IN THE COURT OF 3 JUDGES OF THE GENERAL DIVISION

[2024] SGHC 283

Originating Application No 1 of 2024

Between

Singapore Medical Council

… *Appellant*

And

Ling Chia Tien

… *Respondent*

GROUNDS OF DECISION

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

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Singapore Medical Council
v
Ling Chia Tien

[2024] SGHC 283

Court of 3 Judges of the General Division of the High Court — Originating Application No 1 of 2024
Tay Yong Kwang JCA, Belinda Ang Saw Ean JCA and Judith Prakash SJ
4 July 2024

06 November 2024

Belinda Ang Saw Ean JCA (delivering the grounds of decision of the court):

Introduction

1 C3J/OA 1/2024 ("OA 1") was an appeal by the appellant, the Singapore Medical Council (the "SMC"), against the decision of the disciplinary tribunal (the "DT"). The respondent, Dr Ling Chia Tien ("Dr Ling") faced 32 charges. The DT found that 29 out of the 32 charges were made out against Dr Ling and imposed a term of 19 months' suspension. On appeal, which is on sentence alone, the SMC sought a term of suspension of 36 months based on its primary case. SMC's fallback position in the alternative, was 30 months' suspension.

2 After the hearing of OA 1 on 4 July 2024, this court dismissed the SMC's appeal. In our view, a suspension for a term of 19 months was not manifestly inadequate to warrant this court's intervention. The DT's sanction

was not disproportionate with or out of line in comparison with relevant precedents. We indicated that full written grounds would be provided in due course, and we do so below.

3 As we will explain in details shortly, the SMC overstated its primary case significantly. The SMC's assessment of what the harm/culpability matrix ought to be, which was presented as a departure from the level of the DT's findings on harm and culpability, would have added up to a term of suspension of 81 months. After applying the statutory limit provided for in s 53(2)(*b*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) (the "MRA"), the 81 months was reduced to a period of 36 months' suspension. In our view, the SMC had no basis to put forward a case for 81 months' suspension. On that view, there was no reason to impose the statutory limit of 36 months. Significantly, the SMC's alternative case was premised on the disciplinary tribunal's findings on harm and culpability. That stance speaks to the excessiveness and unreasonableness of SMC's primary case. The SMC's alternative case challenged firstly, the DT's assessment of the appropriate starting point for Dr Ling's failure to refer patients to a specialist in a timely manner (*ie*, the benzodiazepine referral charges) which the SMC said should be a period of six months and not four months as the disciplinary tribunal had indicated as the starting point of sentencing. Second, there was no inordinate delay in the prosecution of the 32 charges against Dr Ling and, therefore, the DT's application of a discount for prosecutorial delay was in error. Both reasons were problematic for the SMC. The second reason challenged the DT's factual findings whereas the first reason questioned the correctness of the DT's exercise of discretion within a range of sentences guided by similar cases.

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Facts

Background to the dispute

4 Dr Ling is a General Practitioner ("GP") at Apex Medical Centre (Jurong) Pte Ltd (the "Clinic"). Dr Ling graduated in 1983 and had been in practice for 40 years. He set up his first clinic in 1990. Dr Ling had three clinics with a total of five doctors working in them. At the material time, there were three doctors working at the Clinic: Dr Ling, Dr Tay Sok Hoon ("Dr Tay"), and Dr Goh Miah Kiang ("Dr Goh").

5 On 1 November 2016, the Ministry of Health (the "MOH") conducted an audit at the Clinic. In that audit, the MOH officers obtained copies of 16 patient-medical records (the "PMRs"). At that time, the MOH was concerned about Dr Ling's prescribing practice with respect to hypnotics or benzodiazepines, and his poor documentation of his patients' medical records.

6 In view of this, the MOH reported its concerns to the SMC on 10 January 2017. The SMC, thereafter, referred this matter on 25 May 2017 to the Complaints Panel pursuant to s 39(3)(*a*) of the MRA.

7 On 14 November 2017, the Investigations Unit of the SMC sent a letter to Dr Ling pursuant to s 60A(2) of the MRA. The letter informed Dr Ling of the appointment of a Complaints Committee (the "First CC") which had been appointed to inquire into the 16 PMRs, and it also requested the type-written transcriptions of the 16 PMRs.

8 The First CC issued a notice of complaint (the "First Notice of Complaint") on 12 March 2018, and it requested a written explanation by Dr Ling to address: (a) Dr Ling's diagnoses and reasons for the prescriptions of

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hypnotics or benzodiazepines to each of the 16 patients; (b) whether Dr Ling considered referring each of the 16 patients for specialist treatment; and (c) Dr Ling's poor medical documentation.

9 On 23 April 2018, Dr Ling submitted his letter of explanation (the "First Letter of Explanation"). In his First Letter of Explanation, Dr Ling provided the SMC with a brief description of his general practice, his thoughts on the complaint, a brief background on how he treats patients, and a more detailed explanation regarding each of the 16 patients.

10 Around 10 months later, on 19 February 2019, the First CC informed Dr Ling that it had ordered a formal inquiry to be held by a disciplinary tribunal. On the same day, the First CC wrote to Professor Tan Ser Kiat, the President of the SMC, to inform him that the First CC had discovered that Dr Ling had prescribed codeine-containing medications to five patients.

11 After about another 10 months, on 12 December 2019, the Investigations Unit of the SMC sent a second notice of complaint (the "Second Notice of Complaint") to Dr Ling. This Second Notice of Complaint informed Dr Ling that a second Complaints Committee (the "Second CC") had been appointed. The Second Notice of Complaint also sought a written explanation from Dr Ling pursuant to s 44(2) of the MRA in respect of, amongst other things, the question of whether Dr Ling had prescribed codeine-containing medications to the five patients over a long-term period without proper clinical assessment.

12 Dr Ling submitted his written explanation (the "Second Explanation") to the Investigations Unit on 3 February 2020. On 3 July 2020, the Second CC wrote to Dr Ling to inform him that it had ordered for a formal inquiry to be held by a disciplinary tribunal.

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13 On 13 April 2021, around nine months since the Second CC's last correspondence, the SMC's solicitors, WongPartnership LLP ("WongPartnership"), served two Notices of Inquiry ("NOI(1)" and "NOI(2)", respectively) on Dr Ling. The two NOIs contained a total of 32 charges that the SMC had preferred against Dr Ling in respect of 15 patients. The charges pertained to his prescription of benzodiazepines and codeine-containing medications, his failure to refer his patients to an appropriate specialist in a timely manner, and his inadequate documentation of his patients' records.

The charges

14 NOI(1) contained 27 charges that pertained to Dr Ling's inappropriate prescription of benzodiazepines (the "Benzodiazepine Prescription Charges"), his failure to maintain adequate documentation (the "Documentation Charges"), and his failure to refer patients to a specialist in a timely manner or at all (the "Benzodiazepine Referral Charges"). NOI(2) contained five charges that pertained to Dr Ling's inappropriate prescription of codeine-containing medications (the "Codeine Prescription Charges"). All 32 charges alleged that Dr Ling had committed professional misconduct pursuant to s 53(1)(*d*) of the MRA.

15 We set out the 32 charges that were preferred against Dr Ling. These charges were preferred in respect of 15 out of the 16 patients whose PMRs the SMC was initially investigating. The five charges in bold reflect the charges to which Dr Ling eventually pleaded guilty. Only the remaining 27 charges were contested before the DT:

S/N	Category	Charges

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NOI(1)		
(a)	Benzodiazepine Prescription Charges	1st Charge (Patient 1)
		4th Charge (Patient 2)
		7th Charge (Patient 3)
		10th Charge (Patient 4)
		12th Charge (Patient 5)
		15th Charge (Patient 6)
		17th Charge (Patient 7)
(b)	Documentation Charges	**2nd Charge (Patient 1)**
		5th Charge (Patient 2)
		8th Charge (Patient 3)
		11th Charge (Patient 4)
		13th Charge (Patient 5)
		16th Charge (Patient 6)
		18th Charge (Patient 7)

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		20th Charge (Patient 8)
		21st Charge (Patient 9)
		22nd Charge (Patient 10)
		23rd Charge (Patient 11)
		24th Charge (Patient 12)
		25th Charge (Patient 13)
		26th Charge (Patient 14)
		27th Charge (Patient 15)
(c)	Benzodiazepine Referral Charges	3rd Charge (Patient 1)
		6th Charge (Patient 2)
		9th Charge (Patient 3)
		14th Charge (Patient 5)
		19th Charge (Patient 7)
NOI(2)		
(d)	Codeine	1st Charge (Patient 11)

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	Prescription Charges	2nd Charge (Patient 12)
		3rd Charge (Patient 13)
		4th Charge (Patient 14)
		5th Charge (Patient 15)

16 The proceedings before the DT took place over three tranches: (a) 7 to 10 February 2022, (b) 29 to 30 August and 7 to 8 September 2022, and (c) 14 and 16 November 2022. At the start of the first tranche on 7 February 2022, Dr Ling initially pleaded guilty to 11 charges. Subsequently, in view of the amendment of some charges, he pleaded guilty in respect of only five charges (see [18] below).

17 During the hearing on 9 February 2022, Dr Ling gave evidence that some entries in the PMRs were made by Dr Goh and Dr Tay when they saw the patients. The DT noted that the typewritten transcriptions that Dr Ling had provided to the DT did not distinguish between the notes taken by the different doctors. In view of this, the DT directed that Dr Ling provide the SMC with an amended and supplementary transcripts of the PMRs. Dr Ling provided the SMC with these transcripts of the PMRs on 24 March 2022.

18 Following this, on 15 July 2022, the SMC made various amendments to the charges and the corresponding schedules in NOI(1) and NOI(2). Dr Ling thus amended his plea at the start of the second tranche on 29 August 2022 and only pleaded guilty to five charges.

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19 During the second tranche, on 6 September 2022, WongPartnership wrote to the DT to inform the DT that there were 69 missing entries from the schedules to the NOI(1) and NOI(2). These entries were PMRs within the charge periods that were previously left out. The SMC raised this matter during the hearing on 7 September 2022 and sought the DT's permission to replace the schedules with the corrected ones that included these additional entries.

20 Dr Ling objected to the late amendment to the charges. He submitted that to have to revisit 69 additional occasions without the opportunity to properly consider every one of those occasions should not be something that he should be subjected to.

21 The DT allowed the application and directed that Dr Ling be given sufficient time to consider and address the additional entries in the Schedules. Dr Ling thus filed his third affidavit on 7 October 2022.

22 On 4 November 2022, the SMC wrote to the DT seeking to amend the charges again with a corrected version of the dosages for some of Dr Ling's prescriptions. At the start of the third tranche, on 14 November 2022, the SMC submitted that Dr Ling had provided certain clarifications on the dosages of some prescriptions, particularly for the proportion of codeine in some of the admixtures (see [84] below). The amendments to the charges reflected those clarifications. Dr Ling did not object to the amendments, and the DT allowed the application.

23 On 16 November 2022 – the end of the third tranche – the SMC sought leave for one further amendment. This amendment was based on Dr Ling's clarification that one of the entries was made by Dr Tay and not by Dr Ling. The SMC wished to amend the schedule to remove this entry. The DT noted

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that there was no objection by Dr Ling and approved this further amendment to the schedule.

The DT's decision

24 The DT released its grounds of decision in *Singapore Medical Council v Dr Ling Chia Tien* [2023] SMCDT 7 (the "Decision") on 14 December 2023.

25 First, as a preliminary point, the DT rejected Dr Ling's submission that the SMC did not put its case to him as there was no need for the SMC to formally do so pursuant to s 51(4) of the MRA: Decision at [27]. The DT then considered the charges against Dr Ling and grouped them into the following four categories (see [14]–[15] above):

(a) Documentation Charges;

(b) Benzodiazepines Prescription Charges;

(c) Benzodiazepine Referral Charges; and

(d) Codeine Prescription Charges.

26 We summarise the DT's findings in relation to each set of charges.

Documentation Charges

27 The DT placed the Documentation Charges in three categories: (a) the documentation in respect of other medications (the "General Documentation Charges"); (b) the documentation in respect of Benzodiazepines (the "Benzodiazepine Documentation Charges"); and (c) the documentation in respect of codeine-containing medications (the "Codeine Documentation Charges"): Decision at [29].

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The General Documentation Charges

28 The DT noted that the parties were largely aligned as to the applicable standard. The parties did not dispute that guidelines 4.1.2 and 4.1.3 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines ("2002 ECEG") set out the applicable standard: Decision at [31]–[32]. Furthermore, the disciplinary tribunal in *Singapore Medical Council v Dr Tang Yen Ho Andrew* [2019] SMCDT 8 ("*Andrew Tang*") made clear what must be documented, especially for a GP. Both *Andrew Tang* and the SMC's expert witness, Dr Eng Soo Kiang ("Dr Eng"), indicated that there was a need to document a summary of the medical records or the key points of a patient's medical history, a patient profile and the important details of the physical examination conducted: Decision at [37].

29 The DT found that while the duty to document applies even when a doctor approves the sale of medication over the counter, the standard of care in relation to prescriptions by way of approving the sale of medications cannot be the same as the standard of care that applies when a doctor personally sees a patient because there are some matters that could be documented only after seeing a patient. However, the doctor is still required to document the medication requested by the patient and the medical grounds for the prescription: Decision at [39] and [42].

30 Considering the PMRs, the DT found that Dr Ling's entries were lacking in detail and extremely difficult to decipher. Accordingly, Dr Ling had fallen short of the applicable standards in respect of the 20th (Patient 8), 21st (Patient 9) and 22nd (Patient 10) Charges in NOI(1): Decision at [48]–[50], [54]–[57] and [64]–[65].

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The Benzodiazepine Documentation Charges

31 The DT noted that the same standards that were applicable to the General Documentation Charges also applied to the Benzodiazepine Documentation Charges. It was also undisputed that the MOH Administrative Guidelines on the Prescription of Benzodiazepines and other Hypnotics (14 October 2008) (the "2008 Administrative Guidelines") formed part of the applicable standards: Decision at [66].

32 In respect of the 5th Charge (Patient 2) of NOI(1) (see [15] above), the DT found that there was insufficient documentation because Dr Ling did not properly document his investigations or diagnosis. Dr Ling's misconduct was sufficiently egregious to amount to professional misconduct: Decision at [72]–[74]. The DT found that the 16th Charge (Patient 6) of NOI(1) was not made out because the patient's complaints, Dr Ling's examination and his treatment plan were documented in sufficient detail: Decision at [78].

The Codeine Documentation Charges

33 The DT found that the applicable standards for the General Documentation Charges applied to the Codeine Documentation Charges. Just as in the case of the General Documentation Charges, the standard of documentation expected of a doctor when approving the sale of medicines was lower than when prescribing the medication following a review of the patient: Decision at [85]–[86].

34 Dr Ling pleaded guilty to the charges where he had reviewed the patients personally, and the DT agreed that he had breached the applicable standards in respect of those five charges, *ie*, the 2nd (Patient 1), 8th (Patient 3), 11th (Patient 4), 13th (Patient 5) and 18th (Patient 7) Charges in NOI(1): Decision at [87].

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35 As for the remaining charges under this category – *ie*, the 23rd to 27th (Patients 11–15) Charges of NOI(1) – the DT found that Dr Ling had breached the applicable standards for documentation. Generally, only the date, name and quantity of the medicines were recorded. In almost all instances, there was no documentation of the medical grounds for allowing the sale of the medications. The number of instances where there was a lack of such documentation was also fairly large. Therefore, the DT concluded that Dr Ling's departure from the applicable standards was intentional and deliberate, and Dr Ling's misconduct was sufficiently egregious to amount to professional misconduct: Decision at [88]–[89].

Benzodiazepine Prescription and Benzodiazepine Referral Charges

Applicable standards for the Benzodiazepine Prescription Charges

36 It was undisputed before the DT that the 2008 Administrative Guidelines, which were in effect from 14 October 2008, were applicable to the Benzodiazepine Prescription Charges: Decision at [92].

37 As for the applicable clinical practice guidelines, the parties agreed that guidelines published by MOH are treated as withdrawn five years after publication. However, the SMC submitted that the principles underlying the recommendations of the MOH Clinical Practice Guidelines on Prescribing of Benzodiazepines (September 2008) (the "2008 CPG") continued to apply despite being treated as withdrawn at the material time. In contrast, Dr Ling referred to the guidelines published by Royal Australian College of General Practitioners in 2015 (the "2015 RACGP Guidelines") – these guidelines provide that benzodiazepines may be used for longer than four weeks where it is clear that the benefits outweigh the risks, or where a detailed individual

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assessment has been made. The DT found that the principles behind the 2008 CPG were consistent with the 2015 RACGP Guidelines: Decision at [97]–[101].

38 With regard to the concomitant prescriptions of benzodiazepines with other benzodiazepines or sedating drugs, the DT found that the applicable standard was set out in the 2008 Administrative Guidelines at para (i), which states that doctors should avoid prescribing two or more benzodiazepines: Decision at [105].

39 In response to Dr Ling's submission that he had made some prescriptions of benzodiazepines for the treatment of vertigo, the DT found that benzodiazepines are not clinically indicated for vertigo. Dr Ling also failed to refer to any peer-reviewed medical literature or established guidelines to support the use of benzodiazepines for vertigo: Decision at [107].

40 As for the purported treatment of anxiety disorders, the DT found that Selective Serotonin Reuptake Inhibitors ("SSRIs") should be prescribed as the first-line treatment instead. In this regard, the MOH's specific guidelines on anxiety disorders, not recommendations found in foreign medical literature, set out the applicable standard: Decision at [109]–[110].

41 Furthermore, the DT found that the applicable standard of care requires doctors to see patients each time before making a prescription of benzodiazepines: Decision at [112]–[114].

Applicable standards for the Benzodiazepine Referral Charges

42 The DT agreed with the SMC that the relevant benchmark standard for when specialist referral is warranted is set out in para (n) of the 2008 Administrative Guidelines, which provides that the following categories of

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patients should not be further prescribed with benzodiazepines or other hypnotics and must be referred to the appropriate specialist for further management:

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

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

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

43 Moreover, the general guidelines set out at para 4.1.1.6 of the 2002 ECEG, which requires a doctor to practice within the limits of his own competence in managing a patient, were applicable: Decision at [117]–[118].

Departure from the applicable standards

44 The DT found that there had been a departure from the applicable standards vis-à-vis the Benzodiazepine Prescription Charges in respect of six charges involving six patients, and Benzodiazepine Referral Charges in respect of four charges involving four patients: Decision at [120].

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Codeine Prescription Charges

Applicable standards

45 The DT found that paras 4.1.1.1, 4.1.1.4, 4.1.1.6 and 4.1.3 of the 2002 ECEG were applicable at the time of the Codeine Prescription Charges: Decision at [123]–[124]. It was undisputed that the MOH Circular on the Sale and Supply of Cough Mixture containing Codeine (9 October 2000) (the "2000 Circular") formed part of the applicable benchmark standard: Decision at [125]. The MOH National Guidelines for the Safe Prescribing of Opioids (April 2021) (the "2021 Opioid Guidelines"), by contrast, did not form part of the relevant benchmark standard: Decision at [126]–[128].

46 The DT found that the SMC could rely on RS Irwin *et al*, "Classification of Cough as a Symptom in Adults and Management Algorithms" in the CHEST Guidelines and Expert Panel Report (January 2018) (the "CHEST Guidelines") and the British Thoracic Society Guidelines on Recommendations for the management of cough in adults (September 2006) (the "BTS Guidelines"). But the CHEST Guidelines and BTS Guidelines did not support the SMC's position that codeine could not be repeatedly prescribed for cough beyond three weeks and more if the cough lasted beyond eight weeks: Decision at [132]–[134]. As for the management of chronic cough, the DT disagreed with Dr Ling that specialist referral is not warranted if the cough is recurrent: Decision at [137].

47 In sum, the DT found that the applicable standards in relation to the management of chronic cough and the prescription of codeine were as follows (Decision at [142]):

(a) Investigations should be carried out and the underlying cause of the cough should be ascertained and treated. A doctor cannot simply

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prescribe codeine without any investigations as to the cause of the cough.

(b) If the cough persists, the doctor should refer the patient to a specialist.

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

48 As for the applicable standards for approving the sale of codeine-containing medicines, the DT found that it was undisputed that the 2016 SMC Handbook was applicable although it had not formally come into force then: Decision at [143]. Finally, the DT agreed with Dr Ling that there were no applicable guidelines at the material time setting out precise restrictions on the amount of codeine prescribed in solid form: Decision at [146].

Departure from the applicable standards

49 The DT found that there had been an intentional and deliberate departure from the applicable standards in respect of each Codeine Prescription Charge (see [15] above): Decision at [148].

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Conclusion on liability

50 Thus, the DT held that Dr Ling was guilty of 29 charges of professional misconduct under s 53(1)(*d*) of the MRA (Decision at [149]):

(a) 14 Documentation Charges;

(b) six Benzodiazepine Prescription Charges;

(c) four Benzodiazepine Referral Charges; and

(d) five Codeine Prescription Charges.

Sentence

51 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*") and the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* dated 15 July 2020 ("SMC Sentencing Guidelines"), which comprises four steps (Decision at [150]–[154]):

(a) Evaluate the seriousness of the offence, having regard to the harm and culpability.

(b) Identify the applicable indicative sentencing range based on the level of harm and culpability based on the following matrix:

Harm / **Culpability**	**Slight**	**Moderate**	**Severe**
Low	Fine or other punishment not amounting to suspension.	Suspension of three months to one year.	Suspension of one to two years.

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Medium	Suspension of three months to one year.	Suspension of one to two years.	Suspension of two to three years.
High	Suspension of one to two years.	Suspension of two to three years.	Suspension of three years or striking off.

(c) Identify the appropriate starting point within the indicative sentencing range having regard to the level of harm and culpability.

(d) Calibrate the starting point by taking into account offender-specific aggravating and mitigating factors.

52 These steps are applied first to determine the appropriate individual sentence for each charge and the overall sentence should then be calibrated by applying the one-transaction rule and the totality principle: Decision at [155].

Sentence for the Prescription and Referral Charges

53 The DT first considered the appropriate starting point sentences for the Benzodiazepine and Codeine Prescription Charges, and the Benzodiazepine Referral Charges.

54 On the first step, the DT found that the level of harm was in the upper range of slight: Decision at [191]–[202] and [209]. Furthermore, Dr Ling's culpability was at the upper range of medium: Decision at [211]–[223].

55 On the second step, the DT found that the applicable indicative sentencing range was a suspension of three months to one year: Decision at

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[224]. Accordingly, the starting point sentences were as follows (Decision at [226], [228]–[229] and [231]):

(a) suspension of nine months for each Codeine Prescription Charge.

(b) suspension of 11 months for the 4th (Patient 2), 15th (Patient 6) and 17th (Patient 7) Charges of NOI(1) under the Benzodiazepine Prescription Charges.

(c) suspension of 12 months for the 1st (Patient 1), 7th (Patient 3), and 12th (Patient 5) Charges of NOI(1) under the Benzodiazepine Prescription Charges; and

(d) suspension of four months for each Benzodiazepine Referral Charge.

56 Finally, the DT gave a one-third discount on the sentence for the significant delay in prosecution as the delay was not contributed to by Dr Ling and it caused him to suffer prejudice: Decision at [232]–[236] and [239]–[240].

Sentence for the Documentation Charges

57 Instead of applying the sentencing framework in *Wong Meng Hang*, the DT applied the sentencing approach from *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] 4 SLR 1375 ("*Mohd Syamsul*"). The DT imposed a notional suspension period of two months for each Documentation Charge: Decision at [241] and [243]–[247].

Aggregate Sentence

58 The DT imposed an aggregate sentence of 19 months' suspension. The following sentences were held to run consecutively (Decision at [248]):

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(a) Benzodiazepine Prescription Charge: 1st Charge of NOI(1) (Patient 1) – eight months' suspension;

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

(c) Codeine Prescription Charge: 2nd Charge of NOI(2) (Patient 12) – six months' suspension; and

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

The parties' cases on appeal

The SMC's case

59 On appeal, the SMC primary case was that the appropriate cumulative sentence should be 36 months' suspension. This was based on the following charges and sentences running consecutively:

(a) 28 months' suspension for one Benzodiazepine Prescription Charge;

(b) 24 months' suspension for one Benzodiazepine Referral Charge;

(c) 25 months' suspension for one Codeine Prescription Charge; and

(d) four months' suspension for one Documentation Charge.

60 These sentences would have added up to 81 months, which would be reduced to 36 months' suspension after applying the statutory limit provided for in s 53(2)(*b*) of the MRA.

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61 The SMC's primary case rested on three key contentions. First amongst them was the submission that the prolonged and inappropriate prescription of hypnotics created a real risk of dependency of addiction. This translated to a greater potential harm, especially for Dr Ling's elderly patients. The SMC also drew an analogy to *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 ("*Wee Teong Boo*"), to submit that Dr Ling's culpability should have been in the high category. Relatedly, it submitted that the DT incorrectly relied on *Singapore Medical Council v Dr Tan Joong Piang* [2019] SMCDT 9 ("*Tan Joong Piang*") and *Singapore Medical Council v Dr Chia Kiat Swan* [2019] SMCDT 1 ("*Chia Kiat Swan*").

62 Furthermore, the SMC submitted that although the suspension period for each Benzodiazepine Referral Charge should be lower than that for each Benzodiazepine Prescription Charge, the harm and culpability analysis would be largely similar; accordingly, a two-third discount, like what the DT had given (see [55] above), was not justified.

63 Lastly, the SMC submitted that there was no inordinate delay in the prosecution of this matter justifying a discount in the sentence. Even if there was such a delay, the conditions set out in *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("*Ang Peng Tiam*") at [109]–[110] were not made out. The conditions set out in *Ang Peng Tiam* which must be satisfied before a court would exercise its discretion to discount a sentence due to an inordinate delay in prosecution are as follows:

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

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

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

In any event, the SMC submitted that there were public interest considerations that militated against discounting the sentence.

64 The SMC's alternative case was that, if we upheld the DT's findings on harm and culpability, Dr Ling should be suspended for 30 months for two reasons. First, the appropriate starting point for the Benzodiazepine Referral Charges should be six months. Second, there should be no discount for the delay in the prosecution of this matter.

Dr Ling's case

65 Dr Ling challenged the SMC's contention that his prolonged prescriptions posed a substantial potential for serious personal injury; here, the duration of the prescriptions suggested that the harm should have been "slight". In this regard, Dr Ling submitted that SMC failed to discharge its burden to justify the finding of "moderate" harm. It was also reasonable for the DT to find that there was insufficient evidence as to the composition of the admixtures and their effect on the patients. Relatedly, it was inappropriate to compare the use of admixtures in this case to *Wee Teong Boo*, which involved a greater level of harm. Furthermore, there was no medical or legal basis for classifying Dr Ling's patients as "elderly".

66 On his culpability, Dr Ling submitted that the SMC failed to accord sufficient weight to his state of mind and motivations. This case was unlike *Wee Teong Boo* which involved egregious, intentional and deliberate wrongdoing, and Dr Ling's culpability was not greater than that of the errant doctors in *Tan*

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Joong Piang and *Chia Kiat Swan*. His departure from the applicable guidelines were also not too severe.

67 Dr Ling submitted that the Benzodiazepine Referral and Prescription Charges should be assessed separately, instead of applying the same harm and culpability analysis twice. Finally, Dr Ling submitted that the DT's imposition of a one-third discount on account of the SMC's inordinate delay should be upheld.

Issues to be determined

68 The appeal before us only concerned the appropriate sanction. In light of that, there were four issues that arose for our determination:

(a) what the appropriate sanction should be for each Benzodiazepine and Codeine Prescription Charge and Benzodiazepine Referral Charge;

(b) what the appropriate sanction should be for each Documentation Charge;

(c) whether the DT erroneously applied a one-third reduction to the sentences in view of prosecutorial delay; and

(d) what the aggregate term of suspension should be.

The appropriate sanction for each Benzodiazepine and Codeine Prescription Charge, and Benzodiazepine Referral Charge

69 In our view, SMC did not give satisfactory justification for the sentences it sought on appeal.

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70 The applicability of the four-step sentencing framework from *Wong Meng Hang* was not in dispute before us (see [51]–[52] above). The overarching sentencing objective and public interest considerations apply throughout the analysis. The public interest and the need for general deterrence will often be the central and operative considerations in the sentencing inquiry: *Wong Meng Hang* at [44].

71 We note that this sentencing framework is also reflected in the SMC Sentencing Guidelines at para 41. In particular, the SMC Sentencing Guidelines provide further guidance on a situation where a doctor is guilty of multiple offences. In such cases, the court should first determine the appropriate individual sentence for each charge using the *Wong Meng Hang* sentencing framework. Next, the court should determine the aggregate sentence with reference to the one-transaction rule and the totality principle, just as in criminal cases: SMC Sentencing Guidelines at paras 73–78.

72 With the relevant sentencing principles in mind, we discuss the starting point sentences for each set of charges.

Benzodiazepine Prescription Charges

73 We begin by considering the level of harm and culpability in respect of the Benzodiazepine Prescription Charges.

Harm

74 We considered the following cases to be instructive in assessing the level of harm in the present case:

(a) *Singapore Medical Council v Dr Tang Yen Ho Andrew* [2019] SMCDT 8 ("*Andrew Tang*"): the errant doctor faced 30 charges

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involving ten patients for, amongst other things, the inappropriate prescription of codeine-containing medications for periods of five weeks to 19 months (*Andrew Tang* at [22]). There was no actual harm. The tribunal found that the harm that the patients could potentially have suffered was slight (*Andrew Tang* at [38]).

(b) *Singapore Medical Council v Dr Tan Kok Jin* [2019] SMCDT 3 ("*Tan Kok Jin*"): the errant doctor pleaded guilty to, amongst other things, 11 charges for the inappropriate prescription of benzodiazepines to 11 patients for periods of time spanning 16 months to 33 months, and one charge for his failure to refer one patient to an appropriate specialist for the management of his medical issues(*Tan Kok Jin* at [2(a)], [2(c)] and [10]). The tribunal found that if there had been evidence of actual harm caused to the patients, it would have been persuaded to classify the level of harm as "moderate". However, in the absence of actual harm, the tribunal classified the harm as "slight" for each charge of inappropriate prescription and the failure to refer to an appropriate specialist (*Tan Kok Jin* at [43]).

(c) *Singapore Medical Council v Dr Eugene Ung* [2021] SMCDT 4 ("*Eugene Ung*"): the errant doctor faced, amongst other things, 13 charges for the inappropriate prescription of benzodiazepines and hypnotics for periods ranging from 19 months to 38 months (*Eugene Ung* at [5] and [16]–[38]). The Tribunal found that there was no actual harm but there was potential harm in the form of an increased likelihood for tolerance or psychological and physical dependence. As such, the level of harm was classified as "slight" (*Eugene Ung* at [52]).

(d) *Chia Kiat Swan*: the errant doctor inappropriately prescribed medications for periods ranging from 74 months to 140 months. The

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tribunal found that the harm fell in the "moderate" category (*Chia Kiat Swan* at [15]).

(e) *Tan Joong Piang*: the inappropriate prescriptions ranged for durations of 121 months to 170 months. The tribunal found that the harm was "moderate" although there was no actual harm (*Tan Joong Piang* at [42]).

75 We reproduce a summary of the duration of the prescriptions of benzodiazepines in respect of the charges that Dr Ling was liable for (Decision at [193]):

Patient	**Duration (as per Schedules to the Charges)**	**Prescription**
1st Charge (Patient 1), NOI(1)	2 years 10 months	Benzodiazepines (Alprazolam)
4th Charge (Patient 2), NOI(1)	1 year 3 months	Benzodiazepines (Diazepam, Lorazepam & Bromazepam)
7th Charge (Patient 3), NOI(1)	2 years 6 months	Benzodiazepines (Alprazolam)
12th Charge (Patient 5), NOI(1)	1 year 7 months	Benzodiazepines (Alprazolam)

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15th Charge (Patient 6), NOI(1)	2 months	Benzodiazepines (Lorazepam)
17th Charge (Patient 7), NOI(1)	1 year 9 months	Benzodiazepines (Lorazepam)

76 As the table above shows, of the six charges (involving six patients) that the DT found were made out, the prescriptions ranged from two to 34 months. One patient was prescribed benzodiazepines for two months, three other patients under two years and two other patients under three years. In addition, the number of charges and patients who were prescribed benzodiazepines were generally fewer than the precedents set out in [74(a)]–[74(c)] above. Importantly, SMC was not able to show that there was actual harm to any of the patients due to the prescriptions. In relation to actual harm, the SMC submitted that the DT had incorrectly accepted Dr Ling's submission of an absence of harm based on medical reports for a single patient. But the burden of proving actual harm was on the SMC, which it failed to discharge. Considering the circumstances, we upheld the DT's finding that the harm was in the upper range of the "slight" category (see [54] above). We explain the reasons for our conclusion in greater detail.

(1) The SMC failed to show that any therapeutic dependence caused harm

77 The SMC emphasised that the patients' therapeutic dependence, and not addiction, created a potential for more serious harm in the future. In the course of the hearing on 4 July 2024, we questioned the SMC on when exactly prolonged prescriptions should lead to a finding of moderate harm. The SMC's

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submission on this was that this question requires a fact-specific inquiry dependent on the period of use, the frequency at which the medication was given and whether there was any clinical basis to give those medicines. While we agreed that the court does necessarily have to consider the circumstances, the SMC's evidence to support its contention was sparse.

78 The SMC relied primarily on the findings in the report of one Dr Gomathinayagam Kandasami ("Dr Kandasami") who reviewed one of Dr Ling's patients. We observed that the patient (Patient 14) on whom Dr Kandasami reported was assessed on her consumption of codeine for cough related symptoms and not for benzodiazepines. In short, Dr Kandasami's opinion would have had no evidential value in respect of the Benzodiazepine Prescription Charges. Assuming the same opinion could equally apply to prescriptions of benzodiazepines for the same patient (and SMC had not explained how this is possible), the opinion would not assist SMC. Dr Kandasami reported that the patient had no features of "Opioid [Codeine] Use Disorder or addiction". Furthermore, Dr Kandasami caveated in that very report that he "would not be able to comment on whether prescribing codeine for her cough related symptoms was appropriate or whether she continues to require codeine prescriptions". Whilst the report opined that it is possible for a patient to have therapeutic dependence on a medication, that did not suggest that codeine was not appropriately prescribed to that patient. In our view, this report undercut the SMC's submission. Dr Kandasami's opinion that the patient in question was likely to have developed therapeutic dependence did not immediately mean that there was significantly greater harm or potential harm caused. Instead, it could have very well been a situation of the patient rightfully requiring the codeine prescriptions – a matter on which Dr Kandasami did not comment. Thus, Dr Kandasami's report did not bring the SMC's case far.

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79 We also briefly address some of the factors relevant to the inquiry as to the harm caused by prolonged prescriptions, as suggested by the SMC – the frequency of use and the number of prescriptions given. The facts did not reveal a high frequency or number of prescriptions such that there would have been an increased potential of harm. There was no pattern of prescriptions or a correlation between the time gap between successive visits and the number of prescribed tablets. The duration of the prescriptions was shorter than that in *Tan Joong Piang* (*ie*, more than ten years) and *Chia Kiat Swan* (*ie*, six years and two months to 11 years and eight months). The number of prescriptions in this case was also significantly shorter than that in *Tan Joong Piang* (*ie*, 731), *Tan Kok Jin* (*ie*, 469) and *Wee Teong Boo* (*ie*, at least 310). This, in our view, suggested that Dr Ling had not been feeding patients' dependence or addictions; Dr Ling had prescribed medications to these patients with medical complaints rather than for the ulterior purpose of fuelling their addictions. Thus, we could not accept the SMC's case on this point.

(2) There was increased potential harm for elderly patients

80 The definition of an "elderly" person can be gleaned from the 2008 CPG at para 6.1 which states that an elderly person is one aged 65 years or more. That same paragraph also states that the elderly are more susceptible to the effect of benzodiazepines; prolonged use is associated with cognitive impairment and prolonged use of more than one month has been shown to be associated with an increased risk of fractures from falls due to associated cognitive impairment.

81 The patients' ages as of the date of their first visit and as of 1 November 2016 (*ie*, the date of MOH's audit at the Clinic) were as follows:

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Patient	**Date of first visit**	**Age (as at first visit)**	**Age (as at 1 November 2016)**
Patient 1	13 April 2006	67	**77**
Patient 2	12 September 2002	58	**72**
Patient 3	23 April 1990	55	**81**
Patient 5	16 May 1990	33	59
Patient 6	11 December 2012	57	61
Patient 7	22 September 2011	52	57

82 In relation to the Benzodiazepine Prescription Charges, three out of six patients were over the age of 65 by the time the prescriptions started. This means, with reference to the 2008 CPG, that these three patients who were prescribed benzodiazepine would potentially be exposed to an increased risk of harm as described in [80] above. However, we have to view this caution in the 2008 CPG with the DT's Decision at [101]–[102]:

> 101 … This suggests that even in the 2008 CPG, long-term use of benzodiazepines may be allowed in limited instances. In fact, Dr Eng himself acknowledged that there is no absolute restriction on the long-term therapeutic use of benzodiazepines, and that most guidelines, including the 2008 CPG, allow for some clinical leeway for such a practice.

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

(3) There was no evidence of potential harm due to the use of concomitant prescriptions

83 The SMC alleged that Dr Ling had concomitantly prescribed benzodiazepines together with another benzodiazepine, opioids and/or other sedating drug(s) in respect of the six patients. This included the occasions where two or more benzodiazepines were prescribed concurrently, and where one or more benzodiazepines were prescribed alongside other opioids and/or other sedating drugs. Dr Ling argued that the mere fact of concomitant prescriptions did not, without more, mean that the harm must be assessed to be in the "moderate" category.

84 The SMC's expert, Dr Eng, stated that the concomitant use of benzodiazepines with another sedating drug and/or the concomitant use of more than one benzodiazepine at a time is not appropriate. Furthermore, Dr Eng made mention of the 2008 Administrative Guidelines, which provides, at paras (i) and (l), as follows:

> (i) The concurrent prescribing of two or more benzodiazepines should be avoided".
>
> …
>
> (l) Care should be taken when prescribing benzodiazepines/ other hypnotics to avoid excessive sedation (which may pose a risk to the patient who drives, operates heavy machinery, etc).

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85 At the outset, it bears noting that the MOH guidelines do not have the same force as legislation. While MOH guidelines set out a presumptive standard of care, departures may be permissible in individual cases if they are justified or supported by good reasons. The evidential burden falls on the medical practitioner to demonstrate that the deviation from the codified standards was justified or supported by good reasons: *Ang Yong Guan v Singapore Medical Council and another matter* [2024] SGHC 126 ("*Ang Yong Guan*") at [59]–[60]. A medical practitioner can justify his departures from the applicable standards of care if (*Ang Yong Guan* at [84]):

(a) he has considered the rationale behind that standard and concluded after a risk-benefit analysis of a prospective departure from it that it is justified;

(b) the medical practitioner's conduct is objectively defensible in the circumstances, as determined with reference to the prevailing test for medical negligence; and

(c) at least in certain circumstances, the medical practitioner has first discussed a prospective departure with the patient including any safety measures, and the patient must have consented to such a departure.

86 We noted that there was a lack of assessment in the sense explained in *Ang Yong Guan* at [84] behind Dr Ling's concomitant prescriptions (*ie*, the concurrent prescriptions of two or more benzodiazepines, or the concurrent prescriptions of one or more benzodiazepines with opioids and/or other sedating drugs). During the proceedings, Dr Ling's testimony hinged primarily on his ability to exercise his clinical judgment in respect of his patients. But he failed to show that he had directed his mind to the rationale behind the relevant

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standards that he was departing from when prescribing benzodiazepines with another sedating drug, *ie*, to avoid an increased risk of toxicity, respiratory depression, falls, fractures, coma, and death. Furthermore, Dr Ling did not show that his decision to prescribe these medications was within the acceptable limits set out in the test for medical negligence accepted locally in *Khoo James and another v Gunapathy d/o Muniandy and another appeal* [2002] 1 SLR(R) 1024: *Ang Yong Guan* at [75]. Finally, there was no evidence that Dr Ling had informed his patients about his departure from the applicable guidelines when prescribing such medication: *Ang Yong Guan* at [78]–[80].

87 Notwithstanding Dr Ling's inability to justify the use of the concomitant prescriptions, we could not agree with the SMC that the mere fact of the concomitant prescriptions was by itself sufficient to warrant the finding of a much higher level of harm as advocated by the SMC. The SMC still bore the burden of showing that the use of the specific prescriptions here caused either an increased potential harm or actual harm. However, the SMC failed to show either.

(4) Conclusion on the level of harm

88 Considering the circumstances in the round, we accepted the DT's finding that the harm fell in the upper end of the "slight" category (see [51(b)] above).

89 We add, for completeness, that even if we had accepted the SMC's submission that the level of harm was "moderate", it would not have significantly affected the aggregate sanction. We would have sentenced Dr Ling to a suspension of between 13 months and 14 months for each Benzodiazepine Prescription Charge, which would have been reduced to about nine months' suspension following a one-third discount to the sentence (see [137] below).

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The aggregate duration of suspension would have only increased to 20 months, which would not have been sufficient to warrant appellate intervention on any of the four grounds set out in *ADF v Public Prosecutor* [2010] 1 SLR 874 at [17] (see [136]–[138] below). We turn to consider Dr Ling's culpability in respect of the Benzodiazepine Prescription Charges.

Culpability

90 The SMC submitted that Dr Ling's culpability was high. Dr Ling contended that his culpability fell in the upper range of medium. We agreed with the DT's finding which is that Dr Ling's culpability fell within the medium category.

91 The SMC Sentencing Guidelines set out the following non-exhaustive factors that a court may consider when assessing an errant doctor's culpability:

(a) the doctor's state of mind;

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

(c) whether the doctor was motivated by financial gain, and the extents of profits gained by that doctor from his or her breach;

(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;

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(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, having regard to the circumstances underlying the continuance of the offending conduct; and

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

92 We begin by dealing with the SMC's reliance on *Wee Teong Boo*. We do not accept that case as a good comparison. In *Wee Teong Boo*, the court found that Dr Wee had no clinical basis for his prescriptions and that he must have been cognisant of the fact that his prescriptions were perpetuating his patients' drug dependency issues. This was deemed to be a flagrant abuse of Dr Wee's privileges as a medical practitioner and a gross dereliction of his duties as a doctor: *Wee Teong Boo* at [39] and [61]. The doctor's conduct in *Wee Teong Boo* was especially egregious given his knowledge of some of his patients' drug dependency issues and his underlying motivations for prescribing the medications – to fuel their addictions: *Wee Teong Boo* at [43]. It was dissimilar to the present case.

93 It was undisputed that Dr Ling did not make the inappropriate prescriptions for improper financial gain: Decision at [220]. Instead, Dr Ling appeared to us to hold strong patient-centric views. In particular, Dr Ling's testimony before the DT was that doctors could have different opinions on how to treat patients; a doctor should have the discretion to decide on the appropriate treatment for his patient so long as the patient benefits and there is no harm caused. In Dr Ling's view, the patient's interest is paramount.

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94 We empathise with Dr Ling's sentiment of wanting to help patients. Many of them were his patients for a very long time (between one and more than two decades). The others were under his care for between four and six years. Notwithstanding Dr Ling's misunderstanding of the extent to which he could exercise his clinical judgment, in his view, he was acting in what he considered to be in his patients' best interests. But his beliefs, as noble as they might be, did not justify his departure from the applicable standards in the manner and to the extent to which he did.

95 Furthermore, we considered that Dr Ling's culpability was lower than the errant doctor's culpability in *Tan Joong Piang*. The key distinguishing factor in this case was that Dr Ling's prescriptions lasted for a significantly shorter duration than the errant doctor's in *Tan Joong Piang*. Therefore, we agreed with and upheld the DT's finding that fixed his culpability to be in the medium category.

Starting point sentence for each Benzodiazepine Prescription Charge

96 Given that the Benzodiazepine Prescription Charges fell within the upper end of slight harm, and the medium culpability categories, the indicative sentencing range was a suspension of three months to one year per charge ([51(b)], [88] and [95] above). We concluded that the starting point sentence for each Benzodiazepine Prescription Charge should be 11 to 12 months' suspension.

97 There was a variance of one month to account for more serious charges of inappropriate prescriptions where the number and duration of prescriptions were significantly greater. As such, the starting point sentence was 11 months' suspension for the following Benzodiazepine Prescription Charges:

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(a) 4th Charge (Patient 2) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on five occasions. The first two occasions were over a period of seven months and three days, and the last three occasions spanned seven months and 19 days.

(b) 15th Charge (Patient 6) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on three occasions over a period of one month and 23 days.

(c) 17th Charge (Patient 7) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on four occasions over a period of one year and nine months.

98 On the other hand, the starting point sentence was 12 months' suspension for the following Benzodiazepine Prescription Charges:

(a) 1st Charge (Patient 1) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on 23 occasions over a period of two years and 10 months. Out of the 23 occasions, Dr Ling failed to review the patient before prescribing them the medications on 15 occasions.

(b) 7th Charge (Patient 3) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on 17 occasions over a period of two years and six months. Out of these 17 occasions, Dr Ling failed to review the patient before prescribing them the medication on seven occasions.

(c) 12th Charge (Patient 5) of NOI(1): Dr Ling prescribed benzodiazepines to the patient on 21 occasions over a period of one year and seven months. Of these 21 occasions, Dr Ling did not review the patient on 17 occasions.

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99 We now turn to consider the starting point sentences for the Benzodiazepine Referral Charges.

Benzodiazepine Referral Charges

100 At the outset, we emphasise that the applicable sentencing framework should be applied individually to each set of charges. Dr Ling's counsel, Ms Loh Jen Wei ("Ms Loh") submitted, correctly in our view, that the SMC could not simply allow the assessment of one set of charges to "piggy-back" on another set of charges. In other words, just because the Benzodiazepine Prescription Charges and the Benzodiazepine Referral Charges stem from a similar set of facts, it does not follow that the harm-culpability analysis would be similar. This would be unprincipled not least because it penalises an errant doctor twice for the same "wrong".

101 We accept, however, that in many cases there would be similar facts that would present themselves when assessing the two types of charges, as was the case with the Benzodiazepine Prescription and Referral Charges. One example of such a common fact would be the failure to review patients in a timely manner, which then leads to the prolonged prescriptions and the failure to refer. However, the need to separate the analyses for the two sets of charges should remain at the front of the court's mind.

102 Here, it did not follow that the inappropriate prescriptions of benzodiazepines to the elderly patients meant that the failure to refer those patients caused a similar extent of harm. We further disagreed with the SMC's suggestion that the harm caused by the failure to refer patients could be evidenced by the National Electronic Healthcare Records (the "NEHR") records of the patients who were concurrently visiting a polyclinic to get assessed for other matters. The core of the matter is that the SMC's submission did not

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address the nub of our query – if there was indeed harm suffered by the failure to refer, why did none of the patients step forward to complain or reflect signs of addiction? The absence of an answer to this question weighed against the SMC's suggestion that the mere failure to refer was *ipso facto* sufficient to warrant a sentence similar to that imposed for the Benzodiazepine Prescription Charges.

103 In the round, we concluded that a duration of suspension of four months per Benzodiazepine Referral Charge was appropriate, and we upheld the DT's finding that the starting point sentence should be four months' suspension: Decision at [231].

104 We make two observations in relation to the Benzodiazepine Referral Charges. First, *Tan Kok Jin* did not lay down a rule that a 50% discount must be applied to the sentences for a charge relating to the failure to refer vis-à-vis a corresponding charge for an inappropriate prescription. In *Tan Kok Jin*, the tribunal had merely accepted the SMC's submission that the gravity of the inappropriate prescription of benzodiazepines *may* be considered more aggravated than the failure to refer to an appropriate specialist. In that case, the outcome was that the sentence for each charge of inappropriate prescription was a six months' suspension and the sentence for each charge of failure to refer to a specialist was a three months' suspension: *Tan Kok Jin* at [45]–[46].

105 Second, there is also no bright line rule on how the two types of charges – referral and prescription charges – should generally be treated in relation to one another.

106 Here, we found that the harm was slight and the culpability was medium. The harm was slight for the reasons given above. There was scant evidence of

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potential or actual harm which was not already accounted for in respect of the Benzodiazepine Prescription Charges. On the other hand, culpability was in the medium category because of some common features in the Benzodiazepine Referral Charges – Dr Ling failed to review his patients in a timely manner. This contributed to both the prolonged prescriptions and his failure to refer. The prescriptions given over the counter without a physical review exacerbated this problem. This went towards Dr Ling's medium culpability. The indicative sentencing range would have thus been suspension for a period of three months to one year (see [51(b)] above). We agreed with the DT that the sentence of four months' suspension for each Benzodiazepine Referral Charge was an appropriate starting point sentence.

Codeine Prescription Charges

107 We agreed with the DT that the initial starting point sentence for each Codeine Prescription Charge should be nine months' suspension: Decision at [226]. We found that the harm was slight, and the culpability was moderate in respect of each charge. In reaching this conclusion, we noted that the parties did not dispute that the Codeine Prescription Charges warranted a shorter sentence than the Benzodiazepine Prescription Charges.

108 Importantly, there were two key points of distinction. First, the level of harm would have been lower than in the case of the Benzodiazepine Prescription Charges because there was little evidence as to the potential or actual harm that could be caused by the prolonged prescriptions of codeine-containing medications. We applied our analysis at [78] above in rejecting the submission based on Dr Kandasami's report. Admittedly, Dr Eng did refer to international guidelines that provided that codeine-containing medications would not be effective in treating coughs that last beyond three weeks, and would be even

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less effective for coughs that last beyond eight weeks. However, as the DT found, there was no standard that codeine could not be repeatedly prescribed for cough beyond three weeks and more so if the cough lasted beyond eight weeks. As such, there was little, if anything, that clearly indicated that the prolonged prescriptions of codeine-containing medications would have likely caused harm to Dr Ling's patients.

109 Furthermore, we agreed with the DT's finding that there was insufficient evidence to show that elderly patients (there were three patients who were over 65 years of age at the time the prescription ended) would face an additional risk of harm from codeine-containing medications: Decision at [204]. We also agreed with the DT that there was insufficient evidence as to the effect of the admixtures of codeine, and antihistamines and steroids used by Dr Ling: Decision at [198]. As such, we found that the harm was in the slight category but lower than that for the Benzodiazepine Prescription Charges.

110 As for Dr Ling's culpability in respect of this set of charges, we found it to lie in the medium category for the same reasons expressed above at [90]–[95]. This meant that the indicative sentencing range was a term of suspension of three months to one year (see [51(b)] above).

111 We conclude our analysis on this point by highlighting that the SMC's reliance on *Wee Teong Boo* was inappropriate. *Wee Teong Boo* was a particularly egregious case where the errant doctor was aware of his patients' drug dependency issues. It was also plain to the court that Dr Wee's prescriptions were for the sole purpose of fuelling their addictions: *Wee Teong Boo* at [42]–[43] and [69]. The court's finding as to the level of harm in *Wee Teong Boo* stemmed, at least partially, from the patients' pre-existing dependency issues. In contrast, the SMC did not adduce evidence reflecting

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such pre-existing dependency issues in any of the patients here. The level of harm here could not be compared to that in *Wee Teong Boo*.

112 In view of the lower degree of harm, we held that the starting point sentence ought to be a term of suspension of nine months for each Codeine Prescription Charge.

The appropriate sanction for each Documentation Charge

113 Preliminarily, we note that the *Wong Meng Hang* sentencing framework should rightly apply to the Documentation Charges too. The SMC Sentencing Guidelines have also envisioned the applicability of the *Wong Meng Hang* framework to offences involving documents: see SMC Sentencing Guidelines at paras 15, 44 and 51(j)(ii). Nevertheless, the DT adopted the approach in *Mohd Syamsul* ([57] *supra*). Its reason for so doing was that the precedent cases have not applied the *Wong Meng Hang* framework: Decision at [241]. On appeal, neither party contended that the *Wong Meng Hang* framework should apply. As such, we proceeded on this issue with reference to the *Mohd Syamsul* decision.

114 In *Mohd Syamsul*, the court held that the failure to keep adequate records is not a minor or technical breach. The court imposed a sentence of three months' suspension for one charge of failing to keep adequate medical records: *Mohd Syamsul* at [12], citing *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [10].

115 The same reasoning was applicable here. Dr Ling's inadequate documentation was especially problematic because he worked alongside two other doctors in the Clinic. The patients he would see could also see the other two doctors in the Clinic. Although Dr Ling testified that neither Dr Tay nor Dr Goh had problems understanding his notes, the risk that the continuity of care

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could have been compromised due to the poor documentation remained. Accordingly, the duration of suspension should be three months for each Documentation Charge.

116 We pause at this juncture to mention that we agreed with the DT that there should not be an uplift of one month for each Documentation Charge on the basis that Dr Ling's decision to contest the charges reflected a lack of remorse. The act of contesting charges is not *ipso facto* ground for finding a lack of remorse which could aggravate the sentence. Dr Ling's case was not extravagant or unnecessary such that an uplift was warranted: see *Ching Hwa Ming (Qin Huaming) v Public Prosecutor and another appeal* [2024] 3 SLR 1547 at [72], citing *Public Prosecutor v Ridhaudin Ridhwan bin Bakri and others* [2020] 4 SLR 790 at [56]. Although the cases cited pertained to criminal sentencing, the principles therein should be applicable to quasi-criminal proceedings such as this disciplinary proceeding: see, for example, *Ang Peng Tiam* at [110].

117 As such, we concluded that the starting point sentence for each Documentation Charge should be a term of suspension of three months.

The application of a one-third discount for the delay in prosecution

118 We accepted the DT's decision to apply a one-third discount to the starting point sentences given the delays involved in the prosecution of this matter before the DT which were on the evidence found to be inordinate.

Whether a discount should be applied

119 A court may extend leniency to an offender and exercise its discretion to discount the sentence if there is a significant delay in investigation and/or

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prosecution. The following cumulative conditions must be satisfied before a court may decide to apply a discount (*Ang Peng Tiam* at [109], and *Wong Poon Kay v Public Prosecutor* [2024] 4 SLR 453 ("*Wong Poon Kay*") at [66]):

(a) there has been a significant delay in the investigation and/or prosecution of the matter;

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

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

120 We agreed with the SMC's submission that the delay has to be *inordinate*. For a delay to be inordinate, it must be unusually long and inexplicable on reasonable grounds: *Wong Poon Kay* at [68]. For the sake of clarity, we note that the reference in [119] above to a "significant" delay must necessarily also be a reference to an "inordinate" delay – the two terms do not impose two different standards. This much is clear from the test set out above at [119]. The DT, and in our view correctly, also utilised these two terms interchangeably as opposed to setting out different tests for them: see Decision at [233]–[234]. Furthermore, as suggested in *Wong Poon Kay,* the defendant ordinarily bears the burden of proving that there was an inordinate delay in the prosecution and that the delay resulted in real injustice or prejudice to the defendant. Nevertheless, it would promote the expeditious conduct of proceedings if the Prosecution (here, the SMC) provides information about matters that occurred some time ago in the past to the defendant and to the court or tribunal at an earlier stage of proceedings: *Wong Poon Kay* at [77] and *Ang Peng Tiam* at [117].

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121 The underlying rationale for discounting the sentence in such cases is fairness to the offender. Where there is an inordinate delay in prosecution, the sentence should reflect the fact that the matter has been pending for some time, likely inflicting undue suffering that stems from the prolonged agony, suspense and uncertainty: *Wong Poon Kay* at [66].

122 As for the computation of the length of the delay, this is fact-specific. Therefore, it would be impracticable to refer only to the delay between the issuance of the notice of complaint and the notice of inquiry, contrary to what the SMC had submitted. Indeed, it would be difficult to justify any strict rule on which delays the court must consider. Instead, the inquiry necessarily has to be a holistic one, taking into account the context of the proceedings and complexity of the case: see *Wong Poon Kay* at [68].

123 We emphasise that the application of a sentencing discount is not meant to be a purely arithmetic endeavour. It would be artificial to rely on merely the absolute length of the delay to find the corresponding discount that should be applied. Instead, a tribunal or a court should, for instance, consider, amongst other things, the reasons for the delay, whether the reasons proffered were defensible, and the effect that the delay would have had on the offender. As foreshadowed, this has to be a fact sensitive inquiry. As such, the DT did not compare merely the length of the delay in this case against precedents to determine the appropriate discount. Instead, the DT also considered the SMC's proffered reasons for the delay, and the effect of the delay on Dr Ling: Decision at [233]–[236].

124 We add that the reference to "investigations" in *Ang Peng Tiam* does not, in our minds, refer strictly to delays up to the point in time before the start of DT proceedings. A court may, in an appropriate case, even consider the

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delays during DT proceedings that were occasioned by the SMC's far from seamless approach to prosecuting the matter. This was one such case. The SMC introduced 69 amendments to NOI(1) and NOI(2) during the second tranche of proceedings. The introduction of these amendments late in the day was a matter that we could reasonably consider because they were relevant to the SMC's investigations and/or prosecution of the matter. Dr Ling had to take time and consider the additional entries and file a third affidavit in response to these amendments (see [19]–[21] above). In the circumstances, we had to inquire into the reasons for these amendments sought, and the effect that they had on the proceedings and Dr Ling. Paying attention to such delay coming well after the issuance of NOI(1) and NOI(2) would give effect to the underlying rationale of fairness that underpins the court's discretion to apply a discount to an offender's sentence.

125 We set out the timeline of events to better illustrate the delays caused by the SMC in this case.

126 Dr Ling was first notified of the complaint on 14 November 2017. The First CC requested for a written explanation on 12 March 2018. The First CC concerned 16 patients initially. Dr Ling submitted his First Letter of Explanation on 23 April 2018. The next time he heard from the First CC was on 19 February 2019 – about 10 months after the First Letter of Explanation – informing him of a formal inquiry.

127 It was also on that date that the First CC wrote to the President of the SMC to inform him about Dr Ling's prescriptions of codeine-containing medications to five patients. The SMC sent the Second Notice of Complaint on 12 December 2019. Dr Ling sent the Second Explanation on 3 February 2020. The SMC requested Dr Eng for a second expert report in relation to Dr Ling's

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prescriptions of codeine-containing medications on 28 September 2020. Dr Eng's second expert report was prepared by 19 March 2021. On 13 April 2021 – 14 months after the Second Explanation – the SMC issued NOI(1) and NOI(2), which contained a total 32 charges in respect of 15 patients.

128 In the middle of the second tranche of proceedings, on 6 September 2022, WongPartnership wrote to the DT to inform the DT that there were 69 missing entries from the schedules to the NOI(1) and NOI(2). These entries were PMRs within the charge periods that were left out previously, and they were based on the updated transcripts that Dr Ling provided the SMC on 24 March 2022. The SMC raised this matter during the hearing on 7 September 2022 and sought the DT's permission to replace the schedules with the corrected ones that included these additional entries. The DT allowed the amendments. This delayed the proceedings further as a third tranche of proceedings, which took place on 14 and 16 November 2022, was required for Dr Ling to confirm his position on the amended charges.

129 The SMC's submission before the DT and on appeal was that the First CC had no power to investigate into the codeine prescription offences and had to limit its investigations to the benzodiazepine prescription offences. This explanation was unsatisfactory and rejected by the DT as it did not address the DT's concern. We agreed with the DT's finding that there was no explanation offered as to why all the prescription charges could not have been investigated at one time rather than the piecemeal approach taken by SMC: Decision at [233].

130 There were other lengthy delays that remained unexplained in respect of both sets of proceedings. There was a gap of around 14 months between the Second Explanation and the issuance of NOI(2). There was a further delay of about two months arising from the SMC's failure to timeously incorporate the

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69 amendments it introduced in the second tranche of the proceedings. We consider the delay that occurred during the DT hearing because the SMC failed to act in a timely manner when seeking to amend the charges. The basis of these proposed amendments were transcripts that Dr Ling had provided the SMC on 24 March 2022, just over five months before the SMC sought the amendments. This gap was also left unaccounted for. As such, even accounting for the need to appoint the Second CC to investigate the prescriptions of codeine-containing medications, there was an inordinate delay in the prosecution of the matter.

131 Notably, the delays that we have highlighted were in no way caused by Dr Ling. Indeed, the SMC did not make a submission to this effect. We agreed with the DT that the significant delays here would have prejudiced Dr Ling by causing him great anxiety and distress. It followed that a discount ought to be applied to the starting point sentences. The only question that remained was what the discount should be.

The appropriate discount that should be applied to the starting point sentences

132 We begin by noting the approach adopted by the courts in *Ang Peng Tiam* and *Chia Kiat Swan*. In *Ang Peng Tiam*, the court found that there were insufficient reasons to explain the delays caused at three junctures in particular: (a) the complaints committee took almost one and a half years to conduct investigations, obtain an expert report and deliberate; (b) the SMC then took another three years to obtain two further expert reports, liaise with the witnesses, prepare the notice of inquiry and constitute the DT; and (c) after one member of the first disciplinary tribunal recused herself and the chairman resigned on account of ill health, it took about a year for the SMC to revoke the appointment of the first disciplinary tribunal and an additional month for a disciplinary

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tribunal to be constituted: *Ang Peng Tiam* at [121]. The court halved the errant doctor's sentence from 16 months' suspension to eight months' suspension.

133 In *Chia Kiat Swat*, the tribunal agreed with the parties that a delay of about two years and eight months from the time the notice of complaint was issued to the service of the notice inquiry was inordinate. The tribunal applied a one-third discount to the sentence: *Chia Kiat Swan* at [19].

134 Taking the circumstances in the round, the following delays in this case were noted:

(a) There was a gap of about 10 months between Dr Ling's First Letter of Explanation dated 23 April 2018 and the First CC informing him of a formal inquiry on 19 February 2019.

(b) There was a gap of about 14 months between the Second Explanation on 3 February 2020 and the issuance of NOI(1) and NOI(2) on 13 April 2021. In full fairness, we acknowledged that this period coincided with the COVID-19 pandemic. On account of the delays caused by the pandemic, including the circuit breaker measures which kicked in from 7 April 2020 to 1 June 2020, we were prepared to treat those four months as neutral and they did not count towards our assessment of the overall delay. We were mindful that the complaints in this case pertained to a relatively small number of patients and the investigations were not all that complex. As such, we considered the delay of about ten months to be inexplicable.

(c) There was also a gap of six months between the SMC's request on 28 September 2020 and Dr Eng's preparation of his second expert report by 19 March 2021.

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(d) The proceedings were delayed by about an additional two months due to the 69 amendments that the SMC sought to introduce during the second tranche of proceedings.

135 We were satisfied that the cumulative delays were inordinate, that Dr Ling had not contributed to the delays, and that Dr Ling had been prejudiced by these delays. Thus, considering the circumstances, we agreed with the DT's decision to apply a one-third discount to the sentence.

The aggregate term of suspension

136 In view of the analyses above, the starting point sentences for each set of charges should be as follows:

(a) Benzodiazepine Prescription Charges ([97]–[98] above):

(i) 11 months' suspension for the 4th (Patient 2), 15th (Patient 6), and 17th (Patient 7) Charges of NOI(1).

(ii) 12 months' suspension for the 1st (Patient 1), 7th (Patient 3), and 12th (Patient 5) Charges of NOI(1).

(b) Codeine Prescription Charges: nine months' suspension ([112] above).

(c) Benzodiazepine Referral Charges: four months' suspension ([106] above).

(d) Documentation Charges: three months' suspension ([117] above).

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137 Applying a one-third discount on account of the delay in the prosecution of this matter ([135] above), we found that the final notional sentences for each set of charges should be as follows:

(a) Benzodiazepine Prescription Charges ([97]–[98] above):

(i) seven months' suspension for the 4th (Patient 2), 15th (Patient 6), and 17th (Patient 7) Charges of NOI(1).

(ii) eight months' suspension for the 1st (Patient 1), 7th (Patient 3), and 12th (Patient 5) Charges of NOI(1).

(b) Codeine Prescription Charges: six months' suspension ([112] above)

(c) Benzodiazepine Referral Charges: three months' suspension (rounded up).

(d) Documentation Charges: two months' suspension.

138 As mentioned above at [71], the court should assess the aggregate sentence with reference to the one-transaction rule and the totality principle. We found it appropriate to have the sentence for one charge per group of charges to run consecutively. Therefore, the aggregate sentence was 19 months' suspension with the following sentences running consecutively:

(a) Benzodiazepine Prescription Charge: 1st Charge (Patient 1) of NOI(1) – eight months' suspension

(b) Codeine Prescription Charge: 2nd Charge (Patient 1) of NOI(2) – six months' suspension

(c) Benzodiazepine Referral Charge: 3rd Charge (Patient 1) of NOI(1) – three months' suspension

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

Conclusion

139 For those reasons, we dismissed the appeal. There was no merit in SMC's primary case nor its alternative case. The orders made by the DT continued to stand. We also ordered the SMC to pay Dr Ling costs fixed at $50,000 (all-in). The usual consequential orders applied.

Tay Yong Kwang
Justice of the Court of Appeal

Belinda Ang Saw Ean
Justice of the Court of Appeal

Judith Prakash
Senior Judge

Chang Man Phing Jenny, Dorcas Ong Gee Ping (Wang Yubin) and Goh Sher Hwyn Rebecca (WongPartnership LLP) for the applicant;
and
Loh Jen Wei and Yeng Jun Kai (Dentons Rodyk & Davidson LLP) for the respondent.

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