IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2021] SMCDT 4

Between

Singapore Medical Council

And

Dr Eugene Ung

... Respondent

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

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Singapore Medical Council
v
Dr Eugene Ung

[2021] SMCDT 4

Disciplinary Tribunal – DT Inquiry No. 4 of 2021
Prof Lee Eng Hin (Chairman), Dr Chan Kin Ming, Mr Soh Boon Leng Kessler (Legal Service Officer)
12 November 2020, 8 February 2021 and 3 May 2021

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

11 August 2021

GROUNDS OF DECISION

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

INTRODUCTION

1 The Respondent, Dr Eugene Ung, is a registered medical practitioner. The proceedings before this Disciplinary Tribunal related to 22 charges of professional misconduct brought by the Singapore Medical Council ("**SMC**") under the Medical Registration Act (Cap. 174) (the "**MRA**"). The Respondent was charged with the inappropriate prescription of benzodiazepines and other hypnotics to 13 patients between January 2012 and March 2015, and inadequate medical record-keeping for nine of these patients. He pleaded guilty to the charges on 3 May 2021. We ordered that he be suspended for a period of 10 months, and that he be censured, provide a written undertaking not to repeat the misconduct, and pay the costs of the SMC.

2 We set out the grounds of our decision below.

BACKGROUND AND CHRONOLOGY

3 At the material period, the Respondent was a registered medical practitioner operating a medical practice at a Medical Centre (the "**Clinic**").

4 The following table provides a broad chronology of the main events leading up to the inquiry before this Tribunal:

	Date	Event
1.	9 March 2015	Officers from the Ministry of Health ("**MOH**") visited the Clinic and audited the drug dispensing records for the period of 1 to 28 February 2015 as well as the medical records of 10 patients. Upon reviewing the documents, MOH became concerned over the Respondent's prescribing practice with respect to benzodiazepines and hypnotics.
2.	17 June 2015	MOH sent a letter to the SMC to inform of its concerns.
3.	31 July 2015	SMC sent a letter to the Chairman of the Complaints Panel, referring a complaint against the Respondent.
4.	17 January 2017	SMC's Investigation Unit (the "**IU**") conducted a visit to the Clinic and notified the Respondent that a Complaints Committee ("**CC**") had been appointed under the MRA to inquire into a complaint against him. (The IU subsequently obtained copies of the medical records for the period of 1 January 2012 to 9 March 2015 in relation to 33 patients.)
5.	15 August 2017	The IU issued a Notice of Complaint to the Respondent and invited him to submit a written explanation relating to his prescribing of benzodiazepines and/or hypnotics for 22 patients.
6.	26 September 2017	The Respondent sent a letter to the IU providing his written explanation.
7.	12 April 2019	The CC sent a letter to notify the SMC and the Respondent that a formal inquiry would be held before a Disciplinary Tribunal ("**DT**").
8.	7 October 2020	A Notice of Inquiry was served on the Respondent informing that an inquiry into 30 charges (with 30 alternative charges), in relation to 15 patients, was to be held.
9.	12 November 2020	First Pre-Inquiry Conference ("**PIC**") was held before this Tribunal.

	Date	Event
10.	26 January 2021	Amendments to Notice of Inquiry (Amendment No. 1).
11.	8 February 2021	Second PIC was held.
12.	9 April 2021	Notice of Inquiry was amended (Amendment No. 2) ("**NOI**"). The NOI reflected the present 22 charges. (These 22 charges were the *alternative* charges under the Notice of Inquiry of 7 October 2020, with amendments made under Amendment No. 1 and Amendment No. 2.)
13.	3 May 2021	The Respondent pleaded guilty to the 22 charges and was sentenced by this Tribunal.

PLEA OF GUILT

Charges

5 The Respondent pleaded guilty to 22 charges, which fell within two broad categories:

(a) Nine charges of keeping inadequate medical records (the "**inadequate records charges**"); and
(b) 13 charges of inappropriate prescription of benzodiazepines and hypnotics (the "**inappropriate prescription charges**").

Inadequate records charges (Nine charges)

6 Under the 2002 edition of the SMC's Ethical Code and Ethical Guidelines ("**2002 ECEG**"), which was in force at the material period, the Respondent was required, among other things, to keep clear and accurate medical records of sufficient detail. Guideline 4.1.2 of the 2002 ECEG stated:

> "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."

7 The MOH "Administrative Guidelines on the Prescribing of Benzodiazepines and other Hypnotics" dated 14 October 2008 ("**2008 AG**") were applicable during the material period. Of relevance to the present inquiry were the following guidelines:

(a) Guideline (d)(ii): indications and/or justifications for prescribing benzodiazepines and hypnotics, among other things, must be documented in the medical records of every patient each time the patient was prescribed such medicine (either initially or as repeat prescriptions).

(b) Guideline (o): the refusal of patients to be referred to a specialist should be documented in the patients' medical records.

8 The Respondent pleaded guilty to nine charges of serious negligence in the keeping of medical records for nine patients. They related to various breaches of the above guidelines in the 2002 ECEG and 2008 AG. The charges were similarly worded, with different details relating to the *period* of offending, the *patient*, the *guidelines breached* and the *particulars* of the breach:

CHARGE

That you, Dr Ung Eugene, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed), are charged that *[period]*, whilst practicing as a medical practitioner at the Clinic, had acted in breach of *[guidelines breached]*, in relation to the medical records of *[Patient]*, *to wit*:

Particulars

[Particulars]

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges of being registered as a medical practitioner, and that you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap. 174).

9 Details of the charges:

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[Particulars]*
"**C1**" [Patient A]	from 4 February 2012 to 27 February 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Lorazepam was prescribed to Patient A during 36 consultations from 4 February 2012 to 27 February 2015; (b) The medical records do not contain the indications and/or justifications for prescription which was required for each time (whether initially or for repeat prescriptions) that Lorazepam was prescribed; (c) There was no documentation of the refusal by Patient A to be referred to a psychiatrist.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[Particulars]*
"**C3**" [Patient B]	from 28 March 2013 to 23 February 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Lorazepam, Alprazolam, Zolpidem and Zopiclone were prescribed (either alone or in combination) to Patient B during 51 consultations from 28 March 2013 to 23 February 2015; (b) The medical records do not contain the indications and/or justifications for prescription which was required for each time (whether initially or for repeat prescriptions) that Lorazepam, Alprazolam, Zolpidem and/or Zopiclone were prescribed; (c) There was no documentation of the refusal by Patient B to be referred to a psychiatrist.
"**C7**" [Patient D]	from 3 January 2012 to 8 March 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Dormicum was prescribed to Patient D during 100 consultations from 3 January 2012 to 8 March 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Dormicum was prescribed; (c) There was no documentation of the refusal by Patient D to be referred to the Institute of Mental Health or to a psychiatrist from 3 January 2012 to 8 March 2015.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[Particulars]*
"**C11**" [Patient F]	from 27 March 2012 to 1 February 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Dormicum was prescribed to Patient F during 24 consultations from 27 March 2012 to 1 February 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Dormicum was prescribed; (c) There was no documentation of the refusal by Patient F to be referred to the Institute of Mental Health or to a psychiatrist from 27 March 2012 to 1 February 2015.
"**C13**" [Patient G]	from 9 January 2012 to 15 March 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) of the 2008 AG	(a) Diazepam was prescribed to Patient G during 29 consultations from 9 January 2012 to 15 March 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Diazepam was prescribed.
"**C15**" [Patient H]	from 3 January 2012 to 8 March 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Lorazepam and Zolpidem were prescribed (either alone or in combination) to Patient H during 34 consultations from 3 January 2012 to 8 March 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Lorazepam and/or Zolpidem were prescribed; (c) There was no documentation of the refusal by Patient H to be referred to a psychiatrist.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[Particulars]*
"**C19**" [Patient J]	from 20 January 2012 to 2 March 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Lorazepam was prescribed to Patient J during 44 consultations from 20 January 2012 to 2 March 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Lorazepam was prescribed; (c) There was no documentation of the refusal by Patient J to be referred to a psychiatrist.
"**C21**" [Patient K]	from 13 January 2012 to 16 February 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) and Guideline (o) of the 2008 AG	(a) Alprazolam and Zopiclone were prescribed to Patient K during 29 consultations from 13 January 2012 to 16 February 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Alprazolam and/or Zopiclone were prescribed; (c) There was no documentation of the refusal by Patient K to be referred to a psychiatrist.
"**C25**" [Patient M]	from 8 January 2012 to 28 February 2015	Guideline 4.1.2 of the 2002 ECEG as well as Guideline (d)(ii) of the 2008 AG	(a) Lorazepam was prescribed to Patient M during 46 consultations from 8 January 2012 to 28 February 2015; (b) The medical records do not contain the indications and/or justifications for prescription which were required for each time (whether initially or for repeat prescriptions) that Lorazepam was prescribed; (c) There was no documentation on whether there was an on-going co-management of Patient M with the Institute of Mental Health.

Inappropriate prescription charges (13 charges)

10 Under Guideline 4.1.3 of the 2002 ECEG, a doctor shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects.

11 In relation to the prescription of benzodiazepines and hypnotics, the following guidelines under the 2008 AG were relevant to the present inquiry:

(a) Guideline (e): medical practitioners are strongly discouraged from prescribing highly addictive benzodiazepines such as midazolam [i.e., Dormicum] and nimetazepam (except for midazolam use in surgical procedures).

(b) Guideline (i): the concurrent prescribing of two or more benzodiazepines should be avoided.

(c) Guideline (n)(i): patients who require or have been prescribed benzodiazepines and other hypnotics beyond a cumulative period of eight weeks should not be further prescribed with such medicines and must be referred to the appropriate specialist for further management.

12 The *MOH Clinical Practice Guidelines 2/2008* on "Prescribing of Benzodiazepines" ("**2008 CPG**") were also applicable during the material period. Of relevance to the present inquiry were the following guidelines:

(a) Guideline 3.1: Prescription of zolpidem and zopiclone should be treated with the same cautions as benzodiazepines. Judicious use of hypnotic medications (e.g. benzodiazepines) may be indicated for short-term (up to two to four weeks) relief of insomnia symptoms after considering non-pharmacological treatments. Instructions are necessary concerning side effects (including tolerance and dependence), follow-up for efficacy and discontinuation. If treatment does not work with a shorter-acting benzodiazepine, zolpidem or zopiclone, the doctor should not prescribe one of another shorter-acting benzodiazepine, zolpidem or zopiclone.

(b) Guideline 3.1.3: For chronic insomnia (longer than four weeks), non-pharmacological therapies are the mainstay of management. Hypnotic drug use in patients with chronic insomnia (longer than four weeks) should be avoided as far as possible because efficacy is not clearly established.

(c) Guideline 5.1: Long-term chronic use of benzodiazepines (e.g. for the treatment of insomnia or anxiety symptoms) is not recommended because efficacy is not clearly established. In view of this, for any continued or repeat benzodiazepine

prescription, there must be appropriate clinical review, clear indications and adequate documentation.

(d) Guideline 5.1.1: Benzodiazepine use should be limited to short-term relief (between two to four weeks), at the lowest dose and be taken intermittently (e.g. one night in 2 or 3 nights). Extended use of benzodiazepines (especially those with short half-lives) beyond two to four weeks is not recommended, even when prescribed at the therapeutic dosages. All patients receiving benzodiazepines should be routinely advised about the risk of developing dependence.

(e) Guideline 5.1.2: Oral midazolam (e.g. Dormicum) and nimetazepam (e.g. Erimin) are not recommended for routine outpatient prescription as they are highly addictive and commonly abused by drug addicts in Singapore.

(f) Guideline 6.1: Long-term use of benzodiazepines should be avoided in the elderly in view of the increased risk of cognitive impairment and fractures.

13 The Respondent pleaded guilty to 13 charges of serious negligence in the prescription of benzodiazepines and hypnotics to 13 patients. They related to various breaches of the guidelines in the 2002 ECEG, 2008 AG and 2008 CPG. The charges were similarly worded, with different details relating to the the *period* of offending, the *patient*, the *guidelines breached*, the *medicine* prescribed and the *particulars* of the breach:

CHARGE

That you, Dr Ung Eugene, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed), are charged that *[period]*, whilst practicing as a medical practitioner at the Clinic, had acted in breach of *[guidelines breached]*, in relation to the inappropriate prescription of *[medicine]* to *[Patient]*, *to wit*:

Particulars

[*Particulars*]

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges of being registered as a medical practitioner, and that you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

14 Details of the charges:

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C2**" [Patient A]	from 4 February 2012 to 27 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1 and Guideline 5.1.1 of the [2008 CPG]	Lorazepam	(a) Lorazepam was prescribed to Patient A beyond a cumulative period of eight weeks; (b) The treatment of Patient A's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder.
"**C4**" [Patient B]	from 28 March 2013 to 23 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (i) and Guideline (n)(i) of the 2008 AG, as well as Guideline 3.1 and Guideline 3.1.3 of the 2008 CPG	medicine	(a) There was one consultation whereby both Lorazepam and Alprazolam were prescribed together; (b) Hypnotic drugs were prescribed to treat chronic insomnia for a period longer than four weeks; (c) Lorazepam, Alprazolam, Zolpidem and Zopiclone were prescribed (either alone or in combination) to Patient B beyond a cumulative period of eight weeks.
"**C8**" [Patient D]	from 3 January 2012 to 8 March 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (e) and Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1.2 of the 2008 CPG	Dormicum	(a) Despite the high likelihood of Patient D having developed an addiction towards Dormicum, there was continued prescription of Dormicum; (b) Dormicum prescribed to Patient D beyond a cumulative period of eight weeks.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C10**" [Patient E]	from 24 July 2013 to 8 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (i) and Guideline (n)(i) of the 2008 AG, as well as Guideline 3.1 of the 2008 CPG	medicine	(a) There was one consultation whereby both Alprazolam and Diazepam were prescribed together; (b) Despite the high likelihood of Patient E having developed an addiction towards both Alprazolam and Zolpidem, there was continued prescription of Alprazolam and Zolpidem; (c) Alprazolam, Lorazepam, Diazepam, Librax, Zolpidem and Zopiclone were prescribed (either alone or in combination) to Patient E beyond a cumulative period of eight weeks.
"**C12**" [Patient F]	from 27 March 2012 to 1 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (e) and Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1.2 of the 2008 CPG	Dormicum	(a) Despite the high likelihood of Patient F having developed an addiction towards Dormicum, there was continued prescription of Dormicum; (b) Dormicum was prescribed to Patient F beyond a cumulative period of eight weeks.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C14**" [Patient G]	from 9 January 2012 to 15 March 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 3.1.3 of the 2008 CPG	Diazepam	(a) Despite the high likelihood of Patient G having developed an addiction towards Diazepam, there was continued prescription of Diazepam; (b) Hypnotic drugs were prescribed to treat chronic insomnia for a period longer than four weeks; (c) Diazepam was prescribed to Patient G beyond a cumulative period of eight weeks.
"**C16**" [Patient H]	from 3 January 2012 to 8 March 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1, Guideline 5.1.1 and Guideline 3.1 of the 2008 CPG	medicine	(a) Despite the high likelihood of Patient H having developed an addiction towards both Lorazepam and Zolpidem, there was continued prescription of Lorazepam and Zolpidem; (b) Lorazepam and Zolpidem were prescribed (either alone or in combination) to Patient H beyond a cumulative period of eight weeks.
"**C20**" [Patient J]	from 20 January 2012 to 2 March 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1 and Guideline 5.1.1 of the 2008 CPG	Lorazepam	(a) Lorazepam was prescribed to Patient J beyond a cumulative period of eight weeks; […] (d) The treatment of Patient J's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C22**" [Patient K]	from 13 January 2012 to 16 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1, Guideline 5.1.1 and Guideline 3.1 of the 2008 CPG	medicine	(a) Alprazolam and Zopiclone were prescribed to Patient K beyond a cumulative period of eight weeks.
"**C24**" [Patient L]	from 14 June 2012 to 27 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (i) and Guideline (n)(i) of the 2008 AG, as well as Guideline 3.1, Guideline 5.1 and Guideline 5.1.1 of the 2008 CPG	medicine	(a) Despite the high likelihood of Patient L having developed an addiction towards Lorazepam, there was continued prescription of Lorazepam; (b) Lorazepam, Librax and Zopiclone were prescribed (either alone or in combination) to Patient L beyond a cumulative period of eight weeks; (c) There were four consultations whereby both Lorazepam and Librax were prescribed together; (d) The treatment of Patient L's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C26**" [Patient M]	from 8 January 2012 to 28 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1, Guideline 5.1.1 and Guideline 6.1 of the 2008 CPG	Lorazepam	(a) Patient M is an elderly lady (with increased risk of cognitive impairment and fractures from the long-term use of benzodiazepines); (b) Lorazepam was prescribed to Patient M beyond a cumulative period of eight weeks; […] (d) The treatment of Patient M's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder.
"**C28**" [Patient N]	from 20 May 2013 to 4 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1, Guideline 5.1.1 and Guideline 3.1 of the 2008 CPG	medicine	(a) Alprazolam, Diazepam and Zopiclone (either alone or in combination) was prescribed to Patient N beyond a cumulative period of eight weeks.

Charge / *[Patient]*	*[period]*	*[guidelines breached]*	*[medicine]*	*[Particulars]*
"**C30**" [Patient O]	from 22 January 2012 to 28 February 2015	Guideline 4.1.3 of the 2002 ECEG, Guideline (i) and Guideline (n)(i) of the 2008 AG, as well as Guideline 5.1, Guideline 5.1.1 and Guideline 3.1 of the 2008 CPG	medicine	(a) Lorazepam. Librax, Alprazolam, Diazepam and Zopiclone (either alone or in combination) were prescribed to Patient O beyond a cumulative period of 8 weeks; (b) There was one consultation whereby both Alprazolam and Diazepam were prescribed together; (c) There was one consultation whereby both Lorazepam and Diazepam were prescribed together; (d) There was one consultation whereby both Librax and Lorazepam were prescribed together.

Facts

15 The facts relating to each charge are set out below.[1]

Patient A (Charges C1, C2)

16 From 4 February 2012 to 27 February 2015, the Respondent prescribed Lorazepam to Patient A during a total of 36 consultations. The intervals of prescriptions were mainly at monthly intervals. The prescription quantity and frequency were sufficient for daily consumption. The medical records do not contain the indications or justifications for prescription for every time that Lorazepam was prescribed. There was also no documentation of the refusal by Patient A to be referred to a psychiatrist. Apart from an annotation of "Review" for the visits when Lorazepam were prescribed, there was no documentation on Patient A's condition nor what advice was given to Patient A for her well-being. There were occasions where only Patient A's parameter readings and prescription of medication were documented. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C1**)

[1] Agreed Statement of Facts ("**ASOF**"). A summary of the benzodiazepines and hypnotics prescribed by the Respondent to the 13 patients is set out at Schedule 1 to the ASOF.

17 Lorazepam was continually prescribed to Patient A for a prolonged period of three years, despite the absence of adequate documentation of appropriate clinical review and clear indications. In addition, the treatment of Patient A's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder, which recommends that:

(a) either Selective Serotonin Reuptake Inhibitors or venlafaxine should be used as first-line pharmacological treatment for patients with Generalised Anxiety Disorders.

(b) Cognitive Behaviour Therapy may be used as first-line psychotherapy treatment for Generalised Anxiety Disorders.

(c) Clinical Global Impression scales may be used to measure illness severity and treatment progress during consultations for anxiety disorder.

The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 5.1 and 5.1.1 of the 2008 CPG in relation to inappropriate prescription of Lorazepam. (**Charge C2**)

Patient B (Charges C3, C4)

18 From 28 March 2013 to 23 February 2015, the Respondent prescribed Lorazepam, Alprazolam, Zolpidem and Zopiclone (either alone or in combination) to Patient B during a total of 51 consultations. The intervals of prescriptions were close, majority being two-weekly intervals. The prescription quantity and frequency were sufficient for daily use. The medical records do not contain the indications or justifications for prescription for every time that Lorazepam, Alprazolam, Zolpidem and Zopiclone were prescribed. There was also no documentation of the referral of Patient B to a psychiatrist or the refusal by Patient B to be referred to a psychiatrist. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C3**)

19 Lorazepam, Alprazolam, Zolpidem and Zopiclone were prescribed (either alone or in combination) to Patient B for a prolonged period of 1 year 11 months. Furthermore, there was one consultation where both Lorazepam and Alprazolam were prescribed together. This was despite Guideline (i) of the 2008 AG providing that the concurrent prescribing of two or more benzodiazepines should be avoided. In addition, hypnotic drugs were prescribed to treat chronic insomnia for a period longer than four weeks despite the 2008 CPG stating that the efficacy of hypnotic drugs for chronic insomnia has not been clearly established, and that non-pharmacological therapies are the mainstay of management for chronic insomnia. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guidelines (i) and (n)(i) of the 2008 AG, and Guidelines 3.1 and 3.1.3 of the 2008 CPG in relation to the inappropriate prescription of the medication listed above. (**Charge C4**)

Patient D (Charges C7, C8)

20 From 3 January 2012 to 8 March 2015, the Respondent prescribed Dormicum to Patient D during a total of 100 consultations. The intervals of prescriptions were close, majority being 10-day or 11-day intervals. The prescription quantity and frequency were almost always sufficient for consumption every two days. The medical records do not contain the indications and justifications for prescription for every time that Dormicum was prescribed. While there was a signed document dated October 2008 from Patient D declining referral to the Institute of Mental Health ("**IMH**") or to a psychiatrist, there was no documentation of the refusal by Patient D to be referred to the IMH or to a psychiatrist from 3 January 2012 to 8 March 2015. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C7**)

21 Even though the 2008 CPG states that Dormicum is not recommended for routine outpatient prescription as they are highly addictive and commonly abused by addicts in Singapore, the Respondent prescribed Dormicum to Patient D and continued to do so when there was a high likelihood that Patient D had developed an addiction to Dormicum. Guideline (e) of the 2008 AG also strongly discourages against prescription of the highly addictive Dormicum. Moreover, Dormicum was continually prescribed to Patient D for a prolonged period of 3 years and 2 months. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guidelines (e) and (n)(i) of the 2008 AG, and Guideline 5.1.2 of the 2008 CPG in relation to the inappropriate prescription of Dormicum. (**Charge C8**)

Patient E (Charge C10)

22 From 24 July 2013 to 8 February 2015, the Respondent prescribed Alprazolam, Lorazepam, Diazepam, Librax, Zolpidem and Zopiclone (either alone or in combination) to Patient E during a total of 25 consultations. The prescription quantity and frequency were sufficient for the daily consumption of at least one type of the prescribed medicines. Furthermore, there was one consultation where Alprazolam and Diazepam were prescribed together. This was despite Guideline (i) of the 2008 AG providing that the concurrent prescribing of two or more benzodiazepines should be avoided. Despite the high likelihood of Patient E having developed an addiction towards both Alprazolam and Zolpidem given the quantity and frequency of prescription of these medicines (sufficient for the daily consumption of at least one type), there was continued prescription of Alprazolam and Zolpidem. Moreover, Alprazolam, Lorazepam, Diazepam, Librax, Zolpidem and Zopiclone were prescribed (either alone or in combination) to Patient E for a prolonged period of 1 year 7 months. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guidelines (i) and (n)(i) of the 2008 AG, and Guideline 3.1 of the 2008 CPG in relation to the inappropriate prescription of the medication listed above. (**Charge C10**)

Patient F (Charges C11, C12)

23 From 27 March 2012 to 1 February 2015, the Respondent prescribed Dormicum to Patient F during a total of 24 consultations. 20 tablets of Dormicum were prescribed regularly at approximately 4-6 weekly intervals. The medical records do not contain the indications or justifications for prescription for every time that Dormicum was prescribed. While there was a signed document dated September 2008 from Patient F declining referral to the IMH or to a psychiatrist, there was no documentation of the refusal by Patient F to be referred to the IMH or to a psychiatrist from 27 March 2012 to 1 February 2015. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C11**)

24 Despite the 2008 CPG stating that Dormicum is not recommended for routine outpatient prescription as they are highly addictive and commonly abused by addicts in Singapore, the Respondent prescribed Dormicum to Patient F and continued to do so when there was a high likelihood that Patient F had developed an addiction to Dormicum. Guideline (e) of the 2008 AG also strongly discourages against prescription of the highly addictive Dormicum. Moreover, Dormicum was continually prescribed to Patient F for a prolonged period of 2 years and 11 months. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guidelines (e) and (n)(i) of the 2008 AG, and Guideline 5.1.2 of the 2008 CPG in relation to the inappropriate prescription of Dormicum. (**Charge C12**)

Patient G (Charges C13, C14)

25 From 9 January 2012 to 15 March 2015, the Respondent prescribed Diazepam to Patient G during a total of 29 consultations. 20 tablets of Diazepam were prescribed each time (save for one instance where 15 tablets were prescribed) at approximately four to six weekly intervals. The medical records do not contain the indications or justifications for prescription for every time that Diazepam was prescribed. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guideline (d)(ii) of the 2008 AG in relation to inadequate medical records. (**Charge C13**)

26 Diazepam was continually prescribed to Patient G for a prolonged period of 3 years and 2 months, and there was a high likelihood that Patient G had developed an addiction. In addition, Diazepam was prescribed to treat chronic insomnia for a period longer than 4 weeks despite the 2008 CPG stating that the efficacy of hypnotic drugs for chronic insomnia has not been clearly established, and that non-pharmacological therapies are the mainstay of management for chronic insomnia. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guideline 3.1.3 of the 2008 CPG in relation to the inappropriate prescription of Diazepam. (**Charge C14**)

Patient H (Charges C15, C16)

27 From 3 January 2012 to 8 March 2015, the Respondent prescribed Lorazepam and Zolpidem (either alone or in combination) to Patient H during a total of 34 consultations. The prescription quantity and frequency were sufficient for the daily use of both Lorazepam and Zolpidem (save for one occasion where only Zolpidem was prescribed). The medical records do not contain the indications or justifications for prescription for every time that Lorazepam or Zolpidem were prescribed. There was also no documentation of the referral of Patient H to a psychiatrist or the refusal by Patient H to be referred to a psychiatrist. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C15**)

28 Despite the high likelihood of Patient H having developed an addiction towards both Lorazepam and Zolpidem given the quantity and frequency of prescription (sufficient for the daily consumption of both Lorazepam and Zolpidem), there was continued prescription of Lorazepam and Zolpidem for a prolonged period of 3 years and 2 months. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 3.1, 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of the medicine listed above. (**Charge C16**)

Patient J (Charges C19, C20)

29 From 20 January 2012 to 2 March 2015, the Respondent had prescribed Lorazepam to Patient J during a total of 44 consultations. 60-100 tablets of Lorazepam were prescribed each time over four to six weekly intervals. The quantity and frequency of Lorazepam prescribed were sufficient for daily consumption. The medical records do not contain the indications or justifications for prescription for every time that Lorazepam was prescribed. There was no documentation of the referral of Patient J to a psychiatrist or the refusal by Patient J to be referred to a psychiatrist. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C19**)

30 Lorazepam was continually prescribed to Patient J for a prolonged period of 3 years and 2 months despite the absence of adequate documentation of appropriate clinical review and clear indications. In addition, the treatment of Patient J's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder (see [17], above). The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of Lorazepam. (**Charge C20**)

Patient K (Charges C21, C22)

31 From 13 January 2012 to 16 February 2015, the Respondent prescribed Alprazolam and Zopiclone together in combination to Patient K during a total of 29 consultations. 20 tablets of Alprazolam and 20 tablets of Zopiclone were prescribed each time, at mostly four to six weekly intervals (mostly sufficient for daily consumption of at least one type of medicine). The medical records do not contain the indications or justifications for prescription for every time that Alprazolam and Zopiclone were prescribed. There was also no documentation of the referral of Patient K to a psychiatrist or the refusal by Patient K to be referred to a psychiatrist. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guidelines (d)(ii) and (o) of the 2008 AG in relation to inadequate medical records. (**Charge C21**)

32 Alprazolam and Zopiclone were continually prescribed to Patient K over a prolonged period of 3 years and 1 month despite the absence of adequate documentation of appropriate clinical review and clear indications. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 3.1, 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of the medicine listed above. (**Charge C22**)

Patient L (Charge C24)

33 From 14 June 2012 to 27 February 2015, the Respondent prescribed Lorazepam, Librax and Zopiclone (either alone or in combination) to Patient L during a total of 37 consultations. The majority of Lorazepam prescriptions were at 30 tablets at a frequency of monthly intervals (sufficient for daily consumption of Lorazepam). Despite the high likelihood of Patient L having developed an addiction towards Lorazepam, given the quantity and frequency of prescription, there was continued prescription of Lorazepam. Lorazepam was continually prescribed to Patient L over a prolonged period of 2 years and 8 months. There were four consultations where both Lorazepam and Librax were prescribed together. This was despite Guideline (i) of the 2008 AG providing that the concurrent prescribing of two or more benzodiazepines should be avoided. In addition, the treatment of Patient L's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder (see [17], above). The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guidelines (i) and (n)(i) of the 2008 AG, and Guidelines 3.1, 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of the medicine listed above. (**Charge C24**)

Patient M (Charges C25, C26)

34 From 8 January 2012 to 28 February 2015, the Respondent prescribed Lorazepam to Patient M during a total of 46 consultations. The intervals of prescriptions were close, with the majority being monthly intervals or shorter. The prescription quantity and

frequency were sufficient for daily consumption. The medical records do not contain the indications or justifications for prescription for every time that Lorazepam was prescribed. There was also no documentation on whether there was an on-going co-management of Patient M with the IMH. The Respondent thus acted in breach of Guideline 4.1.2 of the 2002 ECEG, and Guideline (d)(ii) of the 2008 AG in relation to inadequate medical records. (**Charge C25**)

35 Despite Patient M being an elderly lady (with increased risk of cognitive impairment and fractures from the long-term use of benzodiazepines), Lorazepam was continually prescribed to Patient M for a prolonged period of 3 years and 1 month despite the absence of adequate documentation of appropriate clinical review and clear indications. In addition, the treatment of Patient M's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder (see [17], above). The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 5.1, 5.1.1 and 6.1 of the 2008 CPG in relation to the inappropriate prescription of Lorazepam. (**Charge C26**)

Patient N (Charge C28)

36 From 20 May 2013 to 4 February 2015, the Respondent prescribed Alprazolam, Diazepam and Zopiclone (either alone or in combination) during a total of 15 consultations. The quantity and frequency of Alprazolam prescriptions was sufficient for daily consumption most of the time; and on certain instances the prescription quantity and frequency were sufficient for the use of two tablets of Alprazolam per day. Alprazolam was continually prescribed to Patient N for a prolonged period of 1 year and 9 months. The Respondent thus acted in breach of Guideline 4.1.3 of the 2002 ECEG, Guideline (n)(i) of the 2008 AG, and Guidelines 3.1, 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of the medicine listed above. (**Charge C28**)

Patient O (Charge C30)

37 From 22 January 2012 to 28 February 2015, the Respondent prescribed Lorazepam, Alprazolam, Librax, Diazepam and Zopiclone (either alone or in combination) to Patient O during a total of 39 consultations. The quantity and frequency of prescription were sufficient for daily consumption most of the time, and on several instances the prescription quantity and frequency were sufficient for use of two tablets of Lorazepam per day. Benzodiazepines or other hypnotics were continually prescribed to Patient O for a prolonged period of 3 years and 1 month. There was one consultation where both Alprazolam and Diazepam were prescribed together, one consultation where both Lorazepam and Diazepam were prescribed together, and one consultation where both Librax and Lorazepam were prescribed together. This was despite Guideline (i) of the 2008 AG providing that the concurrent prescribing of two or more benzodiazepines should be avoided. The Respondent thus acted in breach of Guideline 4.1.3 of the

2002 ECEG, Guidelines (i) and (n)(i) of the 2008 AG, and Guidelines 3.1, 5.1 and 5.1.1 of the 2008 CPG in relation to the inappropriate prescription of the medicine listed above. (**Charge C30**)

Conviction for professional misconduct

38 On the basis of the Respondent's plea of guilt to all the charges, and his admission to the facts without qualification, we found the Respondent guilty of professional misconduct, and he was convicted accordingly. As was stated in each charge, his conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges of being registered as a medical practitioner.

SENTENCING

39 We then turned to the question of the appropriate sentence to be imposed.

Overview of parties' sentencing submissions

40 The broad sentencing positions of the parties were as follows:[2]

(a) The SMC submitted that the Respondent ought to be suspended for an aggregate period of 27 months (as a starting point); but, on account of the inordinate delay in the prosecution of the matter, the period of suspension be reduced by one-third, to *18 months*. In addition, the SMC submitted that the Respondent ought to be censured; ordered to provide a written undertaking not to engage in the conduct complained of or any similar conduct; and pay the cost of these proceedings.

(b) The Respondent submitted that the aggregate period of suspension as a starting point ought to be lower, at 18 months; and, on account of the inordinate delay in prosecution, reduced by 50%, to *9 months*. The Respondent did not object to the other orders sought by the SMC.

41 Both parties agreed that the proper sentencing approach was to impose separate sentences for the separate categories of charges, similar to the approach taken by the DT in *SMC v Dr Tan Kok Jin* [2019] SMDT 3 ("***Tan Kok Jin***") at [35]-[38].

42 Adopting this approach, the SMC submitted that:

(a) for the inappropriate prescription charges, having regard to the sentences imposed in *Tan Kok Jin*, a suspension of five or six months ought to be imposed

[2] SMC's Sentencing Submissions ("**SMS**"); Respondent's Mitigation Plea & Submissions on Sentencing ("**RM**"); Respondent's Reply Submissions on Sentencing ("**RR**").

for the four most serious charges (Charges C8, C14, C24, C26), with these periods of suspension to run consecutively, giving a sub-total of 21 months;

(b) for the inadequate records charges, having regard to *SMC v Mohd Syamsul Alam bin Ismail* [2019] SGHC 58 ("***Mohd Syamsul***") and *Tan Kok Jin*, a suspension of three months ought to be imposed for each charge, with the periods of suspension for two charges (Charges C7, C25) to run consecutively, giving a sub-total of six months;

(c) the periods of suspension for the inappropriate prescription charges (21 months) and the inadequate records charges (six months) ought to run consecutively, giving an aggregate period of suspension of 27 months as a starting point (reduced by one-third, to 18 months, on account of delay).

43 The Respondent was prepared to go along with the sentencing approach submitted by the SMC, including the charges for which the periods of suspension ought to run consecutively. It was submitted, however, that the present case was less egregious than in the precedents cited by the SMC, and that shorter periods of suspension ought to be imposed:

(a) for the inappropriate prescription charges, suspension of three or four months per charge would suffice (for Charges C8, C14, C24, C26), giving a sub-total of 15 months;

(b) for the inadequate records charges, suspension of one or two months would suffice (for Charges C7, C25), giving a sub-total of three months;

(c) with the periods of suspension for the inappropriate prescription charges (15 months) and the inadequate records charges (three months) running consecutively, an aggregate period of suspension of 18 months as a starting point (reduced by 50%, to nine months, on account of delay).

44 In summary, the sentencing positions were as follows:

Charge	Category	SMC	Respondent
C8 [Patient D]	Inappropriate prescription	5 months	4 months
C14 [Patient G]	Inappropriate prescription	5 months	3 months
C24 [Patient L]	Inappropriate prescription	5 months	4 months
C26 [Patient M]	Inappropriate prescription	6 months	4 months
C7 [Patient D]	Inadequate records	3 months	2 months
C25 [Patient M]	Inadequate records	3 months	1 month
	Aggregate (starting point)	27 months	18 months
	Reduction on account of delay	One-third	50%
	Proposed period of suspension	*18 months*	*9 months*

45 The detailed submissions in respect of each charge are considered later in these grounds of decision.

General sentencing approach

46 In our decision on sentencing, we were guided by the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* published on 15 July 2020 (the "**Sentencing Guidelines**").

47 The Sentencing Guidelines emphasise (at [9]-[11]) that public interest considerations are paramount in medical disciplinary proceedings. These include upholding the reputation of and confidence in the medical profession; and the protection of the health, safety and well-being of the public. Other sentencing considerations also apply, such as general deterrence, specific deterrence, retribution and rehabilitation.

48 Given the multiple charges, we adopted a two-step sentencing approach (Sentencing Guidelines, at [73]-[78]): (a) first, we determined the appropriate individual sentence for each charge; (b) second, we determined and calibrated the overall sentence to ensure proportionality.

49 Finally, we considered to what extent the sentence ought to be reduced, in fairness to the Respondent, on account of inordinate delay in the prosecuting of the matter.

Sentencing for inappropriate prescription charges

50 In deciding the sentence for the inappropriate prescription charges, we applied the sentencing framework laid down by the Court of Three Judges in *Wong Meng Hang v SMC* [2018] 3 SLR 526 ("***Wong Meng Hang***"). *Wong Meng Hang* laid down a four-step sentencing framework and a "harm-culpability matrix", the application of which is elaborated in the Sentencing Guidelines. The four steps are:

(a) Step 1 – Evaluate the seriousness of the offence with reference to harm and culpability;
(b) Step 2 – Identify the applicable indicative sentencing range using the harm-culpability matrix;
(c) Step 3 – Identify the appropriate starting point within the indicative sentencing range; and
(d) Step 4 – Adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

Step 1 – Evaluating harm and culpability

51 "Harm" refers to "the type and gravity of the harm or injury that was caused to the patient and society by the commission of the offence" (Sentencing Guidelines, at [47]). Apart from actual harm, the potential harm that could have resulted from the breach, even if such harm did not actually materialise on the given facts, should be considered.

When assessing potential harm, both (i) the seriousness of the harm risked, and (ii) the likelihood of the harm arising should be considered. Potential harm should be taken into account only if there was a *sufficient likelihood* of the harm arising. (Sentencing Guidelines, at [50])

52 In the present case, it was not in dispute that in the case of each patient, the harm was "slight". There was a general risk of harm from the long-term use of benzodiazepines and hypnotics, and there was potential harm in the form of an increased likelihood for tolerance or psychological and physical dependence. There was, however, no evidence of actual harm caused to any patient, for example, that any patient in fact developed such dependence.

53 "Culpability" is a measure of the doctor's degree of blameworthiness (Sentencing Guidelines, at [53]). It was submitted by the SMC, and undisputed by the Respondent, that the Respondent's culpability was "medium". We accepted the SMC's submission. The Respondent was charged with conduct that amounted to *serious negligence* rather than intentional and deliberate misconduct. There was no evidence that his inappropriate prescription of benzodiazepines and hypnotics was done for any improper motives, such as improper financial gain. That said, his lack of restraint in prescribing the medicine to each of the 13 patients was systemic: the prescriptions were made by him over extended periods of time and in the course of many consultations.

Step 2 – Identifying the applicable indicative sentencing range

54 In *Wong Meng Hang* at [33], the following indicative sentencing ranges were laid down with a harm-culpability matrix:

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

55 We noted that the Sentencing Guidelines at [55] reproduced the harm-culpability matrix set out in *Wong Meng Hang*, with a slight modification. For moderate harm with low culpability, or slight harm with medium culpability, the indicative sentencing range was

reflected as suspension "of up to 1 year". In our opinion, this must be read subject to s 53(2)(b) of the MRA, which provides that a DT may order a period of suspension of "not less than 3 months and not more than 3 years". Hence, if suspension is ordered by a DT, it must be for a period of at least 3 months and not for any shorter duration.

56 Given our evaluation at Step 1 that the harm was slight and the culpability medium for each inappropriate prescription charge, the applicable indicative sentencing range for each charge was a suspension of 3 months to 1 year.

Step 3 – Identifying appropriate starting point within indicative sentencing range

57 The SMC submitted that the starting point for each inappropriate prescription charge ought to be a period of suspension of four to six months, in line with *Tan Kok Jin* at [44]. For the more serious charges – Charges C8, C14, C24, C26 – a sentence at the higher end of the range ought to be imposed, as follows:

(a) Charge C8: Five months' suspension. There was higher potential for harm to the patient (Patient D). Dormicum was prescribed over 100 consultations over a duration of three years. The majority of prescriptions were at intervals of 10 days and at 5 tablets each, which would have been sufficient for regular use of 1 tablet every two days. SMC's appointed medical experts opined that "*[t]he regular frequency at which the patient was prescribed Dormicum and the quantity that was dispersed out over the stated period from January 2012 to March 2015 is highly suggestive that the patient may have developed an addiction to Dormicum.*"[3]

(b) Charge C14: Five months' suspension. There was higher potential for harm to the patient (Patient G). Diazepam was prescribed over 29 consultations and over the duration of 3 years and 2 months. 20 tablets were prescribed at four to six weekly intervals since 2012, with the last 12 consultations from March 2014 onwards at four-weekly intervals. This meant that there was an increase in the frequency of usage over time. SMC's appointed medical experts opined that "[t]he regular frequency at which [Patient G] was prescribed Diazepam and the quantity that was dispersed out over the stated period from March 2013 to March 2015 is highly suggestive that the patient may have developed an addiction to Diazepam".[4]

(c) Charge C24: Five months' suspension. There was higher potential for harm to the patient (Patient L). Lorazepam, Librax and Zopiclone (either alone or in combination) were prescribed over 37 consultations and over a duration of 2 years and 8 months. The majority of Lorazepam prescriptions were 30 tablets at monthly intervals and were sufficient for daily use. There were also four consultations which involved the concurrent prescription of two

[3] Agreed Bundle of Documents ("**ABOD**"), p 590. Expert Opinion of Dr Xu Bang Yu and Dr Eng Soo Kiang prepared in 2020 ("**SMC's Expert Report**"), at [8.2.4 V].
[4] ABOD, p 592. SMC's Expert Report, at [8.2.7 III].

benzodiazepines in breach of Guideline (i) of the 2008 AG. SMC's appointed medical experts opined that it was "highly suggestive that [Patient L] may have developed an addiction to Lorazepam".[5] The treatment of Patient L's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder (which recommended methods other than the use of benzodiazepines or hypnotics).

(d) Charge C26: Six months' suspension. There was higher potential for harm to the patient (Patient M). Patient M was an elderly lady, aged 67 to 69 years during the relevant period from 2012 to 2015. Guideline 6.1 of the 2008 CPG cautions that that long-term use of benzodiazepines "should be avoided in the elderly in view of the increased risk of cognitive impairment and fractures". Lorazepam was prescribed over 46 consultations and over a duration of 3 years and 1 month, with the prescription quantity and frequency sufficient for the daily use of Lorazepam. The treatment of Patient M's anxiety disorder did not comply with the MOH Clinical Practice Guidelines on Anxiety Disorder.

A longer suspension of six months would be appropriate in light of Patient M being an elderly person who would be even more vulnerable as a patient, and the increased harm that could have been caused to her.

58 The Respondent submitted that the starting point in sentencing ought to be lower than in *Tan Kok Jin*. The charges against the Respondent were for serious negligence rather than intentional and deliberate misconduct. The actual doses prescribed were on the low end of the therapeutic ranges, and his patients were advised to take their medication when necessary and not nightly or daily as a routine. The Respondent was not motivated by any selfish intent to exploit his patients for financial gain. He was motivated by a sincere desire to help his patients and acted in what he considered was the best interest of each patient. For Charges C8, C14, C24, C26, an appropriate period of suspension was three or four months:

(a) Charge C8: Four months' suspension. The Respondent felt genuine sympathy for Patient D, who suffered terrible hardships at work and in his marriage, and faced difficulty getting enough sleep. He usually prescribed the lowest recommended dose of Dormicum, at 7.5mg per day on a when necessary basis. The Respondent was conscious that Dormicum could be abused by addicts. To address this, he would review the patient's condition and the amount required for sleep, and would conduct a physical examination to check for signs of abuse (usually needle marks), which were then recorded in the clinic notes. The clinic notes for Patient D showed that reviews were carried out regularly, at almost every consultation. The Respondent also included entries in the case notes of the earliest date that Patient D could return for further prescription of the medication, as an earlier return date would indicate either that Patient D had

[5] ABOD, p 595. SMC's Expert Report, at [8.2.14 VII].

balance medication or was consuming more. Patient D had also declined the Respondent's suggestion that he seek specialist referral.

(b) Charge C14: Three months' suspension. The Respondent empathised with Patient G's work-related sleep disorders and genuinely wanted to help Patient G with his sleep difficulties. The amount prescribed and the time intervals between appointments clearly demonstrated that Patient G was not taking the medication on a daily basis. The medication was to help address the sleep disorder. The Respondent regularly reviewed the patient's condition at each consultation as annotated in the case notes. Patient G did not exhibit any signs of addiction or withdrawal while being treated. There was no evidence that the decrease in intervals between consultations (from four to six weekly to four-weekly) was due to any addiction or withdrawal issues.

(c) Charge C24: Four months' suspension. Patient L consulted the Respondent for a variety of ailments. The Respondent prescribed Patient L with very low doses of Lorazepam, Librax and Zopiclone. Each medication was to address different conditions as noted in the clinic records. Lorazepam was prescribed mainly for depression and anxiety. On the one occasion when Zopiclone was prescribed together with Lorazepam, it was recorded that the Zopiclone was for insomnia and the Lorazepam (together with Imipramine) was for anxiety.[6] As highlighted in the report of the defence expert, Librax is used to treat bowel irritation rather than for sedation; it is not a commonly abused medication due to the anticholinergic effect.[7] The records showed that Librax was prescribed for that purpose. The dosages were not excessive. The dosage of 0.5 mg of Lorazepam on a when necessary basis and not more than twice a day was much lower than the maximum dose of 6 mg per day, and was on the lower end of the recommended daily dose of 1-3 mg per day.[8] Zopiclone was not a benzodiazepine and the dosage of 7.5 mg of Zopiclone was also within the recommended daily dose.

(d) Charge C26: Four months' suspension. The Respondent was treating Patient M for various chronic conditions. He prescribed a low dose of 0.5 mg of Lorazepam to Patient M on a when necessary basis and not more than twice a day. This dosage was much lower than the maximum dose of 6 mg per day and was on the lower end of the recommended daily dose of 1-3 mg per day. There was no actual harm suffered by Patient M, and she did not exhibit any signs of cognitive impairment, addiction or withdrawal while being treated. She continued to work as a school servant at the time.

[6] ABOD, p 208.
[7] ABOD, p 727. Expert Report by Dr DE dated 9 December 2020 ("**Respondent's Expert Report**"), at [41].
[8] ABOD, p 691. 2008 CPG, Annex A, Table A1 "Benzodiazepine indications and dosages in adults".

59 In our opinion, the appropriate starting point for Charges C8, C14, C24 and C26 ought to be a *suspension of four months for each charge*. For each charge, the harm was slight and the Respondent's culpability was medium (above, at [51]-[53]). The Respondent's main breach was that he continued to prescribe the medicine beyond a cumulative period of 8 weeks. The dosages, however, were not excessive and were well within the recommended daily dosages in Annex A of the 2008 CPG. We accepted that the Respondent's prescription of benzodiazepines and hypnotics to his patients was not motivated by financial gain but out of a genuine desire to help each patient. There was no evidence of actual harm caused to any patient. Hence a period of suspension at the lower end of the indicative sentencing range (of three months to one year) would be appropriate. That said, given the long periods of inappropriate prescription far in excess of a cumulative period of eight weeks, the period of suspension ought to be higher than the three-month minimum.

60 We accepted the submission of the Respondent that the sentences ought to be lower than in *Tan Kok Jin*.

(a) In *Tan Kok Jin*, the inappropriate prescription charges were more egregious as they *all* involved the prescription of Dormicum and Erimin, which are *highly addictive* benzodiazepines commonly abused by drug addicts: Guideline (e) of the 2008 AG, Guideline 5.1.2 of the 2008 CPG (above, at [11(a)], [12(e)]).

(b) In *Tan Kok Jin*, there were many charges which, though not proceeded with, were taken into consideration (TIC) for the purposes of sentencing. This would likely have led to higher individual sentences being imposed for the proceeded charges. (In the present case, there were no TIC charges.)

(c) *Tan Kok Jin* involved misconduct that was *intentional and deliberate*. Cases involving intentional and deliberate wrongdoing commonly attract heavier sentences relative to those which concern negligent misconduct (although this would not invariably be the case): *Wong Meng Hang* at [28].

61 We did not consider that the facts relating to Charge C26 (involving an elderly lady) sufficiently warranted a higher sentence than the other three charges, as submitted by the SMC (above, at [57(d)]). Likewise, we were not persuaded that the facts relating to Charge C14 warranted a sentence lower than the other charges, as submitted by the Respondent (above, at [58(b)]). Our opinion was that a suspension of four months would be an appropriate starting point for each of the four charges (Charges C8, C14, C24, C26).

62 (While the parties did not specifically address in their written submissions what the sentence ought to be for the remaining nine inappropriate prescription charges, it was submitted orally by the SMC and Counsel for the Respondent that a four-month suspension would be appropriate. We were prepared to accept their submission.)

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

63 It was stated in the Respondent's mitigation plea that he was a family physician. He had been in private practice since August 1982 and in solo practice as a family physician at the Clinic since July 1995. He had treated patients for a wide range of mental conditions. He obtained his Graduate Diploma in Mental Health in 2011 (jointly issued by the IMH and the National University of Singapore) and was a current associate member of the Singapore Psychiatric Association. In the close to 40 years that he had been in active clinical practice, he had been devoted to serving the community and providing accessible, affordable medical care to those in need. He was a compassionate and caring doctor who had always been motivated by a desire to help his patients. He did not have any antecedents. He had an unblemished track record for his entire medical career.

64 It was further highlighted, in mitigation, that the Respondent had been cooperative with the authorities at every stage of the investigations. He provided all the requested medical records and submitted his written explanation in a prompt and timely manner. He demonstrated remorse by acknowledging his errors and accepting responsibility with an early plea of guilt. He would continue to do better to adhere to the relevant guidelines and rules in order to uphold the ethical standards of the profession. He would exercise greater care and caution in prescribing benzodiazepines and hypnotics.

65 The SMC submitted that their sentencing submissions had taken into account the Respondent's plea of guilt as a mitigating factor. It was submitted, however, that the Respondent's seniority in the profession was an aggravating factor: Sentencing Guidelines, at [69(b)]. Further, a doctor's general good character and past contributions to society in and of itself was not regarded as a mitigating factor: Sentencing Guidelines, at [70(b)].

66 We accepted the submission of the SMC that the Respondent's seniority in the medical profession was an aggravating factor. As explained in the Sentencing Guidelines, at [69(b)] "*the seniority and/or eminence of a doctor attracts a heightened sense of trust and confidence in the practitioner and the profession, and the negative impact on public confidence in the integrity of the medical profession is amplified when such an offender is convicted of professional misconduct.*" On the other hand, the Respondent's cooperation with the investigations, early plea of guilt and demonstration of remorse were mitigating factors. All in, balancing the aggravating and mitigating factors, we did not consider it necessary to adjust the starting points in sentencing derived at Step 3.

67 Hence, at the conclusion of our analysis applying the four-step process, we considered it appropriate to impose a period of suspension of four months each for Charges C8, C14, C24 and C26 (as well as the other inappropriate prescription charges).

Sentencing for inadequate records charges

68 For the inadequate records charges, the SMC and the Respondent did not apply the four-step sentencing framework in *Wong Meng Hang*. This was consistent with the sentencing approach of the High Court in *Mohd Syamsul* (cited above, at [42(b)]) where the sentencing framework was not applied to the charge of failure to keep adequate medical records (*Mohd Syamsul*, at [12]-[13]).

69 The SMC submitted that for each inadequate records charge, a suspension of three months ought to be imposed, in line with the sentences imposed in *Mohd Syamsul* and *Tan Kok Jin*. For Charges C7 and C25, the following submissions were made:

(a) Charge C7: Three months' suspension. Dormicum was prescribed to Patient D over 100 consultations and over a duration of three years. The medical records did not contain the indications or justifications for prescription for every time that Dormicum was prescribed. There was no documentation of the refusal by Patient D to be referred to the IMH or to a psychiatrist during that period.

(b) Charge C25: Three months' suspension. Patient M was an elderly lady who was prescribed Lorazepam at a quantity and frequency which was sufficient for daily use, over 46 consultations and over a duration of 3 years and 1 month. The medical records did not contain the indications or justifications for prescription for every time that Lorazepam was prescribed. There was no documentation on whether there was an on-going co-management of Patient M with the IMH.

70 The Respondent submitted that the present case was distinguishable from *Mohd Syamsul* and *Tan Kok Jin*.

(a) In *Mohd Syamsul*, the doctor's breach in failing to keep proper medical records was aggravated by the fact that the doctor operated as part of a group practice. This made it all the more crucial that detailed medical notes be kept by the doctor, as the next doctor seeing the patient would have to depend on the previous doctor's notes to take over the care of the patient. This warranted the imposition of a three-month suspension (*Mohd Syamsul*, at [13]). The present Respondent, on the other hand, was the sole practitioner at his clinic and did not operate as part of a group practice.

(b) In *Tan Kok Jin*, the charge that attracted a three-month suspension was the second charge, which charged the doctor with failing to maintain sufficient details in the patient's medical records. This failure was in breach of Guideline 4.1.2 of the 2002 ECEG and four Guidelines in the 2008 AG. The doctor also failed *to entirely reproduce the original set of the patient medical records upon request by the SMC* (*Tan Kok Jin* at [12]). This element of failing to reproduce the original set of medical records was not present in any of the inadequate records charges against the present Respondent. As the Respondent had

faithfully produced the medical records requested by SMC, a sentence lower than three months should be imposed for each charge.

71 The Respondent submitted that suspension for one or two months would suffice. The following submissions were made in respect of Charges C7 and C25:

(a) Charge C7: Two months' suspension. The Respondent had been charged with breaching Guideline 4.1.2 of the 2002 ECEG and *two* Guidelines in the 2008 AG (Guidelines (d)(ii) and (o)). Although the indications or justifications for the prescription were not recorded each time, there were occasions when the indications were noted. Patient D's refusal to be referred for specialist treatment had been recorded before, albeit not for the period stated in the charge.[9]

(b) Charge C25: One month's suspension. The Respondent had been charged with breaching Guideline 4.1.2 of the 2002 ECEG and only *one* Guideline in the 2008 AG (Guideline (d)(ii)). Similarly, there were occasions when the indications for the prescription were noted. Particular (c) of the charge, that there was no documentation whether there was on-going co-management of the patient with the IMH, was not a breach of any guideline. A one-month suspension for this charge was fair, considering that fewer guidelines were breached.

72 We accepted the submission of the Respondent that the present case was distinguishable from *Mohd Syamsul* as the Respondent was a sole practitioner and was not involved in a group practice. We also accepted that the Respondent was less culpable than in *Tan Kok Jin*: the Respondent cooperated fully with the investigations and produced the medical records of the patients when required to do so; unlike in *Tan Kok Jin* where the doctor failed to reproduce the original set of the patient's medical records upon request by the SMC, and the misconduct was intentional and deliberate. We also noted that the Respondent did maintain clinical notes, although the entries tended to be brief and lacking in detail; it was not a case where there was a complete lack of documentation.

73 Hence, we accepted the submission of the Respondent that for each inadequate records charge, the sentence ought to be lower than a three-month suspension. We were mindful that a DT could not order a period of suspension of less than three months in view of s 53(2)(*b*) of the MRA (as discussed above, at [0]). *Notionally*, however, a lower suspension period of two months for each inadequate records charge would have been appropriate to reflect the lower culpability of the Respondent compared with *Mohd Syamsul* and *Tan Kok Jin*. We did not consider that a (notional) one-month suspension would suffice for Charge C25, as submitted by the Respondent: there was insufficient basis on the facts to distinguish the Respondent's culpability in Charge C25 from Charge C7. In our opinion, the failure of the Respondent to maintain adequate medical records over numerous consultations and over long periods was a serious breach in each

[9] ABOD, pp 92-93.

case; hence, for each charge, a (notional) period of suspension of two months would be appropriate.

Aggregate sentence, comparison with precedents

74 In summary, our decision on the periods of suspension to be imposed on the individual charges (to run consecutively), and the aggregate sentence, are set out below:

Charge	Category	SMC	Respondent	**Tribunal**
C8	Inappropriate prescription	5 months	4 months	**4 months**
C14	Inappropriate prescription	5 months	3 months	**4 months**
C24	Inappropriate prescription	5 months	4 months	**4 months**
C26	Inappropriate prescription	6 months	4 months	**4 months**
C7	Inadequate records	3 months	2 months	**2 months (notional)**
C25	Inadequate records	3 months	1 month	**2 months (notional)**
	Aggregate	27 months	18 months	**20 months**

75 The aggregate was thus 20 months' suspension. In our opinion, this was proportionate to the overall culpability of the Respondent and the potential harm that the 13 patients could have suffered. It was also a sentence comparable to the aggregate or global sentences applied in precedent cases.

76 The relevant sentencing precedents referred to by the parties are summarised in the following table:

Precedent	Salient Particulars	Sentencing Approach
*SMC v Dr Chia Kiat Swan ("**Chia Kiat Swan**")* [2019] SMCDT 1 Pleaded guilty	12 charges in total Proceeded: 8 charges. TIC: 4 Proceeded charges: • Inappropriate prescription of benzodiazepines (Four charges). - duration of prescriptions ranged from more than 7 years up to 11 years and 8 months • Failure to keep medical records of sufficient detail (Three charges). • Failure to refer patient to a psychiatrist or medical specialist (One charge). Number of patients: Four Delay: 2 years and 8 months	Global sentencing approach: Harm: "Moderate" Culpability: Upper range of "medium" or lower range of "high" Global sentence (starting point): 24 months' suspension Reduction for delay: One-third **Final sentence:** **16 months' suspension (and a penalty of $15,000)**
*SMC v Dr Tan Joong Piang ("**Tan Joong Piang**")* [2019] SMCDT 9 Pleaded guilty	18 charges in total Proceeded: 18 charges • Failure to provide appropriate care, management and treatment to patients in the prescription of hypnotics (Six charges) • Failure to maintain medical records of sufficient detail (Six charges) • Failure to refer patients to a psychiatrist or other specialist for management (Six charges) Number of patients: Six Delay: 2.5 years	Global sentencing approach: Harm: "Moderate" Culpability: "High" Global sentence (starting point): 33 months' suspension Reduction for delay: One-third **Final sentence: 22 months' suspension.**

Precedent	Salient Particulars	Sentencing Approach
Tan Kok Jin Pleaded guilty	34 charges in total Proceeded: 14 charges. TIC: 20 Proceeded charges: • Inappropriate prescription of benzodiazepines (11 charges). - intentional, deliberate misconduct - Harm: "Slight" - Culpability: "Medium" • Failure to keep proper medical records (Two charges) • Failure to refer a patient to the appropriate specialist (One charge). Number of patients: 11 Delay: 3 years and 10 months	Individual sentences: • Inappropriate prescription: Four to six months' suspension per charge. *Three sentences* at higher end of range – *Six months' suspension per charge* (ordered to run consecutively). • Failure to keep proper medical records – *Three months' suspension (consecutive);* two months' suspension (concurrent) • Failure to refer patient to appropriate specialist – *Three months' suspension (consecutive)* Aggregate sentence: 24 months' suspension Reduction for delay: 50% **Final sentence: 12 months' suspension.**

77 In our opinion, the misconduct of the present Respondent was less egregious than in the precedent cases, and a correspondingly lower aggregate sentence was appropriate.

(a) In *Chia Kiat Swan*, while there were fewer patients involved (four patients, compared to 13 in the present case), and fewer charges (eight, compared to 22), *the duration of inappropriate prescription was far longer*, ranging from more than seven years to more than 11 years (far longer than the longest period in the present case of about 3 years and 2 months.) That the period of inappropriate prescription in the case of each patient was far longer greatly increased the risk of potential harm to the patient. The DT in that case applied a global approach in sentencing, and the harm was assessed to be "moderate" and the doctor's culpability to be in the upper range of the "medium" level or the lower range of the "high" level. On that basis, the DT arrived at a suspension of two years (24 months) as a starting point (*Chia Kiat Swan*, at [15]-[18]). On balance, we assessed the overall harm and culpability in the present case to be slightly lower than in *Chia Kiat Swan* given the much shorter periods of prescription; hence,

the lower aggregate period of suspension that we arrived at (20 months) was appropriate.

(b) In *Tan Joong Piang*, while there were fewer patients involved (six, compared to 13), and slightly fewer charges (18, compared with 22), the durations of the inappropriate prescriptions were far longer, ranging from around 10 years to more than 14 years. There were also serious aggravating factors. The doctor had allowed patients or even their proxies to collect repeat prescriptions without a clinical review on multiple occasions. Two of the patients consulted with psychiatrists, but the doctor failed to follow the advice given by the specialists. The 6 patients involved were *all* elderly. The charges involved misconduct that was intentional and deliberate. The harm was assessed to be "moderate" and the doctor's culpability to be "*high*" (*Tan Joong Piang*, at [42], [57]). Compared with *Tan Joong Piang*, the Respondent's breach in the present case was far less egregious, and a substantially shorter period of suspension was appropriate.

(c) *Tan Kok Jin* was the precedent that was closest to the present case in terms of the duration of the inappropriate prescriptions. There were slightly fewer patients involved (11, compared to 13). There were more charges (34, compared with 22), although only 14 charges were proceeded with and the remaining 20 charges were taken into consideration for sentencing. The charges in *Tan Kok Jin* involved intentional, deliberate misconduct (compared with negligent misconduct in the present case). It was appropriate that the aggregate sentence in the present case be slightly lower than in *Tan Kok Jin*.

Reduction in aggregate sentence on account of delay

78 Finally, we considered to what extent the sentence ought to be reduced on account of the delay in the prosecuting of the matter. The Respondent was first notified that there was a complaint against him on 17 January 2017, when the SMC's IU visited his Clinic (above, at [4]). On 15 August 2017, he was issued a Notice of Complaint and invited to submit a written explanation. He provided the written explanation on 26 September 2017. A Notice of Inquiry was served on him more than three years later, on 7 October 2020. It was not in dispute that there had been an inordinate delay in prosecution, for which the Respondent was not responsible, and that there ought to be a reduction in the sentence on that account.

79 The SMC submitted for a *one-third* reduction in the sentence. There were initially 33 patients' worth of prescriptions and medical documents which were investigated. This number was narrowed down to 15 patients in the first Notice of Inquiry. It was submitted that the need for general deterrence in cases involving benzodiazepine was especially acute due to the inherently addictive nature of such medication. Patients prescribed benzodiazepines ought to be considered a vulnerable class of patients. They might be unaware of the harm caused over time from the consumption of benzodiazepines and were dependent on the medical professional to a high degree. Given the public interest considerations, a one-third reduction would be fair and

reasonable. In *SMC v Yip Man Hing Kevin* [2020] SMCDT 3, having regard to countervailing public interest considerations in the case, the DT applied a one-third discount for sentencing for inordinate delay of about 3 years and 2 months. In both *Tan Joon Piang* and *Chia Kiat Swan*, which related to inappropriate benzodiazepine prescriptions and involved delays of more than two years, a one-third reduction was also applied.

80 The Respondent submitted, on the other hand, that there ought to be a 50% reduction in the sentence on account of the delay. The inordinate delay in prosecution had caused him to suffer considerable anxiety, distress and uncertainty. He had been aware of the complaint against him since 17 January 2017. There was a delay of more than 3 years and 8 months before a Notice of Inquiry was issued on 7 October 2020. He did not contribute to the delay in any way; he was thoroughly cooperative throughout the investigation process. The precedents showed that, in general, where the period of delay exceeded three years, a 50% discount was applied to the period of suspension. This was illustrated in a few cases:

(a) In *Ang Peng Tiam v SMC* [2017] 5 SLR 356 ("***Ang Peng Tiam***"), the Court of Three Judges held that a delay of nearly 4½ years between the SMC's receipt of the complaint and the issuance of the notice of inquiry to the respondent constituted an inordinate delay. The Court was prepared to accept "as a matter of natural inference" that the matter had been hanging over the head of the doctor and caused him great anxiety and distress (at [123]). The aggregate sentence of suspension of 16 months which would have been imposed was halved to eight months.

(b) In *Jen Shek Wei v SMC* [2018] 3 SLR 943, there was a delay of nearly three years from the issuance of the notice of complaint to the issuance of the notice of inquiry. The Court of Three Judges considered that the delay in the case warranted halving the term of suspension from 16 months to eight months.

(c) In *Tan Kok Jin*, there was a delay of 3 years and 10 months between the dates of service of the Notice of Complaint and the Notice of Inquiry. The DT held that there should be a 50% reduction in sentencing and the doctor was suspended for 12 months instead of 24 months.

81 We accepted the submission of the Respondent that there ought to be a 50% reduction in the sentence on account of the delay in prosecution. There had been a delay of more than three years between the issuance of the Notice of Complaint (on 15 August 2017) and the service of a notice of inquiry (on 7 October 2020), for which the Respondent was not responsible. A reduction of the aggregate period of suspension by 50% would be fair in light of the precedents cited above (at [80]). Further, in our opinion, considerations of fairness to the Respondent were not offset or outweighed by any countervailing public interest which demanded the imposition of a heavier penalty (*Ang Peng Tiam*, at [118]). We were not persuaded by the SMC's submission that patients

prescribed benzodiazepines ought to be considered a vulnerable class of patients and that a heavier penalty ought to be imposed in such cases as a matter of public interest.

82 Accordingly, we reduced the starting aggregate period of suspension of 20 months by 50% to arrive at a final sentence of 10 months' suspension.

Other orders

83 Apart from a period of suspension, we also considered it appropriate the impose the "usual orders" (Sentencing Guidelines, at [19]) of a censure, a written undertaking by the Respondent to abstain from the conduct complained of, and the payment of costs by the Respondent. These orders were sought by the SMC and were not opposed by the Respondent.

CONCLUSION

84 Accordingly, we ordered that:

(a) the Respondent be suspended for a period of 10 months;
(b) the Respondent be censured;
(c) the Respondent provide a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct in the future; and
(d) the Respondent pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

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

86 The hearing is hereby concluded.

Prof Lee Eng Hin
Chairman

Dr Chan Kin Ming

Mr Soh Boon Leng Kessler
Legal Service Officer

Ms Sharon Lin and Mr Daniel Chong (M/s Withers KhattarWong LLP)
for Singapore Medical Council; and

Mr Christopher Chong and Ms Sarah Lim (M/s Dentons Rodyk & Davidson LLP)
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