IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2018] SMCDT 10

Between

Singapore Medical Council

And

Dr Lee Siu Lin

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension / Fine

Singapore Medical Council
v
Dr Lee Siu Lin

[2018] SMCDT 10

Disciplinary Tribunal — DT Inquiry No. 10 of 2018
Dr Chan Wing Kwong (Chairman), Dr Kwan Yew Seng and Ms Jasvender Kaur (Legal Service Officer)

Administrative Law — Disciplinary Tribunals
Medical Profession and Practice — Professional Conduct — Suspension / Fine

26 November 2018;
12 December 2018

GROUNDS OF DECISION

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

1. The Respondent is a registered medical practitioner who at the material time was practising at Focus Medical Group ('FMG') located at Block 226C Ang Mo Kio Avenue 1. She pleaded guilty to three charges of professional misconduct under s 53(1)(d) of the Medical Registration Act (Cap 174) ('the Act') which related to inappropriately prescribing hypnotics to Patient A and cough mixtures containing codeine to Patient B and Patient C over various dates.

SUMMARY OF FACTS

2. The facts in relation to the three charges are set out in the Agreed Statement of Facts, and are summarised below.

3. On 5 June 2012, Inspectors from the Regulatory Compliance & Enforcement Division of the Ministry of Health ('MOH') conducted an inspection at FMG. Copies of the Drug Dispensing Registers for the period between 24 May 2011 to 16 May 2012 and the patient medical records of 16 patients of FMG were obtained.

Facts relating to the 1st charge – Patient A

4. *Lexotan* belongs to a group of medicines called benzodiazepines as it contains the active ingredient, bromazepam. The MOH Clinical Practice Guidelines on the Prescribing of Benzodiazepines (2/2008) ("MOH Clinical Practice Guidelines (2/2008)") state, amongst other things, that:

(a) Benzodiazepine use should be limited to short-term relief (between 2 to 4 weeks), at the lowest dose and be taken intermittently (e.g. 1 night in 2 or 3 nights).

(b) The extended used of benzodiazepines beyond 2 to 4 weeks is not recommended, even when prescribed at the therapeutic dosages.

(c) All patients receiving benzodiazepines should be routinely advised about the risk of developing dependence.

5. The MOH Administrative Guidelines on the prescribing of Benzodiazepines and other Hypnotics dated 14 October 2008 (MH 70:41/24 Vol. 3) ("MOH Administrative Guidelines (14 October 2008)"), state, amongst other things, that:

(a) Where there are doubts about dosage prescription or tapering of benzodiazepines/ other hypnotics, a psychiatrist or other specialists should be consulted.

(b) Patients who require or have been prescribed benzodiazepines/ other hypnotics beyond a cumulative period of 8 weeks should not be further prescribed with benzodiazepines/ other hypnotics and

must be referred to the appropriate specialist for further management.

6. On 28 October 2008, the Respondent prescribed 10 tablets of 1.5 mg *Lexotan* to Patient A. This was the first prescription of *Lexotan* to Patient A ("first prescription"). After the first prescription, the Respondent subsequently prescribed *Lexotan* on the following dates and in the following dosages:

S/ No.	Date	Dosage	Lapse of time from First Prescription
1	23 November 2008	20 tablets of 1.5 mg *Lexotan*	3 weeks and 5 days from the First Prescription
2	15 January 2009	30 tablets of 3 mg *Lexotan*	2 months and 18 days from the First Prescription
3	13 February 2009	30 tablets of 3 mg *Lexotan*	3 months and 16 days from the First Prescription
4	28 February 2009	30 tablets of 3 mg *Lexotan*	4 months and 3 days from the First Prescription
5	20 March 2009	30 tablets of 3 mg *Lexotan*	4 months and 23 days from the First Prescription
6	7 May 2009	10 tablets of 1.5 mg *Lexotan* and 30 tablets of 3 mg *Lexotan*	6 months and 10 days from the First Prescription
7	12 May 2009	30 tablets of 3 mg *Lexotan*	6 months and 15 days from the First Prescription
8	30 May 2009	10 tablets of 1.5 mg *Lexotan* and 30 tablets of 3 mg *Lexotan*	7 months and 2 days from the First Prescription
9	12 June 2009	30 tablets of 3 mg *Lexotan*	7 months and 15 days from the First

S/ No.	Date	Dosage	Lapse of time from First Prescription
			Prescription
10	22 June 2009	10 tablets of 1.5 mg *Lexotan*	7 months and 25 days from the First Prescription
11	1 July 2009	30 tablets of 3 mg *Lexotan*	8 months and 4 days from the First Prescription
12	13 July 2009	30 tablets of 3 mg *Lexotan*	8 months and 16 days from the First Prescription
13	28 October 2009	30 tablets of 3 mg *Lexotan*	1 year from the First Prescription
14	10 November 2009	30 tablets of 3 mg *Lexotan*	1 year and 13 days from the First Prescription

7. The prescriptions of *Lexotan* to Patient A as set out in the table above extended beyond a cumulative period of 8 weeks in breach of the MOH Clinical Practice Guidelines (2/2008). The Respondent also did not refer Patient A to a medical specialist and/or psychiatrist for further and/or joint management. This was a breach of the MOH Administrative Guidelines (14 October 2008).

8. Accordingly, the Respondent failed to provide appropriate care, management, and treatment to Patient A, which failure constituted a breach of Guidelines 4.1.1.6 and 4.1.3 of the Singapore Medical Council's ('SMC') Ethical Code and Ethical Guidelines (2002 Edition).

Facts relating to the 2nd charge – Patient B

9. *Dhasedyl*, *Promedyl* and *Cosedyl* are cough mixtures that contain codeine. The MOH Circular to doctors and pharmacists on the Sale and Supply of Cough Mixtures containing Codeine dated 9 October 2000 (MH 36:10/5) ("MOH Circular 2000") states, amongst other things, that:

(2) Cough mixtures containing codeine carry the potential for abuse as drug addicts tend to consume these preparations in between their supply of illicit drugs.

(3) … In 1996, the NPA [National Pharmaceutical Administration] sought the cooperation of retail pharmacists in implementing some restrictive measures to curb the abuse of these preparations by drug addicts, such as limiting sale to 240 ml (2 x 120 ml bottles) per customer and no sale to the same customer within 4 days, whenever possible.

(4) The Ministry seeks your co-operation to help prevent the potential abuse of codeine by exercising greater control on the sale and supply of these preparations to patients.

10. On 28 June 2009, the Respondent prescribed 2 x 90 ml bottles of *Dhasedyl* to Patient B. This was two days from the last prescription of *Dhasedyl* which was given by the Respondent on 26 June 2009.

11. After the prescription on 28 June 2009, the Respondent next prescribed *Dhasedyl* to Patient B on 11 August 2009. Thereafter, she prescribed on the following dates and in the following dosages:

S/ No.	Date	Dosage	Lapse of time from last Prescription.
1	14 August 2009	2 x 90 ml bottles of *Dhasedyl*	3 days from the last prescription
2	8 September 2009	2 x 90 ml bottles of *Dhasedyl*	4 days from the last prescription of *Dhasedyl* which was given by Dr Ho Thong Chew ("Dr Ho"), who also practiced at FMG, on 4 September 2009. The Respondent was aware of this prescription from the medical records.
3	28 November 2009	2 x 90 ml bottles of *Dhasedyl*	3 days from the last prescription of *Dhasedyl* which was given by Dr

S/ No.	Date	Dosage	Lapse of time from last Prescription.
			Ho on 25 November 2009. The Respondent was aware of the prescription by Dr Ho from the medical records.
4	7 May 2010	2 x 90 ml bottles of *Dhasedyl*	3 days from the last prescription of *Dhasedyl* which was given by the Respondent on 4 May 2010.
5	25 June 2010	2 x 90 ml bottles of *Dhasedyl*	4 days from the last prescription of *Dhasedyl* which was given by the Respondent on 21 June 2010.
6	29 June 2010	2 x 90 ml bottles of *Dhasedyl*	4 days from the last prescription of *Dhasedyl* which was given by the Respondent on 25 June 2010.

12. The prescriptions of *Dhasedyl* to Patient B by the Respondent were in breach of the MOH Circular 2000. By virtue of her conduct, the Respondent failed to provide appropriate care, management, and treatment to Patient B, which failure constituted a breach of Guidelines 4.1.3 of the SMC's Ethical Code and Ethical Guidelines (2002 Edition).

Facts relating to the 3rd charge – Patient C

Facts relating to the prescription of Dhasedyl

13. On 7 July 2008, the Respondent prescribed 1 x 90 ml bottle of *Dhasedyl* to Patient C. This was two days from the last prescription of *Dhasedyl* given by

the Respondent on 5 July 2008. On 12 September 2008, the Respondent prescribed 1 x 90 ml bottle of *Dhasedyl* to him. This was two days from the last prescription of *Dhasedyl* which was given by the Respondent on 10 September 2008. On 20 November 2008, the Respondent prescribed 1 x 90 ml bottle of *Dhasedyl* to him. This was two days from the last prescription of *Dhasedyl* which was given by the Respondent on 18 November 2008.

Facts relating to the prescription of Promedyl

14. On each of the 121 occasions between 28 March 2011 and 24 September 2012 which are detailed in Annex A to the Agreed Statement of Facts, the Respondent prescribed 2 x 90 ml bottles of *Promedyl* to Patient C. All the prescriptions were given within a continuous period of 4 days from the last prescription of *Promedyl*, or another cough mixture containing codeine. In addition, on 14 October 2011, 16 November 2011 and 7 December 2011, the Respondent prescribed 3 x 90 ml bottles (totalling 270 ml) of *Promedyl* to Patient C.

Facts relating to the prescription of Cosedyl

15. On 27 June 2011, the Respondent prescribed 2 x 90 ml bottles of *Cosedyl* to Patient C. This was two days from the last prescription of *Cosedyl* which was given by Dr Ho on 24 June 2011. The Respondent was aware of the prescription by Dr Ho on 24 June 2011 from Patient C's medical records.

16. On 29 June 2011, the Respondent prescribed 2 x 90 ml bottles of *Cosedyl* to Patient C. This was two days from the last prescription of *Cosedyl* which was given by the Respondent on 27 June 2011.

17. The prescriptions of *Dhasedyl*, *Promedyl* and *Cosedyl* to Patient C by the Respondent were inappropriate and in breach of the MOH Circular 2000. By virtue of her conduct, the Respondent failed to provide appropriate care, management, and treatment to Patient C, which failure constituted a breach of

Guidelines 4.1.3 of the SMC's Ethical Code and Ethical Guidelines (2002 Edition).

ADDRESS ON SENTENCE

18. Counsel for the SMC submitted for a suspension period of at least four months, a fine of $12,000 and the usual orders. It was submitted that ordinarily a suspension of six months, which was at the upper end of the range as reflected in the sentencing precedents, would have been sought but taking into account the delay, a period of four months was appropriate.

19. As regards Patient A, it was submitted that the breach was egregious as the Respondent had within a period of 1 year and 13 days prescribed 420 tablets of *Lexotan*, which worked out to an average of just less than eight tablets a week. The submission then went as follows:

> 26. …it is stated in the CPG that benzodiazepine use should be limited to 2 to 4 weeks, be taken intermittently, e.g., 1 night in 2 or 3 nights, and extended use beyond 2 to 4 weeks is not recommended, even when prescribed at the therapeutic dosages. All of these have been egregiously breached by Dr Lee.
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> 27. Further, in the MOH Administrative Guidelines, patients who require or have been prescribed benzodiazepines/ other hypnotics beyond a cumulative period of 8 weeks should not be further prescribed with benzodiazepines/ other hypnotics and must be referred to the appropriate specialist for further management
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> 28. Despite the fact that the prescription of *Lexotan* to [Patient A] stretched to about 54 weeks, which is about 7 times longer than the period prescribed in the MOH Administrative Guidelines, Dr Lee took no steps to refer him to any specialist, to manage [her] condition

20. Reference was made to the decision of the Disciplinary Tribunal ("DT") *In the Matter of Dr Ng Teck Keng* [2014] SMCDT 9, where the inappropriate

prescription of Dormicum was for a period exceeding 7 years, for the sentencing considerations that were taken into account. The DT stated at paragraph 15(b):

> besides the length of time in which the inappropriate prescription was made, we were also taken aback by the huge quantum of Dormicum the Respondent prescribed to the Patient, i.e., a total of 80 tablets of Dormicum 15 mg on 8 occasions within a 5-month period between 5 March 2012 and 31 July 2012. As physicians are empowered to decide the dispensation of such drugs, the authority must be exercised with extreme prudence and caution. If misapplied, the consequences may be dire as it happened to the Patient in the present case. He was warded into the Intensive Care Unit for overdose.

21. With respect to Patient B, it was stressed that the Respondent breached the MOH circular seven times within 1 year. As regards Patient C, it was said that it was "particularly egregious" given the magnitude of the number of occasions on which the codeine was prescribed.

22. It was submitted that there was a blatant disregard of the well-being and interests of the three patients.

MITIGATION

23. The Respondent attained her Bachelor of Medicine and Bachelor of Surgery (MBBS) from the National University of Singapore in 1996. She has been a General Practitioner for almost 21 years. She has two children, one of whom suffers from a host of medical conditions. She has an unblemished record save for the present proceedings.

24. The Respondent's cooperation with MOH and SMC throughout the investigations was emphasised. It was said that she accepted responsibility and expressed regret for her actions in her letter of explanation when the SMC's Complaints Committee first wrote to her on 9 March 2016. She also indicated her wish to plead guilty from the outset.

25. It was claimed that the Respondent was not motivated by financial gain in making the inappropriate prescriptions. It was said that she acted out of concern and sympathy for the patients who were struggling with insomnia.

26. It was emphasised that there has been a protracted delay of around six years in the prosecution of the Respondent, and the uncertainty had brought her immense anxiety and distress. On 21 December 2012, the matter was referred by the SMC to the Complaints Committee. On 9 March 2016, she received the Notice of Complaint and was invited to provide a written explanation. On 14 March 2016, the Respondent provided her letter of explanation. On 9 June 2017, the Respondent was informed that the complaint had been referred to the DT. On 25 June 2018, the Respondent received the Notice of Inquiry enclosing the charges.

27. Learned counsel referred to the decisions in *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356 ("*Dr Ang Peng Tiam*") and *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Dr Jen Shek Wei*") to submit that the inordinate delay ought to be regarded as a mitigating factor. In *Dr Ang Peng Tiam*, there was a delay of around 5.5 years from the date of the complaint to the verdict on conviction and sentence. The Court of Three Judges held that it was minded to impose a 16-month suspension but halved the suspension to a period of eight months in consideration of the inordinate delay. In *Dr Jen Shek Wei*, there was a delay of nearly three years before the issuance of the Notice of Inquiry and another three years for the matter to reach the Court of Three Judges. The Court was minded to impose a 16-month suspension but similarly halved the term in view of the inordinate delay.

28. It was submitted that the Respondent's rehabilitative progress over the past six years should be taken into account. She had stopped dispensing hypnotics and cough mixtures which contain codeine at her clinic after the MOH inspection.

Copies of testimonials from six patients attesting to excellent care and dedication by the Respondent were tendered.

29. As for the sanction, learned counsel realistically conceded that the precedents demonstrate that breaches of the SMC Ethical Code and Guidelines for the failure to provide appropriate care, management and treatment to patients by inappropriately prescribing hypnotics and/or cough mixtures containing codeine generally involved a suspension, fine and the usual orders of a censure, written undertaking to the SMC and payment of the SMC's costs and expenses incidental to the proceedings.

30. Learned counsel prepared a diagrammatic representation of the range of sentences that have been ordered for cases involving the prescription of hypnotics and/or codeine (see Annex B to Mitigation Plea). It was submitted that the sentences for similar offences imposed were generally: (i) a suspension in the region of three to six months, (ii) a fine in the range of $1,000 to $12,000; and (iii) the usual orders.

31. Learned counsel distinguished the cases where a six-month suspension was imposed on the ground that they involved multiple charges/ patients that far exceeded three. A summary of those cases is found at Annex C to the mitigation plea. For example, in *Dr Tang Yen Ho Andrew (2013)*, he had claimed trial to 34 charges for 17 patients: (i) 17 charges related to the failure to exercise due care in the management of the patients in prescribing hypnotics and/or codeine; and (ii) 17 charges related to the failure to properly document in medical records sufficient clinical details.

32. The only case in which a suspension of more than six-months was meted out is *Dr AAW (2009)* who was a repeat offender. The disciplinary committee imposed a 30-month suspension, $10,000 fine and the usual orders. The disciplinary committee stated that the long suspension was warranted as Dr AAW

had again committed the same breaches of the SMC's Ethical Code and Ethical Guidelines.

33. Learned counsel referred to a recent DT decision in *Dr Chew Yew Meng Victor (2017)* involving the inappropriate prescription of hypnotics and/or codeine by a general practitioner. Dr Chew faced three charges in relation to (i) a failure to provide appropriate care, management and treatment to the patient in prescribing hypnotics and/or codeine between 2 April 2009 and 21 September 2011 (almost 2 years and 6 months); (ii) failure to maintain sufficient details in the patient's medical records; and (iii) failure to refer the patient to a psychiatrist and/or appropriate specialist in a timely manner. The DT ordered: (i) a suspension of four months; (ii) a fine of $12,000; and (iii) the usual orders.

34. Accordingly, it was submitted that a term of suspension of under four months, a fine that does not exceed $10,000 and the usual orders would appropriately reflect the Respondent's culpability.

DECISION

35. The Respondent is charged under s 53(1)(d) of the Act for professional misconduct. It was not in dispute that professional misconduct was made out as the Respondent's conduct constituted an intentional and deliberate breach of the SMC's Ethical Code and Ethical Guidelines (2002 Edition) which are standards observed or approved by members of the profession of good repute and competency.

36. The parties were agreed that a period of suspension, fine and the usual orders were the appropriate sanctions. The issue before the DT was the determination of the appropriate period of suspension and the quantum of the fine.

37. In deciding on the appropriate sanction, we first bore in mind the primary objectives of disciplinary proceedings. In *Singapore Medical Council v Kwan*

Kah Yee [2015] 5 SLR 201, the Court of Three Judges observed (at [50]) that sanctions in medical disciplinary proceedings serve two functions: first, to ensure that the offender does not repeat the offence so that the public is protected from the potentially severe outcomes that may arise from the conduct of errant doctors; and second, to uphold the standing of the medical profession. In addition, we are of the view that a breach involving an inappropriate prescription of hypnotics and/or codeine necessitates a sentencing approach based on deterrence.

38. Under s 53(2)(b) of the Act, the minimum period of suspension is three months and up to a maximum of three years. Based on the sentencing precedents brought to our attention, the suspension terms imposed have clustered within a tight band of between three to six months. The only case which is outside of this range involved a repeat offender. We have not found this to be satisfactory. We are of the view that if a suspension and/or fine is deemed appropriate, the parties should refer to the entire range of the sentence provided by the Act and submit where the sentence should be placed within the range having regard to the aggravating and mitigation factors.

39. In the instant case, we evaluated the seriousness of the misconduct by considering the number of patients involved, the type and quantity of the inappropriate prescriptions, the frequency and duration of the inappropriate prescriptions, harm to the patients (if any) and the motivation of the Respondent.

The aggravating factors

40. In respect of Patient A who was prescribed benzodiazepines, the MOH Administrative Guidelines (14 October 2008) state the need for every doctor to ensure that benzodiazepines are used appropriately. It states that "Tolerance and drug dependence can be the undesired result." It states categorically that patients who have been prescribed benzodiazepines/other hypnotics beyond a cumulative period of 8 weeks should not be further prescribed and must be referred to the appropriate specialist for further management. In addition, to assist medical

practitioners, the MOH Clinical Practice Guidelines (2/2008) state that the prescription of benzodiazepines should be limited to short-term relief.

41. The Respondent inappropriately prescribed *Lexotan* to Patient A at close intervals for a duration of 1 year and 13 days after the first prescription. The initial dose prescribed on 28 October 2008 was 1.5mg. It was increased to 3mg on 15 January 2009. Subsequently the increased dose was prescribed except on three occasions where 1.5mg was prescribed.

42. The extended prescription of the benzodiazepines coupled with the non-referral to a specialist was in blatant disregard of the MOH Clinical Practice Guidelines (2/2008) and the Administrative Guidelines (14 October 2008). The Respondent's actions were plainly not in the best interests of Patient A and constituted a serious breach of the duty to provide appropriate care, management and treatment.

43. As regards Patient B, he was first seen on 26 June 2009 and the last consultation was on 9 June 2010. During this period, he was prescribed *Dhasedyl* on seven occasions at intervals of between two to four days. With respect to Patient C, he was prescribed 1 x 90m bottle of *Dhasedyl* within a continuous period of two days from the last prescription on three occasions, and prescribed 2 x 90 bottles of *Promedyl* or *Cosedyl* on 124 occasions within a continuous period of four days from the last prescription. On three out of the 124 occasions, he was prescribed 3 x 90 ml bottles of *Promedyl*. Patient C was given codeine cough mixture at an alarming frequency in deliberate disregard of the MOH Circular 2000, which sought the cooperation of doctors to exercise greater control on the sale of cough mixtures to prevent abuse.

44. We would add for completeness that in respect of the three patients, there is no evidence of any resulting harm to them that was presented before the DT.

45. With respect to the claim that the accused was not motivated by financial gain but acted out of concern and sympathy, we are unable to accept this explanation. In view of the frequency and long duration over which the prescriptions were given, especially to Patient A and Patient C, the Respondent would have realised that the prescriptions were not in their best interests due to the potential for psychological and/or physical dependency or abuse or misuse by the patients. In our view, there is no acceptable excuse for the Respondent's misconduct.

The mitigation factors

46. In favour of the Respondent, we took into account her cooperation and timeous plea of guilt.

47. As regards the long delay in the proceedings, the matter was referred by the SMC to the Complaints Committee on 21 December 2012. On 9 March 2016, the Respondent received the Notice of Complaint. On 9 June 2017, she was informed that the complaint had been referred to the DT. On 25 June 2018, the Respondent received the Notice of Inquiry enclosing the charges. Although there is a time lag of five and a half years since the receipt of the Complaint, the Respondent received the Notice of Complaint in March 2016.

48. Looking at the matter in the round, we agree that there has been an inordinate delay for which the Respondent was in no way responsible. However, in our view the relevant period from which the Respondent would have been under anxiety and distress should begin from 9 March 2016 onwards, the date when she received the Notice of Complaint. This was just slightly over two years.

49. We agree with the parties that the sentence should be discounted on account of the overall delay. In light of the relevant period of the delay, in our view the discount ought to be less than half.

50. We have also considered the insight gained by the Respondent into her offending conduct and the steps taken by her to ensure that there is no similar occurrence. In this regard, we have noted that she stopped prescribing benzodiazepines and cough mixture containing codeine after the MOH inspection.

51. Taking into account the matters identified above, the Tribunal orders that the Respondent:

a. be suspended for a term of four (4) months;
b. be fined $12,000;
c. be censured;
d. give a written undertaking to the SMC that she will not engage in the conduct complained of or any similar conduct; and
e. pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

PUBLICATION OF DECISION

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

53. The hearing is hereby concluded.

Dr Chan Wing Kwong	Dr Kwan Yew Seng	Ms Jasvender Kaur
Chairman	Member	Legal Service Officer

Mr Christopher Anand s/o Daniel and Ms Harjean Kaur (M/s Advocatus Law LLP)
for Singapore Medical Council; and
Ms Mak Wei Munn and Ms Rachel Ong (M/s Allen & Gledhill LLP)
for the Respondent.