SINGAPORE MEDICAL COUNCIL
DISCIPLINARY INQUIRY FOR DR WONG CHOO WAI
HELD ON 22 TO 25 NOVEMBER 2010 AND 2 JUNE 2011

Disciplinary Committee:
Dr Lim Cheok Peng (Chairman)
A/Prof Siow Jin Keat
A/Prof Koo Wen Hsin
Mr Chan Kok Way (Lay Member)

Legal Assessor:
Mr Andy Chiok (M/s Michael Khoo & Partners)

Prosecution Counsel (M/s Tan Rajah & Cheah):
Mr Burton Chen
Ms Edith Chen Yixin

Defence Counsel (M/s Donaldson & Burkinshaw):
Mr Eric Tin
Ms Kang Yixian
Ms Jessica Soo
Mr Pritam Singh (Intern)

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. These proceedings arose out of a letter of complaint made against the Respondent, Dr. Wong Choo Wai on 30 January 2008 by the Ministry of Health to the Singapore Medical Council (the "SMC").

2. Following the complaint, a written response dated 1 May 2008 by the Respondent was submitted to the Complaints Committee, which then referred the matter to this Committee for formal inquiry.

The Charges

3. In the Notice of Inquiry dated 7 October 2009, the SMC framed 27 charges against the Respondent. It is alleged that by reason of the conduct as set out in these charges, the Respondent failed to exercise due care in the management of the patients referred to in the charges, in particular (and as the case may be in respect of the relevant charge), that he

(1) engaged in inappropriate prescribing practice by prescribing benzodiazepines to his patients without exercising an acceptable standard of diligence and care;

(2) engaged in inappropriate prescribing practice by prescribing medication containing codeine to his patients without exercising an acceptable standard of diligence and care;

(3) he failed to properly record or document in the patients' Patient Medical Records, sufficient details of the patients' diagnosis, symptoms, condition and/or any management plan to enable a proper assessment of the patient's medical condition during the period of treatment; and/or

(4) he failed to refer the patients to the relevant specialist for further management of benzodiazepines medication and/or codeine medication and/or failed to refer the patient for blood or chest x-ray investigations, as the case may be.

4. On the first day of the inquiry, Charges Nos. 13, 16, 21 and 22 were stood down as the Respondent did not contest those charges and indicated that he would take a certain course of action for them. The Respondent elected to contest the remaining 23 charges ("the Charges").

The Proceedings

5. The hearing was conducted over 4 days. The SMC relied on the expert evidence and testimony of Dr. P as part of its case against the Respondent. An expert witness Dr. D testified on behalf of the Respondent. The parties tendered written submissions.

6. We now turn to the specific elements of the Charges against the Respondent.

Preliminary Point – Reading of the Charges

7. The Defence raised the preliminary point that by the charges as framed, the particulars of the charges are "collectively and specifically tied" to the allegation of the Respondent's misconduct i.e. his management of his patients. The Respondent's point is that the particulars do not stand alone and hence, all of them in respect of each charge must be proven beyond reasonable doubt for each charge to succeed.

8. On the other hand, the SMC contends that the particulars can stand alone by themselves such that proof of any single particular can amount to professional misconduct, with the proof of the other particulars being relevant towards the gravity of the misconduct. Authorities on the drafting of particulars were cited in the SMC's Closing Submissions.

9. Having considered the arguments on this point, this Committee is of the view that the particulars in the present Charges are not framed conjunctively and that the Respondent's objection is not upheld. In any case, and as it would be seen, this point will be addressed by the findings as set out below.

A. Inappropriate prescription of Benzodiazepines

10. This particular is stated in support of all of the Charges except Charges Nos. 1, 4, 5, 7, 11, 14, 25 and 27. The said particular relates to the inappropriate prescription of benzodiazepines. The relevant prescriptions of the medication are contained in the Schedule annexed to the Notice of Inquiry.

11. Briefly, the SMC relied upon the MOH Guidelines for Prescribing Benzodiazepines dated 17 August 2002 (the "MOH Guidelines") and its case consists of the following points:

    (1) The MOH Guidelines contain limits on the prescription of hypnotic medication to patients. In particular, the SMC relied on the statement that the prescription of hypnotics for the treatment of insomnia should

not be more than 2 weeks. Its case is that the Respondent had repeatedly breached this limitation on prescription.

(2) Counsel for the SMC also said that the MOH Guidelines state that there must be proper history taking and documentation, with the assessment of, and justification for any need for repeated prescription to be clearly documented. This was not done by the Respondent upon an examination of the relevant patients' medical records. The SMC also relied on the evidence of the Respondent's own expert Dr. D on this point.

(3) Concurrent prescription of two or more benzodiazepines should be avoided. However, the SMC's case is that the Respondent had so prescribed for the patients in Charges Nos. 17, 19 and 23.

(4) The SMC also emphasised that the Respondent did not consider non-benzodiazepines treatment options.

12. The SMC also relied upon the expert opinion and evidence provided by Dr. P for its case on the following points:

(1) That the Respondent had breached the MOH Guidelines, in that the prescriptions were excessive in the circumstances.

(2) Dr. P also opined that there was a lack of clear documentation to justify the prescriptions provided by the Respondent.

(3) The SMC also relied on Dr. P's evidence on the unsuitability of Dormicum for patients at the first consultations without a thorough history taking.

(4) Dr. P also testified that there was no reduction of the prescriptions of the benzodiazepines by the Respondent. The concern expressed by Dr. P was that there was no positive action taken by the Respondent to

address the long-term reliance of the benzodiazepines by these patients.

13. Generally, the Respondent's case is:

(1) He did not inappropriately prescribe the benzodiazepines for chronic insomnia because he had based his prescription "intermittently on an as necessary basis" for the patients concerned. He would ensure that there was a sufficient interval before the patient return to the clinic for the next dosage. Sufficient information was also obtained from the patients by the Respondent before prescription was made.

(2) The Respondent provided a table marked "D3" titled "Breakdown of Consumption" which sets out the prescriptions of the benzodiazepines and which shows that the average dosage consumed are not inappropriate.

(3) The Respondent's case is that his management plan was to "gradually reduce" the dosage of hypnotics at a pace tolerable to the patient. A period of 2 to 3 months to a year was indicated in the MOH Guidelines.

(4) Apart from the Respondent, no one is in a position to prove what transpired at the consultations with the patients where he had adequately carried out his evaluation and assessment of the patients[1] before prescribing the medication. Hence the SMC would not be able to prove otherwise.

14. This Committee make the following findings in respect of this element of the relevant Charges:

(1) It is disconcerting that even with consultation of his own case-notes, under examination the Respondent had demonstrated an inability to recollect in detail what happened at consultations with the patients. While this is a matter that is more relevant to the particular in connection

[1] See paragraphs 96 to 98 of the Defence Closing Submissions.

with the maintenance of medical records, it has a bearing on this particular because the Respondent had justified his prescription on the outcome of consultations with the patients.

(2) Our observation of the Respondent's practice is that he did not seem to evaluate the patients adequately as to the nature or severity of their insomnia, or to go into the history of the patient with sufficient detail to justify the prescriptions made by him. The Respondent was too ready to accept the patients' account of their insomnia, or their basis for it e.g. shift-work as the reason to dispense benzodiazepines. There was no close monitoring of the dosages prescribed to the patients. Taking a few examples,

(a) for Patient 2 the Respondent was unable to recollect whether he had evaluated the patient's type of insomnia, but believed that he "would have done so" from the type of medication disbursed,

(b) for Patient 3, the Respondent had prescribed 40 tablets of 7.5 mg Dormicum at the first visit. This was when the patient had informed him of his chronic insomnia. The Respondent ought to have been alerted to the suitability of continuing benzodiazepines prescription for such a patient as against the other option of a referral to a specialist,

(c) for Patient 6, the Respondent had no record of the frequency of the patient's insomnia, and had to infer the type of insomnia from the medication prescribed,

(d) for Patient 8, the Respondent had started a prescription on Dormicum when, in the view of Dr. P, valium (which is longer acting) should be prescribed for "mild insomnia",

(e) for Patient 10, the Respondent had started a prescription of 20 tablets of Dormicum for the first visit. He explained that it was for the patient's "convenience". Similarly, for Patient 12 the

Respondent gave the patient 6 extra tablets because of the patient's account of his family history and convenience, but cannot recollect whether he had asked the insomnia pattern, and

(f) for Patient 23, the Respondent prescribed about 180 tablets over 6 consultations spanning 2 months. Even though the Respondent seemed to recognise that there was an addiction problem by attempting to make a referral to a specialist, he then continued to prescribe inappropriate quantities of medication to the patient.

(g) Further examples of the poor practice of the Respondent are set out in the submissions of the counsel for the SMC[2]. There were also instances where benzodiazepines were prescribed even without any record of insomnia – see e.g. Patient 1 at the consultation on 24 July 2007 and Patient 5 in respect of the consultation on 1 November 2007.

For the other patients not mentioned above, there were other defaults by the Respondent as summarised by the SMC in its Closing Submissions.

(3) This Committee also found it disturbing that for Patient 3, the Respondent had prescribed more to him because he had a "long standing history". For Patient 24 he had justified the prescription on "convenience and cost-effectiveness" to the patient. Prescription of medication to a patient must be controlled by a physician and not mandated by what the patient stipulates. We note that the MOH Guidelines had stipulated that benzodiazepines should be prescribed "*only when the insomnia is severe, disabling or subjects the individual to extreme distress*". On this point, we agree with the SMC's case that the Respondent should have given more thought to non-benzodiazepines options before prescribing benzodiazepines.

[2] See paragraphs 50, 60 and 86 of the SMC's Closing Submissions.

(4) With regard to the Respondent's reliance on the statement in the MOH Guidelines that a period of "2 to 3 months to a year was indicated" in the Guidelines, that period is stipulated to the management of patients undergoing benzodiazepines withdrawal, which is not the category of patients been treated by the Respondent, even by his own evidence.

(5) In respect of the table "D3" that was produced by the Respondent, we do not think that it is appropriate to look at the average consumption with the benefit of hindsight. The proper approach that ought to have been taken was to evaluate the Respondent's conduct at each point when the medication was prescribed by him, and examine whether there was any good basis for him to make the prescription and/or whether such prescription was in breach of good clinical practice or the relevant guidelines.

(6) In respect of the reduction of the dosages of the benzodiazepines, we note that there were some attempts to reduce the prescriptions after the MOH had conducted an audit on the Respondent's clinic in late 2007. Nonetheless, we also noted the SMC's case at paragraph 68 of its submissions that there was no cutting down for about 10 patients even after the audit was conducted.

15. We therefore come to the conclusion that this particular in respect of all relevant Charges (excluding Charges Nos. 1, 4, 5, 7, 11, 14, 25 and 27) has been proven beyond reasonable doubt.

B. Inappropriate prescribing practice of Dhasedyl

16. This particular is stated in support of all Charges except 5 charges i.e. Nos. 3, 6, 10, 18 and 23. The said particular relates to the inappropriate prescription of Dhasedyl, a codeine-based medication. The relevant prescriptions of the medication are contained in the Schedule annexed to the Notice of Inquiry.

17. It is common ground that apart from the contents of a letter dated 9 October 2000 from the Ministry of Health to clinics ("the 2000 Guidelines"), there is no

guideline on the prescription of codeine-based medication. It is also common ground that the Respondent did not exceed the threshold of 240ml per customer and sale within 4 days as stipulated in the 2000 Guidelines.

18. The SMC's case is that on the medical records there was inappropriate prescription of Dhasedyl, a cough medication containing codeine in that:

(1) there was insufficient history taking of these patients,

(2) the prescriptions of the cough medication containing codeine was for exceedingly long periods of time, and there was a lack of proper documentation justifying the repeated prescriptions of cough medication,

(3) there was no attempt to switch the medication from a codeine-based one to a non-codeine medication,

(4) there was no documented attempts to initiate measures to get the patients to stop or reduce their smoking habits which the Respondent believes to be the cause of the cough,

(5) there was no referral to a specialist or for blood / x-ray investigations, and/or

(6) that the Respondent should seek to address the underlying cause e.g. the smoking habit of patients instead of merely treating the symptom of cough.

19. It is the Respondent's defence that he had in place a treatment plan for his patients i.e. putting the patients on a long-term or maintenance dosage of Dhasedyl. His evidence consists of the following points:

(1) These patients are smokers and/or patients with respiratory problems arising from their smoking habits or environment. The long term prescription of Dhasedyl is necessary for the treatment and relief of the chronic cough that these patients have.

(2) The Respondent did not advise the patients on the use of non-codeine based medication because he believed that such medication is not as efficacious as codeine-based medication. In any case, as part of his system of treating patients with chronic cough, the Respondent had reduced the dosage of the cough medication to 90ml, and/or had mixed the Dhasedyl with Dhasedyl DM a non-codeine cough medication from January 2008 onwards[3].

(3) It is undisputed that the Respondent did not refer the patients to a respiratory specialist or for further blood / x-ray investigations. This was justified by the Respondent on the basis of his view that such a referral would not be of use to the patients, as compared to his treatment and provision of relief for their symptoms.

(4) In his evidence, the Respondent also testified that he did not make use of smoking cessation aids because he takes the view that with patients who have a heavy smoking habit, such a course of action would have been futile.

20. The findings of the Committee on this aspect of the case are:

(1) A physician ought to treat the underlying cause of patients' symptoms and not simply provide relief for the symptoms. In the present case, the Respondent's management plan appeared to be one of providing relief for the coughing symptoms exhibited by his patients, without addressing the underlying causes.

(2) Further, we are of the view that the long term prescription of codeine medication puts the patient at risk of addiction. Dr. P had opined that the Respondent could have assessed his patients for codeine addiction by reducing / withholding the medication from the patients. It is undisputed that this was not done because the Respondent took the

[3] See paragraph 24 of the Defence Closing Submissions.

view that only codeine-based medication is effective to address these patients' cough.

(3) While the Respondent did carry out the practice of diluting the codeine-based Dhasedyl with Dhasedyl DM, such a practice was only belatedly carried out *after* the MOH had carried out the audit on his clinic in 2007. Examples of these are set out at Annex C of the SMC's Closing Submissions.

(4) Similarly, the Respondent's limitation of the dosages of the codeine medication to 90ml a week was predominantly implemented after the MOH's audit of his clinic in 2007.

(5) On the failure to refer to a specialist and/or further blood / x-ray investigations, we take the view that these options ought to have been explored by the Respondent. More details of the basis for our views are set out in the paragraphs at the later part of these grounds. For now, we take the view that even though limited success may be achieved with attempts to get smoking patients to quit or reduce the habit, we are not convinced that the Respondent had done enough for his patients by simply providing relief with long term cough medication.

21. In this regard, in respect of Charges except 5 charges i.e. Nos. 3, 6, 10, 18 and 23, this Committee finds that the SMC has successfully proven the particular relating to the inappropriate prescription of the codeine-based medication.

C. Failure to maintain proper documentation of patients' records and/or treatment plan

22. This is a particular that is common to all of the Charges. The SMC's case is that the Respondent did not record or document in his patients' medical records details or sufficient details of the patients' diagnosis, symptoms and/or condition and/or advice given and/or any management plan such as to enable a proper assessment of the patients' medical condition over the period of treatment. It is

also the case for the SMC that the Respondent did not document any proper treatment plan for his patients in his case-notes.

23. It is the Respondent's case that on the evidence,

(1) the maintenance of the patients' record was of sufficient detail such that the particular relied upon by the SMC is not made out.

(2) his medical records are not deficient in that he is able to use them in connection with the treatment of his patients. These notes enable him to recollect with sufficient clarity for him to explain his management of his patients. It is sufficient so long as the Respondent himself can rely on his own notes to manage his patients. In any case, there was no actual harm to the patients, something that the SMC has to show before it can prove that the Respondent was unable to assess his patients[4].

24. In the course of the proceedings, the Committee had been referred by both counsel to the patients' medical records in respect of the Charges. The Committee notes the following aspects of the evidence relating to these medical records:

(1) Both of the expert witnesses agree that for these patients that are dependent on the hypnotic medication, comprehensive history taking is necessary for proper treatment by a physician.

(2) Under cross-examination, the Respondent was unable to point to the relevant portions of his medical records where he had taken details of the patients' history and outcome of the reviews / assessments conducted on them subsequently. It is clear to this Committee that the Respondent was, apart from what was recorded on the patients' medical records, heavily reliant on his recollection of his consultations with the patients. However, there were many moments in cross-examination when the Respondent was unable to say with certainty the details of the treatment.

[4] See paragraph 104 of the Defence Closing Submissions.

25. This Committee notes that in paragraph 4.1.2 of the Ethical Code and Guidelines[5], it is stated 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*"

26. While this Committee accepts that the Respondent is not expressly charged with any breach of paragraph 4.1.2 of the Ethical Guidelines, it takes the view that in considering whether the particular in respect of inadequate record-keeping is proved, paragraph 4.1.2 is a relevant and valuable yardstick to determine the standard of record keeping required of physicians.

27. This Committee also takes the view that paragraph 4.1.2 of the Ethical Guidelines applies to history taking as well as subsequent consultations. Coupled with the evidence of Dr. P and Dr. D, this Committee can only conclude that proper documentation of history taking and assessments / reviews are important.

28. In the present case, the Committee is not satisfied that on the evidence, the Respondent had properly maintained the relevant patients' records for the management of the patients' treatment:

    (1) While there was some history taking, the standard fell short of what was required, as stated above. This is a view that was shared by Dr. D[6].

    (2) Further, in the course of the Respondent's evidence, we observed that much reliance was placed by him on his own recollection of the consultations with the patients. If there was proper documentation in the

[5] Prosecution's Bundle of Authorities, Tab 3, page 7

first place, this would not have been necessary. This Committee wants to make the point that even if a physician feels that he is keenly attuned to a patient, this does not mean that there can be a lowering of the standard of maintenance of medical records.

(3) Nonetheless, this Committee also notes that under cross-examination, the Respondent was unable to recollect details of the consultations even with the aid of his own records. This exposes the weakness of the Respondent's own case that his medical records enable him to recollect with sufficient detail the consultations with the relevant patients. This Committee is therefore not convinced from its observation of the Respondent when he gave evidence that he is capable of using his own notes to assess his patients.

(4) We would also add that even though occasions of consultations were recorded, there was a dearth of the details of each consultation and the results of any review conducted by the Respondent. For example, a mere record of "*insomnia*" without any accompanying details of the observation, discussion and conclusion is inadequate. Justification for repeated prescriptions must be clearly documented. This is a point that was agreed by the Respondent's own expert, Dr. D.

(5) This Committee also disagree with the Respondent's contention that the SMC has to show that there was actual harm suffered by the patients before it can prove that the Respondent was unable to properly assess his patients using his case notes. It is sufficient so long as the Respondent's practice and methods posed potential harm to befall the patient for misconduct to be proven.

(6) This Committee also cannot accept that it is good clinical practice for a physician to not expressly document a treatment or management plan that he had in mind, and then to justify this failure to document on the basis that such a plan can be inferred from the history of the previous consultations or the subsequent pattern of prescriptions of medication.

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[6] See paragraph 104 of the SMC's Closing Submissions.

Unfortunately, in the present case, this Committee is not convinced that on the totality of the evidence, the Respondent even had any treatment plan to treat the underlying causes of patients' need for cough / hypnotic medication, apart from the long-term prescription of such medication, which we do not accept to be a clinically sound treatment plan.

29. Finally, this Committee would add that all physicians ought to maintain adequate and proper patients' records, as these documents will form the primary evidence of the work and treatment by them. Given the express stipulation for proper record keeping in the Ethical Guidelines and for the reasons set out above, the failure to maintain proper records amounts to misconduct.

30. On the above basis, this Committee concludes that the SMC had proven beyond reasonable doubt that the Respondent did not maintain proper or sufficient record of the patients' treatment and/or a management plan in the patients' medical records for all of the Charges.

D. Failure to refer patients to further investigations and/or specialist and/or psychiatrist

31. This is a particular that is relevant to two aspects of the SMC's case i.e.

(1) The failure to refer the patients who were receiving prescriptions of cough medication for blood or chest x-rays investigations and/or a medical specialist and/or a psychiatrist (for all Charges except Charges Nos. 3, 6, 10, 18 and 23) and/or (as the case may be).

(2) The failure to refer the patients who were receiving prescriptions of benzodiazepines to a medical specialist and/or a psychiatrist (for all Charges except Charges Nos. 1, 4, 5, 7, 11, 14, 25 and 27).

32. The SMC's case is:

(1) It was beyond the ability of the Respondent to treat the relevant patients in respect of this particular.

(2) In respect of the patients who were prescribed the benzodiazepines, the Respondent ought to have referred these patients to specialists as recommended in the MOH Guidelines.

(3) In respect of the patients who were prescribed codeine-based medication, the Respondent ought to have referred these patients to respiratory specialists and/or conducted blood / chest x-ray investigations, instead of simply relying on long-term medication.

33. The Respondent's case is:

(1) For patients on cough medication, he is treating the patients for chronic cough due to the patients' smoking habits or exposure to smoke. For patients who were prescribed benzodiazepines, they were being treated for chronic insomnia.

(2) The Respondent had advised / counselled his patients to reduce smoking and/or cut down on the codeine medication.

(3) It is unnecessary to refer the patients for further investigations / to a specialist because referral to a specialist is unhelpful without solving the underlying cause or trigger for the chronic cough.

(4) In any case, the test under paragraph 4.1.1.6 of the Ethical Guidelines in respect of the limits of a doctor's own competence is a subjective one, and at no time did the Respondent think that he had exceeded his own competence in treating his patients.

(5) Dr. P as a psychiatrist is in no position to provide any opinion on the necessity for blood / x-ray investigations.

34. This Committee takes the following views in respect of this as aspect of the relevant Charges:

(1) There is inadequate documentation in the patients' medical notes of the steps purportedly taken by the Respondent to advise or counsel his patients to reduce smoking and/or cut down on the codeine medication. Even if such steps were taken by the Respondent, the fact that the patients were on long term use of the codeine medication (e.g. Patient 1 with 38 consultations over 10 months, Patient 2 with 34 consultations over 12 months, Patient 4 with 22 consultations over 9 months, Patient 7 with 11 consultations over 3 months, Patient 15 with 27 consultations over 15 months, Patient 11 with 11 consultations over 5 months and Patient 27 with 13 consultations over 7 months) demonstrated that such efforts were futile.

(2) The Respondent should reasonably recognise his inability to help these patients given the extended periods of the prescriptions. We take the view that the fact that the Respondent has a Masters in Medicine (Family Medicine) "*which involved 3 additional years of training in additional specialities including Psychiatry*"[7] meant that the Respondent should be more knowledgeable than the average general practitioner to recognise the futility of his treatment given the extended periods of the prescriptions of the medication.

(3) Unfortunately, it appears that the Respondent had, perhaps because of his additional qualification, believed in his own competence and hence reluctance to refer his patients to specialists[8]. This Committee notes that the Respondent's view was that he had done what a chest physician would have done[9]. He had the assumption that the chest physician will not treat the patient differently. We also noted that the fact that he did not have an x-ray centre next to him was a factor that he considered in not sending his patients for x-ray investigations. We are of the view that this is not acceptable as x-rays could have been taken

[7] See paragraph 87 of the Defence Closing Submissions.
[8] See paragraph 105 where the Respondent stated that "he believed himself to be acting within his competence".
[9] See the exchange under cross-examination as set out at paragraph 82 of the Defence Closing Submissions.

at other locations even if the patient remains under the care of the Respondent.

(4) We would next refer to paragraph 4.1.1.6 of the Ethical Guidelines:

> "4.1.1.6 A doctor should practise within the limits of his own competence in managing a patient. Where he believed 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 branch of medicine without having the appropriate knowledge and skill or having the required experience."

We do not accept that the test is a subjective one because if that is the case, then no doctor can ever run afoul of this Guideline by simply relying on his own judgment that his competence was not exceeded. We take the view that the purpose of this Guideline is to ensure that doctors will refer patients to another doctor when the objective facts show that he is no longer capable of treating the patient or when his treatment has failed.

(5) Even if the Respondent believed that he was competent in treating these patients, as physicians, members of this Committee find that a reasonable general practitioner would adopt a good clinical practice of conducting further investigation like a chest x-ray to assist him in making a determination of the cause of the chronic cough that the patients were experiencing for a period exceeding 6 months. Further investigations would have been useful to eliminate something more sinister than smokers' cough e.g. lung cancer. In the present case, the Respondent had simply continued his "treatment" of and "provided relief" against the symptoms of cough on a long-term basis without addressing the objective of curing the condition. This Committee makes this finding even if we disregard Dr. P's evidence on account of his expertise in psychiatry, and not in respiratory medicine. To us, what ought to have

been done by the Respondent, but which was not, is good basic clinical practice.

(6) Dr. P also opined that the Respondent, instead of continuing on with "treatment" that was yielding the same outcome, could have let another doctor or a specialist try to solve the underlying cause, or co-manage the relevant patient with a specialist, which was not done.

(7) The Committee also found that the Respondent had, for Patient 20, explained his position that he will discharge himself from treating her if she does not end her dependence. Oddly, such a stance was not taken with the other patients. However, we accept the Respondent's evidence that for Patients 15 and 20, efforts were made to refer the patients to see a specialist. This is a point that this Committee has to take into account insofar as mitigation is concerned.

35. On the above basis, this Committee finds that except for Charge Nos. 15 and 20, the SMC had proved that the Respondent failed to refer patients to further investigations and/or specialist and/or psychiatrist (as the case may be).

Findings of the Committee

36. On the totality of the evidence, this Committee finds that all of the Charges were made out by the SMC against the Respondent. Further, as all of the particulars to all of the Charges (except for a single particular under Charges No. 15 and 20 as highlighted in these Grounds) have been made out, the preliminary objection by the Respondent would not have assisted his case insofar as the finding of guilt by this Committee on those Charges.

37. The Committee therefore finds that the Respondent is guilty of the professional misconduct in respect of the Charges to the extent as stated above and called for his counsel to address us in respect of the matter of mitigation, and his position in respect of charges Nos. 13, 16, 21 and 22.

38. Following his conviction, the Respondent pleaded guilty to charges 13, 16, 21 and 22. His counsel then mitigated on his behalf in respect of all 27 charges.

39. In mitigation, counsel for the Respondent had relied upon various factors as set out in the written plea in mitigation. Testimonials of various individuals in support of the Respondent were also presented to the Committee.

40. Counsel for the SMC and the Respondent both presented precedents for this Committee's consideration on sentencing.

41. This Committee considers that the following factors are mitigating:

    (1) The Respondent is a first-time offender with a clean record, although we note that the infringing acts took place fairly soon after his practice commenced,

    (2) The Respondent also pleaded guilty to 4 charges, although that must be considered in the context that he had elected to contest 23 charges,

    (3) There were a few instances of advice by the Respondent advocating referral of patients to specialists,

    (4) We also note that the Respondent had voluntarily stopped accepting patients with insomnia, and

    (5) There are credible testimonials by patients in favour of the Respondent.

42. This Committee takes the view that a period of suspension is mandatory for misconduct of the nature as set out in our Grounds. On the appropriate length of the period of suspension, we note that in the sentencing precedents, where the sentences imposed were on the lower-end, the doctor concerned had pleaded guilty as opposed to the contest of the charges and/or had ceased his practice as the case may be. In the present case, the majority of the charges were contested by the Respondent. While this is not an aggravating factor per se, nevertheless it is a relevant consideration for the purpose of sentencing. In

particular, this Committee is guided by the precedent case involving Dr. F where he contested 16 charges of inappropriate prescriptions and was convicted on 15 charges, a sentence involving 6 months' suspension was imposed.

43. Having regard to the representations made by both counsel and the nature of the misconduct, it is this Committee's decision that the appropriate sentence is as follows:-

(a) the Respondent's registration in the Register of Medical Practitioners shall be suspended for a period of **6 months**;

(b) that the Respondent shall be fined the sum of **$5,000**;

(c) that the Respondent shall be censured;

(d) that the Respondent shall give a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct; and

(e) that the Respondent pays the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the SMC and the Legal Assessor.

44. We hereby order that the Grounds of Decision be published.

45. The hearing is hereby concluded.

Dated this 2nd day of June 2011.