20 February 2006	23	33
PAT 7	22 February 1997	63	82
PAT 9	17 August 2011	63	69

[60] This table was set out at [15] of the Respondent's Reply Submissions on Sentencing dated 2 October 2023. The SMC confirmed by way of its email dated 10 November 2023 that the ages of the patients are as set out in the table.

PAT 11	14 September 2001	29	45

204. We agree with the Respondent that the risks of harm would only be higher where benzodiazepines, as opposed to codeine-containing medications, are prescribed to elderly patients. There was no evidence adduced in the course of the inquiry which demonstrated that elderly patients would face additional risks of harm from codeine-containing medications as compared to the general population.

205. We observed that of the benzodiazepine patients, who are the first six patients in the table above, three were in their 70s and 80s as at 1 November 2016, while the youngest of the three remaining patients was 57 years of age. We note the Respondent's submission that an "elderly patient" should only be one who is aged 65 or more, as this is how "elderly" is defined in the 2008 CPG.

206. We agree further with the Respondent that SMC has not established that there would be greater harm if there is a failure to refer elderly patients to specialists. SMC referred to the ACE Guidelines Clinical Guidance for Asthma, which recommends specialist referral for elderly patients, but that recommendation had been made specifically in relation to patients with asthma, and not for all elderly patients in general.

207. We also do not agree with SMC's submission that there was greater harm because the Respondent had prescribed benzodiazepines to patients who had multiple pre-existing conditions and were taking other kinds of medications. As the Respondent submitted, a patient would suffer greater harm only if he/she is prescribed with benzodiazepines when they are contraindicated.

208. In summary, while we agree with the SMC that the Respondent's inappropriate prescriptions caused harm to the benzodiazepine patients, particularly since a number of them were elderly patients, the SMC had overstated the level of harm.

209. We should state that we did not place much weight on the Respondent's submission that he had adopted various appropriate safeguards to ensure that his patients did not develop dependence to benzodiazepines and/or codeine-containing medications. We

note that several prescriptions were over the counter prescriptions, which did not involve any clinical review of the patients by the Respondent. Where such over the counter prescriptions were made, there would not have been any review by the Respondent for any signs or evidence of misuse or dependence in the patients.

210. On balance, having considered the various factors set out above, we are of the view that the harm should be classified as slight. Given the periods of time over which the inappropriate prescriptions of benzodiazepines and codeine-containing medications were made, and the fact that there were a number of elderly benzodiazepine patients involved, we are of the view that the harm should be classified at the upper range of the "slight" level.

(2) Culpability

211. We are of the view that the Respondent's culpability was at the upper range of the "medium" level. Our reasons are as follows.

212. As SMC pointed out, the Respondent had failed in numerous aspects of the care, management and treatment of his patients, and there was no clear clinical basis for many of the Respondent's prescriptions. Among other things, the Respondent had inappropriately prescribed benzodiazepines or codeine-containing medications over the specified periods, he had not carried out an adequate assessment of his patients' medical condition over the period of treatment, and as can be seen from the Annex, there were no clear medical grounds for many of his prescriptions. For example, the Respondent had prescribed benzodiazepines instead of SSRIs as the first-line treatment for anxiety disorder to patients such as PAT 10, and we found that there was no clear diagnosis which justified the prescription of codeine to PAT 9. The extent of departure from the standard of care is one of the factors to be considered when assessing the level of culpability,[61] and the extent of the Respondent's departure from the standard of care in this case was not insubstantial.

[61] Sentencing Guidelines at [54(d)].

213. While the Respondent sought to argue that his prescriptions were part of a sincere attempt to help the patients concerned to function in their respective lives and that he had his patients' best interests in mind, we note that the Respondent had in many instances not reviewed his patients before prescribing medications to them. Without clinically reviewing the patients, the Respondent could not have assessed whether the condition of the patients had changed since their last visit. He could not have made a proper assessment of the patients before prescribing the medications, and he would not have been in a position to ascertain whether his prescriptions would indeed help the patients to function. For example, in respect of the patient PAT 7, between the period 6 May 2016 to 31 October 2016, which was a period of around six months, the Respondent prescribed codeine-containing medication on 11 occasions without reviewing the patient.

214. The Respondent also submitted that he had prescribed benzodiazepines and/or codeine-containing medications to patients who refused to or were unable to proceed with alternative options of managing their medical conditions. One example cited by the Respondent was PAT 3, whom he said refused to return to Institution C to visit a psychiatrist and wanted the Respondent to continue treating her anxiety with Alprazolam. However, as pointed out by SMC, there was no documentation of the patient seeing an Institution C psychiatrist or refusing to go back to Institution C. In addition, the Respondent claimed that he had prescribed benzodiazepines to patients who were unable to tolerate SSRIs, and he cited PAT 15 as an example. However, as SMC pointed out, the Respondent had actually started the patient with Lorazepam and Fluoxetine (a benzodiazepine and a SSRI respectively) on the same day, when benzodiazepines should not have been prescribed as the first-line treatment for the patient's anxiety and insomnia.

215. The Respondent also submitted that he had taken remedial steps after the MOH audit, by seeking to wean his patients off benzodiazepines/codeine-containing medications where possible. However, we note that the Respondent cited only two examples in support of this submission, and these were with respect to the patients PAT 14 and PAT 15.

216. As SMC pointed out, the Respondent admitted to breaching paragraphs (f) and (j) of the 2008 Administrative Guidelines. The Respondent also admitted that he had breached the 2000 Circular on three occasions in respect of PAT 5, by prescribing more than 240 ml of codeine-containing medications to the patient within four days. Whilst the Respondent submitted that there were no applicable local guidelines in relation to solid form codeine at the material time and he should not be unduly penalised for his prescriptions of solid form codeine, the Respondent should have been aware that there were risks of codeine dependence or misuse associated with the consumption of solid form codeine.[62]

217. We also took into account the fact that the Respondent was convicted of inappropriate prescriptions of benzodiazepines and codeine-containing medications to 11 patients over an extended period of time, as set out at [193] above. The Respondent's inappropriate prescriptions of benzodiazepines ranged for a period between two months to two years and ten months, whereas the Respondent's inappropriate prescriptions of codeine-containing medications ranged for a period between one year and five months to seven years and one month. The offending behaviour took place over a sustained period of time.

218. Given the factors set out above, we are of the view that the Respondent's culpability should at least be classified as medium. We note in this regard that in *Eugene Ung* and *Tan Kok Jin,* which were cases where the level of culpability was classified as medium, the duration of the offending behaviour was shorter than the duration in the present case. In *Eugene Ung*, the respondent was charged with inappropriate prescriptions involving 13 patients. The duration of inappropriate prescriptions ranged from one year and seven months to three years and two months. In *Tan Kok Jin*, the respondent was charged with inappropriate prescriptions involving 11 patients. The duration of inappropriate prescriptions ranged from one year and four months to two years and nine months. In our view, the level of culpability in the present case was higher than the level of culpability in those cases, and we would place the Respondent's culpability at the upper range of the "medium" level.

[62] See page 138 of these Grounds of Decision, point 7 of the column titled "DT's Decision".

219. However, we do not think that the Respondent's culpability should be classified as high.

220. First, we accept the Respondent's submission that the Respondent did not make inappropriate prescriptions for improper financial gain. There was no suggestion that he had acted maliciously.

221. Second, we are of the view that the Respondent's culpability was lower than that of the respondents in *Tan Joong Piang* and *Wee Teong Boo*, cases where the level of culpability was classified as high:

(a) In *Tan Joong Piang*, the scale and extent of the wrongdoing was severe. Six patients were prescribed hypnotics over a period that ranged from ten years to 14 years and two months. In the present case, the period of time over which inappropriate prescriptions were made was much shorter.

(b) In *Wee Teong Boo*, the court held that the respondent prescribed medication without any clinical basis for doing so, knowing full well that his prescriptions would likely perpetuate his patients' drug dependency issues. As indicated at [197] above, the court found that the respondent's prescriptions for five of his patients were for the sole purpose of fuelling the patients' addictions, and not because of the patients' underlying medical condition. For another five of the patients, the court found that the respondent had known that they were dependent on codeine-containing cough mixtures and benzodiazepines and had knowingly perpetuated their addictions. The present case was clearly distinguishable from *Wee Teong Boo*. There was no evidence in the present case that any of the patients had dependency or addiction issues, and the Respondent had clearly not prescribed the medications to fuel his patients' addictions.

222. We also considered the case of *Chia Kiat Swan* in coming to our assessment of the level of culpability. In *Chia Kiat Swan*, the tribunal found the level of culpability to be somewhere at the upper range of the "medium" level or the lower range of the "high" level. The respondent in that case inappropriately prescribed benzodiazepines for a long period of time, from over six years to nearly 12 years. This was much longer than in

the present case, where there was only one patient to whom medications were inappropriately prescribed for a period of over six years. However, we note that in *Chia Kiat Swan*, the respondent had conducted careful clinical reviews of his patients and sought to gradually taper doses for long-term patients, findings which we were not prepared to make in the present case.

223. On balance, considering the various points set out above, we are of the view that the Respondent's culpability should be at the upper range of the "medium" level.

Step 2: Identify the applicable indicative starting range

224. The second step is to identify the applicable indicative sentencing range. As indicated above, our view is that the harm should be classified at the upper range of the "slight" level, and the Respondent's culpability is at the upper range of the "medium" level. Based on the harm-culpability matrix, the applicable indicative sentencing range is a suspension of three months to one year.

Step 3: Identify the appropriate starting point within the indicative sentencing range

225. As we have indicated that harm and culpability should be classified at the upper range of the levels of "slight" and "medium" respectively, the appropriate starting point should be at the upper end of the applicable sentencing range. In our view, the starting point within the range should be nine to 12 months. We do not agree with the Respondent that the starting point should be three to six months. That submission was on the premise that the level of harm ought to be slight and the level of culpability ought to be at the lower range of "medium".

(1) Benzodiazepine Prescription Charges and Codeine Prescription Charges

226. In our view, the applicable starting point for the Codeine Prescription Charges should be nine months, whereas the applicable starting point for the Benzodiazepine Prescription Charges should be higher. In this regard, we agree with SMC that the Respondent's misconduct in respect of the Benzodiazepine Prescription Charges was more egregious, thus warranting a higher starting point. The 2008 Administrative

Guidelines provide clear guidance on the prescription of benzodiazepines. The Respondent also admitted to breaching the 2008 Administrative Guidelines, which expressly prohibit the prescription of benzodiazepines beyond intermittent use and the repeat prescriptions for benzodiazepines without a clinical review. In contrast, the only local guideline dealing specifically with the prescription of codeine at the material time was the 2000 Circular, and the Respondent breached the 2000 Circular relating to the prescription of liquid codeine in respect of only one patient on limited occasions. In our view, the Respondent's misconduct in respect of the Benzodiazepine Prescription Charges was more egregious.

227. We should state that we do not agree with SMC's submission that a higher starting point for the Benzodiazepine Prescription Charges was warranted because many of the benzodiazepine patients had multiple pre-existing conditions. As the Respondent pointed out, the risks of harm from benzodiazepines in patients with pre-existing conditions are not necessarily greater unless those conditions are contraindications, and SMC did not adduce evidence to show that benzodiazepines were contraindicated in the patients.

228. In our view, a starting point of 11 months for the following charges would be appropriate:

(a) 4th Charge of NOI (1) (PAT 4): The Respondent had prescribed benzodiazepines to this patient on a total of five occasions. The first two occasions were over a period that spanned seven months, while the last three occasions were over a period that spanned seven months.

(b) 15th Charge of NOI (1) (PAT 15): The Respondent had prescribed low doses of benzodiazepines (140 tablets of Lorazepam) to the patient on three occasions over a cumulative period of two months.

(c) 17th Charge of NOI (1) (PAT 16): The Respondent had prescribed low doses of benzodiazepines (100 tablets of Lorazepam) to the patient on only four occasions over a period that spanned one year and nine months.

229. In our view, a starting point of 12 months should apply to the following Benzodiazepine Prescription Charges. The number of occasions on which benzodiazepines were prescribed was much higher, and the prescriptions were for an extended period of time:

(a) 1st Charge of NOI (1) (PAT 3): The Respondent had prescribed 620 tablets of Alprazolam to the patient on 23 occasions over a period of two years and ten months. Fifteen of the prescriptions were made over the counter without a review of the patient.

(b) 7th Charge of NOI (1) (PAT 10): The Respondent had prescribed 860 tablets of Alprazolam to the patient on 18 occasions over the course of two years and six months. On seven of these occasions, the prescriptions were made over the counter without a review of the patient.

(c) 12th Charge of NOI (1) (PAT 14): The Respondent had prescribed 585 tablets of Alprazolam to the patient on 21 occasions over a period of one year and seven months. Seventeen of these prescriptions were over the counter prescriptions.

(2) Benzodiazepine Referral Charges

230. We agree with the Respondent that the applicable suspension period for each of the Benzodiazepine Referral Charges should be lower than the suspension period for each of the Benzodiazepine Prescription Charges. We agree that the gravity of the inappropriate prescription charges may be considered more aggravated than the failure to refer to an appropriate specialist. This was the approach taken in *Tan Kok Jin*. In *Tan Kok Jin*, the tribunal had imposed a suspension of three months for the respondent's failure to refer a patient to an appropriate specialist, whereas for the prescription charge in relation to the same patient, the tribunal had imposed a suspension of six months.

231. In the present case, the Respondent exercised his clinical judgment not to refer the patients to a specialist as there were no signs of dependence, addiction or any other issues that called for a referral. While the Respondent had not complied with the 2008 Administrative Guidelines in not referring the patients to a specialist when the patients

had been prescribed with benzodiazepines beyond eight weeks, the failure to refer did not result in any actual harm to the patients. The Respondent's clinical judgment proved to be correct. We are of the view that the applicable suspension period should be lower than the suspension period for each Benzodiazepine Prescription Charge. In our view, a suspension period of four months for each Benzodiazepine Referral Charge would be adequate to reflect the gravity of the breach.

Step 4: Taking into account offender-specific aggravating and mitigating factors

232. We are of the view that a discount should be given for the delay in prosecution. In *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356 ("***Ang Peng Tiam***"), it was recognised that the court or tribunal could exercise its discretion to discount the sentence if the following cumulative conditions were met:

(a) There has been a significant delay in prosecution;

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

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

In addition, the court held that while the underlying rationale for a sentencing discount to be applied in such cases of delay is fairness to the offender as an individual, broader public interests which demand the imposition of stiff penalties may sometimes take precedence.

233. In the present case, we are of the view that there has been a significant delay in prosecution. The first NOC was served on the Respondent on 12 March 2018, the second NOC was served on 12 December 2019, and the NOIs were issued on 13 April 2021. While we note SMC's submission that it was only in the course of investigations into the first NOC that information relating to the Respondent's prescriptions of codeine-containing medications came up, there was no explanation as to why the Respondent's prescription practices as a whole were not investigated at the outset. Further, once information relating to the Respondent's prescriptions of codeine-containing medications came up, the process should have been expedited so that the

NOIs could be issued, bearing in mind the fact that the first NOC was issued some time earlier. Instead, the Respondent was left with the matter hanging over his head until NOI (1) and NOI (2) were issued on 13 April 2021, which was three years and one month from the date the first NOC was served on the Respondent, and one year and four months from the date the second NOC was served on the Respondent.

234. The delay in prosecution was not contributed to by the Respondent, and resulted in prejudice to the Respondent. In this regard, even though the Respondent could carry on his practice, we accept the Respondent's submission that he had suffered anxiety and distress during this extended period. As recognised by the court in *Ang Peng Tiam* at [111], where there has been inordinate delay in prosecution, the sentence should reflect the fact that the matter has been pending for some time, likely inflicting undue suffering on the offender stemming from the anxiety, suspense and uncertainty.

235. A reduction in sentence of either one-third or half was given in the following cases as a result of a delay in prosecution:

(a) In *Chia Kiat Swan*, there was a delay of two years and eight months from the time of the issue of the NOC to the service of the NOI. A one-third discount on the period of suspension was given.

(b) In *Tan Joong Piang*, a reduction of one-third of the term of suspension was given as there was a delay of 2.5 years in the prosecution of the case.

(c) In *Eugene Ung*, there was a delay of three years and two months between the issuance of the NOC and the service of the NOI. A 50% reduction in sentencing was applied.

(d) In *Tan Kok Jin*, there was a delay of three years and ten months between the dates of service of the NOC and the NOI. A 50% reduction in sentencing was applied.

236. In the present case, the NOI was issued three years and one month from the date the first NOC was served on the Respondent, and one year and four months from the date the second NOC was served on the Respondent. In the light of the circumstances of the case, which involved two investigations against the Respondent, we think it would be appropriate to give a reduction in sentence of one-third on account of the delay. We are not persuaded that broader public interests which demand the imposition of a stiff penalty should take precedence in this case over considerations of fairness to the Respondent.

237. The SMC submitted that an aggravating factor that should be taken into account was that the Respondent repeatedly embellished his evidence and gave an account of events that was not borne out by objective contemporaneous evidence. We note that there were indeed instances where the Respondent gave evidence that was not borne out by what was set out in the PMRs or his witness statements. However, we took into account the Respondent's submission that he had been dedicated towards serving the community at large, and that he had shown remorse and insight and had taken steps to improve his prescription practices and exercised greater caution in prescribing benzodiazepines and/or codeine-containing medications.

238. In relation to the Respondent's submission that a mitigating factor that should be taken into account was the fact that he had a long unblemished track record for his medical career spanning almost 40 years, this was balanced against the seniority of the Respondent, which can be regarded as an aggravating factor in medical disciplinary cases: Sentencing Guidelines at [69]. The seniority and eminence of a doctor attracts a heightened sense of trust and confidence, and the negative impact on public confidence in the integrity of the medical profession is amplified when such a person is convicted of professional misconduct.

239. On balance, taking into account the various aggravating and mitigating factors, we do not consider it necessary to make any further adjustments to the starting point, apart from a reduction in sentence of one-third on account of the delay in prosecution.

240. Applying a one-third reduction in sentence, we consider that it would be appropriate for the period of suspension for each charge to be as follows:

Charge	**Starting Point**	**Sentence (after discount)**
Benzodiazepine Prescription Charges		
1st Charge of NOI (1) (PAT 3)	12 months	8 months
4th Charge of NOI (1) (PAT 4)	11 months	7 months and 2 weeks (rounded up)
7th Charge of NOI (1) (PAT 10)	12 months	8 months
12th Charge of NOI (1) (PAT 14)	12 months	8 months
15th Charge of NOI (1) (PAT 15)	11 months	7 months and 2 weeks (rounded up)
17th Charge of NOI (1) (PAT 16)	11 months	7 months and 2 weeks (rounded up)
Benzodiazepine Referral Charges		
3rd Charge of NOI (1) (PAT 3)	4 months	3 months (rounded up)
9th Charge of NOI (1) (PAT 10)	4 months	3 months (rounded up)
14th Charge of NOI (1) (PAT 14)	4 months	3 months (rounded up)
19th Charge of NOI (1) (PAT 16)	4 months	3 months (rounded up)
Codeine Prescription Charges		
1st Charge of NOI (2) (PAT 5)	9 months	6 months
2nd Charge of NOI (2) (PAT 6)	9 months	6 months
3rd Charge of NOI (2) (PAT 7)	9 months	6 months
4th Charge of NOI (2) (PAT 9)	9 months	6 months
5th Charge of NOI (2) (PAT 11)	9 months	6 months

Documentation Charges

241. While the Sentencing Guidelines state that the sentencing framework in *Wong Meng Hang* can apply to non-clinical offences, the precedent cases involving inadequate medical documentation have not applied that sentencing framework. Instead, the cases have referred to the sentencing approach of the High Court in *Mohd Syamsul*. This was

also the approach adopted by the Respondent in the Respondent's Sentencing Submissions.

242. In *Mohd Syamsul*, the court imposed a suspension period of three months for the respondent's failure to keep proper records. The court found that the consultation note in that case was extremely brief and bereft of important details, which would have been essential to allowing another doctor reading the records to take over the management of the case. The court held that there was a grievous breach of the obligation to keep medical records, and the breach was aggravated by the fact that the respondent operated as part of a rota of doctors assigned to the company's medical centre. The court stated at [12] that the respondent was "thus effectively part of a group practice, which made it all the more crucial that detailed medical notes be kept by [the respondent], as the next doctor to see the [p]atient might well have been some other doctor who would then have had to depend on [the respondent's] notes to take over the care of the [p]atient."

243. In the present case, we agree with SMC that the documentation was inadequate and extremely lacking in details. The Respondent was also part of a group practice, where the patients could be seen by two other doctors, Dr F2 and Dr F1. Similar to *Mohd Syamsul*, we are of the view that a starting point of three months' suspension for each Documentation Charge would be appropriate. Even though the Respondent submitted that he had documented the diagnoses, findings and treatment plans on the initial consultations with each patient, the Respondent had not demonstrated that this was indeed done, and in any case, the diagnoses, findings and treatment plans could change over time. During the time period set out in the charges, the documentation was extremely inadequate.

244. We do not agree with the Respondent that a starting point of two months' suspension would be appropriate for each Documentation Charge apart from the Benzodiazepine Documentation Charges, whilst a starting point of three months' suspension would be appropriate for each Benzodiazepine Documentation Charge. The Respondent submitted that this would be in line with the decision in *Tan Kok Jin*, where a suspension of three months was imposed for inadequate documentation in relation to the prescription of benzodiazepines given the potentially harmful and addictive nature

of the drugs, and a suspension of two months was imposed for a charge which did not concern any prescription of benzodiazepines. However, we do not agree with the Respondent's submission for the following reasons:

(a) First, we note that in *Mohd Syamsul*, the court imposed a suspension of three months for a general documentation charge which did not concern any prescription of benzodiazepines. In the present case, given the lack of details in the documentation and the fact that the Respondent was part of a group practice, we are of the view that a starting point of three months for each General Documentation Charge is similarly appropriate. We do not think there is a need to impose a longer suspension period for each Benzodiazepine Documentation Charge, and we note that that was also not SMC's position.

(b) Second, it was not clear from *Tan Kok Jin* whether the respondent in that case was a sole practitioner, and whether a lower suspension period was given for the general documentation charge because the respondent was not part of a group practice. In contrast, the Respondent in the present case was part of a group practice.

(c) Third, if a longer period of suspension is imposed for each Benzodiazepine Documentation Charge, a longer suspension period should similarly be imposed for each Codeine Documentation Charge, given the potentially harmful and addictive nature of both types of drugs. Even though there are no guidelines on documentation relating specifically to the prescription of codeine-containing medications, there are general guidelines on documentation which the Respondent failed to comply with.

245. We would add that the case of *Eugene Ung* can be distinguished. In *Eugene Ung*, a notional suspension period of two months was imposed for each documentation charge relating to the prescription of benzodiazepines. However, in *Eugene Ung*, the tribunal found that the respondent was a sole practitioner and was not involved in a group practice, unlike the case of *Mohd Syamsul*. In the present case, the Respondent was in a group practice.

246. We are therefore of the view that a starting point of three months' suspension for each Documentation Charge is appropriate. We do not agree with the SMC that an uplift of one month's suspension should be given because the Respondent contested the charges when it was unmeritorious to do so, and that showed a lack of remorse. As the Respondent pointed out, he had a right to contest the charges and that should not result in an uplift of the sentence.

247. Instead, the delay in prosecution and the Respondent's plea of guilt in relation to five of the Documentation Charges are factors which would weigh in favour of the Respondent. We note however that the Respondent had pleaded guilty to only five out of the 15 Documentation Charges. Overall, we are of the view that a one-third reduction in sentence should be applied. Applying the one-third reduction in sentence, a notional suspension period of two months is imposed for each Documentation Charge.

Aggregate sentence

248. We agree with the parties that it would be reasonable to have the sentences for one Benzodiazepine Prescription Charge, one Benzodiazepine Referral Charge, one Codeine Prescription Charge and one Documentation Charge run consecutively, with the remaining sentences running concurrently. The aggregate sentence was therefore 19 months' suspension, with the following sentences running consecutively:

(a) Benzodiazepine Prescription Charge: 1st Charge of NOI (1) (PAT 3) – 8 months' suspension;

(b) Benzodiazepine Referral Charge: 3rd Charge of NOI (1) (PAT 3) – 3 months' suspension;

(c) Codeine Prescription Charge: 2nd Charge of NOI (2) (PAT 6) – 6 months' suspension; and

(d) Documentation Charge: 5th Charge of NOI (1) (PAT 4) – 2 months' suspension.

249. In our view, the aggregate sentence was proportionate to the overall culpability of the Respondent and the potential harm that the patients could have suffered. The sentence was also comparable to the aggregate sentence in precedent cases:

(a) In *Eugene Ung* and *Tan Kok Jin*, a sentence of 10 months' suspension and 12 months' suspension respectively was imposed. While the aggregate sentence in the present case was higher, this was reflective of the fact that in the present case, harm was classified at the upper range of the "slight" level and culpability was classified at the upper range of the "medium" level. In contrast, in *Eugene Ung* and *Tan Kok Jin*, harm was simply classified as slight and culpability was medium.

(b) In *Andrew Tang*, a case where harm was classified as slight and culpability was in the low to mid-range of "medium", a suspension period of three years and a fine was imposed. However, in that case, the respondent refused to participate in the proceedings and had antecedents. The tribunal took those aggravating factors into account.

(c) The period of suspension in the present case was higher than the 16 months' suspension period in *Chia Kiat Swan*, where harm was classified as moderate and culpability was at the upper range of "medium" or lower range of "high". In *Chia Kiat Swan*, the respondent was also ordered to pay a penalty of $15,000. However, the present case involved a much larger number of charges and patients. The Respondent in the present case was convicted of 29 charges, most of which were contested, whilst the respondent in *Chia Kiat Swan* pleaded guilty to eight charges with four charges being taken into consideration. In addition, the inappropriate prescriptions in the present case involved 11 patients whilst the inappropriate prescriptions in *Chia Kiat Swan* involved four patients.

(d) In *Tan Joong Piang*, the respondent was sentenced to 22 months' suspension. However, in that case, harm was classified as moderate and culpability was high.

250. In our view, the overall sentence of 19 months' suspension is appropriate.

Other orders

251. The SMC submitted that the usual orders of a censure, undertaking, and for the Respondent to pay the costs of the proceedings ought to be given. The Respondent also submitted that these related orders should be given, but submitted that SMC should only be allowed 85% of its costs. This was because:

(a) The first tranche of the DT inquiry was adjourned on 10 February 2022 for the Respondent to provide amended and supplementary transcripts of the PMRs to SMC. That led to NOI (1) and NOI (2) being amended, as the original charges against the Respondent had been brought on the basis that all the entries in the transcripts were made by the Respondent, when some of those entries were actually made by Dr F1, Dr F2 and the clinic assistants. The Respondent submitted that he should not be responsible for the costs incurred in relation to the amendment of the NOIs, as SMC should have ascertained these matters earlier, in the course of their investigations.

(b) On 7 September 2022, the SMC sought leave to amend certain Schedules to the NOIs, as there were 69 entries missing from those Schedules. The DT allowed the amendments and gave the Respondent the opportunity to address those amendments by way of a third witness statement. The Respondent should not be responsible for the costs of these amendments.

252. We consider it appropriate to make the usual orders of a censure and undertaking. In relation to costs:

(a) We do not agree with the Respondent that the first set of costs mentioned at [251(a)] should not be attributable to him. The Respondent acknowledged that in his letters of explanation to the CC dated 23 April 2018 and 3 February 2020, he had provided an explanation for the treatment of all the patients and he had indicated that he had treated the patients, even though he was not the doctor who

had treated the patients on certain occasions. It only came to light during the DT inquiry that some of the entries in the transcripts of the PMRs were not made by the Respondent. In such circumstances, we are of the view that the costs occasioned by the amendments should be borne by the Respondent.

(b) In relation to [251(b)], SMC had applied to amend seven Schedules to the NOIs because SMC had not included 69 entries in those Schedules. Those amendments were not necessitated by the acts of the Respondent in any way. We agree that the costs occasioned by these amendments should not be borne by the Respondent.

CONCLUSION

253. Accordingly, this Tribunal orders that:

(a) The Respondent be suspended for a period of **19 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; and

(d) The Respondent pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC, but excluding the costs occasioned by the amendments to the Schedules to the NOIs that were made by the SMC on 7 September 2022.

254. SMC suggested that the suspension commence 40 days after the date of the order. The Respondent did not object. In the premises, we order that the period of suspension is to commence 40 days after the date of the order.

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

256. The hearing is hereby concluded.

Prof Siow Jin Keat	Dr Siaw Tung Yeng	Ms Janice Wong
Chairman	Member	Judicial Service Officer

Ms Chang Man Phing and Ms Dorcas Ong (M/s WongPartnership LLP)
for Singapore Medical Council; and

Ms Loh Jen Wei and Mr Yeng Jun Kai (M/s Dentons Rodyk & Davidson LLP)
For Dr Ling Chia Tien

ANNEX: SUMMARY OF PARTIES' SUBMISSIONS AND THE DT'S DECISION

The SMC's submissions and the Respondent's submissions on each charge are set out in the columns titled "SMC's position" and "Respondent's position" respectively. These are reproduced in their entirety from the Joint Schedule of Positions on Charges.[63]

Benzodiazepine Prescription Charges and Benzodiazepine Referral Charges

SN	Charge	SMC's position	Respondent's position	DT's Decision
1.	Benzodiazepine Prescription Charge for PAT 3: 1st Charge of NOI (1)	1. In respect of Charge 1, the relevant period of the Respondent's treatment for PAT 3 spans the period 23 February 2014 to 1 November 2016. 2. The PMRs for PAT 3 between 2006 and 2013 were missing. The Respondent stated that they were disposed of as part of his clinic's culling process when a patient's PMRs get too thick. This has resulted in a significant gap in the initial portion of PAT 3's case notes, such that the Respondent was unable to conclude with certainty and had to speculate on the reasons and timing for his treatment of this patient with	Dr Ling diagnosed the patient with anxiety disorder, as (1) she had been prescribed with Alprazolam and Faverin by an Institution B psychiatrist and (2) she worries excessively. Dr Ling prescribed her with Alprazolam, as the patient did not find Faverin to be useful and he did not stock Faverin. Dr Ling advised the patient on the risks of prolonged use of benzodiazepines, but the patient did not wish to discontinue Alprazolam as it had been effective in controlling her symptoms.	1. The Respondent had prescribed Alprazolam, a benzodiazepine, to the patient many times between the period 23 February 2014 to 1 November 2016, which is the period set out in the charge. 2. While the Respondent's evidence was that Alprazolam was prescribed because of the patient's anxiety disorder, this diagnosis did not appear in the Respondent's PMRs, either in 2006 when the Respondent first started reviewing the patient, or in 2014 to 2016 during the period of the charge. The notes kept by the Respondent

[63] The columns "SMC's position" and "Respondent's position" contain certain abbreviations. Some of these abbreviations and the words they stand for are set out here for reference: (a) "RCS" – Respondent's Closing Submissions; (b) "RRS" – Respondent's Reply Submissions; and (c) "WS" – written submissions.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		benzodiazepines. The 2015 Guidelines for Retention Periods of Medical Records, MOH Circular 05/2015 ("**2015 Retention Guidelines**") require a doctor to retain medical records in paper form for at least 6 years. This is necessary for continuity of treatment. The Respondent had failed to do this. 3. Further, the Respondent had prescribed PAT 3 with Alprazolam concomitantly with Panaco / Hydroxyzine for his treatment of her anxiety issues. This diagnosis was made in July 2006 and premised on a brief documentation in an entry dated 15 July 2006. However, information which which is fundamental and critical to his management of PAT 3 was not documented in his PMRs. This included: a. PAT 3's medical history; b. Outcome of any physical examinations or assessments conducted by the Respondent on PAT 3; and	Dr Ling prescribed the patient with the daily lowest dosage of Alprazolam 0.25mg to 0.75mg to relieve her symptoms. He closely monitored the patient's condition and pattern of benzodiazepine use. Though the patient came back earlier on a few occasions, Dr Ling assessed that her overall use was under control and that she was not at risk of dependence. Dr Ling attempted to wean the patient off Alprazolam and convince her to start on antidepressants, but the patient insisted on continuing with Alprazolam. While Alprazolam was prescribed concomitantly with Panaco / Hydroxyzine on several occasions, the individual dosages did not exceed the recommended maximum daily dose. Overall, Dr Ling's management and care of the patient was appropriate.	were scanty and hardly set out any symptoms that would support the diagnosis of anxiety order or the prescription of Alprazolam over an extended period of time. 3. While the lack of documentation does not necessarily indicate that a proper examination and diagnosis were not made, we note that the Respondent was not entirely consistent in his explanations as to why Alprazolam had been prescribed to the patient. For example, he had indicated in his first explanation to the CC that he did not prescribe Faverin to the Respondent as he did not stock Faverin, but the Respondent later said that the patient had informed him that Faverin did not work for her.[64] Moreover, the Respondent conceded that the patient came back earlier than she was supposed to, to obtain benzodiazepines on a few occasions. This calls into question whether the

[64] Transcript of DT Inquiry on 30 August 2022, page 59.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		c. Reasons for the changes in medications prescribed to PAT 3. 4. At the outset, the Respondent's retrospective diagnosis of anxiety disorder for PAT 3 (to justify his prescriptions of Alprazolam) fails to meet the applicable standard: a. There was no mention of "anxiety disorder" in the Respondent's case notes for PAT 3 at all. b. There was no physical examination or physical assessment of PAT 3 carried out c. There were no symptoms indicated in the case notes such as "*frequent panic attacks, palpitations, giddiness and insomnia*" to form the basis of his diagnosis of anxiety disorder. 5. The Respondent's inconsistent position in explaining his prescription of Alprazolam (i.e. that PAT 3 did not find Faverin to be useful) is unreliable as none of it was recorded in his case notes. For example, the Respondent stated that	*(See RCS from [157] to [166]; RRS from [29] to [33] and from [114] to [125])*	Respondent's prescription of benzodiazepines was appropriate. 4. We note as well that there were no clinical grounds documented when the Respondent changed his dosage of Alprazolam for the patient. In addition, several prescriptions of Alprazolam were made without the Respondent reviewing the patient. This was a breach of paragraph (j) of the 2008 Administrative Guidelines, which states that repeat prescriptions for benzodiazepines should not be provided without a clinical review. 5. The Respondent had also prescribed Alprazolam rather than a SSRI as a first-line treatment to the patient. The Respondent indicated that he did not find it necessary to prescribe SSRIs, as the patient's symptoms could be controlled with Alprazolam without any side effects. However, this breaches the applicable standard, which is that SSRIs, rather than benzodiazepines, should be prescribed as the first-

SN	Charge	SMC's position	Respondent's position	DT's Decision
		PAT 3 had requested for him to provide "*these medications to her to relieve her frequent panic attacks, palpitations, giddiness and insomnia*". In respect of Faverin, the Respondent claimed that he "[does] *not stock Faverin and did not prescribe this to her*". However, on the stand, he suddenly claimed that PAT 3 had told him that "*Faverin doesn't work... she didn't find it to be useful*" and that PAT 3 did not request for Faverin. 6. Further, the Respondent stated that "[a]*lthough she had reported that she had seen an Institution B psychiatrist, she was a difficult patient and did not want to go back to Institution B to see the psychiatrist.* [The Respondent] *therefore continued to prescribe Alprazolam to her so as to keep her anxiety under control.*" This was not documented in the PMRs, when it should have been. However, in cross-examination in August 2022, the Respondent suddenly claimed that he was giving these medications as she had already been taking these same		line treatment for anxiety disorders. 6. We note as well that the Respondent had concomitantly prescribed the patient benzodiazepines together with opioids or other sedating drugs several times during the relevant period. 7. Overall, we are satisfied that the Respondent did not provide appropriate care, management and treatment to the patient and that the charge is made out. Given the guidelines in question and the protracted period over which benzodiazepines were prescribed, we find that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		medications from a psychiatrist at the material time in 2006. 7. The Respondent's glaring lapses in his treatment of PAT 3 is exacerbated by the fact that he is unable to even confirm when he first started prescribing Alprazolam to PAT 3. As noted above, the Respondent had discarded his old medical records for PAT 3, and did not even transfer over the important details, such as when he started prescribing Alprazolam to PAT 3. This is significant as the duration for which a patient has been taking benzodiazepines is of great importance as long term use can create tolerance and dependence due to its addictive nature. 8. There were many occasions when PAT 3 came back for a repeat purchase of Alprazolam much earlier than warranted. Yet, the Respondent did not elicit from PAT 3 why she was returning earlier for the repeat prescriptions, given that the medications should have lasted her a while more.		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		9. There was also no basis or clinical grounds documented for the Respondent's changes in the Alprazolam dosage. When questioned on whether there was a reason for this change in dosage, the Respondent was unable to point to a definite reason, and instead could only speculate that there was "*possibly a change in the symptom*". 10. The Respondent also concomitantly prescribed PAT 3 with benzodiazepines with other hypnotic medications, such as the anti-histamine Hydroxyine (Atarax) and codeine-containing medications. 11. Further, the Respondent's assertions are self-contradictory. At paragraph 158 of the RCS, the Respondent asserted that the patient had been seen by a psychiatrist from Institution B before 2006. This was not documented. In contrast, at paragraph 165 of the RCS, the Respondent submitted "the patient was seen once by a psychiatrist from Institution B. This was documented		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		by Dr F2 when the patient saw Dr F2 on 25 September 2016."		
	Benzodiazepine Referral Charge for PAT 3: 3rd Charge of NOI (1)	1. In respect of Charge 3, the relevant period of the Respondent's treatment for PAT 3 spans the period 23 February 2014 to 1 November 2016. 2. Although PAT 3's National Electronic Healthcare Records ("**NEHR**") shows that she has many health problems, this was not recorded in the "Past Medical History" section of the PMRs. The Respondent admitted that he did not do a comprehensive review of all of PAT 3's medical conditions before continuing her on Alprazolam. In spite of PAT 3's complicated medical history, the Respondent did not refer her to a specialist for management. 3. Further, the Respondent's knowledge on whether PAT 3 had previously seen a psychiatrist at Institution B, and whether she had refused to go back to the psychiatrist, is also inconsistent. Throughout the entire period of treatment with benzodiazepines for PAT 3, there	Dr Ling did not find it necessary to refer the patient to a psychiatrist, as he had assessed that she was not at risk of dependence / addiction and that Alprazolam was effective for her. Moreover, the patient refused to return to Institution B to see a psychiatrist. *(See RCS at [165]; RRS from [122] to [125])*	1. It was not disputed that the Respondent did not refer the patient to a specialist. The Respondent was of the view that it was not necessary to do so, as the patient was not at risk of dependence or addiction and Alprazolam was effective for her. In addition, the Respondent's position was that the patient refused to return to Institution B to see a specialist. 2. The Respondent's failure to refer the patient to a specialist was a clear breach of paragraph (n) of the 2008 Administrative Guidelines, which provides that patients who have been prescribed benzodiazepines beyond a cumulative period of eight weeks must be referred to the appropriate specialist for further management. 3. Here, the patient had been prescribed benzodiazepines for an extended period, which was beyond eight weeks, but the

SN	Charge	SMC's position	Respondent's position	DT's Decision
		was no record of any referral made by the Respondent, any offer to refer, or any refusal by the patient of such an offer.		patient was not referred to a specialist. Given the clear guidelines, the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.
2	Benzodiazepine Prescription Charge for PAT 4: 4th Charge of NOI (1)	1. In respect of this charge, the relevant period of the Respondent's treatment for PAT 4 spans the periods 12 September 2002 to 14 April 2003 and 13 March 2016 to 31 October 2016. 2. The Respondent claims that he had prescribed Lexotan / Lorazepam to PAT 4 for the treatment of PAT 4's vertigo. However, his diagnosis was not documented in his case notes. Absent any proper diagnosis recorded, there was no justification or medical grounds for his prescription of benzodiazepines to PAT 4. 3. Further, the Respondent failed to ensure that he carried out a proper diagnosis on PAT 4's to ensure he had proper and adequate medical	Dr Ling prescribed benzodiazepines to the patient on 5 occasions: 2 occasions for vertigo and 3 for insomnia. <u>Vertigo</u> The patient complained of feeling giddy, especially when looking up. Dr Ling's working diagnosis was that the patient's vertigo was benign and vestibular (most common type of vertigo). This diagnosis was confirmed as the vertigo eventually resolved with treatment. Dr Ling prescribed the patient with Lexotan and Lorazepam, as these benzodiazepines act centrally to suppress vestibular response. On each occasion, 1 benzodiazepine and 2 antihistamines were	1. The Respondent had prescribed benzodiazepines to the patient on two occasions for vertigo and three occasions for insomnia. 2. In relation to the prescription of benzodiazepines for vertigo, we agree with the SMC that the Respondent had failed to carry out a proper diagnosis of the patient, and had failed to ensure that there were adequate medical grounds to prescribe benzodiazepines to the patient. The Respondent did not think it was necessary to find out the patient's underlying cause of vertigo and did not do so. He had assumed that the vertigo had benign origins. In any case, as we have indicated at [107] of our grounds of decision, benzodiazepines are not clinically

SN	Charge	SMC's position	Respondent's position	DT's Decision
		grounds to prescribe benzodiazepines to PAT 4. The Respondent did not think it was necessary to find out underlying cause of vertigo as he assumed it had benign origins. 4. Additionally, benzodiazepines can only be used to treat vestibular vertigo, based on the medical literature produced by the Respondent. However, the Respondent did not conduct any assessment or investigations to find out the cause of vertigo, and thus would not have known whether PAT 4 was suffering from vestibular vertigo. 5. Further, the Respondent's lengthy account of events during PAT 4's consultation on 13 March 2016 as provided by him during his EIC was not documented in the PMRs, nor was it corroborated in his 1st Explanation to the CC or even in his 1st WS. It is evident that this was purely an embellishment to justify his prescription of benzodiazepine to PAT 4.	prescribed. As low doses of each class of medicines were given, there would not be any increased risks of falls / accidents. <u>Insomnia</u> On 13 March 2016, the patient complained of insomnia due to breathing difficulties at night (caused by cardiomyopathy and fluid overload). Dr Ling prescribed the patient with Diazepam 10mg at night for 5 days. The patient returned on 17 March 2016, reporting that he was feeling better. Dr Ling continued the patient on 14 days of Diazepam, as he anticipated that the patient would continue to suffer from insomnia due to his ongoing medical and financial problems. While Dr Ling knew it was not ideal to prescribe benzodiazepines as the patient had heart problems, Dr Ling had no choice as the patient was in a very poor state but refused to visit the hospital. Dr Ling also prescribed	indicated for vertigo, and the Respondent's prescription of benzodiazepines to treat vertigo was inappropriate. 3. In respect of the Respondent's prescription of benzodiazepines for insomnia, the Respondent had first prescribed the patient with diazepam for five days on 13 March 2016, followed by another prescription of diazepam on 17 March 2016 for 14 days. This was despite the patient saying he felt better on 17 March 2016. The Respondent indicated that he had prescribed diazepam on 17 March 2016 as he anticipated that the patient may continue to suffer from insomnia due to his ongoing medical and financial problems. 4. The Respondent's prescription of benzodiazepines was a breach of paragraph (f) of the 2008 Administrative Guidelines, which provides that benzodiazepines, when used for treating insomnia, should be prescribed for intermittent use (e.g. one night in

SN	Charge	SMC's position	Respondent's position	DT's Decision
		6. The Respondent prescribed the patient Diazepam 10mg for 5 days on 13 March 2016. No reasons were documented for the prescription of Diazepam. On 13 March 2016, the Respondent's documentation in the PMR is limited to recording the medication the patient received from SGH and the medication he prescribed that visit. There is no observation of symptom or physical examination recorded. 7. With regards to the 17 March 2016 entry, the Respondent claimed that he gave 14 days' prescription of Diazepam as he assumed that the patient would need it because of the patient's ongoing financial problems and worries. He was prepared to give diazepam as long as the patient was distressed and complained about insomnia. This is despite the fact that the patient was already feeling better and his insomnia had improved. He conceded that by prescribing Valium on a continuing basis, someone	Metazine and Spironolactone for his heart condition. Subsequently, on 31 October 2016, the patient complained of asthmatic cough. Dr Ling prescribed Coughlax syrup and added in Lorazepam tablets to reduce sleep disturbance due to cough. As the benzodiazepines were given for short-term use, Dr Ling did not consider the patient to be at risk of dependence / misuse. Dr Ling did not find it appropriate to prescribe SSRIs, as they do not treat vertigo and would not have rapid results on alleviating insomnia. While there were concomitant prescriptions with Panaco / codeine on several occasions, such prescriptions were short-term and the individual doses of each medicine were low. Overall, Dr Ling's management and care of the patient was appropriate.	two or three nights) and only when necessary. It was also a breach of paragraph (h) of the 2008 Administrative Guidelines, which provides that the dosage of benzodiazepines should be the lowest effective dose necessary to achieve symptomatic relief. 5. In addition, the prescription of benzodiazepines when the patient had heart problems was inappropriate. The Respondent himself acknowledged during the inquiry that giving Valium to a patient with such a severe heart condition could end up killing the patient.[65] 6. In relation to the prescription of benzodiazepines on 31 October 2016, the Respondent claimed that he prescribed Ativan to help the patient sleep better due to the cough that was disturbing the patient's sleep. There was however no documentation about the patient's sleep difficulties, and

[65] Transcript of DT inquiry on 30 August 2022, page 218.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		reading his case notes would think that the insomnia continues to bother the patient and he requires Valium to sleep. This is contrary to the patient's actual condition. 8. With regards to the 31 October 2016 entry, the Respondent claimed that he gave Ativan to help the patient sleep better due to the cough that was disturbing his sleep. He agreed that he did not document any sleep difficulties on 31 October 2016. His alleged justification is that he assumed "generally speaking" that patients who came to see the doctor for cough are bothered by the cough at night. This is a sweeping and unsubstantiated assumption as the cough can occur only in the day for some patients and not at night. When confronted with the fact that he could not justify the prescription of Ativan, the Respondent expressed surprise that he was required to justify "every single medication" that he gave to his patients. He disagreed with the express duty stated under paragraph 4.1.3 of the ECEG which required	*(See RCS from [167] to [181]; RRS from [126] to [132])*	the prescription appeared to be based on an unsubstantiated assumption on the part of the Respondent, that patients who visit a doctor for a cough are bothered by the cough at night. 7. In addition, the Respondent had prescribed benzodiazepines concomitantly with other sedating drugs. We note Dr PE's evidence that given that the patient was an elderly patient of 72 years of age, the concomitant prescription of multiple sedating drugs would put the patient at a higher risk of fall. 8. Overall, we are satisfied that the Respondent did not provide appropriate care, management and treatment to the patient and that the charge is made out. Given the clear guidelines in question and the protracted period over which benzodiazepines were prescribed, we are of the view that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently

SN	Charge	SMC's position	Respondent's position	DT's Decision
		him to do so. The Respondent's disagreement is unsustainable. 9. In response to paragraph 176, the Respondent's excuse that he had "no choice but to do so" is a poor excuse for giving benzodiazepine to a patient with such a severe heart condition. On the entry of 6 March 2016, he had already documented that the patient had "fluid overload and cardio myopathy" and he agreed that the patient's heart condition was very severe and this was subsequently confirmed by the SGH memo dated 8 April 2016 where it states the ejection fraction 20-25%. The Respondent was aware that Valium can depress breathing. When asked by the DT about the significance of giving Valium to a patient with such severe heart condition, the Respondent agreed that "yes, I may kill the patient". His only excuse for giving Valium was that he was being humane and trying to alleviate the patient's condition. The Respondent's management of the patient was not in the best interest		egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		of the patient and on the contrary, put the patient's health and safety at risk. 10. The inappropriateness of the Respondent's benzodiazepine prescriptions is further exacerbated by the fact that benzodiazepines were prescribed concomitantly with other sedating drugs on multiple occasions. Given the fact that PAT 4 was an elderly patient with a severe heart condition, the concomitant prescription of multiple sedating drugs would put the patient at a higher fall risk. Despite this, no documentation or assessment of PAT 4's health condition was carried out.		
	Benzodiazepine Referral Charge for PAT 4: 6th Charge of NOI (1)	1. In respect of this charge, the relevant period of the Respondent's treatment for PAT 4 spans the periods 12 September 2002 to 14 April 2003 and 13 March 2016 to 31 October 2016. 2. PAT 4 was an elderly patient with multiple complex conditions. Given that he was already on numerous medications, the Respondent should not have continued to treat him with	The 2008 Admin Guidelines do not require patients with "multiple complex conditions" to be referred to specialists. Also, Dr Ling had assessed that the patient was not at risk of dependence / misuse of benzodiazepines. The patient had also been resistant towards visiting the hospital for treatment.	1. We are of the view that the Respondent had not fallen below the applicable standard. 2. As the Respondent submitted, the 2008 Administrative Guidelines do not require patients with "multiple complex conditions" to be referred to specialists. 3. For the period between 12 September 2002 to 14 April 2003,

SN	Charge	SMC's position	Respondent's position	DT's Decision
		benzodiazepines and should instead have referred him to a specialist for appropriate management. However, the Respondent has confirmed in evidence that he did not refer PAT 4 to a psychiatrist or any other specialist during the material time.	*(See RCS at [180]; RRS from [133] to [134])*	which was a period of around seven months, the Respondent had seen the patient three times, but these were not for problems relating to benzodiazepine addiction. Instead, the patient had consulted the Respondent for issues relating to vertigo and gout. The patient did not fall within the categories of patients set out in paragraph (n) of the 2008 Administrative Guidelines who should be referred to the appropriate specialist for further management. The patient had not been prescribed benzodiazepines or other hypnotics beyond a cumulative period of eight weeks; the patient was not on high-dose and/or long-term benzodiazepines from his specialist or a general hospital; and there was no indication that the patient was non-compliant with professional advice to reduce the intake of benzodiazepines or other hypnotics. There was no indication for referral of the patient to a specialist.

SN	Charge	SMC's position	Respondent's position	DT's Decision
				4. In respect of the second period set out in the charge from 13 March 2016 to 31 October 2016, benzodiazepines were prescribed by the Respondent only three times. This was over a period of around seven months. Specifically, benzodiazepines were prescribed on 13 March 2016 and 17 March 2016, and there was thereafter an interval before benzodiazepines were prescribed again on 31 October 2016. Once again, the patient did not fall within the categories of patients set out in paragraph (n) of the 2008 Administrative Guidelines who should be referred to the appropriate specialist for further management. 5. In our view, the Respondent had not fallen below the applicable standard required of him. The Respondent is not guilty of this charge.
3	Benzodiazepine Prescription Charge for PAT	1. In respect of this charge, the relevant period of the Respondent's treatment	Dr Ling had been seeing the patient for hypertension and the patient's symptoms did not improve with	1. The Respondent had prescribed Alprazolam numerous times over the period 29 April 2014 to 31

SN	Charge	SMC's position	Respondent's position	DT's Decision
	10: 7th Charge of NOI (1)	for PAT 10 spans the period 29 April 2014 to 31 October 2016. 2. The Respondent claims that he had prescribed Alprazolam to PAT 10 for the treatment of General Anxiety Disorder ("**GAD**") and panic disorder. However, it is unclear from the PMRs when he had made these diagnoses, and the Respondent admitted that he was unable to tell himself, because there was a significant gap in the PMRs between 1994 to 2012 where the PMR had been culled. 3. Given that there were no available PMRs documenting the Respondent's diagnoses, it is unclear how he arrived at the two diagnoses of GAD and panic disorder to warrant the prescription of benzodiazepines. Under such circumstances, there were no documented investigations, examinations, and clinical findings leading to and supporting the Respondent's eventual diagnoses that would form the medical grounds for his benzodiazepine prescriptions.	anti-hypertensive medicines. Dr Ling diagnosed the patient with GAD and panic disorder, based on her complaints of giddiness and requests for him to check her blood pressure. Dr Ling prescribed the patient with Alprazolam together with anti-hypertensive medicines. As the patient's hypertension and anxiety were inextricably linked, Alprazolam was effective in keeping both conditions under control. As such, Dr Ling maintained her on a low dose of Alprazolam. Dr Ling assessed that the patient was not at risk of dependence / addiction as she did not escalate her dose or request for earlier refills. Dr Ling did not consider prescribing SSRIs, as her symptoms were well controlled with Alprazolam. Moreover, Dr Ling gave the patient SSRIs after the audit, and she ended up developing hyponatremia.	October 2016, which was the period set out in the charge. While the Respondent claimed that this was for the treatment of General Anxiety Disorder and panic disorder, the PMRs do not document that diagnosis or document any examinations that would lead to that diagnosis. Further, the first time the Respondent mentioned that the patient had panic disorder was during his oral testimony on 9 February 2022. This was not stated in his first letter of explanation to the CC dated 23 April 2018 or his first Statement of Evidence-in-Chief dated 10 December 2021 for the inquiry. This calls into question whether the Respondent's diagnosis of General Anxiety Disorder and panic disorder was indeed made or accurate. 2. In addition, the Respondent's continuous prescription of Alprazolam over the period set out in the charge, which was for a period of some 2.5 years, was not

SN	Charge	SMC's position	Respondent's position	DT's Decision
		4. The alleged diagnosis of panic disorder was not even mentioned in the Respondent's 1st Written Explanation to the CC dated 23 April 2018 or even his 1st Witness Statement for the Inquiry dated 10 December 2021. Instead, the Respondent only mentioned panic disorder for the first time in his oral testimony on 9 February 2022. When questioned on this, he claimed that PAT 10 gets palpitations when seeing her high BP reading. This is again not documented anywhere. 5. The Respondent also did not make any attempts to taper or wean off PAT 10 from benzodiazepines despite the fact that her symptoms improved after she had been started on Alprazolam. Instead, his treatment plan was to give her Alprazolam indefinitely for her high blood pressure, a chronic condition. 6. The Respondent's concession that his benzodiazepine prescriptions were inappropriate is demonstrated by the fact that some time after the	Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [182] to [189]; RRS from [135] to [140])*	in line with the recommendations in the 2008 CPG, which provide that benzodiazepine prescriptions should be limited to short-term relief of between two to four weeks. There was nothing to suggest that the patient fell within the situations set out in the 2015 RACGP Guidelines where benzodiazepines could be prescribed in the long term or for longer than four weeks. While the Respondent indicated that benzodiazepines were required to manage the patient's hypertension and anxiety together, it was not disputed that benzodiazepines are not indicated for the management of high blood pressure. 3. In addition, the Respondent had fallen short of the applicable standard, as he had prescribed benzodiazepines as the first-line treatment for anxiety disorders. The Respondent in fact admitted on the stand that he knew that the guidelines indicate that SSRIs should be the first line of treatment, but he said that as a

SN	Charge	SMC's position	Respondent's position	DT's Decision
		audit in November 2016, the Respondent changed his long-term prescriptions of benzodiazepines to SSRIs instead (on 30 August 2017). He subsequently also weaned PAT 10 off benzodiazepines. 7. In a defensive attempt to maintain that he was correct patient was hospitalised due to side effects from SSRI and tried to blame her hospitalisation on "SMC's interference" (Note that the Respondent was actually referring to the Complainant which had carried out the audit). However, the Respondent tendered no evidence to show whether the patient was hospitalised as a result of the SSRI or due to a reaction to the benzodiazepine that the Respondent prescribed. 8. The Respondent conceded at paragraph 183 of the RCS that he placed PAT 10 "on a trial of anxiolytics" and during the Inquiry he testified that he placed PAT 10 "on a 14 days' trial of benzodiazepines". This supports the		doctor, he had to tie the guidelines in with his own clinical practice and then decide what to do. While the Respondent testified that the patient was hospitalised in 2017 due to side effects from SSRIs, this was unsubstantiated as there was no evidence as to why the patient had to be hospitalised. 4. We are satisfied that the Respondent did not provide appropriate care, management and treatment to the patient and that the charge is made out. Given the clear guidelines in question and the fact that the Respondent admitted that he was aware of the guidelines, we are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		SMC's submissions that the Respondent adopted a "trial and error" approach in practicing medicine. The Respondent had similarly applied a "trial and error" method with PAT 13.		
	Benzodiazepine Referral Charge for PAT 10: 9th Charge of NOI (1)	1. In respect of this charge, the relevant period of the Respondent's treatment for PAT 10 spans the period 18 February 2014 to 31 October 2016. 2. The Respondent had failed to refer PAT 10 to a specialist and continued to treat her with benzodiazepines for 2 years and 6 months, despite the fact that she had a complicated medical history arising from her blood pressure issues and heart palpitations. 3. The Respondent also testified that he had discussed PAT 10's anxiety problems with her and she did not want to be referred to a psychiatrist as she preferred to or was more comfortable to be seen by the Respondent instead. However, none of these discussions, including PAT 10's refusal of the referral, were reflected in the PMRs.	The 2008 Admin Guidelines do not require patients with "multiple complex conditions" to be referred to specialists. In any case, the patient had already been seeing a heart specialist for her high blood pressure and heart problems. Dr Ling did not find it necessary to refer the patient to a specialist, as her condition was well controlled with Alprazolam. *(See RCS at [188]; RRS from [141] to [142])*	1. The Respondent indicated in [119] of his Statement of Evidence-in-Chief dated 10 December 2021 that he did not find it necessary to refer the patient to a psychiatrist. 2. However, paragraph (n) of the 2008 Administrative Guidelines provides that patients who have been prescribed benzodiazepines beyond a cumulative period of eight weeks must be referred to the appropriate specialist for further management. The Respondent was clearly in breach of this guideline. It bears repeating that the Respondent had prescribed benzodiazepines for a prolonged period of around 2.5 years. 3. Given the clear guidelines, we are of the view that the Respondent's departure from the applicable standards was intentional and

SN	Charge	SMC's position	Respondent's position	DT's Decision
				deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.
4	Benzodiazepine Prescription Charge for PAT 13: 10th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 13 spans the period 6 July 2016 to 13 July 2016. 2. The Respondent claims that he had prescribed Lorazepam to PAT 13 for the treatment of night time cough due to post-nasal drip and allergic rhinitis. However, as admitted by the Respondent, this diagnosis was not documented anywhere in his PMRs. 3. The Respondent did not carry out the proper assessment such as asking PAT 13 the relevant questions or conducting other investigations to rule out a possible differential diagnosis. Instead, the Respondent maintained his diagnosis of allergic rhinitis on the basis of PAT 13's prolonged and persistent cough, and practised a "trial and error" method of prescriptions. 4. Further, as admitted by the Respondent, he did not think it was	Dr Ling prescribed benzodiazepines to the patient on 3 occasions for short-term relief of his insomnia. On 6 July 2016, the patient complained that his sleep was disrupted by persistent coughing at night. Dr Ling prescribed the patient with Actifed / Conkoff cough syrup, and added Lorazepam tablets to help him sleep better at night. The patient returned on 8 and 13 July 2016 to repeat the medicines over the counter. Dr Ling prescribed a low dose of Lorazepam for a total duration of 16 days. The patient was not dependent on the benzodiazepines. The Prosecution did not appear to take issue with Dr Ling's prescription of benzodiazepines for the patient's insomnia. It should be noted that the issues raised by the Prosecution in relation to Dr Ling's	1. This charge involves the Respondent's prescription of benzodiazepines on three occasions over an eight-day period in July 2016. 2. The SMC raised issues with the Respondent's diagnosis of nasal drip and allergic rhinitis. However, as pointed out by the Respondent, this was not directly relevant to the charge, as the charge against the Respondent was for inappropriate prescription of benzodiazepines. SMC did not appear to raise issues in relation to the Respondent's prescription of benzodiazepines for the patient's insomnia. 3. As the Respondent pointed out, the patient was prescribed a low dose of Lorazepam for a total duration of 16 days. This fell within the recommended duration of use of benzodiazepines set out in the 2008 CPG, which was a duration of two to four weeks.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		necessary to do a lung function test as he "*had no grounds to suspect that* [PAT 13] *is having asthmatic cough*". He also did not document whether PAT 13 had any wheezing, despite claiming that he had checked with PAT 13 whether there was wheezing, as he claimed that he did not have a practice of recording negative findings. 5. Instead, in spite of PAT 13 returning to him with the same problems, which suggested that the medications he was giving were ineffective, the Respondent continued to give the same medications to PAT 13 without further investigations.	diagnosis of allergic rhinitis are irrelevant. *(See RCS from [190] to [194]; RRS from [143] to [147])*	4. We are of the view that the SMC has not proven that the Respondent fell below the applicable standard in his prescription of benzodiazepines to the patient. The Respondent is not guilty of this charge.
5	Benzodiazepine Prescription Charge for PAT 14: 12th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 14 spans the period 26 January 2015 to 31 October 2016. 2. The Respondent claims that he had prescribed Alprazolam concomitantly with codeine and/or hydroxyzine and SSRIs (Magrilan)	The patient had complained of chronic fatigue. Dr Ling diagnosed the cause of the fatigue to be anxiety and insomnia, and prescribed the patient with Alprazolam and/or Fluoxetine (SSRI). As the patient reported feeling better and less tired, he continued these prescriptions until 31 October 2016.	1. The Respondent prescribed benzodiazepines to the patient at fairly regular intervals over the period of the charge, which spanned approximately 1 year and 7 months from 17 March 2015 to 31 October 2016.[66] There were occasions where the Respondent prescribed benzodiazepines together with SSRIs, or

[66] See the Re-amended 12th Charge of NOI (1) dated 15 July 2022.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		for the treatment of her anxiety and insomnia. 3. Benzodiazepines are not indicated as the first-line treatment for anxiety and insomnia. Instead, the appropriate treatment would have been SSRIs. In this regard, while the Respondent had prescribed SSRIs to PAT 14, there were also occasions where he prescribed benzodiazepines instead of SSRIs, and occasions where he prescribed benzodiazepines together with SSRIs, neither of which are indicated as a suitable first-line treatment. While his explanation for his prescription choices was that "*it depends on whether the patient feels what is working for her*", there was no documentation of the medical grounds or reasons that the SSRIs were not working for PAT 14 that justified the switch in medications or the addition of benzodiazepines. As acknowledged by the Respondent, he himself could not tell from his own notes what were the reasons for the switch.	While Dr Ling advised the patient that Alprazolam was not meant for long-term treatment, she informed him that she found Alprazolam to be more effective than Fluoxetine. Hence, Dr Ling continued to prescribe low doses of Alprazolam to the patient. Dr Ling noted that the patient did not escalate her doses and/or exhibit any signs or evidence of dependence / misuse. While Dr Ling prescribed Alprazolam concomitantly with codeine / hydroxyzine on several occasions, the individual dosage of each medicine was kept low. Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [195] to [201]; RRS from [148] to [152])*	benzodiazepines instead of SSRIs, for the treatment of the patient's anxiety and insomnia. This was in breach of the applicable standard, which was that SSRIs, rather than benzodiazepines, should be prescribed as the first-line treatment for anxiety and insomnia. 2. While the Respondent explained his prescription of Alprazolam on the basis that the patient felt that the medication worked for her, there was no documentation of the medical grounds or reasons as to why SSRIs were not working for the patient. The prescription of benzodiazepines instead of SSRIs was inappropriate. 3. The Respondent had also prescribed Alprazolam concomitantly with codeine and/or hydroxyzine on several occasions. 4. In addition, the Respondent had prescribed benzodiazepines on multiple occasions without reviewing the patient. This was in

SN	Charge	SMC's position	Respondent's position	DT's Decision
		4. The Respondent also alleged that he had advised PAT 14 that Alprazolam was not meant for long-term treatment, but PAT 14 found that it was more effective and wanted to continue with Alprazolam. This advice was not documented. Significantly, on 22 December 2016, a few months after the audit on his clinic, the Respondent reduced PAT 14's dosage of Alprazolam and added antihistamines (Atarax and Amitriptyline) for her insomnia. There was no indication that PAT 14 had resisted such a change, which would likely have been the case if he had been insistent on taking Alprazolam. This suggests that the Respondent was aware that the dosage of Alprazolam he had been prescribing prior to the audit were higher than the appropriate levels, and may not even have been necessary at all given the switch to other medications. 5. Additionally, the onus lies on the Respondent to evaluate the basis for prescription of benzodiazepine on every occasion, instead of justifying		breach of paragraph (j) of the 2008 Administrative Guidelines, which provides that repeat prescriptions for benzodiazepines should not be provided without a clinical review. 5. We agree with the SMC that the Respondent did not provide appropriate care, management and treatment to the patient and that the charge is made out. Given the clear guidelines in question, we are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		his prescription choices by tagging it onto SSRIs or by deferring to "*whether the patient feels what is working for her"*.		
	Benzodiazepine Referral Charge for PAT 14: 14th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 14 spans the period 23 January 2015 to 31 October 2016. 2. Given the extended duration of benzodiazepine treatment, it was inappropriate for the Respondent to continue his prescriptions of Alprazolam for PAT 14 without referring her to an appropriate specialist for further management of her insomnia and anxiety.	There was no need for Dr Ling to refer the patient to a specialist, as he had assessed that she was not at risk of dependence / addiction. Moreover, the patient's anxiety was well-controlled with Alprazolam. *(See RCS from [199] to [200]; RRS from [153] to [154])*	1. The Respondent's failure to refer the patient to a specialist was a breach of paragraph (n) of the 2008 Administrative Guidelines, which provides that patients who have been prescribed benzodiazepines beyond a cumulative period of eight weeks must be referred to the appropriate specialist for further management. 2. Here, the patient had been prescribed benzodiazepines for a fairly long period, which went beyond a cumulative period of eight weeks, but was not referred to a specialist. It was not sufficient for the Respondent to say that there was no need to refer the patient to a specialist as the patient was not at risk of dependence or addiction, given the clear guidelines. 3. We are satisfied that the Respondent's departure from the

SN	Charge	SMC's position	Respondent's position	DT's Decision
				applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.
6	Benzodiazepine Prescription Charge for PAT 15: 15th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 15 spans the period 4 June 2016 to 26 July 2016. 2. The Respondent claims that he prescribed Lorazepam to PAT 15 for the treatment of her anxiety, depression and insomnia. In the course of his oral evidence, he elaborated that the insomnia was caused by anxiety and depression, and PAT 15 actually only suffered from anxiety and depression. 3. However, neither the diagnoses of anxiety or depression were recorded in his PMRs on the first relevant entry dated 4 June 2016 where he prescribed PAT 15 with benzodiazepines. Instead, all that was noted was "*low mood, poor sleep*". These are symptoms, and not a diagnosis. When questioned why his diagnoses were not noted, the	Dr Ling prescribed benzodiazepines to the patient on 4 occasions. Dr Ling diagnosed the patient with having anxiety, depression and insomnia. This was based on his symptoms including low mood and excessive worrying. Dr Ling found it appropriate to prescribe Lorazepam to the patient, as it could treat both his anxiety and insomnia. Dr Ling also prescribed the patient with Zopiclone (for insomnia only) and Fluoxetine (for anxiety only). Generally, benzodiazepines can be prescribed as an adjunct to SSRIs to reduce the symptoms of anxiety. On 8 June 2018, the patient complained of nausea, sweaty palms and increased blood pressure. These were likely to be side effects of Fluoxetine. Dr Ling reduced the	1. As submitted by the SMC, despite anxiety and depression being different disorders, the Respondent did not carry out the appropriate investigations for each such diagnosis of the patient. No proper diagnosis of anxiety or depression was made to justify the prescription of benzodiazepines. 2. In prescribing benzodiazepines as the first-line treatment for the patient, the Respondent did not comply with the standard set out in the 2015 Anxiety Disorders CPG, which was to prescribe SSRIs rather than benzodiazepines as the first-line treatment for anxiety. 3. Even though the Respondent submitted that it was not inappropriate for benzodiazepines to be prescribed as an adjunct to SSRIs to reduce symptoms of anxiety, we note that the

SN	Charge	SMC's position	Respondent's position	DT's Decision
		Respondent admitted that insomnia, or "*poor sleep*", could be caused by many things, and not just anxiety and depression. 4. Further, the Respondent also agreed that anxiety and depression are different disorders, each with its own set of diagnostic criteria. Despite this, the Respondent did not carry out the appropriate investigations for each diagnosis, and instead lumped both diagnoses together under the guise that "*they can overlap, and the treatment involved is actually the same. So to me, in this case, it doesn't make much of a difference*". 5. The Respondent has also admitted that he failed to adhere to the 2015 Anxiety Disorders Guidelines which recommend that benzodiazepine prescriptions should be tapered and withdrawn by four (4) weeks. Instead, in the span of eight (8) weeks, the Respondent actually increased the dosage of benzodiazepines that was prescribed to PAT 15.	dosage of Fluoxetine and continued the patient on low doses of Lorazepam for his anxiety. The patient was weaned off Lorazepam on 31 October 2016. Dr Ling did not advise the patient on the risks of prolonged use of benzodiazepines, as he wanted to avoid causing undue alarm to the patient and he had assessed that the patient was not at risk of dependence. Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [202] to [210]; RRS from [155] to [161])*	Respondent admitted that he did not adhere to the 2015 Anxiety Disorders CPG, which recommends that benzodiazepine prescriptions should be tapered and withdrawn by four weeks. The Respondent did not do so. 4. While the Respondent said that the patient's complaints on 8 June 2018 of nausea, sweaty palms and increased blood pressure were likely to be side effects of Fluoxetine, there was no evidence of this. There was no evidence that the patient did not tolerate SSRIs well. 5. It was not disputed that the Respondent did not advise the patient on the risks of the prolonged use of benzodiazepines. In addition, the Respondent concomitantly prescribed benzodiazepines with other sedating drugs on two occasions during the charge period. 6. We are satisfied that the Respondent did not provide

SN	Charge	SMC's position	Respondent's position	DT's Decision
		6. Finally, the Respondent also failed to advise PAT 15 on the risks that accompanied prolonged used of benzodiazepines. In his 1st WS, the Respondent asserted that he did not do so as he "*wanted to avoid causing undue alarm to him*". This was not a valid reason to breach the 2015 Anxiety Disorders Guidelines, which require the doctor to counsel and advise patients about the risks of benzodiazepines. In any event, the Respondent's shifting position on this issue highlights a further inconsistency in his own practices. While he initially stated in his 1st WS that he did not advise PAT 15 on the risks as he did not want to alarm PAT 15, he subsequently stated on the stand that he did not do so as PAT 15 was not a patient that would have been categorised as high risk for dependence. Most crucially, neither of these factors were reflected in his PMRs for PAT 15.		appropriate care, management and treatment to the patient. Given the clear guidelines, we are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.
7	Benzodiazepine Prescription Charge for PAT 16 : 17th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 16 spans 27 December 2014 to 17 October 2016.	Dr Ling diagnosed the patient with having IBS on 27 December 2014, as she complained of abdominal symptoms and no abnormalities	1. The Respondent had prescribed benzodiazepines on various occasions over a period that spanned approximately one year and nine months.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		2. The Respondent claims that that he had prescribed Lorazepam concomitantly with Amitriptyline and hydroxyzine to PAT 16 for the treatment of her rhinitis, irritable bowel syndrome ("**IBS**") and anxiety. However, none of these diagnoses were documented in the Respondent's case notes. 3. There was also an absence of any treatment plans that justified or explained the benzodiazepine prescriptions for PAT 16. While the Respondent claimed that he had discussed the various treatment options for her IBS, the Respondent similarly did not document any of treatment plans for PAT 16, including his alleged discussions with PAT 16 on the various treatment options for her gastrointestinal problems. 4. Further, the Respondent did not carry out any of the appropriate investigations that support his eventual diagnosis of anxiety that was causing PAT 16's IBS. Where he alleged that he carried out	were found on gastroscopy / colonoscopy. Dr Ling prescribed her with various medicines including Lorazepam, which is useful in treating gastrointestinal illnesses with an anxiety component. Lorazepam would allow the patient to have a good rest, and allow Dr Ling to confirm his diagnosis of IBS. Thereafter, on 7 May 2015, the patient complained of neckache. Dr Ling found that this was linked to her tension headache and anxiety. He prescribed her with Lorazepam and Amitriptyline. As the patient's condition was chronic and recurrent, Dr Ling continued to prescribe intermittent low doses of Lorazepam and Amitriptyline. Dr Ling monitored the patient's use of benzodiazepines closely. He noted that there was no dose escalation and assessed that the patient was not at risk of dependence / addiction.	2. The Respondent's diagnosis of rhinitis, irritable bowel syndrome and anxiety were not documented in the PMRs. The PMRs also did not document any physical examination or investigations that supported the diagnosis of anxiety. In addition, the Respondent's treatment plan was not documented. In our view, there was no proper assessment of the patient's condition that justified the repeated prescription of benzodiazepines. 3. The Respondent also concomitantly prescribed benzodiazepines together with hydroxyzine and Amitriptyline, drugs with sedating effects. 4. We are satisfied that the Respondent failed to provide appropriate care, management and treatment to the patient. The Respondent's conduct demonstrated an intentional, deliberate departure from the applicable standards and the

SN	Charge	SMC's position	Respondent's position	DT's Decision
		physical examinations in order to diagnose PAT 14's neckache to be caused by tension headache and anxiety, this was similarly not reflected in the PMRs. 5. The Respondent had also prescribed Amitriptyline to PAT 16, which had sedating effects. Under such circumstances, it was inappropriate for the Respondent to add another benzodiazepine to her prescriptions, which would have additive sedating effects.	Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [211] to [218]; RRS from [162] to [166])*	misconduct was sufficiently egregious to amount to professional misconduct.
	Benzodiazepine Referral Charge for PAT 16: 19th Charge of NOI (1)	1. In respect this charge, the relevant period of the Respondent's treatment for PAT 16 spans 27 December 2014 to 17 October 2016. 2. The Respondent had failed to refer PAT 16 to a psychiatrist or other appropriate specialist for management of PAT 16's condition. The Respondent's position was that he did not find it necessary to refer PAT 16 to a psychiatrist as "[her] *anxiety and IBS symptoms were kept well under control with medication*". This was unsupported by the applicable guidelines, which clearly	It was not necessary for Dr Ling to refer the patient to a specialist. This was because he had assessed that the patient was not at risk of addiction. Further, the patient's anxiety and IBS symptoms were kept well-controlled with the medication. *(See RCS at [217]; RRS from [167] to [168])*	1. The Respondent's failure to refer the patient to a specialist was a breach of paragraph (n) of the 2008 Administrative Guidelines, which provides that patients who have been prescribed benzodiazepines beyond a cumulative period of eight weeks must be referred to the appropriate specialist for further management. 2. The patient had not been referred to a specialist despite being prescribed benzodiazepines over an extended period. We are satisfied that the Respondent's

SN	Charge	SMC's position	Respondent's position	DT's Decision
		states that a referral must be made if a patient has been prescribed with benzodiazepines for an extended period.		departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

Codeine Prescription Charges

SN	Charge	SMC's position	Respondent's position	DT's Decision
1	Codeine Prescription Charge for PAT 5: 1st Charge of NOI (2)	1. PAT 5 has been seeing the Respondent since 2002, and was prescribed Conkoff (a cough syrup containing codeine) from 2003 to 2016. 2. The Respondent has repeatedly changed his diagnosis of PAT 5 in the course of these proceedings. In his Written Explanation dated 3 Feb 2020, he diagnosed PAT 5 with asthma. Subsequently, in his 1st Written Statement dated 10 December 2021, he diagnosed PAT 5 with COPD and attributed PAT 5's cough to asthmatic bronchitis as well as Enalapril which he had been taking for hypertension.	Dr Ling diagnosed the causes of the patient's chronic cough to be asthma and COPD (as he was a chronic smoker and barrel-chested). Dr Ling later realised that the Enalapril which the patient was on could also have contributed to the cough. As the patient did not exhibit any red flag symptoms or breathlessness, Dr Ling did not perform further investigations / refer him to specialists. As the patient was unwilling to stop smoking, Dr Ling assessed that he would continue to cough and it would be appropriate to relief his symptoms. Dr Ling prescribed	1. There was no clear diagnosis and no clear basis for the prescription of codeine to the patient. 2. In the Respondent's letter of explanation to the CC dated 3 February 2020, the Respondent indicated that the patient had asthma. However, in the Respondent's first Statement of Evidence-in-Chief dated 10 December 2021, the Respondent stated that he had assessed the patient with stage 0 Chronic Obstructive Pulmonary Disorder ("**COPD**") and he attributed the patient's cough to asthmatic bronchitis and the medication

SN	Charge	SMC's position	Respondent's position	DT's Decision
		3. However, there was no record of diagnosis of COPD in the PMR of PAT 5 and no review of the number of pack years. There was also no explanation for the diagnosis of COPD. In fact, the Respondent conceded in his evidence on the stand that he had failed to consider that Enalapril could be the cause of PAT 5's cough, in which case, there would be no need to prescribe codeine. He also admitted on stand that he thought that the diagnosis was inconsequential as long as the treatment was similar, which shows that he did not even apply any significance to the diagnosis. 4. Separately, the Respondent conceded that he breached the 2000 Circular on 3 occasions in relation to his prescription of codeine-containing cough medication for PAT 5. a. Between 11 January 2014 and 18 January, an interval of 7 days, the Respondent prescribed 380ml of codeine-containing cough medication. b. Between 10 February 2014 and 21 February 2014, an interval of	Conkoff/Actifed cough mixture with Ventolin and Dexamethasone tablets added in (to relieve bronchoconstriction and bronchial secretions). Dr Ling assessed that the patient was not at risk of dependence / addiction as there was no dose escalation and request for earlier refills of cough mixture. Dr Ling approved the sale of cough mixture to the patient on various occasions (at intervals of 2 to 3 weeks). While Dr Ling breached the 2000 MOH Circular on 3 occasions, he had good justifications for doing so. Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [255] to [266]; RRS from [178] to [184])*	Enalapril, which the patient had been taking for hypertension. 3. There was however no documentation of the diagnosis of COPD in the PMR and no explanation for the diagnosis of COPD. In addition, the Respondent did not consider that Enalapril could be the cause of the patient's cough and there might therefore be no need to prescribe codeine. There was therefore no clear basis for the prescription of codeine. 4. In addition, the Respondent admitted that he breached the 2000 Circular in respect of this patient, as he had on three occasions prescribed more than 240 ml of cough mixtures containing codeine to the patient within four days. 5. In our view, the Respondent had not carried out appropriate investigations to ascertain and treat the underlying cause of cough before prescribing codeine. Even though the patient's cough had

SN	Charge	SMC's position	Respondent's position	DT's Decision
		21 days, the Respondent prescribed 360ml of codeine-containing cough medication. c. Between 10 April 2015 to 18 April 2015, an interval of 8 days, the Respondent prescribed 620ml of codeine-containing cough medication. 5. Further, the Respondent's prescription of codeine-containing medications to PAT 5 was riddled with inconsistencies and inexplicable variations. For example, the Respondent explained that the changes in the proportion of codeine in the admixture during the treatment period was due to changes in the patient's condition. However, these assertions were not based on recorded observations of the patient's condition. The Respondent also conceded that "*10ml plus/minus is not a big deal*" for him when pressed for his reason for the variations, and that his prescriptions were based on the available stock in his inventory – "*sometimes I just give whatever that I have in hand, that I think the patient needs*".		persisted for a fairly long period of time and the Respondent had prescribed the patient with codeine throughout that period, the Respondent had not referred the patient to a specialist. We are of the view that the Respondent had fallen short of the standards expected of him. 6. We are satisfied that the charge against the Respondent is made out. The Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		6. The fact that the Respondent had both increased and then subsequently decreased the proportion showed that he was unable to titrate the medication to the appropriate levels to adequately address the patient's condition. Under such circumstances, he should have referred PAT 5 to a specialist who would be in a better position to manage the patient's condition, but he had failed to do so. The Respondent's excuse is that he did not observe any physical signs or evidence of misuse or dependence. However, this was not stated in his PMRs and was raised only later when his prescriptions were taken to task.		
2	Codeine Prescription Charge for PAT 6: 2nd Charge of NOI (2)	1. PAT 6 was prescribed Chorsedyl cough syrup (which contains chlorpheniramine 4mg/5ml together with codeine) in the period 16 August 2009 to 31 October 2016. 2. Despite the Respondent's claims in the 1st RWS and 2nd RWS that PAT 6 suffered from chronic protracted cough due to rhinitis and post nasal drip, the diagnosis of "Allergic Rhinitis" was not documented in the	Dr Ling diagnosed the patient's cough to be due to allergic rhinitis. This was mainly because that the patient usually coughed at night and when there was a change in temperature. As Dr Ling understood that the patient's cough would be recurrent, he found it appropriate to provide symptomatic relief. Dr Ling gave the patient Coughlax syrup with	1. This charge spanned a period of over seven years, from 16 August 2009 to 31 October 2016. 2. We are of the view that investigations were not properly carried out as to the underlying cause of the patient's cough, and the underlying cause of the cough was not ascertained and treated. The Respondent had not properly diagnosed the patient before

SN	Charge	SMC's position	Respondent's position	DT's Decision
		PMR until 7 January 2016, a decade after the Respondent began treating PAT 6. 3. When questioned during cross-examination on 14 November 2022 on the lack of documentation of the diagnosis of allergic rhinitis, the Respondent referred to Dr F2's diagnosis of "nose allergy" on 3 February 2015. 4. Firstly, the Respondent incorrectly equated nose allergy with allergic rhinitis and taken the position that documentation of "nose allergy" qualified as documentation of allergic rhinitis. 5. Pursuant to the 2010 Allergic Rhinitis CPG, the diagnosis of allergic rhinitis should be made based upon concordance between a typical history of allergic symptoms and diagnostic tests. However, as evident from the lack of any documentation of any assessment or findings, the Respondent had failed to conduct any clinical examinations of the patient on the day when he made the diagnosis of allergic	Dexamethasone and Loratadine tablets added in to reduce nasal secretions and throat itchiness. He also prescribed oral antihistamines and steroids and an intranasal steroid to treat the rhinitis. Dr Ling did not perform further investigations / refer the patient to a specialist, as it had been established that the patient's cough was due to rhinitis (and the medicines prescribed were effective in controlling cough). Dr Ling had assessed that the patient was not at risk of dependence / addiction. As the patient's condition was stable, Dr Ling approved the sale of codeine-containing cough mixture to the patient over the counter on various occasions. The patient requested to purchase Conkoff/Actifed at fairly regular intervals of 1 to 2 months. Dr Ling had a proper surveillance system. He refused the patient's request on 2 occasions (as the patient had purchased over the counter for 3 consecutive times) and made a note	prescribing codeine-containing medication to the patient. 3. In this regard, the Respondent's diagnosis was allergic rhinitis. The diagnosis of allergic rhinitis was however not documented in the PMR until 7 January 2016. In addition, from the PMR, it appears that there were no clinical examinations of the patient on the day the Respondent made the diagnosis. The diagnosis of allergic rhinitis was questionable. 4. Assuming the diagnosis of allergic rhinitis was correct, the Respondent should have prescribed medication to treat the patient's allergic rhinitis, instead of prescribing codeine-containing medication to the patient. The MOH Clinical Practice Guidelines 2/2010 – Management of Rhinosinusitis and Allergic Rhinitis ("**2010 Allergic Rhinitis CPG**") does not recommend the use of codeine-containing medication to treat allergic rhinitis.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		rhinitis. In the consultations prior to that, there were only sporadic notations of clinical findings such as "*st lung tn*" on 16 August 2009 or "*st cough phlegm rn fever*" on12 June 2010. There were numerous repeat prescriptions of codeine-containing medication without clinical review of the patient. 6. Even if the patient had allergic rhinitis, the Respondent should not have prescribed codeine-containing medication to treat this. The 2010 Allergic Rhinitis CPG does not recommend the use of codeine-containing medication to treat allergic rhinitis. In fact, when the Respondent was referred to these portions of the guidelines, he agreed that "*the MOH guidelines recommend antihistamines, oral or anti-nasal and corticosteroids for the treatment of allergic rhinitis"* and does not recommend the use of opiates or codeine. 7. Despite the clear recommendations in the 2010 Allergic Rhinitis CPG, the Respondent only prescribed loratadine, an oral antihistamine on	down for the patient to be seen at the next visit. Overall, Dr Ling's management and care of the patient was appropriate. *(RCS from [267] to [273]; RRS from [185] to [197])*	5. We note as well that the Respondent approved over the counter sales of codeine on numerous occasions during this period. Between 28 February 2011 and 31 October 2016, the Respondent approved over the counter sales of codeine-containing medication 26 times without a clinical review of the patient. Further, between the period 28 February 2011 to 27 April 2012, the Respondent did not review the patient at all but approved over the counter sales of codeine-containing medication seven times. Even though the Respondent indicated in his Further Statement of Evidence-in-Chief dated 29 July 2022 that he had called the patient to review him personally on 12 November 2012 and 4 September 2013, the PMR does not indicate that that was not done, and the Respondent admitted on the stand that that was not done. In our view, the Respondent had fallen below the applicable standard in prescribing codeine-containing medications to

SN	Charge	SMC's position	Respondent's position	DT's Decision
		18 August 2015, more than 7 years after PAT 6 was started on codeine-containing medications in 2008. Similarly, Esonide Nasal Spray, a gluco-corticosteroid was prescribed only on 31 October 2016, after the audit. The Respondent's treatment of Allergic Rhinitis with codeine-containing medications throughout the 8 years prior to that was entirely inappropriate. 8. As it turned out, PAT 6's NEHR indicated that he was in fact suffering from sinusitis and not allergic rhinitis. Whilst there may overlapping symptoms between the two, the treatment is slightly different, specifically, antibiotics are recommended in rhinosinusitis. 9. When the Respondent was questioned by the DT on the differences between the two conditions, he conceded that he did not know the difference: "*Okay. So just for -- okay, to make things simple, I say I wouldn't -- I don't know the difference between rhinosinusitis and allergic rhinitis. Okay, that one I concede.*" In fact,		the patient without reviewing the patient at appropriate intervals. 6. The Respondent had also fallen below the applicable standard in prescribing codeine-containing medications to the patient instead of carrying out appropriate investigations to ascertain and treat the underlying cause of cough. In addition, the Respondent had fallen below the applicable standard in not referring the patient to a specialist despite the patient's persistent cough. Instead, the Respondent prescribed codeine-containing medication to the patient over a period of over seven years. 7. We are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		the Respondent stated that he used the terms "nose allergy" and "sinusitis" interchangeably to patients when he was referring to allergic rhinitis. As a doctor, he must know the differences in diagnosis so as to prescribe the appropriate treatment, but it does not appear so. 10. Instead, the Respondent simply approved over the counter sale of codeine on numerous occasions over a prolonged period to treat the "nose allergy". Between 28 February 2011 and 31 October 2016, the Respondent approved the over-the-counter sale of codeine-containing medication 26 times without a clinical review of PAT 6. 11. It is further evident that the Respondents' treatment was not dependent on his assessment of the patient's condition as his prescriptions were changed inexplicably even when he had not seen the patient and had clearly not conducted any clinical review of the patient's condition: a. On 19 March 2013, the Respondent prescribed Actifed		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		plain 40cc + **conkoff 80cc** and on the next visit on 25 March 2013, the Respondent changed the prescription to Actifed plain 50 cc + **conkoff 70cc**[244]; and b. On 10 September 2015, the Respondent repeated an earlier prescription from 18 August 2015 and prescribed "Actifed co + conkoff + **8dexa** + 8 loratidine 10cc tds x 120cc" but this was inexplicably changed to "Actifed co + conkoff + **6dexa** + 6 loratidine 10cc tds x 120 cc" on 27 October 2015. 12. The Respondent asserted that he had closely monitored his patients for any signs of dependence, abuse or misuse. In an attempt to demonstrate that he had a surveillance system in place, the Respondent claimed that he "*called patient No.6 to review him personally on 2 occasions*", as he was concerned with PAT 6's requests for codeine-containing cough medicines on those 2 occasions. However, this was not borne out by the PMRs. On both occasions, the Respondent had written "*see next visit*" or "*see n.v.*",		

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		which he had transcribed as a mere approval of the purchase of medications by him without seeing the patient. In fact, the Respondent admitted during cross-examination that his statements that he had closely monitored his patients were incorrect. 13. Lastly, the Respondent failed to refer PAT 6 to an appropriate specialist to follow up on PAT 6's rhinosinusitis. As stated in the 2010 Allergic Rhinitis CPG, "*all adults with persistent and recurrent rhinosinusitis should be referred to a specialist for nasal endoscopy to assess for differential causes*". Similarly, based on the Algorithm for Management of Allergic Rhinitis, where there is a failure of the treatment to resolve the condition, the patient should be referred to a specialist. The patient was prescribed codeine-containing medication for over 8 years from 2008 to 2016. Despite the persistent and recurrent cough that necessitated the prescription of codeine-containing medication, the Respondent failed to		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		refer PAT 6 to an appropriate specialist.		
3	Codeine Prescription Charge for PAT 7: 3rd Charge of NOI (2)	1. PAT 7 was prescribed Conkoff from 19 September 2014 to 31 October 2016. 2. PAT 7 has a complicated medical history, which includes hypertension, hyperlipidaemia, and COPD. In particular, she had 8 chest X-rays performed between 2012 to 2016 and had been smoking 10 cigarettes a day for over 50 years. However, the Respondent did not elicit any of the above details of her medical history from her. He has been treating the patient for over 20 years since 1997, but he was unaware of the medical history until he accessed the NEHR records for the purposes of the Disciplinary Inquiry. 3. At the outset, the Respondent claimed in his 1st RWS that he had diagnosed the patient with acute bronchitis and COPD. This is inconsistent with what he had recorded in the PMR on 27 January 2015, where he had recorded "asthma". We point out that	Dr Ling diagnosed the patient with having asthma and bronchitis. As the patient was unwilling to stop smoking, Dr Ling assessed that she was at risk of having COPD and that it was appropriate to provide symptomatic relief. He prescribed her with Conkoff/Actifed cough mixture with Dexamethasone and Salbutamol / Ventolin tablets added in to reduce bronchial inflammation. Dr Ling had performed investigations on several occasions including an ECG and examination of her lungs. He referred the patient to a cardiologist for her breathlessness on 20 July 2015. However, he did not find it necessary to refer the patient for her COPD/asthma, as she was merely coughing and her lung signs disappeared after treatment. As the patient had chronic cough and her condition was relatively stable, Dr Ling approved the sale of codeine-containing cough mixtures	1. The patient was an elderly patient who was over 80 years of age. There were no clear medical grounds justifying the Respondent's prescription of codeine. While the Respondent recorded in his PMRs on 27 January 2015 that the patient had asthma, he indicated in his first Statement of Evidence-in-Chief dated 10 December 2021 at [157] and [158] that he diagnosed the patient with acute bronchitis and that she was at risk of having COPD. The Respondent's diagnosis of the patient was therefore unclear and there were no clear medical grounds justifying the prescription of codeine. 2. The Respondent also did not refer the patient to a specialist to carry out specialised investigations and provide treatment for the patient's cough, despite the patient's cough persisting. He had only referred

SN	Charge	SMC's position	Respondent's position	DT's Decision
		"asthma" was not mentioned in his 1st RWS or 2nd RWS. Indeed, asthma is a different diagnosis from acute bronchitis or COPD. When he was confronted with the differences during cross-examination on 14 November 2022, he attempted to conflate the three and prescribed the same treatments. However, without a specific diagnosis, there were no clear medical grounds justifying the Respondent's subsequent treatment and prescription. 4. In order to come to a clear diagnosis, the Respondent should have conducted further examinations, but he failed to do so. Further, asthma and COPD should have been treated differently. If the Respondent was uncertain about whether PAT 7's condition was asthma or COPD, or he could not distinguish the relevant symptoms, he should have referred the patient to a specialist who could carry out specialized investigations and treatment for the patient. 5. Instead, codeine-containing medication was prescribed since 2000. This was followed by a series	over the counter on various occasions. This was after he assessed that there were low risks of dependence / addiction. The patient requested to purchase the cough mixtures at fairly regular intervals of 1 month. Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [274] to [280]; RRS from [198] to [208])*	the patient to a cardiologist for breathlessness. 3. In addition, the Respondent prescribed the patient with codeine multiple times without reviewing her. Between 6 May 2016 and 31 October 2016, which was a period of around six months, the Respondent prescribed codeine-containing medication on 11 occasions without reviewing the patient. The Respondent had fallen below the required standard by repeatedly prescribing codeine-containing medication without reviewing the patient at appropriate intervals. 4. We are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		of inexplicable changes in the types of codeine-containing cough medications prescribed. On 6 August 2009, PAT 7 was no longer given conkoff and instead, codipront was prescribed. This continued until 1 November 2009 when the Respondent prescribed both codipront and conkoff. Subsequently, the Respondent changed the prescription to "Actifed co" on 10 March 2010 and to Dhasedryl on 26 December 2013. However, all of the changes in prescription which would affect the concentration of codeine were not substantiated with any changes in diagnosis or recorded observations. 6. Further, the Respondent had given codeine-containing medication to PAT 7 on multiple occasions without seeing her. For example, between 6 May 2016 to 31 October 2016 (period of 6 months), the Respondent prescribed codeine-containing medication on 12 consecutive occasions without seeing PAT 7. The fact that the patient had come back repeatedly for codeine-containing medication within short periods of		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		time should have alerted the Respondent to inquire into the possibility of dependence / abuse. He did not do so and instead he freely prescribed codeine-containing medication without seeing the patient and assessing the patient personally. 7. Lastly, the Respondent failed to refer PAT 7 to a specialist. The ACE Clinical Guidance which was relied on by the Respondent, states that specialist referral could be considered for patients with "*inadequate response to asthma management, such as persistent or worsening symptoms despite having stepped up preventer treatment with BREATHE factors addressed where applicable*" and "*specific patient groups with asthma, such as ... elderly patients*". PAT 7 was 84-year-old and given that she was prescribed with codeine-containing medication from 2000 to 2016, it was apparent that her symptoms were at least persistent, if not, worsening. The Respondent also agreed on the stand that PAT 7 has a complicated medical history and "*it might be*		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		difficult to come to an accurate diagnosis for her". 8. However, the Respondent did not refer PAT 7 to a specialist, even though he conceded that it would be best to do so and that "*theoretically and in principle, that sounds very right*". He only referred PAT 7 to see a cardiologist for her breathlessness, and continued to manage her cough by prescribing codeine-containing medication, even though he agreed that he should have referred her to a multi-disciplinary team of specialists. 9. In reply to paragraph 277 of the RCS, the Respondent's justification for not referring the patient to a specialist is a retrospective excuse based on information from the NEHR which he did not know at the material time. The Respondent submitted that the patient was previously hospitalised for chest pain on coughing in February 2012 and the cardiologists who had seen her did not refer her to a respiratory physician. However, this is based on information from the patient's NEHR which the		

SN	Charge	SMC's position	Respondent's position	DT's Decision
		Respondent was not even aware of at the material time and could not have affected his management of the patient.		
4	Codeine Prescription Charge for PAT 9: 4th Charge of NOI (2)	1. PAT 9 was prescribed codeine-containing medication (Codipront) from 25 March 2013 to 5 December 2016. 2. The Respondent had diagnosed PAT 9 with allergic rhinitis and post-nasal drip that is causing chronic cough. However, and as conceded by the Respondent, this diagnosis was not documented anywhere in PAT 9's PMRs. Instead, the closest reference that the Respondent could point to was the notation by Dr F2 on 26 August 2014 that PAT 9 has vasomotor rhinitis. The Respondent alleged that he was "*just following her prescription*"; however, the Respondent's first prescription of Codipront to PAT 9 was on 25 March 2013, close to 1.5 years after Dr F2's consultation. Despite this extended period where PAT 9 had not attended a consultation with the Respondent or any other doctors in the clinic, the Respondent approved the repeat medication to PAT 9 without seeing	The patient was first seen by Dr F2 on 17 August 2011 for her cough. Dr F2 prescribed the patient with Codipront capsules. The patient found Codipront to be effective, and returned to the Clinic on multiple occasions to purchase Codipront over the counter. Dr Ling and the other doctors in the Clinic allowed their clinic assistants to sell Codipront over the counter without having to seek a doctor's approval. There were no guidelines at the material time in relation to the prescription of codeine in solid form. Dr Ling was also unaware that there were risks of dependence / misuse associated with Codipront. Dr Ling approved the sale of Codipront over the counter to the patient on 25 March 2013. This was after he assessed that the quantities of capsules requested and time interval between requests remained regular.	1. This charge spanned the period 25 March 2013 to 5 December 2016. 2. There was no clear diagnosis of the patient to justify the prescription of codeine-containing medication. The Respondent indicated that he diagnosed the patient with allergic rhinitis and post-nasal drip that was causing chronic cough. This was however not documented in the patient's PMRs. The Respondent pointed to a notation in the PMRs by Dr F2 on 26 August 2014 that indicated that the patient had vasomotor rhinitis, but that was more than one year after the Respondent started prescribing codeine-containing medication to the patient. 3. Further, we note that the Respondent first prescribed Codipront to the patient on 25 March 2013, and the Respondent had not reviewed the patient on that day. Before that date, the last

SN	Charge	SMC's position	Respondent's position	DT's Decision
		her personally or conducting any tests or examinations on her. 3. Further, the Respondent had documented "URTI" in the next consultation on 5 September 2014 when he prescribed Codipront. It would therefore appear that PAT 9 was receiving treatment for URTI, i.e. upper respiratory tract infection. It transpired that the notation of URTI was written by the Respondent for the sole purpose of submission to MOH in order to claim a CHAS subsidy. Putting aside the fact that this was legally improper, the notations on the PMR show that the Respondent's basis for giving Codipront was unclear – whether it was for URTI or for Allergic Rhinitis as he claimed. 4. Further and in any event, the 2010 Allergic Rhinitis CPG does not recommend the use of codeine-containing medication to treat allergic rhinitis. Thus, the Respondent's practice of repeatedly giving Codipront to treat PAT 9's allergic rhinitis was not in	Dr Ling subsequently saw the patient on 5 September 2014. This was after Dr F2 documented her diagnosis of vasomotor rhinitis on 26 August 2014. Dr Ling checked the patient's lungs and did not find any lung sounds. He did not suspect that the patient's cough had any causes other than vasomotor rhinitis. Dr Ling did not find it necessary to refer the patient to a specialist, as she had already been seeing an ENT specialist at Institution B. Dr Ling found it appropriate to continue prescribing Codipront to relieve the patient's cough. It was likely that the patient had already been on nasal spray, and that this was ineffective in relieving her cough. In any case, the patient was also prescribed with Nasonex nasal spray on 2 occasions. Overall, Dr Ling's management and care of the patient was appropriate. *(See RCS from [281] to [289]; RRS from [209] to [228])*	time the patient had consulted a doctor at the Clinic was on 17 August 2011, when the patient consulted Dr F2 and was prescribed Codipront. After that, the patient had gone back to the Clinic 11 consecutive times to get over the counter prescriptions of Codipront, before the Respondent prescribed Codipront over the counter on 25 March 2013. 4. Given the number of times the patient had been buying Codipront over the counter, the Respondent should have been alert to the possibility of abuse of codeine. While the Respondent said that he was just following Dr F2's prescription of Codipront, Dr F2 had not diagnosed the patient with allergic rhinitis at that stage and there was no clear indication for the prescription of codeine-containing medication. 5. The Respondent's prescription of Codipront on 25 March 2013 in these circumstances fell below the applicable standard. The Respondent had not ascertained

SN	Charge	SMC's position	Respondent's position	DT's Decision
		accordance with the applicable guidelines. 5. Additionaly, the Respondent failed to refer PAT 9 to an appropriate specialist to follow up on PAT 9's rhinitis. On the Respondent's own explanation, he was attempting to treat PAT 9's symptoms of "*prolonged and recurrent cough*" which was a symptom of chronic rhinitis, with Codipront. However, that was not the recommended treatment in the 2010 Allergic Rhinitis CPG, which clearly states that for a patient experiencing persistent symptoms, a doctor should first follow the Grade A recommended treatments and review the patient after 2 – 4 weeks. If the treatment fails, the doctor should review diagnosis, review compliance, and query infections or other causes for the symptoms, and potentially adopt one further treatment of a Grade C recommended treatment for a short-term basis. If treatment still fails, then the patient should be referred to a specialist.		the underlying cause of the cough that would justify the prescription. Further, the guidelines in the 2016 SMC Handbook on repeat prescriptions that both parties rely on state that repeat prescriptions without consultations are allowed provided that they do not go on indefinitely and clinical reviews are conducted at intervals appropriate to the patients' diagnoses and medical conditions. Here, the Respondent had fallen below the applicable standard in giving repeat prescriptions of Codipront without reviewing the patient and without ensuring that there were clinical reviews conducted at appropriate intervals. 6. The Respondent testified that he was unaware that there were risks of codeine dependence or misuse associated with the consumption of Codipront capsules, as he was unaware of any literature or advisory regarding the abuse potential of Codipront. The Respondent submitted that he should not be faulted in relation to the prescription of Codipront

SN	Charge	SMC's position	Respondent's position	DT's Decision
		6. Realising the gaps in his defence, the Respondent attempted to rely on the 2021 Opioid Guidelines to support his treatment of PAT 9's persistent cough by asserting that "*chronic rhinitis can lead to prolonged and recurrent cough, which is also reflected in the 2021 Opioid Guidelines*". However, the 2021 Opioid Guidelines actually do not allow for prescription of codeine cough medications in the long term. Instead, it advocates referral to a specialist instead of the long-term use of codeine medications. Thus, the Respondent's practice of prescribing Codipront as long-term symptomatic treatment for chronic cough without treating the patient's underlying conditions goes against all 2021 Opioid Guidelines as well as the 2010 Allergic Rhinitis CPG. 7. Furthermore, the Respondent's position was that the sale of Codipront, unlike other codeine-containing medication, did not require a doctor's approval. This was premised on the 2000 Circular,		capsules as there were no guidelines in relation to the prescription of codeine in solid form at the material time. 7. While there were no guidelines indicating how much solid Codipront could be prescribed, Codipront is a codeine-containing medication, and the standards in relation to the prescription of codeine-containing medication in general would apply. Further, the 2000 Circular, which restricts the prescription of codeine-containing cough mixture, explains that that was to prevent the potential abuse of codeine. Moreover, the Respondent agreed with Dr PE that the pharmacologic effect of codeine would be the same regardless of its form.[67] The Respondent should have been aware that there were risks of codeine dependence or misuse associated with the consumption of Codipront capsules.

[67] Transcript of DT inquiry on 8 September 2022, at Part 2, page 5.

SN	Charge	SMC's position	Respondent's position	DT's Decision
		which refers to "*codeine containing cough mixture*", i.e. codeine in liquid form. However, as opined by Dr PE, the active ingredient (i.e. codeine) remained the same and the pharmacological effects of codeine was unchanged regardless of the form (solid / liquid) that that the medication came in. In fact, as calculated by Dr PE and accepted by the Respondent, 1 tablet of Codipront (with 30mg of codeine) contained more codeine than 1 tablet of Panaco (with 8mg of codeine). 8. Further, the Respondent's position regarding Codipront was entirely inconsistent with his position regarding Panaco. Both Codipront and Panaco are solid Codeine tablets and there was no valid reason to treat them differently. The Respondent accepted that the sale of Panaco would require the clinic assistant to seek the doctor's approval; this was reflected in the medical records of PAT 11 when approval was sought from the doctors on every occasion		8. In any event, the 2010 Allergic Rhinitis CPG does not recommend the use of codeine-containing medication to treat allergic rhinitis. The Respondent fell below the applicable standard in prescribing codeine-containing medication to the patient. Instead of doing so, the Respondent should have treated the underlying cause of the cough and if the cough persisted, he should have referred the patient to a specialist. In this regard, we note that the 2010 Allergic Rhinitis CPG requires a patient to be referred to a specialist if the symptoms are persistent and treatment fails.[68] The Respondent had fallen short of the applicable standard in not referring the patient to a specialist despite her persistent cough. 9. The Respondent further testified that it was likely that the patient had already been on nasal spray at the material time,[69] and that this was ineffective in relieving her

[68] SMC's Bundle of Documents Vol 4 at page 144.
[69] See transcript of DT Inquiry on 8 September 2022, Part 2, page 64; Respondent's Closing Submissions dated 30 December 2022 at [287].

SN	Charge	SMC's position	Respondent's position	DT's Decision
		where there was a sale of Panaco by his clinic assistants. Despite this, he contended that the sale of Codipront did not require approval simply because it was not codeine in liquid form. This is incongruous both in terms of the pharmacological effect as well as his own clinic practice. 9. The Respondent's own conduct after the audit also confirmed his awareness of the addictive nature and potential for abuse of Codipront, After the audit at his clinic on 1 November 2016, the Respondent wanted to see PAT 9 again to confirm that she had not been abusing Codipront. It is clear from the above that prior to the consultation on 5 December 2016, the Respondent was not sure whether PAT 9 was a genuine case. He thus needed to review her again in order to check through whether he had made any errors in his management of PAT 9, and whether he had been lax in his judgment such that PAT 9 could have been abusing Codipront. It is submitted that the Respondent's treatment of PAT 9 with codeine cough medication on a prolonged		cough. It was however not for the Respondent to make such assumptions. The Respondent should have ascertained from the patient what treatment she had already received, before deciding what medication he should prescribe. 10. We are satisfied that the Respondent did not provide appropriate care, management and treatment to the patient. He had not carried out an adequate assessment of the patient's medical condition before prescribing codeine-containing medications, and had inappropriately prescribed codeine-containing medications over a prolonged period of time. He had not referred the patient to a specialist for further investigation and management. We are satisfied that the Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

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		basis was clearly inappropriate and he was well aware that this was the case and needed to take steps to retrospectively justify his treatment.		
5	Codeine Prescription Charge for PAT 11: 5th Charge of NOI (2)	1. PAT 11 was prescribed codeine-containing medication (Panaco) from 12 May 2015 to 31 October 2016. 2. At the outset, the PMRs available for PAT 11 was incomplete. The Respondent has provided the PMR from 14 September 2001 to 21 July 2003 and from 3 May 2013 to 31 October 2016. The missing case notes spanned close to a decade. 3. Since 14 September 2001, the Respondent diagnosed PAT 11 with "chronic migraine and hypertension, which led to headaches and vomiting". However, his observation was not accompanied by any assessment of the severity of headache or a pain score and the only clinical review conducted by the Respondent was on 12 May 2015. 4. PAT 11 was on Diclomelan and / or transgesic since 14 September 2001. For the next few visits, the Respondent continued prescribing	The patient saw Dr Ling for her chronic migraine. She had already been on Atenolol (anti-migraine prophylactic medicine for hypertension). As migraine is a chronic condition, Dr Ling's plan was to provide symptomatic relief to the patient. He prescribed her with Panaco and Vimovo for pain relief. Dr Ling prescribed multiple classes of anti-migraine medicine to provide the patient with better coverage. Also, the patient specifically requested for Panaco as she found it to be useful. Dr Ling and the other doctors in the Clinic allowed their clinic assistants to sell Panaco over the counter without having to seek a doctor's approval. There were no guidelines at the material time in relation to the prescription of codeine in solid form. Dr Ling was also unaware that there were risks of dependence / misuse associated with Panaco.	1. The charge against the Respondent spanned the period 12 May 2015 to 31 October 2016. 2. Save for the prescription of Panaco on 12 May 2015, all the other prescriptions by the Respondent of codeine-containing medication as set out in the Schedule to the charge were over the counter prescriptions, without the Respondent reviewing the patient. There were 18 such over the counter prescriptions by the Respondent. Throughout the entire period between 12 May 2015 to 31 October 2016, the patient had been reviewed by a doctor at the Clinic on only four occasions. The patient was reviewed by the Respondent on 12 May 2015 and 18 May 2015, and by Dr F2 on 29 September 2015 and 31 May 2016. 3. When the Respondent reviewed the patient on 12 May 2015, he merely documented that the

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		Diclomelan and / or transgesic for PAT 11's headache and he also prescribed conkoff, which contains codeine, for PAT 11's cough. The Respondent claimed that was to address her cough and not to address her headache. From 3 May 2013, PAT 11 was already taking Atenolol, which she would obtain from the Respondent or from her own sources, which was effective for migraine, and Vimovo, a painkiller. Notwithstanding that she was already on two different medications to help with her migraine, the Respondent added on Panaco which is a codeine-containing medication to treat the migraine. 5. When pressed further on why he prescribed Panaco on top of Athenolol and either Dicomelan or Vimovo, the Respondent stated that "*that is because sometimes if patient takes Diclomelan or Vimovo, it doesn't work, she can add on the Panaco.*" However, he conceded that there was no notation in the case notes that the patient was not getting sufficient relief from Diclomelan.	The recommendations made in the 2021 Opioid Guidelines in relation to codeine for chronic non-cancer pain are not applicable. The Prosecution has not proven that the guidelines were representative of the applicable standards at the material time. Dr Ling did not find it necessary to perform further investigations / refer the patient to a specialist. This is because the patient responded well to Vimovo and Panaco, and her pain and vomiting were effectively relieved. The patient's migraine attacks did not worsen and she did not exhibit red flag symptoms. In any case, the patient did not consume Panaco excessively and did not show signs of dependence / addiction. She had also been repeating other anti-migraine medications. Overall, Dr Ling's management and care of the patient was appropriate.	patient had a headache. There were no further details regarding the patient's headache, such as the severity of the pain or any other details that would justify the prescription of Panaco over a prolonged period. The Respondent had thereafter prescribed Panaco multiple times without reviewing the patient. Even though the Respondent had reviewed the patient for many years prior to 12 May 2015 and the patient had complained of migraine during that time, that did not justify repeated prescriptions of codeine-containing medication without clinical reviews from 12 May 2015 to 31 October 2016, a period of roughly 1.5 years. The Respondent had fallen short of the standards set out in the 2016 SMC Handbook, which provides that repeat prescriptions should not go on indefinitely and clinical reviews should be conducted at intervals appropriate to the patient's diagnoses and medical conditions. 4. The Respondent submitted that he was unaware of the risk of codeine

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		6. Further, not only was there no assessment of whether PAT 11's condition was of a severity that required additional medications, the Respondent admitted that when PAT 11 said the "*magic word*" – "*migraine*", the Respondent would prescribe the aforementioned 3 medications. 7. The Respondent had also repeatedly prescribed Panaco over-the-counter without seeing the patient. Notwithstanding that the Respondent did not agree that the limit is another two times, the Respondent agreed with the underlying principle that the repeat prescription of medication without consultation should not carry on indefinitely and the prescribing doctor should conduct a clinical review of the patient at appropriate intervals. However, on the basis of PAT 11's "headache", the Respondent has prescribed codeine-containing medication indiscriminately over prolonged periods without any review. 8. The Respondent also conceded that on occasions when he did see PAT	*(See RCS from [290] to [298]; RRS from [229] to [237])*	dependence or misuse associated with the consumption of Panaco. This submission was similar to the submission he made in respect of the 4th Charge of NOI (2) (PAT 9), that he was unaware that there were risks of codeine dependence or misuse associated with the consumption of Codipront capsules. However for the same reasons as those set out at page 138 above, we do not accept this submission. 5. The SMC made submissions regarding the 2021 Opioid Guidelines and the Health Products (Therapeutic Productions) Regulations 2016. However we do not think these submissions assisted the SMC, given our view that the Prosecution had not proven that the 2021 Opioid Guidelines set out the applicable standard at the material time. The Health Products (Therapeutic Productions) Regulations 2016 were also not in effect at the material time.

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		11, it was the patient who requested to see him, and they were not occasions when he wanted to review her. 9. Since the Respondent had prescribed Panaco, a solid form of codeine-containing medication, he had attempted to distinguish between codeine in its solid or liquid form. However, this distinction has no merit. As established above, codeine in its solid or liquid form are equally addictive and the obligations imposed on codeine in its liquid form also applied to codeine in its solid form. 10. Further, the Respondent relied on the MOH Circular on the Revised Restrictions on the Sale and Supply of Codeine Cough Preparations to support the assertion that the 2021 Opioid Guidelines did not apply to chronic non-cancer pain such as migraine. However, he conceded that it was only the limits on quantity (set out in Regulation 14 of the Health Products (Therapeutic Products) Regulations 2016) that did not apply		6. Given that the cough persisted for a prolonged period, the Respondent should have referred the patient to a specialist, but he did not do so. 7. We are satisfied that the Respondent failed to carry out appropriate care, management and treatment to the patient. The Respondent's departure from the applicable standards was intentional and deliberate, and the misconduct was sufficiently egregious to amount to professional misconduct.

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		and the rest of the 2021 Opioid Guidelines did in fact apply. 11. As such, the Respondent should have been cognisant of and abided by the fundamental principles when he prescribed opioids which have addictive properties and he should have watched out for side effects, risks of misuse and conducted a thorough evaluation of the patient. Further, he should have properly documented his assessment and referred the patient to a specialist given the long periods of treatment and the fact that the patient was not getting better and was repeatedly taking not only codeine, but multiple other strong painkillers. Instead, he did none of the above and merely prescribed codeine-containing medication over the counter. 12. In reply to paragraph 292 of the RCS, the Respondent's contention that he was unaware that there were risks of codeine dependence / misuse associated with the consumption of Panaco and he allowed the clinic assistants to sell Panaco over the counter without a doctor's approval,		

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		is contradicted by the evidence. The Respondent had in his Witness Statement, accepted that the sale of Panaco would require the clinic assistant to seek the doctor's approval ; this was reflected in the medical records of PAT 11 when approval was sought from the doctors on every occasion where there was a sale of Panaco by his clinic assistants. The Respondent's about-turn should not be believed.		