IN THE COURT OF THREE JUDGES OF THE REPUBLIC OF SINGAPORE

[2023] SGHC 180

Originating Application No 4 of 2022

Between

Singapore Medical Council

… *Appellant*

And

Wee Teong Boo

… *Respondent*

GROUNDS OF DECISION

[Administrative Law — Disciplinary tribunals]
[Professions — Medical profession and practice — Professional conduct]

Singapore Medical Council
v
Wee Teong Boo

[2023] SGHC 180

Court of Three Judges — Originating Application No 4 of 2022
Sundaresh Menon CJ, Judith Prakash JCA and Steven Chong JCA
10 November 2022, 27 February 2023

3 July 2023

Judith Prakash JCA (delivering the judgment of the court):

Introduction

1 This case concerned a medical practitioner who had pleaded guilty in disciplinary proceedings to ten charges involving inappropriate prescription of medication and ten charges of keeping inadequate records of his consultations. While at first glance, the charges appeared to be far from the most serious that could be mounted against a doctor in respect of the practice of medicine, the evidence disclosed a pattern of behaviour that required us to consider what the concept of being fit to practice as a medical practitioner entails. It also highlighted that a disciplinary tribunal in determining the appropriate sentence for professional misconduct must not only consider the individual charges but should also assess the effect of the misconduct on the standing of the profession.

2 The Singapore Medical Council (the "SMC") brought this case as an appeal against the sentence imposed by a disciplinary tribunal (the "DT") on the respondent, Dr Wee Teong Boo ("Dr Wee"). Dr Wee pleaded guilty before the DT to 20 charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("MRA"). Seven of these charges related to Dr Wee's inappropriate prescription of codeine-containing cough mixtures to seven patients, while three charges related to Dr Wee's inappropriate prescription of benzodiazepines to another three patients (collectively, the "Inappropriate Prescription charges"). Dr Wee prescribed these medicines to his patients in a manner that breached the relevant prescription guidelines issued by the Ministry of Health. The remaining ten charges faced by Dr Wee pertained to his failure to keep adequate medical records in respect of these patients (the "Inadequate Records charges").

3 The DT applied the sentencing framework set out in *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 ("*Wong Meng Hang*"). In relation to the Inappropriate Prescription charges, the DT assessed Dr Wee's culpability to be medium and the harm caused by his offending to be moderate, and sentenced Dr Wee to periods of suspension varying between 12 and 18 months per charge. As for the Inadequate Records charges, the DT imposed periods of suspension of either three or four months per charge. The DT considered that an aggregate sentence of 30 months' suspension was appropriate but applied a one-third sentencing discount on account of a delay in prosecution. Accordingly, the DT ordered that Dr Wee be suspended from the Register of Medical Practitioners for 20 months. This appeal was brought by the SMC on the ground that the sentence imposed by the DT was manifestly inadequate.

4 Having considered the material before us, we agreed with the SMC that the sentence imposed in no way reflected the gravity of Dr Wee's misconduct. We allowed the appeal on 27 February 2023 and ordered that Dr Wee be struck off the Register of Medical Practitioners with immediate effect. These are the reasons for our decision.

The applicable sanctions under s 53 of the MRA

5 We begin by setting out the applicable sanctions under s 53 of the MRA to set the context in which the DT and this court operated.

6 Where a registered medical practitioner is found to have been guilty of professional misconduct, the possible sanctions that may apply are found in s 53(2) of the MRA. The relevant provisions state as follows:

> **Findings of Disciplinary Tribunal**
>
> **53.**—(1) Where a registered medical practitioner is found by a Disciplinary Tribunal —
>
> …
>
> (*d*) to have been guilty of professional misconduct; …
>
> …
>
> the Disciplinary Tribunal may exercise one or more of the powers referred to in subsection (2).
>
> (2) For the purposes of subsection (1), the Disciplinary Tribunal may —
>
> (*a*) by order remove the name of the registered medical practitioner from the appropriate register;
>
> (*b*) by order suspend the registration of the registered medical practitioner in the appropriate register for a period of not less than 3 months and not more than 3 years;
>
> (*c*) where the registered medical practitioner is a fully registered medical practitioner in Part I of the Register of Medical Practitioners, by order remove his name from Part I of that Register and register him instead as a medical practitioner with conditional registration in Part II of that

> Register, and section 21(4) and (6) to (9) shall apply accordingly;
>
> (*d*) where the registered medical practitioner is registered in any register other than Part I of the Register of Medical Practitioners, by order impose appropriate conditions or restrictions on his registration;
>
> (*e*) by order impose on the registered medical practitioner a penalty not exceeding $100,000;
>
> (*f*) by writing censure the registered medical practitioner;
>
> (*g*) by order require the registered medical practitioner to give such undertaking as the Disciplinary Tribunal thinks fit to abstain in future from the conduct complained of; or
>
> (*h*) make such other order as the Disciplinary Tribunal thinks fit, including any order that a Complaints Committee may make under section 49(1).

7 As is apparent from the wording of s 53(1) of the MRA, a disciplinary tribunal may opt for a combination of the sanctions provided for under s 53(2) of the MRA. Pursuant to s 53(2)(*b*) of the MRA, however, any period of suspension imposed by a disciplinary tribunal must not exceed three years. This statutory cap applies regardless of how many charges the medical practitioner is found guilty of in a single proceeding. In our view, this is clear from the language of s 53(2)(*b*), which provides that "*the* Disciplinary Tribunal may … by order suspend the registration of the registered medical practitioner" [emphasis added]. We agreed with counsel for Dr Wee that the reference to a single disciplinary tribunal necessarily means that the cap applies to the *overall* period of suspension imposed by a disciplinary tribunal in a single proceeding. Where a medical practitioner is found guilty of multiple charges of professional misconduct, and each charge attracts a period of suspension, it is therefore not open to a disciplinary tribunal to impose *consecutive* periods of suspension if doing so would mean that the aggregate period of suspension faced by the medical practitioner exceeds three years.

8 As for how the appropriate sanction should be determined, we have referred to the sentencing framework set out in *Wong Meng Hang*. Under this framework, the disciplinary tribunal (or court) first evaluates the seriousness of the offence, having regard to the two principal parameters of harm and culpability: *Wong Meng Hang* at [30]. Next, the disciplinary tribunal identifies the applicable indicative sentencing range based on the following 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

9 The above matrix serves only as a guide and can be departed from where appropriate to do so: *Wong Meng Hang* at [33].

10 The third step is to identify the appropriate starting point within the indicative sentencing range. At the fourth step, the disciplinary tribunal considers if the starting point should be adjusted on account of offender-specific aggravating or mitigating factors: *Wong Meng Hang* at [42] and [43].

11 As may be seen from the harm-culpability matrix set out above, serious cases of professional misconduct may warrant an order striking off the errant

doctor from the Register of Medical Practitioners. In deciding whether a doctor should be struck off, the ultimate question is whether the misconduct in question was so serious that it rendered the doctor unfit to remain as a member of the medical profession: *Wong Meng Hang* at [66]. In *Wong Meng Hang* at [67], this court set out some factors that may be relevant in undertaking this broader inquiry. For present purposes, we highlight the following considerations:

(a) Striking off should be considered when the misconduct in question involves a flagrant abuse of the privileges accompanying registration as a medical practitioner: *Wong Meng Hang* at [67(a)].

(b) Striking off should also be considered where the practitioner's misconduct has caused grave harm: *Wong Meng Hang* at [67(b)].

(c) Culpability will be a critical and relevant consideration. Striking off may be warranted where a doctor deliberately and improperly prescribes and sells controlled medicines over extended periods of time, thereby acting in callous disregard of his/her professional duties as well as the health of his/her patients or the general public (see, *eg*, *In the Matter of Dr AAN* [2009] SMCDC 2 and *In the Matter of Dr Ho Thong Chew* [2014] SMCDT 12): *Wong Meng Hang* at [67(c)].

(d) Finally, where any of the above factors exists, a further consideration which might suggest striking off is warranted is where the errant doctor has shown a persistent lack of insight into the seriousness and consequences of his misconduct: *Wong Meng Hang* at [67(f)].

12 Further, we note that following the decision in *Wong Meng Hang*, the SMC published the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals (June 2020) (the "Sentencing Guidelines"), which serve to "explain,

elucidate and elaborate" the *Wong Meng Hang* sentencing framework (Sentencing Guidelines at para 7). While the Sentencing Guidelines are not binding on this court, we nonetheless considered them to be a useful tool in the application of the *Wong Meng Hang* sentencing framework.

Background facts

13 We now set out the facts of this appeal. Dr Wee was registered as a medical practitioner on 26 April 1977 and practised as a general practitioner thereafter. At the material time, he was carrying on his practice at Wee's Clinic & Surgery located at Blk 418 Bedok North Avenue 2, Singapore.

14 On 28 October 2016, the SMC received a complaint from the Ministry of Health relating to the manner in which Dr Wee prescribed benzodiazepines and codeine-containing cough mixtures. On 25 April 2018, the SMC issued a Notice of Complaint to Dr Wee, which stated that a Complaints Committee (the Committee") had been appointed and that the Committee had directed an investigation to be conducted. In the Notice of Complaint, the SMC also invited Dr Wee to submit a written explanation addressing, among other things, the clinical basis for his prescriptions of codeine-containing cough mixtures and benzodiazepines to certain patients. Dr Wee sent his letter of explanation to the SMC on 20 June 2018 (the "Letter of Explanation"). We say more about the contents of the Letter of Explanation later. After considering the Letter of Explanation, the Committee referred Dr Wee to the DT for a formal inquiry.

The charges

15 On 9 February 2021, the SMC served a Notice of Inquiry on Dr Wee. The Notice of Inquiry set out a total of 50 charges against Dr Wee – 25 of these charges alleged that Dr Wee had conducted himself in a manner that constituted

an intentional and deliberate departure from standards observed or approved by members of the profession of good repute and competency, such that he was guilty of professional misconduct under s 53(1)(*d*) of the MRA. The remaining 25 charges were "alternate" charges, which alleged that Dr Wee's conduct amounted to such serious negligence that it objectively constituted an abuse of the privileges of being a registered medical practitioner, and that Dr Wee was accordingly guilty of professional misconduct under s 53(1)(*d*) of the MRA.

16 The SMC ultimately decided to proceed on 20 of the alternate charges. These charges concerned ten patients who had consulted Dr Wee on various occasions between 2009 and 2016. In respect of each patient, Dr Wee was alleged to have (a) inappropriately prescribed codeine-containing cough mixtures or benzodiazepines; and (b) failed to keep adequate patient medical records. Accordingly, as already noted, the proceeded charges against Dr Wee comprised ten Inappropriate Prescription charges and ten Inadequate Records charges.

17 In relation to the Inappropriate Prescription charges, Dr Wee was alleged to have prescribed medicines to his patients at such frequencies and/or in such quantities as breached the Ministry of Health's letter dated 9 October 2000 on the Sale and Supply of Cough Mixtures Containing Codeine (the "Codeine Guidelines"), and the Ministry of Health's Administrative Guidelines on the Prescribing of Benzodiazepines and Other Hypnotics dated 14 October 2008 (the "Benzodiazepines Guidelines"). The Codeine Guidelines provide that codeine-containing cough mixtures are not to be sold to the same patient within four days, while the Benzodiazepines Guidelines provide that benzodiazepines are not to be prescribed for a cumulative period longer than eight weeks.

18 For present purposes, it suffices for us to reproduce the wording of one of the Inadequate Records charges, and one of the Inappropriate Prescription charges:

> Alternate 1st charge
>
> That you, DR WEE TEONG BOO, are charged that, between 22 June 2014 to 5 September 2016, whilst practicing as a medical practitioner at the Clinic, you had acted in breach of Guideline 4.1.2 of the [2002 edition of the Singapore Medical Council Ethical Code and Ethical Guidelines ('2002 ECEG')] in that you failed to keep clear and accurate medical records in respect of P1, to wit:-
>
> Particulars
>
> (a) You were consulted by P1 on 40 occasions, particulars of which are set out in Schedule 1 annexed hereto; and
>
> (b) At all material times, you failed to keep legible, complete and/or accurate records of the aforesaid consultations in P1's [patient medical records], in that:-
>
> (i) you did not document the details of three consultations;
>
> (ii) you failed to properly document P1's medical history / medical conditions; and
>
> (iii) you failed to properly document your findings, diagnoses and/or the reasons/bases for your prescriptions to P1, in relation to P1's medical condition,
>
> and your aforesaid conduct amounts to such serious negligence that it objectively constitutes an abuse of the privileges of being registered as a medical practitioner, and that in relation to the facts alleged you are thereby guilty of professional misconduct under section 53(1)(*d*) of the MRA.
>
> Alternate 2nd charge
>
> That you, DR WEE TEONG BOO, are charged that, between 22 June 2014 to 5 September 2016, whilst practicing as a medical practitioner at the Clinic, you had acted in breach of Guideline 4.1.3 of the 2002 ECEG in that you failed to prescribe, dispense or supply medicines in reasonable quantities to P1, to wit:-
>
> Particulars

> (a) At all material times, you were obliged to comply with the standards in relation to the prescription of codeine-containing cough mixtures as set out in the Codeine Guidelines;
>
> (b) The Codeine Guidelines seek to restrict the sale of codeine-containing cough mixtures by restricting such a sale to the same patient who had been sold codeine-containing cough mixtures, within 4 days; and
>
> (c) In breach of the Codeine Guidelines, you inappropriately prescribed codeine-containing cough mixture, namely *Dhasedyl*, within 4 days of the last prescription of codeine-containing cough mixture, on 32 occasions to P1, particulars of which are set out in Schedule 1 annexed hereto,
>
> and your aforesaid conduct amounts to such serious negligence that it objectively constitutes an abuse of the privileges of being registered as a medical practitioner, and that in relation to the facts alleged you are thereby guilty of professional misconduct under section 53(1)(*d*) of the MRA.

19 In addition, we set out below the salient facts relating to the proceeded charges, as contained in the Agreed Statement of Facts ("Agreed Facts"). The Agreed Facts stated that Dr Wee "was aware and/or ought to have been aware" that five of his patients (identified as P1, P2, P3, P11 and P13) were dependent on codeine-containing cough mixtures. The Agreed Facts did not contain a similar statement in respect of the remaining patients (identified as P4, P5, P9, P10 and P15):

Patient	Time Period	Facts
P1	22 June 2014 to 5 September 2016	P1 consulted Dr Wee on a total of 40 occasions. <u>Alternate 1st charge:</u> On three occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P1. On several occasions, Dr Wee wrote only one word, "cough", in P1's patient medical records.

		<u>Alternate 2nd charge:</u> On 32 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P1 (Dhasedyl) within four days of the last prescription of the same. Dr Wee knew and/or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine. Dr Wee also knew or ought to have known that P1 was dependent on codeine-containing cough mixtures.
P2	7 November 2013 to 8 August 2016	P2 consulted Dr Wee on a total of 28 occasions. <u>Alternate 3rd charge:</u> On 12 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P2. On several occasions, Dr Wee wrote only one word, "cough", in P2's patient medical records. <u>Alternate 4th charge:</u> On 23 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P2 (Dhasedyl) within four days of the last prescription of the same. Dr Wee knew and/or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine. Dr Wee also knew or ought to have known that P2 was dependent on codeine-containing cough mixtures.

P3	20 August 2013 to 8 August 2016	P3 consulted Dr Wee on a total of 47 occasions. <u>Alternate 5th charge:</u> On 18 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P3. On several occasions, Dr Wee wrote only one word, "cough", in P3's patient medical records. <u>Alternate 6th charge:</u> On 38 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P3 (Dhasedyl) within four days of the last prescription of the same. Dr Wee knew and/or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine. Dr Wee knew or ought to have known that P3 was dependent on codeine-containing cough mixtures.
P4	2 December 2011 to 6 November 2016	P4 consulted Dr Wee on a total of 50 occasions. <u>Alternate 7th charge:</u> On 25 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P4. On several occasions, Dr Wee wrote only one word, "cough", in P4's patient medical records. <u>Alternate 8th charge:</u> On 36 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P4 (Dhasedyl) within four days of the last prescription of the same.

		Further, on 4 April 2016, P4 was simultaneously prescribed three psychoactive drugs (Dhasedyl, Dextromethorphan and Chlorpheniramine), which increased the risk of potentially lethal drug interactions, the adverse synergistic effects of such interactions and the addiction and abuse of such drugs. Dr Wee knew or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine, and that the combination of psychoactive drugs increases the risk of potentially lethal drug interactions.
P5	11 October 2011 to 10 August 2016	P5 consulted Dr Wee on a total of 25 occasions. <u>Alternate 9th charge:</u> On nine occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P5. <u>Alternate 10th charge:</u> On 21 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P5 (Phenexpect CD) within four days of the last prescription of the same. Dr Wee knew and/or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine.

P9	2 January 2009 to 4 December 2016	P9 consulted Dr Wee on a total of 19 occasions. <u>Alternate 14th charge:</u> On eight occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P9. On several occasions, Dr Wee wrote only one word, "anxiety", in P9's patient medical records. <u>Alternate 15th charge:</u> In breach of the Benzodiazepines Guidelines, Dr Wee prescribed benzodiazepines (Xanax) to P9 beyond a cumulative period of eight weeks. The cumulative periods that P9 was prescribed Xanax were: (a) from 2 January 2009 to 25 March 2009 (2 months and 24 days); and (b) from 30 August 2015 to 4 December 2016 (1 year 3 months and 5 days). Dr Wee knew or ought to have known that long-term use of benzodiazepines places patients at risk of harm, including harm from dependence and addiction.
P10	29 October 2009 to 5 August 2016	P10 consulted Dr Wee on a total of 27 occasions. <u>Alternate 16th charge:</u> On two occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P10.

		Alternate 17th charge: In breach of the Benzodiazepines Guidelines, Dr Wee prescribed benzodiazepines (Diazepam and Dormicum) to P10 beyond a cumulative period of eight weeks. The cumulative period that P10 was prescribed benzodiazepines was from 14 January 2016 to 5 August 2016 (6 months and 23 days). Further, on ten occasions, P10 was prescribed multiple psychoactive drugs, which increased the risk of potentially lethal drug interactions, the adverse synergistic effects of such interactions and the addiction and abuse of such drugs. Dr Wee knew or ought to have known that long-term use of benzodiazepines places patients at risk of harm, including harm from dependence and addiction, and that the combination of psychoactive drugs increases the risk of potentially lethal drug interactions.
P11	22 February 2016 to 8 August 2016	P11 consulted Dr Wee on a total of 93 occasions. Alternate 18th charge: On 37 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P11. On several occasions, Dr Wee wrote only brief remarks like "cough" or "can't sleep", in P11's patient medical records. Alternate 19th charge: On 90 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P11 (Dhasedyl) within four days of the last prescription of the same.

		Dr Wee knew or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine, and that P11 was dependent on codeine-containing cough mixtures and benzodiazepines.
P13	28 September 2015 to 8 August 2016	P13 consulted Dr Wee on a total of 54 occasions. <u>Alternate 21st charge:</u> On 17 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P13. On several occasions, Dr Wee wrote only brief remarks like "cough" or "can't sleep" in P13's patient medical records. <u>Alternate 22nd charge:</u> On 49 occasions, in breach of the Codeine Guidelines, Dr Wee prescribed a codeine-containing cough mixture to P13 (Dhasedyl) within four days of the last prescription of the same. Further, on ten occasions, P13 was prescribed two psychoactive drugs (Diazepam and Dhasedyl), which increased the risk of potentially lethal drug interactions, the adverse synergistic effects of such interactions and the addiction and abuse of such drugs. Dr Wee knew or ought to have known that repeated prescriptions of codeine place patients at risk of harm, owing to the risk of dependence and/or potential abuse of codeine, and that the combination of psychoactive drugs increases the risk of potentially lethal drug interactions.

		Dr Wee also knew or ought to have known that P13 was dependent on codeine-containing cough mixtures and had a history of drug abuse since September 2015.
P15	14 December 2014 to 11 November 2016	P15 consulted Dr Wee on a total of 23 occasions. <u>Alternate 24th charge:</u> On 11 occasions, Dr Wee failed to keep legible, complete and/or accurate records of his consultations with P15. On several occasions, Dr Wee wrote only brief remarks like "can't sleep" in P15's patient medical records. <u>Alternate 25th charge:</u> In breach of the Benzodiazepines Guidelines, Dr Wee prescribed two benzodiazepines (Diazepam and Xanax) concurrently to P15 and continued to prescribe benzodiazepines beyond a cumulative period of eight weeks. The cumulative periods that P15 was prescribed benzodiazepines were: (a) from 29 May 2015 to 6 August 2015 (2 months and 9 days); and (b) from 1 November 2015 to 11 November 2016 (1 year and 11 days). Dr Wee knew or ought to have known that long-term use of benzodiazepines places patients at risk of harm, including harm from dependence and addiction, and that the combination of psychoactive drugs increases the risk of potentially lethal drug interactions.

20 Dr Wee pleaded guilty to the above charges and was convicted accordingly. Dr Wee also consented to five charges being taken into consideration for the purposes of sentencing. These charges related to his failure to keep adequate medical records for another five patients (the "TIC charges").

The remaining charges set out in the Notice of Inquiry were withdrawn by the SMC.

The DT's decision on sentence

21 The reasons for the DT's decision can be found in *Singapore Medical Council v Dr Wee Teong Boo* [2022] SMCDT 1 (the "GD"). We summarise them below.

The Inappropriate Prescription charges

22 As we have mentioned, the DT applied the sentencing framework set out in *Wong Meng Hang* and found that Dr Wee's culpability was medium. The DT observed that Dr Wee had inappropriately prescribed medication to a total of ten patients and did not appear to have any structured treatment plan for them. His offending may have intensified the addictions of his patients who had underlying drug dependency issues, and the inappropriate prescriptions had been frequent and issued over an extended period of time. That being said, the DT noted that Dr Wee had not exploited his patients for profit and had been convicted of conduct amounting to serious negligence rather than intentional and deliberate misconduct. Accordingly, the DT declined to find that Dr Wee's culpability was high: GD at [21].

23 As for the level of harm caused by the offences, the DT accepted the SMC's submission that the harm caused by Dr Wee's misconduct was moderate: GD at [23]. The SMC did not appeal against the DT's finding on the level of harm caused.

24 Applying the matrix set out at [8] above, the DT accordingly found that the indicative sentencing range for each of the Inappropriate Prescription

charges was a suspension of one to two years: GD at [25]. As for the appropriate starting point, the DT found that a starting point of 12 months' suspension was appropriate: GD at [29].

25 Turning to the relevant offender-specific factors, the DT considered Dr Wee's seniority in the medical profession to be an aggravating factor, as a higher degree of trust and confidence would have been reposed in him. On the other hand, the DT considered Dr Wee's cooperation with investigations and his expression of remorse to be mitigating factors. The DT also noted that Dr Wee's conduct did not appear to be motivated by financial gain: GD at [28].

26 All things considered, the DT found that it was not necessary to amend the starting point of 12 months' suspension for most of the Inappropriate Prescription charges. The DT accepted the SMC's submission that an uplift of six months was warranted in respect of P3, P11 and P13, given the high number of inappropriate prescriptions in those cases, as well as in relation to P10, given the long duration of the inappropriate prescription in that case: GD at [29]. The DT accordingly sentenced Dr Wee for the Inappropriate Prescription charges as follows:

Patient	**Charge**	**Period of suspension**
P1	Alternate 2nd charge	12 months
P2	Alternate 4th charge	12 months
P3	Alternate 6th charge	18 months
P4	Alternate 8th charge	12 months
P5	Alternate 10th charge	12 months
P9	Alternate 15th charge	12 months

P10	Alternate 17th charge	18 months
P11	Alternate 19th charge	18 months
P13	Alternate 22nd charge	18 months
P15	Alternate 25th charge	12 months

The Inadequate Records charges

27 The DT found that a suspension of three months was appropriate for each of the Inadequate Records charges, save for the alternate 7th charge for which a suspension of four months was warranted: GD at [31]–[32]. The SMC did not appeal against the sentence imposed in respect of the Inadequate Records charges.

The aggregate sentence

28 In calibrating the aggregate sentence, the DT took into account the fact that Dr Wee had five TIC charges. The DT considered it appropriate to run the sentences for the alternate 2nd charge (12 months' suspension) and the alternate 19th charge (18 months' suspension) consecutively: GD at [36]. The DT noted that, however, it was undisputed that there had been an inordinate delay in prosecution, as 2 years and 11 months had lapsed between the time of the Ministry of Health's complaint and the issuance of the Notice of Inquiry. The DT therefore reduced the aggregate sentence by one-third to arrive at a final sentence of 20 months' suspension: GD at [37] and [41].

The parties' cases on appeal

29 The SMC appealed against the sentence imposed by the DT on the basis that it was manifestly inadequate. In relation to the sentences imposed for the

Inappropriate Prescription charges, the SMC submitted that the DT had failed to properly take into account the seriousness of Dr Wee's misconduct, and had consequently erred in finding that Dr Wee's culpability was medium rather than high. First, the SMC contended that a finding of high culpability was justified by the fact that Dr Wee had no clinical basis for any of the prescriptions that formed the subject of the Inappropriate Prescription charges, and he knew or ought to have been aware that some of his patients suffered from drug dependency issues. The SMC categorised the Inappropriate Prescription charges as follows:

SMC's Classification	
Category	**Patient**
Category 1 (most serious) No clinical basis for the medication prescribed and the patient had an existing drug dependency	P1, P2, P3, P11 and P13
Category 2 No clinical basis for the medication prescribed and the patient had no existing drug dependency	P4, P5, P9, P10 and P15
Category 3 Arguable clinical basis for the medication prescribed and patient had an existing drug dependency	NA
Category 4 (least serious) Arguable clinical basis for the medication prescribed and patient had no existing drug dependency	NA

30 Secondly, the SMC submitted that in assessing Dr Wee's culpability, the DT had placed undue weight on the fact that Dr Wee had been convicted of serious negligence rather than intentional and deliberate misconduct. Thirdly, the DT had also erred in accepting Dr Wee's unsubstantiated allegation that he

had not exploited his patients for profit. Had the DT found that Dr Wee's culpability was high, it should have imposed a suspension of 34 to 36 months for the Inappropriate Prescription charges falling into Category 1 (the "Category 1 charges"), and a suspension of 30 to 33 months for the Inappropriate Prescription charges falling into Category 2 (the "Category 2 charges").

31 As for the aggregate sentence, the SMC submitted that the sentences for the following charges should be ordered to run consecutively: (a) one to two of the most serious Category 1 charges (*ie*, 36 to 72 months' suspension); (b) one to two of the most serious Category 2 charges (*ie*, 33 to 65 months' suspension); and (c) the most serious Inadequate Records charge (*ie*, 4 months' suspension). The SMC accordingly proposed a starting point of 73 to 141 months' suspension. Next, applying a one-third sentencing discount on account of the delay in prosecution, and taking into account the statutory cap under s 53(2)(*b*) of the MRA, the SMC submitted that a final sentence of 36 months' suspension was appropriate (*ie*, the maximum possible suspension under s 53(2)(*b*) of the MRA). In the alternative, the SMC highlighted that this court had the power under s 53(2)(*a*) of the MRA to order that Dr Wee be struck off the Register of Medical Practitioners.

32 Dr Wee submitted that the DT's reasoning was sound and that this appeal should therefore be dismissed. In relation to the Inappropriate Prescription charges, Dr Wee's position was that the DT had correctly characterised his culpability as medium. First, Dr Wee argued that there *had* been an arguable clinical basis for his prescriptions. As such, while Dr Wee did not object to the categories proposed by the SMC at [29] above, he contended that the Inappropriate Prescription charges were properly categorised as follows:

Dr Wee's Classification	
Category	**Patient**
Category 1 (most serious) No clinical basis for the medication prescribed and the patient had an existing drug dependency	NA
Category 2 No clinical basis for the medication prescribed and the patient had no existing drug dependency	NA
Category 3 Arguable clinical basis for the medication prescribed and patient had an existing drug dependency	P1, P2, P3, P11 and P13
Category 4 (least serious) Arguable clinical basis for the medication prescribed and patient had no existing drug dependency	P4, P5, P9, P10 and P15

33 Secondly, while Dr Wee did not dispute the SMC's classification of the patients who suffered from existing drug dependency issues, he pointed out that the Agreed Facts had only stated that he "was aware and/or *ought to have been aware*" [emphasis added] that patients P1, P2, P3, P11 and P13 had dependency issues. Accordingly, Dr Wee submitted that he "ought to be given the benefit of the lower state of mind", except in cases where there was clear evidence that he was in fact aware of his patients' drug dependency issues.

34 Thirdly, Dr Wee contended that there was insufficient evidence that he had obtained a financial benefit from his offending. He had not prescribed medication to his patients for the purpose of making a profit, and had instead planned to manage P1, P2, P3, P11 and P13's drug dependency issues (in so far as he was aware of them) by prescribing them diluted codeine-containing cough mixtures "in combination with verbal counselling". Dr Wee also claimed that

he had been unaware of the requirements under the Codeine Guidelines until sometime in July 2017, and had complied with the guidelines thereafter. In the circumstances, Dr Wee submitted that he had not acted in blatant disregard of his patients' well-being, and that a finding of medium culpability was therefore appropriate.

35 Turning to the aggregate sentence, Dr Wee submitted that the threshold for striking off had not been crossed in the present case, having regard to the factors stated above at [11]. In particular, Dr Wee highlighted that it was not disputed that the harm caused by his prescriptions was moderate rather than high, and that there was no evidence that any of his patients developed drug dependency issues as a result of his conduct. An order striking Dr Wee off the Register of Medical Practitioners would also be "too crushing", in light of precedent cases such as *Singapore Medical Council v Dr Tang Yen Ho Andrew* [2019] SMCDT 8 ("*Dr Andrew Tang*").

Issues to be determined

36 The essential determination that we had to make was whether the sentence imposed by the DT was manifestly inadequate. To so determine we had to decide the following issues:

(a) Did the DT err in characterising Dr Wee's culpability for the Inappropriate Prescription charges as medium rather than high?

(b) If so, and in the light of all the facts, what was the appropriate sanction to be imposed on Dr Wee?

Whether the DT erred in assessing Dr Wee's culpability for the Inappropriate Prescription charges

37 The culpability of an offender refers to the degree of blameworthiness disclosed by the misconduct: *Wong Meng Hang* at [30(b)]. The Sentencing Guidelines set out the following non-exhaustive factors which may be considered when assessing a doctor's culpability (at para 54):

(a) the doctor's state of mind;

(b) the extent of premeditation and planning involved, including the lengths the doctor went to cover up his/her misconduct;

(c) whether the doctor was motivated by financial gain, and the extent of profits gained;

(d) the extent of departure from the standard of care or conduct reasonably expected of a medical practitioner;

(e) the extent and manner of the doctor's involvement in causing the harm;

(f) whether the treatment was an appropriate management option, and within the doctor's area of competence;

(g) the extent to which the doctor failed to take prompt action when patient safety or dignity was compromised;

(h) the urgency of the situation;

(i) the duration of the offending behaviour; and

(j) the extent to which the doctor abused his/her position of trust and confidence.

38 We begin by noting that it was not disputed in the present appeal that the duration and frequency of Dr Wee's misconduct was significant, and that his culpability was therefore at least in the medium range. As can be seen from the table at [19] above, Dr Wee prescribed codeine-containing cough mixtures and benzodiazepines to his patients in breach of the relevant guidelines over several years. In some instances, Dr Wee did so at a striking frequency – for instance, P11 was prescribed codeine-containing cough mixtures in breach of the Codeine Guidelines on *90* occasions, over the course of approximately six months. Certain patients were also prescribed with multiple drugs on several occasions, which increased the risk of potentially *lethal* drug interactions (see, *eg*, P4, P10 and P13). The question was whether the totality of Dr Wee's conduct justified finding that his culpability for the Inappropriate Prescription charges was *high*. For the reasons set out below, we found that this threshold was amply crossed on the facts of the present appeal. Accordingly, we considered that the DT had, with respect, fallen into error by characterising Dr Wee's culpability as medium instead of high.

Dr Wee had no clinical basis for his prescriptions

39 First, and most significantly, it was clear to us that the present appeal was not a case of Dr Wee simply prescribing an *excess* of medication to his patients in a bid to treat medical conditions they suffered from. Instead, Dr Wee had *no* clinical basis for his prescriptions and must have been cognisant of the fact that his prescriptions were perpetuating his patients' drug dependency issues. This, in our view, was a flagrant abuse of Dr Wee's privileges as a medical practitioner and a gross dereliction of his duties as a doctor, which justified a finding of high culpability. We first address Dr Wee's prescriptions in relation to patients P1, P2, P3, P11 and P13, before turning to his prescriptions in relation to patients P4, P5, P9, P10 and P15.

P1, P2, P3, P11 and P13

40 With regard to P1, P2, P3, P11 and P13, we found it apparent from Dr Wee's Letter of Explanation that he had no clinical basis for his prescriptions to these patients. As we have explained, Dr Wee submitted his Letter of Explanation in response to the SMC's invitation to provide a written explanation for the prescriptions he had made. In response to the SMC's request to "provide the clinical basis for prescribing codeine-containing cough mixtures to the same patient within four days" in relation to P1, P2, P3, P11 and P13 (among other patients), Dr Wee stated as follows:

> **2(g) – APPROACH ADOPTED TO MANAGE PATIENTS WITH DEPENDENCY ON COUGH SYRUP WITH CODEINE**
>
> …
>
> 2. Approach Adopted – Social Stability
>
> (a) The approach adopted is based on my experience in the rehabilitation centre while serving in the army. ***I had observed that recovery/complete turning away from use of addictive substances was very difficult.*** Relapse rate is known to be very high.
>
> (b) My focus was on helping such patients to continue:
>
> i. To remain socially stable;
>
> ii. To be able to work and earn a living so that financial stress can be reduced.
>
> (c) At the same time, this approach will help them avoid interacting with suppliers (especially in Geylang area) who would encourage heavier usage and even the use of other stronger addictive drugs.
>
> (d) Each time patient came for cough mixture, I will make an assessment of their mental/social state.
>
> 3. Two-Prong Approach Adopted: Dilution of Cough Mixtures Used for Treatment and Verbal Counselling
>
> Purpose: The purpose is to enable identified patients to continue their daily lives as normally as possible with less/no reliance on a stronger concentration.

> (a) Dilution Method using 25% Dhasedyl DM
>
> Dhasedyl cough syrup is not 100 percent concentration but diluted with Dhasedyl DM as follows:
>
> 75% Dhasedyl plus 25% Dhasedyl DM (Dhasedyl DM does not contain Codeine)
>
> …
>
> ***My aim is to dilute Dhasedyl cough syrup to 50% concentration eventually.***
>
> (b) Verbal Counselling & Assessment of Patient Mental/Social Stability
>
> Patients were provided verbal counselling regularly, advised to seek specialist assistance, reduce dependency on condeine [*sic*] cough syrup. Assessments on patient mental/social stability were also made and diluted cough syrup was only dispensed when patient was found to be mentally/socially stable.
>
> …
>
> [emphasis in original omitted; emphasis added in bold italics]

41 The remainder of the Letter of Explanation contained further elaboration as to why Dr Wee had prescribed codeine-containing cough mixtures to each individual patient. In respect of P1, P2, P3, P11 and P13, Dr Wee expressly acknowledged that these patients suffered from dependency issues and that he had therefore "applied the approach to manage patient [*sic*] with dependency to help them remain socially stable". For instance, in relation to P1, Dr Wee explained as follows:

> …
>
> 3. Clinical Basis: Patient made frequent requests for Dhasedyl mainly due to cough aggravated by smoking.
>
> Patient had dependency and applied the approach to manage patient with dependency to help them remain socially stable.
>
> Each time patient consulted me, assessment was made to ensure that he is mentally/socially stable.

> Aim is to give diluted form of Dhasedyl which is given at cost to help patient be able to continue to work.
>
> …
>
> [emphasis in original omitted]

42 We make two observations in relation to the above extracts. First, it was plain to us that Dr Wee had in fact known that P1, P2, P3, P11 and P13 were dependent on codeine-containing cough mixtures. To begin with, this section of Dr Wee's Letter of Explanation was titled "Approach adopted to manage patients *with dependency on cough syrup with codeine*" [emphasis added], and Dr Wee expressly acknowledged in his explanation that P1, P2, P3, P11 and P13 suffered from dependency issues. Accordingly, while the Agreed Facts stated that Dr Wee "was aware and/or ought to have been aware" that P1, P2, P3, P11 and P13 suffered from existing drug dependency issues, we were unable to accept Dr Wee's argument that he should therefore be afforded "the benefit of the lower state of mind". As Dr Wee rightly acknowledged, he should only be given the benefit of the less culpable state of mind if there was no clear evidence to the contrary – in our view, the admissions in Dr Wee's Letter of Explanation were clear evidence that he had been aware of P1, P2, P3, P11 and P13's drug dependency issues.

43 Secondly, it was plain that Dr Wee had prescribed codeine-containing cough mixtures to P1, P2, P3, P11 and P13 for the sole purpose of fuelling their addictions, and not on account of any underlying medical condition that they suffered from. Dr Wee explained that he had made the prescriptions as he believed that "recovery/complete turning away from use of addictive substances was very difficult" and that his patients would otherwise approach suppliers "especially in [the] Geylang area" who would "encourage heavier usage and even the use of other strong addictive drugs". It therefore appeared to us that Dr Wee prescribed codeine-containing cough mixtures to P1, P2, P3, P11 and

P13 so that they could *continue* to abuse such substances without having to turn to illicit suppliers. While Dr Wee claimed in his Letter of Explanation that this approach helped his patients to remain "socially stable", this was ultimately a mere assertion on Dr Wee's part. Dr Wee did not provide any evidence that his approach was clinically sound or that the patients would otherwise have turned to illicit suppliers. On the contrary, the medical expert report of Dr Eng Soo Kiang dated 5 February 2021 ("Dr Eng's report"), which was tendered by the SMC, made clear that patients who are drug addicts "require proper assistance in overcoming their addiction – *not more drug prescriptions*" [emphasis added].

44 In the same vein, we noted that it was also not Dr Wee's position that he had been trying to *treat* his patients for their addictions. Instead, according to his Letter of Explanation, his plan had been to dilute "Dhasedyl", a codeine-containing cough syrup, with "Dhasedyl DM", which did not contain codeine, with the goal of diluting Dhasedyl to "50% concentration eventually". This, however, meant that Dr Wee's patients would *still* be addicted to codeine, albeit to an admixture with a lower concentration of the drug. In the circumstances, we did not see how Dr Wee could have genuinely believed that he had a medical basis for his prescriptions. For the avoidance of doubt, Dr Eng also clarified in his report that Dr Wee's practice of adding Dhasedyl DM did *not* actually have the effect of diluting the codeine-containing cough mixture, but instead created an admixture of two psychoactive drugs, thus significantly increasing the risk of harm to the patient. This left us in no doubt that Dr Wee's alleged plan of prescribing "diluted" codeine-containing cough mixtures was not, by any measure, an appropriate treatment option for his patients.

45 In any event, we noted that the veracity of Dr Wee's alleged plan to prescribe "diluted" cough mixtures could also be questioned. In this regard, there was no evidence that Dr Wee had in fact tried to reduce the concentration

of the codeine-containing cough mixtures that he prescribed over time. Instead, based on Dr Wee's description in his Letter of Explanation of the cough mixtures that had been prescribed to P1, P2, P3, P11 and P13, it appeared that these patients were consistently given codeine-containing cough mixtures of the *same* concentration (*ie*, 75% Dhasedyl mixed with 25% Dhasedyl DM). In this light, Dr Wee's alleged plan of eventually "diluting" the cough mixtures he prescribed to "50% concentration" was simply a self-serving and unsubstantiated assertion on his part, and appeared to us to be an afterthought.

46 In his submissions for the appeal, Dr Wee highlighted the fact that P1, P2, P3, P11 and P13 were recorded to be suffering from genuine medical conditions (such as fever, cough or upper respiratory tract infection) during their first consultation with him, and that he had written down words like "cough" in their respective patient medical records on subsequent occasions. In our view, this did not assist Dr Wee. In the first place, Dr Wee's patient medical records were scant and did not explain why codeine-containing cough mixtures had been prescribed to P1, P2, P3, P11 and P13 at *each* consultation. In any event, even if these patients had presented genuine medical conditions on their first consultation with Dr Wee or on subsequent occasions, it was clear that their medical conditions were at most an ancillary concern in Dr Wee's mind – when asked by the SMC to justify why he had prescribed codeine-containing cough mixtures to the same patient within the span of four days, Dr Wee's first reaction was to explain that he had done so to help his patients cope with their dependency issues. He did not then proffer the explanation that the medical conditions that they had presented required such prescriptions.

47 For the foregoing reasons, we rejected Dr Wee's submission that he had a clinical basis for his prescriptions to P1, P2, P3, P11 and P13. It was clear to us that Dr Wee had not made his prescriptions because of medical conditions

that his patients suffered from, or because he had a treatment plan for them. Instead, the overall picture that emerged was that Dr Wee had prescribed codeine-containing cough mixtures simply because he knew that his patients were dependent on such drugs, and he wanted his patients to obtain such drugs from him rather than other suppliers. In short, he was abusing his registration as a medical practitioner as a licence to sell such drugs to his patients without any proper clinical basis. Dr Wee had essentially decided to perpetuate his patients' dependency issues by providing them with a ready and steady supply of codeine-containing cough mixtures. Whether or not Dr Wee did so for profit (which we discuss below), we found it evident that Dr Wee's conduct constituted a flagrant abuse of his privileges as a medical practitioner, and that his culpability in respect of these patients could not be anything short of high.

P4, P5, P9, P10 and P15

48 We turn to address Dr Wee's prescriptions in relation to P4, P5, P9, P10 and P15. In our judgment, Dr Wee did not have any clear clinical basis for his prescriptions to these patients either. He must have been aware that his prescriptions were perpetuating his patients' drug dependency issues.

49 As noted above, the Agreed Facts did not contain any statement to the effect that P4, P5, P9, P10 and P15 suffered from drug dependency issues at the material time. In his Letter of Explanation, Dr Wee also did not make mention of these patients being dependent on codeine or benzodiazepines. This appears to be why both the SMC and Dr Wee classified P4, P5, P9, P10 and P15 as patients who did not suffer from drug dependency issues. Nevertheless, we stress that a sentencing tribunal or court is entitled to draw inferences based on the material facts before it – as observed in *Chng Yew Chin v Public Prosecutor* [2006] 4 SLR(R) 124 at [44], judges should address the facts before them and

duly make logical inferences. In our view, even if there was no direct evidence as to whether P4, P5, P9, P10 and P15 had suffered from drug dependency issues, and whether Dr Wee had been aware of such issues, the facts of the present appeal amply supported the drawing of such inferences.

50 We found it significant that P4, P5, P9, P10 and P15 had all obtained prescriptions from Dr Wee frequently over an extended period. For instance, from 8 June 2016 to 8 August 2016, P4 obtained a prescription for codeine-containing cough mixture every one to five days. Likewise, P5 was given a prescription for 180ml of codeine-containing cough mixture every one or two days, from 15 July 2016 to 10 August 2016. As for P9, P10 and P15, they were respectively prescribed benzodiazepines for cumulative periods of up to (a) 1 year 3 months and 5 days; (b) 6 months and 23 days; and (c) 1 year and 11 days. In our view, the frequency and duration of the prescriptions in question strongly suggested that P4, P5, P9, P10 and P15 were in fact dependent on such medications, or had *become dependent* on such medications as a result of Dr Wee's prescriptions. Moreover, it must have become readily apparent to Dr Wee that P4, P5, P9, P10 and P15 suffered from such issues, given the frequency at which these patients consulted him. In particular, given that Dr Wee was well aware that P1, P2, P3, P11 and P13 were dependent on codeine, we did not see how it could have escaped Dr Wee that his *other* patients who were obtaining codeine-containing cough mixtures on a regular basis (namely, P4 and P5) were also likely suffering from dependency issues. Accordingly, it appeared to us that although Dr Wee did not admit that these patients were drug dependent, he must have known that P4, P5, P9, P10 and P15 were dependent on codeine or benzodiazepines and that his prescriptions were perpetuating such issues.

51 In our view, the above conclusion was reinforced by the fact that Dr Wee did not appear to have any clear clinical basis for his prescriptions to P4, P5, P9, P10 and P15. In this regard, Dr Wee submitted that his prescriptions were justified by genuine medical conditions presented by the patients in question. For instance, P4 had suffered from asthma and a frequent cough, while P5 "complained of cough regularly in 2014 during consultations". Likewise, P9 suffered from chronic anxiety, P10 had chronic abdominal pain and chronic insomnia, and P15 had chronic asthma, anxiety and insomnia.

52 We were not persuaded that the above constituted a justifiable clinical basis for Dr Wee's prescriptions. While the above explanations were set out in Dr Wee's Letter of Explanation, they did not account for why Dr Wee had prescribed codeine-containing cough mixtures and benzodiazepines at the frequency and for the duration that he did, especially when it would have seemed that the medical conditions allegedly suffered by P4, P5, P9, P10 and P15 were not improving (given their repeated requests for medication). For similar reasons, we did not think that Dr Wee's claim that he had been unaware of the requirements under the Codeine Guidelines until July 2017 assisted his case – even if Dr Wee had been mistaken as to the frequency at which he could prescribe codeine-containing cough mixtures, this did not explain why Dr Wee had *persisted* in prescribing such medication even though his patients showed no improvement. In any event, we did not see how Dr Wee could be excused for being unaware of the requirements of the Codeine Guidelines, given his seniority and that it was his responsibility as a medical practitioner to be apprised of such guidelines. Dr Wee, significantly, did not deny receiving the Codeine Guidelines when they were issued.

53 In this connection, Dr Eng noted in his report that a responsible and competent doctor would not repeatedly prescribe codeine for a cough beyond

three weeks, and more so if the cough lasted beyond eight weeks. Instead, a responsible and competent doctor would stop prescriptions of codeine-containing cough mixtures and refer the patient to a specialist to determine the underlying cause(s) of the cough. As for the prescription of benzodiazepines, Dr Eng stated that a responsible and competent doctor would not have repeatedly prescribed benzodiazepines as the first, main and/or only medication for insomnia/sleep disorders, anxiety, depression, or anxiety-depression, and would have stopped a prescription of multiple psychoactive drugs after a cumulative period of eight weeks.

54 Dr Wee contended that the difference between his prescriptions and Dr Eng's report amounted to "mere disagreement over the appropriate course of treatment". Dr Wee also claimed that the requirements of the Codeine Guidelines were not a "strict prohibition", but instead a "guideline" that such conduct should be avoided "whenever possible.

55 In our view, these submissions did not assist Dr Wee. To begin with, Dr Wee could not claim that the Codeine Guidelines were a mere "guideline" without qualifying his plea of guilt to the Inappropriate Prescription charges, which alleged that he was obliged to comply with the Codeine Guidelines, and that his failure to do so constituted professional misconduct under s 53(1)(*d*) of the MRA (see [18] above). It did not appear to us that it was Dr Wee's intention to qualify his plea as such. As for Dr Wee's contention that Dr Eng's report constituted "mere disagreement over the appropriate course of treatment", we did not think this submission carried weight in the absence of any evidence from Dr Wee to contradict Dr Eng's report, or to suggest that the prolonged prescription of codeine-containing cough mixtures or benzodiazepines was clinically sound. In this regard, while Dr Wee tendered a report from Dr Ng Beng Yeong ("Dr Ng") dated 24 June 2021, Dr Ng's report merely asserted that

Dr Wee's assessment and treatment of various patients had been "adequate" and that Dr Wee had "tried his best" to help his patients. While Dr Ng claimed that the doses prescribed by Dr Wee were "low", Dr Ng's report did not explain why Dr Wee's treatment of his patients was therefore "adequate", or why it had been appropriate for Dr Wee to prescribe medication as frequently and for the periods that he did. In the circumstances, we did not see how Dr Ng's report assisted Dr Wee's position.

56 Consequently, we found it clear that Dr Wee had no clinical basis or satisfactory explanation for his repeated prescriptions to P4, P5, P9, P10 and P15. In the circumstances, it appeared to us that it was reasonable to concludethat Dr Wee had in fact known that his patients were dependent on codeine-containing cough mixtures and benzodiazepines, and had knowingly perpetuated their addictions. Further, even if P4, P5, P9, P10 and P15 had not suffered from drug dependency issues at the time of their first consultation, it was clear to us that they had in fact developed such dependency through Dr Wee's improper prescriptions. This, in our view, was even more aggravating. Either way, Dr Wee's conduct evidenced a blatant and systemic disregard for his patients' well-being, which, in our view, amply justified a finding of high culpability.

The DT placed undue weight on mitigating factors

57 Next, as noted above at [22], the DT considered that a finding of high culpability was not warranted because (a) Dr Wee had been convicted of serious negligence amounting to professional misconduct rather than intentional and deliberate misconduct; and (b) Dr Wee had not been motivated by financial gain. We agreed with the SMC that the DT had incorrectly ascribed mitigating weight to these factors.

58 First, we stress that charges of serious negligence do not necessarily attract findings of lower culpability, compared to charges of intentional and deliberate misconduct. We reiterate the observations of this court in *Wong Meng Hang* at [28], which we reproduce below:

> 28 *Although cases involving intentional and deliberate wrongdoing may commonly attract heavier sentences relative to those which concern negligent misconduct, this will not invariably be the case.* Depending on the facts of the case, negligent wrongdoing may be more serious and deserving of greater censure than intentional misconduct. In *Lee Kim Kwong* at [44], we cited a hypothetical example where a doctor's intentional departure from medically-approved standards may have been motivated by a genuine but mistaken concern for the patient's interests. Such a doctor may be regarded as less blameworthy than one who acted negligently but in blatant disregard of the patient's well-being. In such circumstances, it might well be the case that the negligent doctor ought to be visited with the more severe punishment particularly where his outright lack of concern for the patient's interests may have endangered the patient or caused her grave harm. *The short point, we reiterate, is that each case must, in the final analysis, turn on its own facts.*
>
> [emphasis added]

59 Accordingly, as counsel for Dr Wee conceded at the hearing before us, the mere fact that Dr Wee had been convicted of serious negligence did not preclude a finding that his culpability was high. The relevant query was whether on the facts of the present case, Dr Wee's conduct was sufficiently egregious as to warrant a finding of high culpability. For the reasons set out at [39]–[56] above, it was apparent to us that even though the charges proffered against him asserted serious negligence, Dr Wee had in fact known that he had no clinical basis for his prescriptions. Specifically, in relation to P1, P2, P3, P11 and P13, Dr Wee had not simply been careless or reckless, but had instead *deliberately* prescribed codeine-containing cough mixtures for the purpose of sustaining these patients' addictions. In the circumstances, it seemed to us that Dr Wee's culpability was similar to that of an errant doctor who had been convicted of

intentional and deliberate misconduct, and we saw no reason why Dr Wee should not be sanctioned accordingly.

60 Turning to Dr Wee's alleged lack of a profit motive, the SMC submitted that the DT had erred in accepting Dr Wee's unsubstantiated allegation that he had not exploited his patients for profit. In the event, this point became moot as the SMC eventually conceded that it could not rely on Dr Wee's alleged profit motive as an aggravating factor, in the absence of any evidence adduced by the SMC regarding the profit made by Dr Wee. At the hearing before us, counsel for Dr Wee also conceded that a lack of profit motive was at best a neutral factor, rather than a mitigating factor. In our view, this was correct – while we would have been prepared to consider the presence of a profit motive as an aggravating factor, it is well established that the absence of an aggravating factor is neutral and not mitigating: *Edwin s/o Suse Nathen v Public Prosecutor* [2013] 4 SLR 1139 at [24]. Accordingly, in so far as the DT considered Dr Wee's lack of a profit motive to be a mitigating factor, we agreed with the SMC that the DT had fallen into error in this regard.

Conclusion on Dr Wee's culpability for the Inappropriate Prescription charges

61 To summarise the foregoing, it was clear to us that Dr Wee's culpability for the Inappropriate Prescription charges could not be characterised as anything short of high. Aside from the fact that the duration and frequency of Dr Wee's misconduct was significant, the *motivations* behind Dr Wee's prescriptions betrayed an utter disregard for his patients' well-being and his duties as a medical practitioner. Dr Wee had prescribed medication without any clinical basis for doing so, knowing full well that his prescriptions would likely *perpetuate* his patients' drug dependency issues. We were left in no doubt that this constituted a deliberate departure from the basic standards expected of a

medical practitioner, and that Dr Wee's culpability therefore fell at the highest end of the scale.

62 With this in mind, we turned to consider the appropriate sanction to be imposed in the present case.

The appropriate sanction

63 At the second step of the *Wong Meng Hang* sentencing framework, the court identifies the applicable indicative sentencing range based on the matrix set out above at [8]. Given the DT's finding that the harm caused by the Inappropriate Prescription charges was moderate, and our finding that Dr Wee's culpability was high, it followed that the indicative sentencing range was a suspension of two to three years for each of the Inappropriate Prescription charges.

64 That being said, as we have noted, the sentencing ranges set out in *Wong Meng Hang* are only a guide and can be departed from where it is appropriate to do so. In our judgment, particularly in cases where an errant doctor faces multiple charges, each of which attracts a substantial term of suspension, it would be appropriate for a sentencing tribunal or court to consider if the doctor's overall misconduct warrants an order striking him or her off instead. Given that the statutory cap in s 53(2)(*b*) of the MRA limits the *overall* period of suspension that may be imposed by a disciplinary tribunal to three years, it may well be the case that where an errant doctor has committed multiple counts of professional misconduct, a term of suspension would not adequately reflect the seriousness of the doctor's misconduct and may let the doctor's additional offending go unpunished. Accordingly, while it clearly should not be the case that an errant doctor will be struck off in *every* instance where a disciplinary

tribunal would have desired to impose a suspension that exceeds three years, we note that a disciplinary tribunal should nonetheless remain alive to the possibility of striking the errant doctor off, in place of imposing a term of suspension.

65 For the purposes of the present appeal, we therefore turned to consider whether Dr Wee's misconduct warranted an order striking him off. In the present case, we were more than satisfied that Dr Wee's misconduct in relation to the Inappropriate Prescription charges was so serious as to render him unfit to remain as a member of the medical profession.

66 Firstly, it was apparent to us that Dr Wee's misconduct was a flagrant abuse of the privileges of being a registered medical practitioner. The ability to prescribe controlled and/or addictive medication is one of the unique privileges afforded to medical practitioners and, it goes without saying, medical practitioners are therefore relied upon to exercise good sense and circumspection in prescribing such substances. Yet as we have explained above, not only did Dr Wee make his prescriptions without any sound clinical basis, he did so for the sole purpose of allowing his patients to *abuse* such substances. Instead of gatekeeping access to addictive medication as he was supposed to do, Dr Wee had effectively served as a *supplier* of such drugs. In our view, this itself was such a gross departure from the basic duties of a medical practitioner that it arguably rendered Dr Wee unfit to remain as a member of the medical profession.

67 In any event, that was not the end of Dr Wee's misconduct. We also considered it particularly troubling that Dr Wee's disregard for his patients' well-being was clearly *systemic*, as evidenced by the number of patients involved, the frequency of his prescriptions, and the overall duration of his

misconduct. As the SMC was at pains to emphasise in its submissions, the present appeal appeared to involve the highest number of patients in all precedent cases decided post-*Wong Meng Hang* (*ie*, 15 patients, including the patients who were the subject of the TIC charges), and was one of the most egregious cases of professional misconduct to date involving the inappropriate prescription of codeine-containing cough mixtures and benzodiazepines. In the circumstances, it was apparent to us that Dr Wee's misconduct had to be punished with a sanction of sufficient severity, and that striking him off was justified on the facts of the case.

68 Thirdly, our decision was also fortified by the fact that Dr Wee appeared to demonstrate a persistent lack of insight into the seriousness of his misconduct. As we have noted, when Dr Wee was first confronted by the SMC as to the basis for his prescriptions, Dr Wee sought to explain that he was helping his patients "manage" their dependency by prescribing them with diluted forms of codeine-containing cough mixture. In our view, Dr Wee's explanation alone suggested a severe lack of insight into his role as a doctor. More troublingly, however, Dr Wee *maintained* this explanation up to the time of the present appeal. This was despite the fact that Dr Eng's report (which was tendered before the DT) clearly explained that Dr Wee's practice of diluting cough mixtures significantly increased the risk of harm to his patients, and Dr Wee had not produced any evidence to the contrary. In addition, Dr Wee even suggested in his written submissions for the appeal that the divergence between his prescriptions and Dr Eng's report amounted to "mere disagreement over the appropriate course of treatment". These submissions seemed to suggest that Dr Wee had yet to grasp the full gravity of his misconduct, which was that he had effectively perpetuated his patients' addictions without any sound clinical

basis for doing so. In our view, this was yet another consideration in favour of striking Dr Wee off.

69 We next turned to consider Dr Wee's submissions on why the threshold for striking him off had not been met. First, Dr Wee contended that an order striking an errant doctor off is usually made "in cases involving severe harm and a high level of culpability", but that the present case only involved a moderate level of harm. We were unable to agree with this submission. As we have noted, the ultimate question is whether the errant doctor is fit to remain as a member of the medical profession. Thus, while this court observed in *Wong Meng Hang* that striking off *should* be considered where the doctor's misconduct has caused grave harm (at [67(b)]), an order striking the errant doctor off is not *contingent* on a finding of severe harm. Further, we note that the SMC's position before the DT was that the harm caused by Dr Wee's misconduct was moderate, and that the SMC did not appeal against the DT's assessment of the harm caused. Had this point arisen for our determination, however, we observe that it may well have been the case that we would have found a finding of severe harm to be warranted, on the basis that Dr Wee's conduct may have intensified his patients' addictions, and possibly caused P4, P5, P9, P10 and P15 to develop dependency issues if they had not suffered from these issues before. That said, it was not necessary for us to decide this point and we therefore do not comment further on it.

70 Secondly, Dr Wee relied on the precedent case of *Dr Andrew Tang*, in which a disciplinary tribunal declined to strike Dr Tang off for his inappropriate prescriptions of codeine-containing cough mixtures, to contend that a striking-off order in the present case would be "too crushing". In our view, *Dr Andrew Tang* was of limited assistance as it was not analogous to the facts of the present appeal. For one thing, the disciplinary tribunal in *Dr Andrew Tang* found that

the harm caused by Dr Tang's inappropriate prescriptions of codeine was slight, and that his culpability was medium (at [38] and [41]). Moreover, the disciplinary tribunal found that Dr Tang's treatment of patients and medical record keeping were "not inadequate", and that his treatment plan for each patient was "not inappropriate" (at [53]). This clearly stood in contrast to the present case, which involved high culpability and a moderate level of harm, and an absolute lack of a treatment plan on Dr Wee's part. In our view, it was therefore of little assistance to compare *Dr Andrew Tang* to the present case.

71 For completeness, we also did not consider Dr Wee's personal mitigating circumstances to militate against the making of an order striking him off. As this court observed in *Wong Meng Hang* at [24], the primacy of public interest considerations in disciplinary cases means that an offender's personal mitigating circumstances do not carry as much weight as they typically would in criminal cases. In some cases, an offender's personal mitigating circumstances may even have to give way entirely if this is necessary to ensure that the interests of the public are sufficiently met.

72 In the present case, the main mitigating factors in Dr Wee's favour were the fact that he had entered a timely plea of guilt, cooperated with investigations, and faced an inordinate delay in prosecution. In our judgment, these mitigating circumstances ultimately carried little weight. Given the seriousness of Dr Wee's misconduct, we considered that the interest in ensuring fairness on account of his personal circumstances was eclipsed by the overriding need to uphold the standing of the medical profession, and considerations of general deterrence. Moreover, Dr Wee's mitigating circumstances had to be balanced against the fact that he was a senior member of the profession at the time of his misconduct, having been registered as a medical practitioner for over 30 years at that point. As the DT observed, Dr Wee's patients would have reposed a

higher degree of trust and confidence in him, and this made his misconduct even more reprehensible (GD at [28]). We note that this finding was not seriously disputed by Dr Wee in the present appeal. In the circumstances, we found that Dr Wee's personal mitigating circumstances did not constitute a reason why he should be permitted to remain as a member of the profession, despite the egregiousness of his misconduct.

73 We were therefore amply satisfied that the threshold for striking Dr Wee off had been crossed, and it was clear to us that that was the appropriate sanction in the present case.

74 We conclude by making one further observation. We have mentioned above that the DT, although concluding that the appropriate period of suspension in this case would be 30 months, gave Dr Wee a sentencing discount of one-third of the period on account of the delay in the prosecution of his case. The question of whether a sentencing discount was warranted did not arise for our consideration, given our decision to strike Dr Wee off. Nevertheless, we take this opportunity to stress that a discount in sentence for any delay in prosecution is not automatic or routine. In every case in which there has been a delay, all the circumstances have to be scrutinised to determine whether the application of a discount is appropriate and will not trivialise or undermine the sanction being meted out.

Conclusion

75 For the foregoing reasons, we allowed the appeal and ordered that Dr Wee be struck off the Register of Medical Practitioners with immediate

effect. We awarded costs in favour of the SMC in the aggregate sum of $65,000 (inclusive of disbursements).

Sundaresh Menon
Chief Justice

Judith Prakash
Justice of the Court of Appeal

Steven Chong
Justice of the Court of Appeal

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