IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2017] SGHC 294

Originating Summons No 3 of 2017

In the matter of section 55(1) of the Medical Registration Act (Cap 174)

And

In the matter of the Inquiry by the Disciplinary Tribunal of the Singapore Medical Council for Dr Jen Shek Wei, a registered Medical Practitioner

Between

JEN SHEK WEI

… *Applicant*

And

SINGAPORE MEDICAL COUNCIL

… *Respondent*

JUDGMENT

[Professions] — [Medical profession and practice] — [Professional conduct]

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v
Singapore Medical Council

[2017] SGHC 294

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Andrew Phang Boon Leong JA, Judith Prakash JA and Steven Chong JA
25 July 2017

13 November 2017 Judgment reserved.

Andrew Phang Boon Leong JA (delivering the judgment of the court):

Introduction

1 The appellant in this originating summons, Dr Jen Shek Wei ("Dr Jen"), a gynaecologist, was convicted by a Disciplinary Tribunal ("DT") constituted by the Singapore Medical Council ("SMC") of two charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("the Act").

2 The first charge (set out in full below at [39]) stated that Dr Jen had, sometime between 30 and 31 August 2010, advised a patient ("the Patient") to undergo surgery to remove a pelvic mass, discovered during a Magnetic Resonance Imaging ("MRI") scan on 27 August 2010, without conducting further evaluation and investigation of her condition, when such further

assessment was warranted. This failure to carry out such further evaluation was serious negligence which objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. This, as held by this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37], is one of two limbs under which professional misconduct under s 53(1)(*d*) of the Act could be made out.

3 The second charge (set out in full below at [90]) stated that Dr Jen had, on 31 August 2010, performed a left oophorectomy (a surgical procedure to remove an ovary) on the Patient without having obtained her informed consent, in breach of Guideline 4.2.2 of the 2002 edition of SMC's Ethical Code and Ethical Guidelines ("ECEG"), and that such conduct was an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competence. This, according to *Low Cze Hong*, is the other limb under which professional misconduct could be made out.

4 Having convicted Dr Jen on both charges, the DT ordered that Dr Jen (a) be suspended for a period of eight months, (b) pay a fine of $10,000, (c) be censured, (d) give a written undertaking to the SMC that he would not engage in the conduct complained of or other similar conduct, and (e) pay the costs and expenses of the disciplinary proceedings, including the costs of the SMC's solicitors.

5 By way of this originating summons, Dr Jen appeals against his conviction, and in the alternative, the sentence imposed. We heard the appeal on 25 July 2017 and reserved judgment. We now give our decision.

Facts

6 We start by recounting the facts salient to the present appeal. We have used, as a starting point, the facts as found by the DT in its grounds of decision ("GD") but have supplemented these, where necessary, with references to the record of appeal.

7 Dr Jen runs his practice at Women's Clinic of Singapore, located at Ang Mo Kio Avenue 8, and had, at the time of the disciplinary proceedings, been practising there for 28 years. He obtained his MBBS from the National University of Singapore in 1979 and has specialist qualifications in obstetrics and gynaecology.

8 Before the material events in this case, the Patient had, on 7 June 2010, consulted Dr Jen about her problems with conceiving a child. She was 34 years old at the time. She attended follow-up consultations with Dr Jen on three occasions: 19 June, 29 June and 27 July 2010, respectively. Dr Jen started her on fertility treatment which involved the prescription of a medication known as Clomid.

9 The material events in this case were set in motion when the Patient was referred to Dr Jen by an orthopedic surgeon, Dr Tay Chong Kam ("Dr Tay"). The Patient consulted Dr Tay on 27 August 2010 because she had been suffering from what she described as "very bad backache". An X-Ray and a MRI scan were taken of her spine. The radiologist, Dr Esther Tan, observed in her radiologic report dated 28 August 2010 that, based on the X-Ray, there appeared to be a "lobulated soft tissue density in the pelvis raising the suspicion of a mass", and that, based on the MRI scan, there was a "suggestion of a septated cystic mass in the pelvis anterior to the sacrum" which might be

"ovarian in origin". Dr Tay advised the Patient to evaluate the pelvic mass further and suggested that she consult her gynaecologist. On 30 August 2010, he referred her to Dr Jen with a handwritten letter. The letter said that the Patient had consulted him for "backache and right sciatica", that the MRI scan of her lumbar spine was normal but that it showed a "septated cystic mass in the pelvis". The letter ended with a request for Dr Jen to "see and manage".

The Patient consults Dr Jen

10 On 30 August 2010, the same day that Dr Tay had written the referral letter, the Patient consulted Dr Jen. She was accompanied by her husband. Having read Dr Tay's referral letter and the radiologic report, Dr Jen did a transvaginal scan on the Patient and found that there was a lump in each of her ovaries.

11 We pause to make an observation on the nature of the scan that Dr Jen performed. In her complaint letter to the SMC, dated 12 December 2011, the Patient recounted that Dr Jen "briefly did an ultrasound scan on [her] abdominal surface". This would suggest that what Dr Jen did was a transabdominal ultrasound scan rather than a transvaginal one. However, it later transpired that what had been done was in fact a transvaginal scan. In its GD, the DT constantly described the scan as a transvaginal one. It would thus appear that the Patient's recollection in this regard was inaccurate.

12 As mentioned above, Dr Jen's transvaginal ultrasound scan revealed the presence of two lumps, or masses, one on the Patient's right ovary and one on her left ovary. It is undisputed that Dr Jen performed a right cystectomy (to remove only the cyst) during the same operation in which he performed a left oophorectomy (to remove the entire ovary). The present proceedings only

concern the left oophorectomy. We will henceforth refer only to the mass on the left ovary when describing the operation.

13 What exactly transpired during the consultation is disputed. The DT accepted the Patient's version of events in preference to that of Dr Jen.

14 According to the Patient, Dr Jen had advised her to remove the lumps as soon as possible as the mass was "quite huge" and there "may be a cancer". We note that Dr Jen's account of the diagnosis he gave was to similar effect: he said that he had informed the Patient that the mass was "not a simple cyst but instead it was a suspicious complex mass, probably arising from the ovary"; that the uneven walls and irregular septa meant that "the risk of malignancy was higher, especially with her history of severe back pain"; and that it would be best to have the mass removed for histological examination to confirm the diagnosis.

15 Dr Jen offered the Patient a choice of two surgical procedures for this purpose: keyhole surgery (also referred to in the GD as a laparoscopy) or open surgery on the abdomen (also referred to as an open laparotomy). Dr Jen explained that with keyhole surgery, he would cut a small hole and try to remove the mass, but there was a risk that the mass, if cancerous, could spread to other areas. With open surgery, he would cut a 5 to 8 cm hole in the Patient's abdomen to remove the mass. The Patient and her husband decided that she should go for open surgery as they did not want to take the risk of the cancerous cells in the mass spreading.

16 Dr Jen then offered the Patient and her husband the option of having a pathologist in the operating theatre during the open surgery. This was for the purpose of performing a "frozen section" pathology. What this meant was that if the pathologist were present, Dr Jen would be able to take out the mass and

have the pathologist test it to see if it was cancerous, and, if it were, Dr Jen and the pathologist could, in the Patient's words, "go ahead and remove the womb area". The test conducted by the pathologist in the operating theatre would be 99.9% accurate. If the pathologist were not present, the mass would, after being removed, have to be sent to a laboratory for testing with the result being known two to three days thereafter; if the mass were found to be cancerous, the Patient could then decide whether or not to go for further treatment. Notwithstanding the accuracy rate of this test which could be conducted during the operation, the Patient and her husband "[did] not want to take the risk to remove any part of [her] womb" and therefore opted not to have the pathologist present in the operating theatre. In other words, they opted to have the mass sent to the laboratory for testing after the open surgery.

17 The operation was scheduled at 3:30pm on 31 August 2010 at Mount Alvernia Hospital ("MAH"). In this regard, according to the Patient, Dr Jen had told her and her husband that the mass was "big" and this prompted her husband to ask when the earliest time that Dr Jen could operate on the Patient was. Dr Jen informed them that he would be available on 31 August 2010, the next day, and the Patient and her husband agreed to schedule the operation then. Dr Jen's clinic nurse, Kathy Yip ("Nurse Yip"), made the arrangements for the operation. Nurse Yip gave evidence at the disciplinary proceedings. We will touch again on the relevance of her evidence at [120] below.

The Patient signs a consent form for the left oopherectomy

18 The Patient was admitted to MAH at 12:03pm on 31 August 2010. She signed a number of forms in the admission office, including a document titled "Consent for Operation or Procedure" ("the consent form"). The consent form

was a generic form which allowed the names of the operation and doctor to be filled in, and was as follows.

> I, the undersigned, hereby consent to undergo the mentioned procedure/operation of ~~LEFT~~ OPEN LEFT OOPHERECTOMY _____ of which the nature, effect and purpose have been explained to me by Dr Jen SHEK WEI _____
>
> I also consent to:
>
> (i) The administration of general, local or other forms of anaesthesia or sedation and confirm that the nature, risks and alternatives of such anaesthesia have been explained to me;
>
> (ii) The transfusion of blood and other blood derived products as may be found necessary by my attending doctor(s) and confirm that the nature and risks and alternatives of such transfusions have been explained to me;
>
> (iii) Such further or alternative operative measures or procedures as may be found necessary by my attending doctor during the course of this operation/procedure;
>
> (iv) My attending doctor seeking consultation or assistance from other relevant specialists if the need arises during the course of this operation/procedure.
>
> …

19 The consent form was signed by the Patient, Dr Jen and the anaesthetist. According to the Patient, the words "open left oophorectomy" had not been filled in when she signed the form. In other words, she alleged that she had signed a blank consent form. She stated that she and Dr Jen had signed the consent form at different times. Dr Jen testified that he was not present when the Patient signed the consent form; he signed it before the operation when he saw the Patient in the operating theatre.

Dr Jen operates on the Patient

20 Dr Jen operated on the Patient from around 3:20pm to 4:15pm. According to Dr Jen, throughout the course of the operation, he observed four "suspicious" features which led him to decide to remove the Patient's left ovary: (a) the presence of bloodstained acidic fluid in the Patient's peritoneal cavity, (b) the abnormal position of the Patient's ovaries and fallopian tubes, (c) signs of rupture and herniation on the surface of the ovary, and (d) the fact that the mass occupied the entire ovary.

21 Dr Jen's assessment was that there was no clear way to separate the healthy from the unhealthy tissue. To cut wrongly might cause "spillage", that is, it might leave behind tissue that was possibly cancerous. Since the Patient's wishes were for the mass to be removed without causing any spillage, Dr Jen decided that, to respect those wishes, he would have to remove the whole ovary instead of conserving a small part but risking spillage later. This decision was, he believed, justified by the four suspicious features mentioned above. He also observed that the fallopian tube on the left side was already badly damaged, and that it would not be a good option to leave it there. He thus removed the whole ovary with the fallopian tube.

The Patient's ovarian tissue is sent for analysis

22 After the operation, the Patient was warded in MAH. The Patient recalled that, sometime after the operation, a nurse came to her with a container showing her the masses that had been removed during the operation. The nurse informed the Patient that this would be sent to the laboratory for tests. A histopathology report dated 2 September 2010 indicated that the masses in the

left and right ovaries were not in fact malignant. They were both haemorrhagic corpus luteum cysts. The contents of the report are as follows:

> **Diagnosis:**
>
> **(A & B) Right and left ovarian tissue:**
>
> **Haemorrhagic corpus luteum cysts**
>
> **GROSS DESCRIPTION:**
>
> (A) The specimen is received in formalin, labelled with patient's data and designated "right cyst". It consists of a piece of tissue measuring 3 x 2cm. Cut surface shows a cystic lesion filled with altered blood. The wall is essentially thin and fibrous. There is no evidence of papillary projections.
>
> …
>
> (B) The specimen is received in formalin, labelled with patient's data and designated "left oophorectomy". It consists of a cystic lesion measuring 6 x 4 cm with attached fallopian tube and ampullary end or fimbrial end measuring 4cm. The cyst is intact. Cut surface shows that the cyst is filled with altered blood. The cyst is multiloculated. Papillary projections are not seen.
>
> **MICROSCOPIC DESCRIPTION:**
>
> (A&B) Right and left ovarian tissue:
>
> Both specimens show ovarian tissue with haemorrhagic corpus luteum cyst.
>
> No malignancy seen.
>
> …

23 The Patient did not see Dr Jen until the third day of her hospital stay. Dr Jen informed her that "the lump was benign" and that she could be discharged. The Patient's husband, too, recalled that on the day of his wife's discharge, Dr Jen informed them that the mass was benign.

24 The Patient recalled that the histopathology report was given to her on the day she was discharged, 3 September 2010. Dr Jen testified that he was the one who gave the report to the Patient.

The Patient finds out that her left ovary was removed

25 Some six months later, in January 2011, the Patient's general practitioner assessed her to be six weeks pregnant. The Patient and her husband went to see Dr Jen. He told her that her foetus was not growing and that she might have a miscarriage. The Patient and her husband decided to seek a second opinion and, to this end, they consulted Dr Yap Lip Kee ("Dr Yap"), a gynaecologist practicing at Mount Elizabeth Hospital. Dr Yap saw the Patient on 19 January 2011. Dr Yap confirmed that the Patient might miscarry. She did, in fact, suffer a miscarriage the next day and was treated for this at Kandang Kerbau Hospital. We mention this incident only for completeness as the DT had made reference to it. Nothing eventually turned on it for the purposes of the DT's decision or this appeal.

26 On 4 April 2011, the Patient saw Dr Yap again, this time for a complaint of bleeding during her menstrual cycle. Dr Yap did an ultrasound scan on the Patient and found a cystic lesion in her right ovary measuring 4.0cm in average diameter.

27 On 19 April 2011, Dr Yap saw her for a review. Dr Yap performed another ultrasound scan and this time he found that there was no cyst present in the right ovary. However, while doing the ultrasound scan, Dr Yap found that he was unable to locate the Patient's left ovary. The Patient and her husband wondered how this could be the case. Dr Yap asked the Patient what surgery she had gone for a few months back. In response, the Patient produced the

histopathology report which she had with her at that time. According to the Patient, Dr Yap then highlighted the words "left oophorectomy" in the report and explained that this was a medical term meaning that her left ovary had been removed. The Patient testified before the DT that this was the first time that she and her husband realised what had happened. She had not been told what "oophorectomy" meant; it was only at Dr Yap's office that this medical term was explained to her. In a letter he wrote to the SMC's investigation unit, Dr Yap confirmed that the Patient had only learnt that her left ovary might have been removed when Dr Yap explained the term "oophorectomy" to her. According to Dr Yap, the Patient was "upset" that he was unable to locate the left ovary and was "adamant" that Dr Jen had only performed a cystectomy on her. At the suggestion of the Patient and her husband, Dr Yap wrote a letter to Dr Jen seeking clarification on what surgery the latter had done. The letter was dated 13 May 2011 and was sent to Dr Jen at the address of his clinic, as stated at [7] above. According to Dr Yap, there was no reply from Dr Jen. During the proceedings before the DT, when Dr Jen was shown Dr Yap's letter, he said that he had never received it.

The Patient files a complaint with SMC

28 On 12 December 2011, the Patient filed a letter of complaint with the SMC. On 17 July 2012, the Investigation Unit of the SMC issued a Notice of Complaint to Dr Jen. On 2 August 2012, Dr Jen sent a reply refuting the allegations in the Patient's complaint ("Response to the Notice of Complaint").

29 Almost four years after the Patient's complaint was filed, on 8 July 2015, the SMC issued a Notice of Inquiry setting out two charges and informing Dr Jen that an inquiry would be held by the DT.

30 The DT comprised Dr Joseph Sheares as Chairman, Dr Swah Teck Sin and Mr Siva Shanmugam. The disciplinary inquiry hearings were held on the following dates: 9 May, 17 to 19 May, 15 August and 1 November 2016.

31 The SMC called three witnesses: the Patient, the Patient's husband and its expert witness, adjunct Professor Dr Tay Sun Kuie ("AP Tay"). AP Tay is a senior consultant at the Department of Obstetrics & Gynaecology at Singapore General Hospital and had provided an expert opinion dated 29 October 2015. We will come to the contents of that opinion shortly.

32 Apart from giving evidence in his own defence, Dr Jen called five other witnesses: Dr Chin Kin Wuu ("Dr Chin"), the anaesthetist for the Patient's operation at MAH; Dr John Hoe Wei Ming ("Dr Hoe"), a radiologist who had tendered an expert report; and three nurses: Nurse Yip, his clinic nurse, and two nurses who had been in the employ of MAH on the day of the Patient's operation, *viz*, Ms Chan Yew Meng ("Nurse Chan") and Ms Roslinda binte Mohmmad Hajar ("Nurse Roslinda").

33 The DT delivered its verdict on conviction and sentence on 22 December 2016 – some five years after the Patient's complaint was lodged. The considerable lapse in time in between is material to this appeal because Dr Jen argues that his sentence should be reduced on account of the delay in the SMC's prosecution of his case. We consider this argument from [167] onwards.

34 As mentioned, the DT convicted Dr Jen on both charges and imposed the sentence described at [4]. We will summarise the relevant findings of the DT at the appropriate junctures below when addressing Dr Jen's arguments.

Standard of review

35 Pursuant to s 55(11) of the Act, in any appeal to the High Court against a decision of a DT, the High Court shall accept as final and conclusive any finding of the DT relating to any issue of medical ethics or standards of professional conduct unless such finding is "unsafe, unreasonable or contrary to the evidence".

36 This threshold would only be met if (a) there is something clearly wrong either (i) in the conduct of the disciplinary proceedings; and/or (ii) in the legal principles applied, and/or (b) the findings of the DT are sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence has been misread (see *Low Cze Hong* at [39]–[40] and the decision of this court in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San Lawrence*") at [32]).

37 The court will be slow to overturn the findings of the DT, given that it is a specialist tribunal with its own professional expertise and which understands what the medical profession expects of its members: see the decision of this court in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*") at [39]–[40]. But this is not to say that a court will accept the DT's findings uncritically: a court should not give undue deference to the views of a DT in a way that would effectively render its powers of appellate review nugatory (see *Low Cze Hong* at [42]). The effect of these two statements is that the threshold for appellate intervention is high but by no means insurmountable.

38 Let us now turn to address the main contentions in this appeal with these principles in mind.

Decision on conviction: first charge

39 We start with the first charge against Dr Jen. It reads:

> **1st Charge (Amended)**
>
> That you, DR JEN SHEK WEI, are charged that you, between 30 and 31 August 2010, whilst practising as a gynaecologist at Women's Clinic of Singapore ("**Clinic**"), ***advised [the Patient] to undergo surgery to remove the pelvic mass*** ("**Mass**") seen on Magnetic Resonance Imaging performed on her on about 27 August 2010, ***without carrying out further evaluation and investigation of the Patient's condition*** when such further assessment was indicated.
>
> **Particulars**
>
> You failed to conduct an adequate evaluation and investigation of the Patient's condition when such further evaluation and investigation was indicated in view of:-
>
> (a) the Patient's age and pre-menopausal status;
>
> (b) the clinical symptoms from, and the history, size and suspected pathology of, the Mass;
>
> (c) the Patient's medical history (including, but not limited to, her drug and/or family history); and/or
>
> (d) the possibility that the Patient's ovaries had a marked/excessive response to the Clomid medication you had prescribed her from in or around July 2010 to August 2010;
>
> and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner; and that in relation to the facts alleged you have been guilty of professional misconduct under Section 53(1)(*d*) of the Medical Registration Act (Cap 174).
>
> [emphasis added in bold italics]

The DT's decision

40 To understand the DT's decision, it is necessary to bear in mind that there are two aspects to this charge. As the SMC had submitted to the DT, Dr Jen had been seriously negligent in:

(a) Advising surgery, because surgery should not have been advised at all in the circumstances; and

(b) Doing so without having conducted an adequate evaluation and investigation of the Patient's condition.

41 Therefore, a conviction on this charge, as framed by the SMC, requires two findings: a finding that Dr Jen had advised surgical removal of the mass, and a finding that such advice followed a failure to conduct adequate evaluation and investigation.

42 As a general, preliminary point, we note that the DT had explained that it found no reason not to accept the evidence of AP Tay since it was "clear, compelling and substantiated by relevant medical literature". On the other hand, the DT found that Dr Jen's evidence was "both internally inconsistent and at variance with the extrinsic evidence before the DT" (GD at [17]).

Advising surgery when surgery was inappropriate

43 The DT agreed with the SMC that surgery should not have been advised. It found, in agreement with AP Tay, that the clinical practice in gynaecology in managing women with ovarian cysts was to avoid unnecessary surgery because of the risks of morbidity and mortality. In AP Tay's opinion, a competent and responsible gynaecologist would not, in this case, have advised the removal of

the pelvic mass because the risk of malignancy of the Patient's mass was low. AP Tay's assessment of malignancy was based on the Risk of Malignancy Index ("RMI"), an accepted risk index which has been in existence since the 1990s and is advocated by the Royal College of Obstetricians and Gynaecologists ("RCOG") (GD at [18], [20] and [33]).

44 If surgery was inappropriate, what should the proper clinical practice have been? The DT accepted AP Tay's view on this matter. AP Tay stated that he would have informed the Patient that the risk of malignancy was low and discussed with her the following options: (a) keeping the pelvic mass under observation; (b) removing the mass; and (c) performing a frozen section examination on the mass before deciding, based on the result of that examination, what further management was needed (GD at [19]). If the low risk of malignancy was acceptable to the Patient, AP Tay's management plan would be to treat the mass as a normal physiological cyst that was likely to regress within the next one or two menstrual cycles. An ultrasound scan could be repeated to ascertain that the mass had regressed (GD at [20]). In short, the proper clinical practice would have been to advise conservative treatment, or what has been referred to in the GD and in submissions as a "wait-and-see" approach – that is, to keep the mass under observation rather than to remove it surgically.

45 The DT rejected Dr Jen's defence that advising surgery was appropriate because the Patient's sciatica heightened the risk of malignancy. The DT found, instead, that Dr Jen was not justified in advising urgent surgery to the Patient on the basis of her sciatica (GD at [22]). Dr Jen claimed the Patient's history of sciatica raised a high suspicion that the pelvic mass was malignant; yet he did not present any evaluation or investigation to show a connection between the

pelvic mass and sciatica. The DT also took into account Dr Hoe's evidence that he could not be sure based on the transvaginal ultrasound whether the mass was malignant and that he would have recommended further evaluation such as by performing a CT or MRI scan of the pelvis, or blood tests, so as to better characterise the mass. Dr Jen had not done any such investigation (GD at [23]). Dr Hoe had further testified that it was difficult, based on the X-Ray report by Dr Esther Tan, to link sciatica to the pelvic mass (GD at [24]).

46 The DT found that, in this case, there was no evidence, apart from Dr Jen's bare assertion, that he had advised any treatment or management options of the pelvic mass other than to undergo surgery to remove it (GD at [25]). It is relevant to note that, in a subsequent part of the GD, under the section dealing with the second charge, the DT also observed that although Dr Jen claimed to have offered the Patient the "wait-and-see" option, the Patient denied this. The DT reiterated that there was no documentary evidence that Dr Jen had offered any alternative treatment besides surgery (GD at [46]).

Failure to conduct evaluation and investigation

47 We turn now to the DT's decision on the second aspect of the charge. As the DT noted, since there was no evidence that Dr Jen had advised any treatment or management options other than surgery, the next question to be asked was whether the advice to undergo surgery was based on acceptable evaluation or investigation of the mass (GD at [25]).

48 The SMC submitted that Dr Jen had failed to conduct further evaluation and investigation in that he did not: (a) conduct any tests such as tumour markers apart from an ultrasound scan; (b) carry out any differential diagnosis; (c) assess the risk of the mass being malignant using any form of established

index such as the RMI; (d) consider factors such as those listed in the first charge; or (e) consider the possibility that the mass was in fact a haemorrhagic corpus luteal cyst.

49 The DT broadly agreed and found (at [35] of the GD) that Dr Jen

> … had not taken into account and evaluated the Patient's age, pre-menopausal status, medical history including the Clomid effect on her ovaries and failed to investigate with the necessary blood tests, repeat scans, and risk of malignancy assessments to enable him to advise an acceptable management plan for his Patient. He had failed to show any credible evaluation of the differential diagnosis of his Patient's Mass that there was a high probability of malignancy.

50 In reaching this conclusion, the DT found that, although Dr Jen had claimed that the Patient's history of sciatica raised a high suspicion that the pelvic mass was malignant, he did not present any evaluation or investigation to demonstrate a connection between the pelvic mass and sciatica. The DT did not accept that a history of sciatica would by itself indicate a high risk of malignancy without supporting evaluative evidence (GD at [34]).

51 The DT concluded that Dr Jen had advised the Patient to undergo surgery to remove the pelvic mass without having conducted further evaluation and investigation when such further assessment was warranted. The DT was also satisfied that Dr Jen's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner (GD at [36]). The DT therefore convicted Dr Jen on the first charge.

Dr Jen's grounds of appeal

52 Dr Jen submits that the DT's finding on the first charge was unsafe, unreasonable or contrary to the evidence. He made a number of arguments in his Appellant's Case, his Skeletal Submissions and a note that his counsel, Mr N Sreenivasan SC ("Mr Sreenivasan"), tendered to this court during the hearing of the appeal. These arguments can be distilled into the following five grounds of challenge.

(a) The DT erred in finding that Dr Jen did not offer any other treatment options other than surgery. Dr Jen argues that he had advised other treatment options in the sense that he had discussed the options of laparoscopy biopsy and frozen section pathology with the Patient. Dr Jen also claims to have offered the Patient the option of keeping the mass under observation instead of proceeding for surgery.

(b) The DT erred in finding that Dr Jen failed to consider any of the factors listed in the charge. Dr Jen argues that he was fully aware of the factors identified in the charge because Dr Jen had seen the Patient four times in the three months prior to the surgery. The DT had not explained why they had ignored Dr Jen's documentation in his case notes in finding that Dr Jen had not conducted "further evaluation and investigation".

(c) The DT erred in failing to recognise that Dr Jen had carried out evaluation in the form of the transvaginal ultrasound.

(d) The DT erred in disbelieving Dr Jen's defence that the Patient's sciatica led to a heightened risk of malignancy and, in turn, the need for surgery. In this regard, the DT erred in its unqualified acceptance of AP Tay's view that the mass should be managed in isolation from the

sciatica. The DT erred in finding that Dr Jen did not show any connection between sciatica and the malignancy of the mass.

(e) The DT erred in finding that Dr Jen's conduct amounted to serious negligence. Dr Jen never persuaded the Patient to go for urgent surgery the next day to remove the mass. It was the Patient and her husband who had wanted the mass to be removed urgently. It was not an abuse of the privileges of registration as a medical practitioner for a doctor to conduct surgical removal of a mass from a patient who wanted immediate certainty.

53 We will deal with each of these arguments in turn.

Whether the DT erred in finding that Dr Jen did not offer any treatment option apart from surgery

54 Dr Jen argues that the DT erred in finding that he had not advised any treatment or management options for the Patient's pelvic mass other than surgery. In his submission, the DT was wrong because:

(a) Dr Jen offered the Patient the option to wait and observe the mass (*ie*, the "wait-and-see" approach) rather than proceed with surgery, though this was not documented as it was standard advice; and

(b) Dr Jen had, at the very least, discussed with the Patient the options of laparoscopy biopsy and a frozen section pathology. The discussion of these two options with the Patient demonstrated that Dr Jen did advise other treatment and management options.

55 The SMC's response to these two points is as follows:

(a) The DT found that Dr Jen's assertion that he had advised a "wait-and-see" approach was not corroborated by any independent or contemporaneous evidence. That Dr Jen disagrees with the DT's decision to disbelieve him on this score does not mean the DT's finding should be overturned.

(b) The argument that Dr Jen had advised laparoscopy biopsy and frozen section pathology misses the point because the gravamen of the first charge is that Dr Jen should not have advised any kind of surgery to begin with.

56 In so far as Dr Jen's first point at [54(a)] above is concerned, we agree with the SMC for two main reasons. First, although Dr Jen asserts that he offered the Patient the "wait-and-see" option, it is contradicted by the testimony of the Patient and her husband, which the DT accepted. It is thus imperative that Dr Jen explain why the DT was wrong in preferring their account over his, which he has not done. Second, even if, contrary to the DT's finding, Dr Jen had offered the Patient the "wait-and-see" option, that would not necessarily afford a basis for reversing the DT's conviction on the first charge. We are not persuaded as to the relevance of this argument. As we noted above at [40(a)], the gravamen of the first charge is that Dr Jen should not have advised surgery at all; given the Patient's circumstances, the "wait-and-see" option was the *only* acceptable option. Therefore, even if we take Dr Jen's case at its highest, that he offered the "wait-and-see" option together with the option of surgery, the fact still remains that he should not have offered the option of surgery.

57 We are satisfied, in any case, that Dr Jen did not offer the Patient the "wait-and-see" option. We arrive at this conclusion by considering the issue from two angles.

58 First, the Patient and her husband's testimony on this point was firm and unwavering. The Patient did testify, at first, that she could not remember whether Dr Jen had offered her this option, but she implied that it was unlikely that Dr Jen had done so since he kept emphasising that there was a risk of cancer. When later, over the course of cross-examination, counsel for Dr Jen put to her repeatedly that Dr Jen had offered her this option, she consistently disagreed. The DT noted this (GD at [46]). The Patient's husband, too, flatly denied that Dr Jen had offered this option; he was asked no fewer than five times. We do not think there is any reason to doubt the truth of their testimony.

59 Second, even on Dr Jen's own account, it was doubtful if he had offered the Patient the "wait-and-see" option. While Dr Jen did testify at first that he had given the Patient this option, his answer later on to a different question seemed to reveal that he had a different understanding of what "wait-and-see" meant from the way in which the DT used it. When asked why he did not document his advising of the "wait-and-see" option, Dr Jen said that he did not need to document what was "standard advice", but he explained that the "standard advice" he would give was to this effect: "Yes, you may wish to not operate or you may wish to operate". This suggested that Dr Jen's understanding of "wait-and-see", when he earlier said he had offered such an approach, was that he had offered the Patient the option of not going for surgery. However, given that he advised the Patient that there was a "significant risk of the cancer" being present and that any risk of the spread of cancer would be "entirely on [the Patient's] shoulders", it was implied in this advice that waiting was the much less desirable option as compared with surgery, when it should have been, as the DT had found, the more advisable of the two. It is therefore doubtful if Dr Jen had truly offered the "wait-and-see" option to the Patient, in the sense of

having advised the Patient that the mass might regress after some time. This doubt is amplified by Dr Jen's omission to mention in his Response to the Notice of Complaint that he had offered the "wait-and-see" option to the Patient – an omission the DT noted (GD at [13]). When this is contrasted with the unshaken testimony of the Patient and her husband as we have described above, the conclusion must be that the DT's finding that Dr Jen did not, in actual fact, offer the "wait-and-see" option was not unsafe, unreasonable or contrary to the evidence.

60 In so far as Dr Jen's second point at [54(b)] above is concerned, we broadly agree with the SMC that Dr Jen's discussions of the laparoscopic biopsy and the frozen section pathology are irrelevant to the question of his conviction under the first charge. When the DT said that Dr Jen had not advised "any treatment or management options" other than surgery (GD at [25]), what the DT meant was that Dr Jen did not advise conservative treatment. This is evident from reading this statement of the DT together with its endorsement of AP Tay's opinion that the clinical practice in managing women in the Patient's circumstances was to avoid doing unnecessary surgery due to the low likelihood of an ovarian mass being malignant and, on the other hand, the significant risk of morbidity associated with surgery (GD at [33]).

61 Instead, Dr Jen had proceeded right from the outset on the basis that surgery was required. As the Patient testified, Dr Jen had said that the mass was "quite huge", and her condition was "critical"; he then "suggested" that she "go for an operation to remove it". Dr Jen then offered two types of surgery: keyhole or open surgery. Dr Jen argues that the offering of laparoscopic biopsy and a frozen section pathology – what he described as "intermediate options" – constituted treatment or management options other than surgery. But it is

undisputed, first, that these are also surgical procedures, albeit of an investigative nature, and, second, that these investigative surgical procedures that Dr Jen proposed were with a view eventually to removing the mass if it was found to be malignant. Dr Jen had already decided that the mass was potentially malignant and needed to be removed. But the gravamen of the first charge is that he should not have made that decision without further evaluation. Dr Jen should not have advised any kind of surgery and should instead have recommended conservative management. And as we have already noted, there was no firm proof that he had done that. Hence, the DT's finding that he did not recommend any treatment or management options other than surgery cannot, in our view, be faulted.

62 Mr Sreenivasan made the point in his note that there must be a clear line drawn between medical negligence and misconduct: Dr Jen's advising surgery, and his failure to offer the "wait-and-see" option, would at most amount to medical negligence, not misconduct. There might be force in that submission if not for the fact that it does not address the gravamen of the first charge. The charge requires a finding not only that Dr Jen had advised surgery when he should instead have advised a "wait-and-see" approach, but also that this decision was accompanied by a failure to conduct adequate evaluation and investigation. The choice of a wrong treatment option with adequate evaluation and investigation might be negligence albeit not serious negligence amounting to misconduct (we express no definite view on this), but that same choice made without adequate evaluation and investigation is what would amount to serious negligence (that would, in fact, amount to misconduct). It is, therefore, to the question of whether Dr Jen had conducted adequate evaluation and investigation that we now turn – this brings us to the arguments mentioned in [52(b)]–[52(c)] above.

Whether the DT was wrong to have found that Dr Jen had not considered the factors in the first charge

63 Dr Jen argues that he was fully aware of the factors stated in the charge because he had seen the Patient on four previous occasions and had notes from these consultation in his docket. These notes were available to him during the 30 August 2010 consultation. That he did not re-document these factors in his 30 August 2010 notes does not justify the conclusion that he did not take them into consideration. The Patient's history was within his knowledge at the time of the consultation on 30 August 2010. All this goes towards undermining the DT's finding at [35] of the GD (see [49] above) that Dr Jen had not taken into account and evaluated these factors.

64 The SMC argues that the fact that Dr Jen recorded the Patient's age, pre-menopausal status, and medical history in his earlier notes does not mean that he bore these in mind in determining that the pelvic mass was probably malignant. That he in fact failed to consider and evaluate these characteristics can be seen from his admission at the inquiry that he did not use the RMI – a common guideline used by gynaecologists – or any malignancy guidelines at all, for that matter, to assess the Patient.

65 We reject Dr Jen's argument. There are two difficulties with it. First, Dr Jen's notes do not, as he claims, record the factors mentioned by the SMC in the particulars of the first charge. His record of the 30 August 2010 consultation was scant. It merely said "?malignant" with no explanation. As AP Tay noted, that there was nothing in the clinical records or medical documents showing that Dr Jen recorded the Patient's age, last menstruation period, medical history, family history of risk of ovarian malignancy, or her response to taking Clomid. It is true that, Dr Jen did, in his case note for the 29 June 2010 consultation, state

that he prescribed Clomid to the Patient and recorded the serum progesterone level (a measure of her body's response to the Clomid). However, this particular consultation was some two months before Dr Jen saw the Patient on 30 August 2010, and was therefore before the mass had been detected. There is no evidence that he had considered the effect of Clomid when assessing the Patient's condition on 30 August 2010.

66 Second, and in any event, even if we were to accept that Dr Jen was aware of the factors despite not having written them down in his case notes on 30 August 2010, it does not necessarily follow that he had weighed them in assessing if the mass was malignant.

67 One way for Dr Jen to prove that he had considered the factors listed above would have been to say that he had used an RMI checklist or some other malignancy guideline to assess the Patient's condition. As AP Tay explained, an RMI assessment would have allowed for a malignancy score to be assigned to the Patient's pelvic mass based on three parameters: the risk score of the ultrasound scan, the menopausal status of the Patient, and the CA 125 level (CA 125 being a type of blood test to show if cancer is present). According to the RCOG Guideline on the Management of Suspected Ovarian Masses in Premenopausal Women ("RCOG Guideline") cited by AP Tay, the RMI is the "most widely used model" for assessing malignancy although newer models have been developed.

68 At this juncture, we should deal with Dr Jen's argument that the RMI should not have been used in this case even though it is the most widely-used model in gynaecological practice. Dr Jen refers to the parts of the RCOG Guideline which note that the following matters fell outside the scope of the

Guideline: the ongoing management of "borderline ovarian tumours", the laparoscopic management of highly suspicious or known ovarian malignancies, and the acute presentation of ovarian cysts. Mr Sreenivisan also highlighted during oral submissions that the first edition of the RCOG Guideline was issued on 1 November 2011, which was *after* the event in this case had taken place in 2010. However, Dr Jen's counsel below did not raise these questions about the applicability of the RCOG Guideline during the cross-examination of AP Tay. It is thus difficult for us to fault the DT's reliance on the RMI because we are in no position to second guess how they would have addressed these points raised by Dr Jen.

69 In any event, we need not make a finding on the applicability of the RMI checklist to the Patient and the correctness of the DT's reliance on it. Even if we find that the RMI checklist is not the most appropriate evaluative tool, it does not assist Dr Jen's case. It is undisputed that Dr Jen did not use *any* malignancy guideline to support his assessment that there was a high risk of the Patient's pelvic mass being malignant. Given that he did not use any such malignancy guideline, it is difficult for him to impugn the DT's finding that he had not evaluated these factors. Dr Jen is essentially asking the court to presume that he must have applied his mind to these factors in making his clinical diagnosis. But it is difficult to make such a presumption because most ovarian masses in young, pre-menopausal women like the Patient are benign, as AP Tay had testified (GD at [20]). Dr Jen, too, accepted that malignancy in the ovary was uncommon in a pre-menopausal woman (GD at [25(e)]). Rather than presume than Dr Jen must have considered these factors, it was not unreasonable for the DT to think the opposite: that he had failed to create a reasonable doubt in the SMC's case that he did not consider the factors, because

if he had, he would not have thought that surgery was needed as an option in those circumstances.

70 This then brings us to Dr Jen's argument that the transvaginal ultrasound alone was sufficient evaluation to demonstrate the possibility of the mass being malignant.

Whether the DT had erred in failing to recognise that Dr Jen carried out evaluation in the form of the transvaginal ultrasound

71 Dr Jen challenges the DT's finding that he did not consider any form of evaluation. In his view, the DT was wrong because, in assessing the Patient's mass to be malignant and thus advising her to go for surgery, he had relied on the transvaginal ultrasound scan which he administered on 30 August 2010. We note that Dr Jen had, in challenging the relevance of the RCOG Guideline, referred to its observation that ultimately a pelvic ultrasound is the "single most effective way of evaluating an ovarian mass with transvaginal ultrasonography being preferable due to its increased sensitivity over trans-abdominal ultrasound".

72 SMC's response is that the DT had taken into account Dr Jen's reliance on the scan. The DT (in agreement with AP Tay) found that Dr Jen was not entitled to rely solely on the scan without considering other tests, because the scan results were only one of the components to be considered in an RMI.

73 To the extent that Dr Jen is arguing that the DT did not consider the fact that had he relied on the transvaginal ultrasound scan, that argument is misplaced. The DT *was* aware of the fact that Dr Jen had relied on the ultrasound scan, as it observed that "Dr Jen had informed the Patient that the

[m]ass probably arose from the ovary but he could not be sure of the diagnosis of this [m]ass based on his trans-vaginal ultrasound scan" (GD at [32]). The DT also explained, albeit in a later part of the GD relating to sentencing, that it was not persuaded by Dr Jen's submission that it was "unnecessary to do any further investigations apart from the previous trans-vaginal ultrasound scan" especially since "he could not be sure the [m]ass was malignant" (GD at [54(c)]. The DT thought it essential to apply some form of malignancy guideline, noting that there was "sufficient OBGYN medical literature and guidelines in 2010 to assess the risk of malignancy in ovarian masses" (GD at [54(c)]).

74 As for whether the transvaginal ultrasound scan *alone* was sufficient evaluation and investigation, we find no basis to interfere with the DT's assessment. As noted in the preceding paragraph, the DT was not persuaded that the transvaginal scan alone was sufficient evaluation on which to base a finding of malignancy. In particular, the DT explained at [32] of the GD that although Dr Jen had done the transvaginal ultrasound scan, even he could not be sure about the diagnosis of the mass based on the scan. The DT hence placed little weight on Dr Jen's use of the scan to bolster his assessment of the mass's possible malignancy.

75 On appeal, Dr Jen has pointed to parts of the transcript from AP Tay's and Dr Hoe's testimony where they had stated that it was not possible, based on the ultrasound scan, to rule out the possibility of malignancy. It is correct that one could not completely *rule out* the possibility of malignancy based on the ultrasound scan; however, that does not mean the scan alone *is sufficient evidence* that the mass is malignant. The scan is an indication that further evaluation and investigation need to be undertaken and is not sufficient evaluation and investigation in and of itself. Both AP Tay and Dr Hoe testified

to this effect. In this regard, we refer to the following parts of the transcripts that Mr Sreenivasan has drawn our attention to in the note he submitted.

(a) AP Tay said, under cross-examination, that he could not exclude the possibility that the ultrasound scan showed malignancy. However, before he was asked that question, he had stated that the ultrasound scan itself would not be sufficient and one would need to evaluate the mass with other tools.

(b) Dr Hoe testified that, based on the ultrasound scan, a malignant mass would have been "higher up on [his] list of possibilities". However, Dr Hoe agreed that whether or not that meant that someone could conclude based on the scan, and without any follow-up evaluation, was a different question altogether. And on this point, in the DT's words, Dr Hoe had stated in his expert report that he "would not have been able to offer a specific diagnosis based only on the ultrasound findings, and … would have recommended further evaluation and follow up" in the form of further CT scans, MRI scans or ultrasound scans (GD at [23]).

Hence, even the evidence Dr Jen is trying to rely on shows that an assessment of malignancy based on the transvaginal ultrasound scan *alone* was *not* adequate evaluation and investigation. In the circumstances, Dr Jen has no basis to argue that the DT was wrong in concluding that he had not performed adequate evaluation and investigation.

Whether the DT had erred in rejecting Dr Jen's defence based on sciatica

76 We now turn to Dr Jen's defence to the charge, which is based on the presence of the Patient's sciatica.

77 In Dr Jen's mind, the requirement for surgery was based on the malignancy of the Patient's mass, which in turn was premised on his assumption that the presence of sciatica heightened the risk of malignancy that was suggested by the transvaginal ultrasound scan. If there was such a link, it might go towards showing that his advice to the Patient to remove it through surgery was not negligent. Conversely, however, if there was no such link, then Dr Jen would have had little basis for thinking that the mass might be malignant and that would reinforce the finding that he had been seriously negligent in advising the Patient to remove it surgically without having first conducted further evaluation or investigation.

78 Dr Jen's argument is that the DT was wrong to have accepted, without qualification, AP Tay's view that the Patient's mass should be viewed in isolation from her sciatica. Dr Jen suggests that it was unsafe, unreasonable and/or contrary to the evidence for the DT to form the view that the mass and the Patient's sciatica were unrelated. He argues that the DT failed to explain its preference for AP Tay's evidence over Dr Jen's view on this matter.

79 The relevant part of the GD that deals with AP Tay's evidence is at [21], where the DT noted AP Tay's concession, in cross-examination, that he did not focus on the Patient's sciatica because there was no gynecological reason for her to have sciatica. AP Tay's view was that it was "extremely rare" for an ovarian mass to cause leg pain. This is because the relevant nerve is in a different compartment of the anatomy and an ovarian cyst, even a larger one than the mass in the present case, would not cause sciatica. In his experience, he had never seen an ovarian mass causing sciatica.

80 For a number of reasons, Dr Jen submits that the DT's acceptance of AP Tay's view was unreasonable.

(a) First, he questions the credibility of AP Tay's opinions because, unlike Dr Jen, AP Tay had no experience with patients who had presented with both ovarian masses and sciatica.

(b) Second, and in a related vein, he states that AP Tay's view that sciatica had no link with the mass was questionable because the orthopaedic surgeon, Dr Tay, had referred the mass to Dr Jen precisely for that reason. Dr Tay had taken the view that the cause of the backache and sciatica was not orthopaedic in nature. The implication is this: a doctor who would have been able to treat sciatica would not refer its treatment to a gynaecologist unless there were some gynaecological cause for the sciatica.

(c) Third, he questions why the DT did not consider the medical literature he had cited that showed the possibility of extra-spinal causes of sciatica.

(d) Fourth, he submits that the DT failed to explain its preference for AP Tay's evidence over Dr Jen's views. Dr Jen submits that this renders the DT's decision to convict him on the first charge unsafe. He relies on this court's holding in *Uwe Klima v Singapore Medical Council* [2015] 3 SLR 854 ("*Uwe Klima*") at [74] that a DT's failure to explain its conclusion in the face of conflicting medical evidence could render its conviction unsafe or contrary to evidence.

81 On the first point, we agree with the SMC that the fact that AP Tay had not personally treated patients presenting with ovarian mass and sciatica is not

a sufficient basis for rejecting his views. The question being considered is the likelihood of sciatica being caused by an ovarian mass. A doctor who is familiar with the treatment of ovarian masses is qualified to comment on this question – both AP Tay and Dr Jen qualify. The fact that AP Tay has not treated any case where a patient had both sciatica and an ovarian mass could simply be because, as he says, there is a very low probability of the former being caused by the latter. After all, Dr Jen also agreed that sciatica was a rare symptom in ovarian tumours (see GD at [25(e)]). The fact that AP Tay did not have experience treating patients with both conditions does not mean AP Tay's views are any less credible than Dr Jen's.

82 Furthermore, AP Tay's views are not unreasonable. AP Tay did not say that there *could not* have been any link between an ovarian tumour and sciatica. He accepted that there was a link but that the ovarian tumour would have had to be at an advanced stage of malignancy; before the ovarian tumour could spread to the sciatic nerve, one would first see many other symptoms such as the bloating of the abdomen, eating disorders and bowel or urinary symptoms. Hence, AP Tay clearly considered the possible interaction between sciatica and an ovarian mass. We do not think his views can be rejected simply because he has never treated patients presenting with both sciatica and an ovarian mass.

83 In so far as the second point is concerned, it does not appear that Dr Tay was referring the sciatica to Dr Jen. He did not tell Dr Jen that he suspected or thought that there was a link between the sciatica and the mass and that Dr Jen was required to resolve this. Rather, it appears clear from the referral letter that Dr Tay was highlighting the presence of a mass in the Patient's pelvic region that was discovered during an MRI Scan of the Patient's spine area, and that this should be evaluated by a gynaecologist; it was the mass that Dr Jen was

supposed to "see and manage", not the sciatica. As AP Tay explained, had he been the one attending to the Patient, he would have managed the ovarian mass and Dr Tay would "continue to manage the Patient's spinal problems and her sciatica" (GD at [21]). It was Dr Jen's own assumption that the sciatica had been caused by the mass and that this raised the suspicion of malignancy. Hence, Dr Tay's referral alone does not necessarily mean there must be a link between sciatica and malignancy.

84 The third point is not entirely persuasive either. It is true that the DT did not, in its GD, give reasons for not accepting the medical articles cited by Dr Jen. However, it is clear that it did, in fact, address its mind to the articles during the hearing. The Chairman drew AP Tay's attention to an observation in one of these articles ("CT and MRI in the Evaluation of Extraspinal Sciatica") that "the sciatic nerve may be locally invaded by … ovarian tumours"; AP Tay explained that this would only occur in the case of "advance malignancy". AP Tay's view, in other words, was that unless the ovarian tumour had metastasised, it would not be possible for the Patient to complain of sciatica. The DT may not have addressed those articles explicitly in the GD, but that does not render its conviction unsafe, unreasonable or contrary to evidence. It did consider at least one of these articles during the inquiry. There is no evidence that it had ignored them.

85 In so far as the fourth point is concerned, it is correct that "[w]hen there is a conflict in medical opinion, the preference of one body of opinion over another should not only be stated, but also explained" (see *Ang Pek San Lawrence* at [84], endorsed by this court in *Uwe Klima* at [74]). But it is necessary to be clear about what the "conflict" was here. The conflict was about the alleged link between sciatica and the malignancy of the mass. AP Tay said

that there was no link; Dr Jen claimed that there was. The DT did not explain why it did not rely on the medical articles cited by Dr Jen, but those articles were only cited to prove Dr Jen's point about the causal link between sciatica and the malignancy of the mass, and, on this broader point, the DT explained why it did not think there was such a link. At [34] of its GD, the DT rejected Dr Jen's view, finding that Dr Jen had not presented any "convincing evidence" that sciatica itself would indicate a high risk of malignancy. The DT had explained its reasons for reaching this conclusion in that particular paragraph – it accepted AP Tay's view that it was unlikely that sciatica would be caused by an ovarian mass given that both are in different anatomical compartments, while noting Dr Jen's agreement with the fact that sciatica was an uncommon symptom of an ovarian tumour. It can be inferred that the DT did not find the medical literature cited by Dr Jen persuasive. We acknowledge that its explanation would have been made more complete had it expressly addressed the medical literature relied on by Dr Jen. But that is not the same as saying as there was a complete absence of any explanation. Further, as we have already noted in the preceding paragraph, the DT was cognisant of this literature. Hence, we do not think the omission to refer to it in the GD renders the conviction unsafe, unreasonable or contrary to the evidence.

Whether Dr Jen's conduct amounted to serious negligence

86 We turn to Dr Jen's final argument, which is that he could not be said to have been seriously negligent in offering surgery to a Patient who wanted immediate certainty.

87 We indicated to Mr Sreenivasan during the hearing that we did not find this argument persuasive. Patients with conditions that may be serious may understandably seek an urgent resolution. However, the duty remains on the

doctor to advise on the appropriate course of treatment, and for the patient to decide what to do based on that advice. Even if a patient insists on a particular course of treatment, it is the doctor who possesses the requisite professional expertise and who must therefore advise the patient on the appropriateness or suitability of such a treatment option. Doctors are not there to be hurried along by their patient's demands.

88 In this case, since surgery was, as the DT found, clearly not the appropriate treatment option, Dr Jen could not be absolved of liability by pointing to the fact that it was the Patient who had wanted this treatment option. After all, the Patient's decision to opt for surgery was based on Dr Jen's act of negligence in the first place. Dr Jen had formed the view that the mass might be malignant and had advised the Patient to undergo surgical removal of the mass without further evaluation. That was the act of serious negligence. It was only after he had advised surgical removal did the Patient's husband ask about the earliest time that the surgery could take place.

Conclusion on the first charge

89 In the premises, we find no reason to interfere with the DT's conviction on the first charge and we accordingly uphold it.

Decision on conviction: second charge

90 We now turn to address the second charge which was worded as follows:

2nd Charge

> That you, Dr Jen SHEK WEI, are charged that you, on or about 31 August 2010, whilst practising as a gynaecologist at the Clinic performed a left oophorectomy ("Procedure") on the Patient, at Mount Alvernia Hospital, without obtaining the required informed consent from the Patient for the Procedure,

> in breach of Guideline 4.2.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines ("ECEG").
>
> **Particulars**
>
> You failed to:-
>
> (a) adequately explain to the Patient prior to the Procedure, the nature, risks and possible consequences of the Procedure, including but not limited to, the fact that the Procedure could involve the complete removal of the Patient's left ovary;
>
> (b) adequately explain to the Patient the consequences of the removal of her left ovary; and/or
>
> (c) obtain specific consent from the Patient or her husband to remove the Patient's left ovary, and to record such consent in the Patient's medical notes;
>
> and your aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap 174).

The DT's decision

91 The DT's decision was based on the following critical findings.

(a) Apart from MAH's consent form, there was no contemporaneous evidence that Dr Jen had obtained informed consent through a process of explaining the risks, benefits and possible complications of the left oophorectomy (GD at [41]).

(b) It was not clear what surgical procedure Dr Jen had advised the Patient to undergo based on his documentations. Different surgical procedures were identified in Dr Jen's clinical notes, the admission letter, the MAH consent form, the MAH operation record and the MAH in-patient discharge summary (GD at [43]). The confusion in the

identification of the surgical procedure, coupled with the lack of proper understanding by the Patient of the nature of her disease and surgical treatment, made it difficult for the DT to accept that sufficient information and detail had been given to the Patient in order to enable her to make an informed decision concerning her treatment (GD at [45]).

(c) Dr Jen's answer when asked what he had explained to the Patient regarding the left oophorectomy was "somewhat evasive and repetitive". It was clear to the DT that Dr Jen had not in fact told the Patient clearly the consequences of her left ovary being removed (GD at [48]).

(d) The DT placed little weight on the evidence of the four witnesses Dr Jen had called to address the issue of informed consent (GD at [49]). We will elaborate on this particular point below.

(e) In conclusion, Dr Jen had not ensured "that the Patient who was under his care was adequately informed about her medical condition and options for treatment so that she was able to participate and make informed decisions about her treatment". Significantly, Dr Jen did not document the details of the surgery advised and his taking of informed consent. All things considered, the DT was satisfied that Dr Jen was in breach of Guideline 4.2.2 of the ECEG and, further, that Dr Jen's conduct constituted an intentional, deliberate departure from standards observed or approved by reputable and competent members of the profession (GD at [50]).

Dr Jen's grounds of appeal

92 In the second charge, Dr Jen's failure to obtain informed consent was framed as professional misconduct under the first limb of *Low Cze Hong*,

namely, that it was an intentional and deliberate departure from the applicable standard of conduct observed by members of the profession. It was held by this court in *Ang Pek San Lawrence* at [39], and affirmed in *Wong Him Choon* at [49], that when proceeding under this limb a DT needs to answer three questions:

(a) What the applicable standard of conduct was among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct related to;

(b) If the applicable standard of conduct required the doctor to do something, and if so at what point in time that duty crystallised; and

(c) Whether the doctor's conduct was an intentional and deliberate departure from the applicable standard of conduct.

93 The first two requirements do not present any controversy here. The applicable standard of conduct is the duty to obtain informed consent as set out in Guideline 4.2.2 of the ECEG, as follows:

> It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him.

94 In so far as the second requirement is concerned, it is logical and commonsensical that the duty to obtain a patient's informed consent to a surgical procedure crystallises when the procedure in question is first suggested to the patient; it is at that time that the doctor must explain the benefits, risks and possible complications of the procedure as well as any available

alternatives. For convenience, we will refer to the aforementioned as the "required matters". In this case, the duty would have crystallised at the consultation on 30 August 2010 when Dr Jen advised the Patient to undergo surgery to remove the mass.

95 The crucial question is thus whether Dr Jen's conduct represented an "intentional and deliberate departure" from the applicable standard observed by members of the profession, that is, Guideline 4.2.2 of the ECEG. We will analyse this issue in two parts:

(a) Did Dr Jen obtain the Patient's informed consent to the left oophorectomy?

(b) If he did not, did his failure to do so represent an intentional and deliberate departure from the applicable standard of conduct, that is, Guideline 4.2.2 of the ECEG?

Whether Dr Jen obtained the Patient's informed consent

96 We understand Dr Jen's argument to proceed along two steps: first, that the consent form alone is sufficient evidence of informed consent, and, second, that, in any event, all the other evidence demonstrates that Dr Jen had obtained informed consent. In relation to the second argument, Dr Jen also submits that the DT had erred in believing the Patient's version of events even though it was clearly inconsistent with the evidence of other witnesses and the documentary evidence.

97 As the burden of proof was on the SMC to establish beyond a reasonable doubt that Dr Jen had not obtained the Patient's informed consent to the left oophorectomy, the way to approach the two arguments raised by Dr Jen is to

ask whether either argument raises a reasonable doubt in the SMC's case, such as to render the DT's conviction on this charge unsafe, unreasonable or contrary to the evidence.

Whether the Patient's signature on the consent form was sufficient to demonstrate that Dr Jen had obtained informed consent

98 Dr Jen argues that since the consent form (reproduced at [18] above) was a contemporaneous document, and since DT did not find any irregularities in the manner the consent form had been signed, "the form in itself is evidence of properly obtained informed consent for the left oophorectomy". Underpinning this argument is the submission that the courts should not allow patients to sign consent forms and then claim they did not understand what they were consenting to.

99 Mr Sreenivasan did not specifically pursue this argument in the oral hearing before us. Nor, indeed, was it an argument that Dr Jen raised in his closing submissions to the DT. However, it is imperative that we consider it because it was put forward in the written submissions and because it is a general point of practical significance to the medical profession.

100 We do not think the presence of a signed consent form alone raises a reasonable doubt in the SMC's case.

101 We will first address the point about the consent form being blank when the Patient signed it. The DT did not make a conclusive finding on whether the consent form here was blank when the Patient signed it. It only noted, without further elaboration, that the Patient had alleged that she signed a blank form (GD at [41]).

102 In our view, whether or not the form was blank is not the critical fact in considering whether informed consent had been obtained. Even if the Patient signed a blank form, she must have known that the name of the operation would be filled in later and that her signing it first was only as a matter of convenience. The Patient was aware that by signing the form she was declaring that Dr Jen had explained to her the "nature, effect and purpose" of the operation she was to undergo. The question is what the Patient thought the operation was – what was she declaring that Dr Jen had explained to her? What was in her mind when she signed the consent form?

103 Even if the consent form had the words "left oophorectomy" filled in at the time she signed the form, according to the SMC's case theory, the Patient would have thought that this referred to the removal of the mass from her ovary, because, as mentioned, she did not know what the term "oophorectomy" meant until Dr Yap explained it to her (see [27] above). Dr Jen cannot merely point to the consent form as suggesting – and thereby raising a reasonable doubt in the SMC's case – that he had explained the required matters about the removal of the ovary to the Patient. He must establish the underlying premise of his argument, which is that the Patient knew that the operation she was going for would involve the removal of her ovary. Only when it is established that she understood the nature of the operation, would it be logical to place weight on the consent form that she signed. If the Patient did not understand the purpose of the operation – if she did not know in the first place that the operation was to remove her ovary – then her signing on the form, whether blank or filled in, does not suggest that Dr Jen had explained the required matters about the removal of the ovary to her. Hence, on the unique facts of this case, the consent form alone is irrelevant to the analysis unless and until it is proven that the Patient understood that she was undergoing a left oophorectomy.

104 We would nevertheless stress that the obligation to obtain informed consent is rooted in process and not a mere signed piece of paper. Where a course of medical treatment is to be given or a surgical procedure is to be performed, the process requires a doctor to *explain* the required matters. The signed consent form is the end point of that process. The form is, at best, an indicator (and no more) that the obligation has been discharged but it is not conclusive as a defence to a charge of failing to take informed consent. Whether or not the consent form is a sufficient indicator of informed consent having been taken, such as to raise a reasonable doubt against a charge of failing to take informed consent, has ultimately to be considered in the context of the other evidence.

Whether any other evidence demonstrated that Dr Jen had obtained the Patient's informed consent

105 The next issue that has to be considered is whether there was any other evidence suggesting that Dr Jen had obtained the Patient's informed consent to the left oophorectomy.

106 Dr Jen's overarching argument is that the DT had erred in preferring the Patient's evidence over his. He argues that the Patient's evidence was at odds with the evidence of other witnesses, including independent witnesses as well as the contemporaneous documents (including his clinical case notes). He argues that the Patient's evidence alone is not sufficient to prove the second charge beyond a reasonable doubt.

107 We therefore begin by examining the Patient's evidence. We have summarised her account of her consultation with Dr Jen at [14]–[16] above. Essentially, the Patient's understanding, as she reiterated no fewer than ten

times during her testimony, was that the operation was to "remove the mass from [her] ovary". In a similar vein, the DT found that the Patient "thought the [m]ass was able to be removed from the ovary and she believed her consent for surgery was to remove the [m]ass only" (GD at [37(a)]). The Patient never thought she would have an ovary removed. She only found out from Dr Yap some eight months later that this had in fact happened.

108 The SMC's case was that the Patient never consented to a left oophorectomy In other words, the Patient did not know that a left oophorectomy was part of the surgical procedure she was going for. Agreeing with this, the DT found that the Patient did not have a proper understanding about the type of surgical procedure she was going for (GD at [44]–[45]).

109 If it were true that the Patient did not know that she was going for a left oophorectomy, it would logically follow that Dr Jen had not explained the required matters for such a procedure. On the other hand, if it is established that the Patient in fact knew she was going for a left oophorectomy, how would this assist Dr Jen's case? It would not show that Dr Jen had explained the required matters about the left oophorectomy to her; it would only show that he obtained her *consent*, not her *informed consent*. However, it would mean that the Patient's credibility would be seriously called into question since she insisted all along that Dr Jen had never informed her about the left oophorectomy. That would, in our view, raise a reasonable doubt in the SMC's case rendering the conviction on the second charge unsafe. Hence, the crucial issue is whether the Patient knew that she was going for a left oophorectomy.

110 With this particular issue in mind, we now turn to the evidence that Dr Jen relies on to establish that the Patient knew she was going for a left oophorectomy.

(1) Radiologic report by Dr Esther Tan

111 The first piece of evidence is the radiologic report by Dr Esther Tan. We earlier referred to this report at [9]. Dr Esther Tan observed in her radiologic report that there was the "suggestion of a septated cystic mass in the pelvis anterior to the sacrum" which might be "ovarian in origin". Dr Jen says this is one of the documents that demonstrates that the Patient was aware of the procedure she had undergone.

112 With respect, we are doubtful that this document is of any assistance to Dr Jen. It is not at all apparent how this document would go towards demonstrating that the Patient knew that she was undergoing a left oophorectomy. At the time the Patient received Dr Esther Tan's report, she had not even consulted Dr Jen regarding the mass in her ovary yet. The possibility of surgery had not yet been raised. In fact, as far as we can tell from his written submissions to the SMC at the conclusion of the disciplinary proceedings, Dr Jen did not seek to rely on this document as evidence that the Patient's informed consent had been obtained. That is telling, for it confirms our view that this document, which was given to the Patient before her consultation with Dr Jen regarding the mass, is quite irrelevant to the central question of whether Dr Jen had obtained her informed consent to a surgical procedure that he had advised.

(2) Case notes

113 The next piece of evidence Dr Jen relies on are his clinical case notes from the consultation on 30 August 2010. In these notes, Dr Jen had written the following abbreviated notes: "Mixed echoes Irreg walls, septate +", "?Malignant", "Must prep pat for radical op", "prob need ov removal", "open oophorectomy", "KIV THSBO if cancer" (AP Tay explained that "THSBO" means "Total Hysterectomy, Bilateral Salpingo Oophorectomy") and "explained risks". He argues the DT "did not explain why it had chosen to ignore or to reject" these clinical case notes.

114 The SMC's response is that the DT had in fact considered these case notes but, having found that these notes, along with the other medical documentation Dr Jen had filled in, were "not clear", "inaccurate", "illegible", and possibly "less than contemporaneous" (see GD at [50]), rightly chose not to infer from these notes that Dr Jen had adequately explained the left oophorectomy to the Patient.

115 We think the DT was correct in placing little or no weight on these case notes. We leave aside the question of whether they were "less than contemporaneous". We note that the SMC argued below that Dr Jen had modified some of his original case notes by adding to them after the operation, but has not pursued this argument on appeal.

116 In any event, the mere fact that Dr Jen wrote down the procedure he was going to perform (here, in the case notes) does not necessarily mean that he had explained the procedure to the Patient. Notations such as "prob need ov removal" and "open oophorectomy" do *not necessarily* suggest that Dr Jen had explained that he might have to perform an oophorectomy on the Patient during

the operation on 31 August 2010. These notes could have meant that, if the mass were removed and found, upon histological examination, to be malignant, Dr Jen might then have to prepare the Patient for a "radical op[eration]" that might result in the removal of the ovary. This would be consistent with the Patient's account that Dr Jen had only mentioned the need to remove the mass, and not the ovary.

117 What might possibly weigh in Dr Jen's favour might be the phrase "explained risks". The DT thought that this phrase was insufficient but did not explain why – it merely mentioned the presence of this phrase and went on to state that Dr Jen clearly had not told the Patient about the consequences of her left ovary being removed (GD at [48]).

118 Notwithstanding the point made in the preceding paragraph, we are of the view the DT was correct in finding that this single phrase, "explained risks", was not sufficient basis from which to infer that Dr Jen had explained to the Patient that she would undergo a left oophorectomy, much less the required matters. We say this for two reasons. The first reason requires us to refer to guideline 4.1.2 of the ECEG. This guideline requires that medical records be kept in "sufficient detail so that any other doctor reading them would be able to take over the management of a case", and that "discussion of treatment options" and "informed consents" be documented. The DT referred to this at [39] of the GD. In our judgment, any doctor reading the phrase "explained risks" would not be able to tell what had already been explained to the Patient and what had not. It was not even clear what these "risks" pertained to. Reading the case notes, one might also think they referred to the risks of removing the mass, or to the risks of *not removing* the mass.

119 The second reason is that this court has previously found that it is insufficient for a doctor to record informed consent in a single phrase. In *Low Cze Hong*, the doctor in question tried to rely on the phrase in his case note, "guarded prognosis", as proof that he had discussed the risks, side effects, and nature of a medical procedure (a trabulectomy). The court found that, in the light of Guideline 4.1.2, this "lone phrase" was "woefully inadequate" (at [83]). It is difficult in this case as well to tell from this sole phrase, "explained risks", that Dr Jen had explained the risks of the "left oophorectomy" to the Patient. The presence of this phrase alone, therefore, does not persuade us that the DT's conviction on the second charge might be unsafe.

(3) Admission letter to MAH/Nurse Yip's evidence

120 Next, we turn to the admission letter and the evidence of Nurse Yip who explained that letter to the Patient. After the Patient had decided to undergo surgery, Dr Jen's clinic gave her a letter to produce to MAH when she was admitted. The material parts of the letter are as follows (the "(L)" here representing the letter "L" with a circle around it):

> **HISTORY**: Allergic to Aspirin, Ponstan, Synflex
> **OPERATION:** For Lap (L) Oophorectomy on 31/8/10 at 330pm
> **DIAGNOSIS:** ? (L) ov. ~~ov~~ mass
> **ANAESTHETIST**: Dr KW Chin

It is undisputed that the operation is "laparoscopic left oophorectomy" and the diagnosis is "left ovarian mass".

121 The Patient recalled that Nurse Yip had asked her whether she was allergic to the three drugs mentioned above, and did mention the name of the anaesthetist. However, she denied that Nurse Yip had told her that the operation

was a left oophorectomy and that her left ovary might be removed, as well as that the diagnosis was a left ovarian mass. The Patient did, however, remember Nurse Yip mentioning that she – the Patient – had a "mass in [her] ovary".

122 Nurse Yip herself could not recall what exactly she told the Patient on 30 August 2010. Nurse Yip had no recollection of the Patient at all. She could only assume, looking at the admission letter, that she would have, as was her practice, told the Patient about the nature of the operation. She testified that she would have told the Patient that she was going for a left oophorectomy, and that this meant the "removal of the ovary".

123 The DT placed no weight on her testimony because she could not recall what precisely she had explained to the Patient and her husband in relation to the admission letter (GD at [50]). We do not think the DT acted unreasonably in arriving at this particular conclusion. We think that Nurse Yip's evidence is equivocal since she could not recall what precisely she had said and was only assuming that she would have explained the left oophorectomy to the Patient.

(4) MAH documentation and oral testimony of MAH staff

124 We now come to the evidence from MAH – this takes the form of documentary records and the oral testimony of the staff whom Dr Jen called to testify in his defence.

125 Dr Jen relies on the following *documents* from MAH as demonstrating that the Patient must have been aware that she was proceeding for a left oophorectomy.

(a) In a document titled "Anaesthetic Record", the words "(L) oophorectomy" are filed in next to "Operation".

(b) In a document titled "Nursing Documentation", containing a table allowing nurses to record the "Event" and corresponding "Intervention", the word "procedure" appears under the "Event" column and next to it, under the "Intervention" column, are the words "consent up". We also note that at the top of this document, the Patient's "Diagnosis" is stated as "Left ovarian mass for Left open oophorectomy".

(c) In the consent form, the words "open left oophorectomy" are written. We have already mentioned this.

(d) In a document titled "Operation Record", Dr Jen wrote that the operation he had performed was: "(R) Oophorectomy" and "(L) cystectomy". What was actually performed was a left oophorectomy and a right cystectomy instead.

(e) In a document titled "Inpatient Discharge Summary" the diagnosis is stated as "Bilat[eral] ov[arian] tumour" and the procedures undertaken are stated as "1. (L) oophorectomy" and "2. (R) cystectomy".

126 The relevant *oral* testimony of the MAH staff is as follows:

(a) Dr Chin testified that he could not remember the Patient, much less what exactly he had told her. He could only assume that because he had written "left oophorectomy" in his Anaesthetic Record, he must have asked the Patient what surgery she was going for. He would also have, he assumed, told the Patient that "left oophorectomy" meant "a removal of her left ovary", and that this surgical procedure had to be done because of the left ovarian cyst.

(b) When asked about Dr Chin, all that the Patient recalled was that he had asked her what operation she was going for and she replied that the operation was to remove the mass from her ovary.

(c) Nurse Chan and Nurse Roslinda testified that they did not personally attend to the Patient on the day of the operation itself. Nurse Roslinda did testify that it was standard practice to show the consent form to a patient to ensure that the signature belonged to her, and to read out the procedure to the Patient. But, as she was not personally attending to the Patient, she could not know for a fact that the Patient in this case had been told these things.

(d) When asked about this, the Patient recalled a nurse – she did not say which one – asking her if she was aware what surgery she was going for, and the Patient's reply was that, as explained by Dr Jen, she was there to remove the mass from her ovary.

127 We are of the view that the evidence from MAH does not assist Dr Jen's case. It may be true that all this documentation "showed that the entire healthcare team was aware of the treatment to be undergone by the Patient", as Dr Jen submits. But what the healthcare team knew is one thing; what the Patient knew is another altogether. As for the multiple references to "oophorectomy" in the documentation, there is no evidence that *the Patient* had seen any of this documentation prior to the surgery and would thus have had her attention drawn to the word "oophorectomy". In so far as the evidence of the witnesses such as Dr Chin, Nurse Chan and Nurse Roslinda is concerned, since they were not testifying based on their recollection of events, but based on what they thought must have happened, we are of the view that it was not unreasonable for the DT

to regard their evidence as shedding no light on whether the Patient knew, *in fact*, what surgical procedure she was going for.

128 In the final analysis, what is most critical is the testimony of Dr Jen as weighed against that of the Patient. It is to Dr Jen's testimony that we therefore now turn.

(5) Oral testimony of Dr Jen as against that of the Patient

129 In the appellant's note, Mr Sreenivasan relies on the following excerpts from Dr Jen's testimony as proof that he had explained a left oophorectomy to the Patient:

(a) On 30 August 2010, Dr Jen had already received a "verbal consent" from the Patient and subsequently ran through the consent form again with her in the operating theatre.

(b) On 31 August 2010, before the surgery, Dr Jen had asked the Patient whether she understood the consent form. She replied in the affirmative. He claims that he used the term "oophorectomy" and that the Patient had no issues in understanding that term.

(c) Inside the waiting area of the operating theatre, Dr Jen told the Patient that "her whole ovary on that side may be removed and the final decision of course depend[ed] on exactly what happen[ed] during the surgery". He said that it was "most likely" he would be removing the mass; which "could be the ovary, but … could be also something else". The Patient's response, according to Dr Jen, was that she "looked at [him] and looked like she understood". In a later part of the cross-examination, Dr Jen said that he had asked whether the Patient "understood the

procedure and the procedure in this case was the possible removal of her ovary".

130 We will deal with these points shortly. However, we would first point out that Dr Jen has not addressed what in our view are three critical findings made by the DT.

131 First, the DT noted the fact that "the Patient probably did not understand that the [m]ass and the ovary were one and referred to the same thing" (GD at [44]). This was an admission made by Dr Jen and it is absolutely critical. He made it when asked to comment on AP Tay's assessment that he had not done any differential diagnosis. He, in effect, let slip the fact that the Patient might not have fully appreciated that a removal of the mass would involve a removal of her ovary as well. In his words: "She … for sure knows that some part of her ovary was removed, *maybe she didn't understand that the mass and the ovary are one on the same thing*" [emphasis added]. He continued, as follows:

> I think that's probably the most likely thing, that the mass and the ovary are one and the same thing, and that the mass was removed, the ovary had been stretched so that it just becomes the covering. So that whatever ovarian tissue was left, it just became the capsule of the mass. *So maybe she may not understand that*, but… when she herself said that Dr Jen removed the ovarian mass, I'm not very sure in her mind, what she understands… I think…they felt that the ovary was one part, and … it was completely… two different parts of one mass. *One part is the ovary, one part is the mass. So I suspect that's her … understanding.* [emphasis added]

132 Implicit in this is the fact that Dr Jen might not have fully explained the purpose of an oophorectomy to her. This also coheres with what the Patient said she had understood – she always thought what was being removed was a mass in her ovary and not the ovary itself. The DT found that the lack of proper understanding of the procedure by the Patient, a fact effectively conceded by

Dr Jen, in itself demonstrates that he had not adequately explained the oophorectomy to her.

133 The second point the DT placed emphasis on was that, when queried by the DT what the consequences of the removal of the Patient's ovary would be, Dr Jen claimed to have informed the Patient and her husband that there would be a reduction in their fertility and claimed that their response to this information was that they were more concerned about the Patient's pain and the cancer. The DT found this seeming disinterest about the reduction in fertility by the Patient at odds with her initial concern for her infertility and inability to conceive, and her refusal to accept a 0.1% risk of error by the pathologist's frozen section report that would cause Dr Jen to remove some parts of her reproductive organs (GD at [48]).

134 In our view, this finding significantly undermines Dr Jen's claim that he informed the Patient that she would need to undergo a left oophorectomy. As a matter of logic, it is not likely that Dr Jen could have suggested a left oophorectomy to the Patient without her reacting strongly. Dr Jen claims to have explained to her that he would "remove whatever looked abnormal, and this could mean the removal of [the] entire left ovary, if the ovary looked abnormal". However, Dr Jen had also said that the Patient was "fearful that her reproductive organs would be removed", and that was why she did not want to have a pathologist during the operation to test the mass to determine whether the ovary should be removed. There was, in this regard, a 0.1% chance that the pathologist could make a wrong assessment. It is difficult to believe that, having rejected the option of having the pathologist on hand to confirm (to 99.9% accuracy) if the mass was malignant and thus resulting in the removal of the ovary, the Patient would be comfortable with letting Dr Jen decide whether to remove the

ovary based solely on his own observation – in other words, that she would be comfortable to "leave it to [him] to decide the extent of the ovarian tissue to remove" even if it meant, in his words, that "[if] there [was] any risk that … there is cancer, [he] would just have to remove the whole thing". It was more likely that Dr Jen did not explain that he might have had to remove the left ovary. That would be the only logical reason why the Patient would have agreed to the operation.

135 The third critical point we wish to highlight is the DT's finding that the Patient was not aware that Dr Jen had surgically removed her left ovary until Dr Yap had informed her of this approximately eight months after the surgery (GD at [42]). The Patient was shocked at Dr Yap's explanation that her ovary had been removed. Her reaction was attested to by Dr Yap in the account of the consultation which he independently provided to the SMC as part of its investigations (see [27] above). Dr Jen has been unable to give any explanation for this reaction by the Patient.

136 The truth, it appears, is that the Patient only wanted to remove the mass and have it sent for testing. If it were found to be malignant, she would then decide whether or not to remove the ovary or any further part of her reproductive system. Dr Jen assumed that the Patient would be agreeable to having the ovary removed if the mass was such as to fill up the entire left ovary. But he had not made it sufficiently clear to the Patient that this was one possible surgical option that he might have to undertake.

137 At this juncture, we return to the evidence raised by Dr Jen. We note that most of it pertained to what he said to the Patient *in the operating theatre*.

138 It would have been too late to obtain informed consent in the waiting area of the operating theatre. This principle was established in the SMC's Disciplinary Inquiry against Dr ABK ("*ABK*'s case"), which decision was affirmed on appeal to the High Court. The tribunal in that case rejected the doctor's submission that informed consent had been obtained just moments before the surgical procedure. It accepted that, in theory, patients had a right to choose not to undergo a procedure at the last minute, but found that, in reality, by the time the patient in question turned up at the hospital, he would not have been "in any frame of mind to receive and evaluate any advice that may be rendered to him on the risks and treatment options" (at [40]). To be sure, Dr Jen is not saying that he first explained the procedure just before the operation; his case is that he wanted to "confirm with her" that she had consented to the procedure. Still, *ABK*'s case illustrates the principle that any further explanation he might have given right on the cusp of the oophorectomy would have been immaterial to the crucial question of whether he had fulfilled his duty to obtain the Patient's informed consent before she was admitted for surgery.

139 Looking at matters in the round, we accept the SMC's case that the Patient was under the impression that the operation was only to remove the mass from her ovary. It was that operation to which she had consented and which she was declaring that Dr Jen had explained to her. On the whole, we find Dr Jen's version of the events implausible and that he has failed to raise a reasonable doubt in the SMC's case that he had failed to obtain informed consent.

Whether there was an intentional departure from the applicable standard of conduct

140 We now turn to deal with Dr Jen's final argument: that the DT did not make any findings to demonstrate that his failure to obtain informed consent

was an intentional departure from the applicable standard of conduct – in this case, Guideline 4.2.2 of the ECEG. In fairness to Dr Jen, the DT did not expressly explain in its GD just why Dr Jen's failure to obtain informed consent was an intentional and deliberate departure from the acceptable standards. It simply found that Dr Jen breached Guideline 4.2.2 of the ECEG and this constituted an intentional and deliberate departure. The issue before us is whether that finding is indeed supported by the objective evidence.

141 In this last-mentioned regard, we are of the view that the DT was correct in making the finding it did. If a doctor knows of the applicable standard of conduct but chooses not to comply with it, such non-compliance is an intentional and deliberate departure from the applicable standard. In particular, if the applicable standard of conduct is found in the ECEG, then, as this court held in *Wong Him Choon* at [82], there is a "strong presumption" that the relevant doctor has knowledge of the matters contained therein. This presumption is rooted in the fact that the Guidelines represent the "fundamental tenets of conduct and behaviour expected of doctors practising in Singapore"; they are the "minimum standards required of all practitioners" (see para 1 of the ECEG). The DT was congisant of the fundamental importance of the ECEG; it made reference to our decision in *Wong Him Choon* at [40] of that GD.

142 In *Wong Him Choon*, the applicable standard of conduct that was engaged was Guideline 4.1.1.1 of the ECEG, which dealt with a doctor's duty to provide medical care only after an adequate assessment of a patient's condition through good history-taking and appropriate clinical examination. This court found that the doctor had been guilty of international and deliberate departure from this standard because he had "certified the Patient fit for light

duties without first establishing the availability of such duties *and* with the knowledge that he was required to establish the same" (at [83], emphasis in original); the doctor knew it was "incumbent" on him to ascertain if there were light duties available, yet he certified the Patient for such duties – this was therefore an intentional and deliberate departure from the applicable standard on his part (at [85]).

143 In this regard, counsel for the SMC, Mr Edmund Kronenburg ("Mr Kronenburg"), submitted during the hearing before us that, since Dr Jen had not obtained informed consent despite knowing full well that he had to comply with Guideline 4.2.2 of the ECEG, the natural inference must be that he chose deliberately to depart from that standard.

144 We agree. It cannot be disputed that Dr Jen knew the applicable standard. He admitted, in response to questions from both Mr Kronenburg (who prosecuted the SMC's case below) and from the Chairman of the DT, that he was aware of Guideline 4.2.2. The DT emphasised this at [50] of its GD. Yet, despite knowing it was incumbent on him to obtain the Patient's informed consent, Dr Jen did not explain the left oophorectomy to her and therefore did not obtain her informed consent to the procedure. By analogy with *Wong Him Choon*, Dr Jen's knowing non-compliance with the ECEG was an intentional and deliberate departure from the applicable standard expected of him.

Conclusion on the second charge

145 In the premises, we see no basis for interfering with the DT's conviction on the second charge. We therefore uphold the conviction.

Postscript

146 By way of a postscript, we would add that after an initial draft of this judgment had been prepared, this court released its judgment in *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] SGHC 260 ("*Leslie Lam*"), in which it set aside the conviction of the doctor in question on a charge of failing to obtain a patient's informed consent to an invasive coronary procedure. It is quite apparent that the parties in the present case did not have the opportunity to address on the relevance of that case to the present appeal and so we have not relied on it in the course of reaching our decision on the second charge. Nevertheless, we wish to dispel any suggestion that the decision in *Leslie Lam* would have given us reason to revisit or reconsider the decision we had arrived at in this case.

147 In *Leslie Lam*, this court set aside the conviction of the doctor on a charge of failing to obtain informed consent. This was primarily because, in the court's view, the DT in that case had placed undue emphasis and weight on the fact that the taking of consent had not been recorded in the doctor's contemporaneous clinical notes and had treated the lack of documentation as virtually determinative. The DT in that case failed to consider or give sufficient weight to all the other pieces of evidence, such as the doctor's unchallenged testimony regarding his consistent practice, the patient's credibility (given that the patient's testimony on two other charges had been rejected by the DT), and the patient's obvious knowledge about the salient risks and complications surrounding the procedure (given that he had undergone the exact same procedure a few years before the events of the case occurred).

148 We do not think the DT here could be said, in any way, to have committed the same kind of error. The lack of contemporaneous evidence that

Dr Jen had obtained the Patient's informed consent was one factor that the DT took into account (see [91(a)] above), but it was not treated as virtually determinative. The DT went on to weigh that factor together with the rest of the evidence. This included, among other things, the documents that Dr Jen sought to rely on, the Patient's lack of understanding about what a left oophorectomy was until she was informed on this by Dr Yap, Dr Jen's admissions that the Patient might not have understood that a removal of the mass might also require a removal of the ovary, and the implausibility of the Patient agreeing to undergo a left oophorectomy when she had expressed concern and reluctance to have any part of her reproductive system removed. The conviction of Dr Jen on the second charge did not rest solely on the absence of contemporaneous documentation showing that he had obtained informed consent. Rather, all the evidence, when considered in the round, led the DT to conclude that the second charge against Dr Jen had been proven beyond a reasonable doubt. That is a conclusion which we have found no basis to disturb.

149 We also note that *Leslie Lam* involved an allegation of a rather different nature. In *Leslie Lam*, there was no dispute that the patient was told that he would be undergoing a procedure known as a Percutaneous Coronary Intervention. The complaint was that he had not been adequately advised of the benefits, risks and possible complications of the procedure. In the present case, the Patient's complaint was that she had not been informed that she was undergoing a left oophorectomy at all, which we have accepted as true. Therefore, it follows that the attendant benefits, risks and complications in relation to that procedure (*ie*, the required matters) would not have been explained to her.

150 With that, we turn to the question of the appropriate sentence in this case.

Decision on sentence

151 Dr Jen submits that the sentence of eight months' suspension and a $10,000 fine was manifestly excessive and urges this court to impose a sentence of four months' suspension and a $25,000 fine. The SMC, on the other hand, urges this court to uphold the sentence below.

152 Dr Jen's principal arguments are as follows:

(a) There are no significant aggravating factors in this case.

(b) The usual sentence imposed in cases involving serious negligence and failing to adequately evaluate a patient is a term of suspension of four months.

(c) The term of suspension should be reduced on account of the inordinate delay in the SMC's prosecution of this case, which caused Dr Jen anxiety and distress. In this regard, Dr Jen relies on this court's recent decision in *Ang Peng Tiam v Singapore Medical Council* [2017] SGHC 143 ("*Ang Peng Tiam*"), which was released after the DT's decision, in which the term of suspension imposed on the doctor was halved from 16 months to eight months on account of a four-and-a-half year delay between the time the complaint had been made and the time the Notice of Inquiry had been sent to the doctor.

153 The SMC's response was, broadly speaking, as follows:

(a) There are significant aggravating factors in this case, namely, Dr Jen's egregious lack of care for the Patient's well-being and his lack of remorse.

(b) Not only are the precedents cited by Dr Jen distinguishable, this court has, in a number of recent appeals from SMC disciplinary proceedings, expressed the view that there may be a need to recalibrate sentences upwards.

(c) The delay was, as Mr Kronenburg explained in the hearing before us, not inordinate because counsel for SMC required time to (i) seek clarifications from the complaints committee on the gravamen of the charges, and (ii) review the relevant case law in order to decide how best to frame the charges against Dr Jen. Furthermore, any delay in prosecution should not be counted again in Dr Jen's favour because, in the proceedings below, the SMC had already been asked to take delay into account in arriving at the appropriate sentence (GD at [51]). Finally, and in any event, Mr Kronenburg suggested that the seriousness of Dr Jen's infractions, as disclosed in both charges against him, would have warranted a far longer term of suspension than the SMC had imposed; Mr Kronenburg proposed a suspension of 16 months. Any reduction on account of the delay in prosecution should not, therefore, provide any reason for a downward adjustment of the eight-month suspension that the DT had imposed.

Sentencing Precedents

154 Let us commence by dealing with the relevant precedents since that constitutes a convenient starting-point from which to review the DT's decision.

155 The DT reviewed five precedents. Two concerned the failure to adequately evaluate the patient's medical condition and three concerned the failure to obtain informed consent. None of the precedents involved both types of professional misconduct. This makes them of somewhat limited value. After all, any comparison with sentencing precedents must be on the basis that the facts and circumstances as a whole are truly comparable (as this court stressed in *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [17]).

156 Nonetheless, to the extent the precedents are relevant, they demonstrate that the term of suspension that should be imposed on Dr Jen should be significantly in excess of three months.

157 We start by reviewing two of the five cases relied on by the DT. These concerned charges for the failure to adequately evaluate the patient's medical condition.

(a) In *Dr AAD*'s case (2008), Dr AAD was given a three-month suspension for failing to refer the infant patient to a consultant paediatric ophthalmologist in a timely and expeditious manner. The Disciplinary Committee there emphasised that, in choosing not to refer the infant, Dr AAD had "ignored several clinical features of great significance", in particular, the low birth weight of the infant, choosing instead to base his assessment on the gestational age of the infant (the assessment of which was erroneous). The DT in the present case considered that there was a parallel between the inadequate assessment conducted by Dr AAD and that conducted by Dr Jen, the latter having chosen to base his assessment of the mass's malignancy largely on the assumed link with sciatica, whilst ignoring other clinical features such as the Patient's age, pre-menopausal

status and the Clomid medication she was on. We note that, unlike Dr Jen, Dr AAD only faced a single charge whereas Dr Jen faced two charges. Thus, Dr Jen's sentence should be significantly higher than the three-month suspension that Dr AAD had received.

(b) In *Dr AAX*'s case (2009), Dr AAX was given a three-month suspension for a charge of failing to conduct an adequate evaluation and investigation of the patient's lymphoma, as well as a charge of failing to properly manage a Hepatitis-B infection that the patient developed during the course of treatment. The DT here considered the first charge in that case analogous to Dr Jen's first charge: Dr AAX had failed to screen his patient for Hepatitis-B despite significant medical literature urging such testing; Dr Jen had similarly failed to apply any malignancy guidelines although there were a number of such guidelines he could have chosen from, including the well-accepted RMI. In our view, this demonstrated a lack of medical knowledge. Dr Jen's case is more severe than Dr AAX's because the latter had pleaded guilty. Thus, Dr Jen's sentence should be significantly higher than the three-month suspension that Dr AAX received.

158 We turn now to the remaining three cases, which concerned the failure to obtain informed consent.

(a) In *Dr ABK*'s case (2010), Dr ABK was found guilty of a single charge of failing to obtain his patient's informed consent to a staple haemorrhoidectomy. There are three similarities with Dr Jen's case: there was only a short period of time between the consultation (10 July) and the surgical procedure (13 July); like Dr Jen, Dr ABK did not record in his case notes any discussion of treatment options, or provision of advice on

the nature of the stapled haemorrhoidectomy; and like Dr Jen, Dr ABK relied heavily on what he had explained to the patient on the day of the procedure itself. The Disciplinary Committee there found that Dr ABK had breached the spirit of the consent-taking guidelines. Noting that consent-taking is a pillar of the doctor-patient relationship, the Disciplinary Committee considered that a deterrent sentence needed to be imposed to uphold the standards of the medical profession. These observations are germane to Dr Jen's case. Thus, given that Dr ABK was given a three-month suspension for a single charge of failing to obtain informed consent (which was affirmed on appeal), Dr Jen should be given a sentence far higher than that to reflect the fact that he was convicted of two charges.

(b) In *Dr Looi Kok Poh*'s case (2014), Dr Looi pleaded guilty and was convicted of three charges, including a charge of failure to obtain his patient's informed consent to a surgical procedure on his right hand and wrist. Dr Looi received a 12-month suspension and a fine of $10,000. However, we do not find this case a useful point of comparison given that Dr Looi faced three charges and that one of the three charges was for the more serious charge of falsifying the patient's consent form and there was little discussion regarding the charge of failure to obtain informed consent. As we mentioned earlier, the SMC alleged that Dr Jen altered his case notes after the operation but that did not form the basis of any charge and, in any event, the DT did not make a conclusive finding on this point. We hence do not regard Dr Looi's case as instructive on the question of the appropriate sentence in this case.

(c) *Dr Gan Keng Seng Eric*'s case (2015), in contrast, sits at the lower end of the spectrum of culpability. Dr Gan pleaded guilty and was convicted of two charges of failing to obtain informed consent. He was only given a $5,000 fine. The case, in our view, can be distinguished for the lack of aggravating factors. The Disciplinary Committee held in that case that a fine would only be appropriate in the absence of any aggravating factors, and, as we will explain (in the next sub-section regarding aggravating factors), there were two significant aggravating factors in the present case. The DT here placed weight on these two aggravating factors in distinguishing Dr Gan's case (see GD at [54(e)]). With respect, the DT perhaps went too far in adding a third factor for distinguishing Dr Gan's case: it stated that Dr Jen had seen the Patient on 30 August 2010 "and within 24 hours had persuaded her to undergo a left oophorectomy" without explaining the risks to her, whereas Dr Gan had not pushed his patient into undergoing a procedure. We do not think that finding is justified since the Patient herself admitted that it was she and her husband who had asked Dr Jen when was the earliest he could perform an operation to remove the mass. Even so, however, we think the two remaining factors identified by the DT for the purpose of distinguishing Dr Gan's case are sufficient to militate against any suggestion that Dr Jen should, similarly, receive only a fine.

159 Leaving aside the outliers of *Dr Looi*'s case and *Dr Gan*'s case, the three remaining precedents establish that the minimum period of suspension that Dr Jen should be facing is three months. But that is the *minimum* period of suspension that should be imposed by the Act for a charge of professional misconduct (see s 53(2)(*b*)). As we have stated, however, what the relevant precedents do establish is that a sentence significantly higher than three months

is warranted in the context of the present case. The question that has to be addressed is how much higher.

Aggravating factors

160 It is relevant now to turn to the two aggravating factors identified by the SMC in the present case. It was accepted in *Wong Him Choon* that the indifference to the welfare of a patient is an aggravating factor (at [105]), as is the lack of remorse and the attempt to pin the blame on the patient (at [108]).

161 In so far as the former factor is concerned, the DT found that Dr Jen was indifferent to the Patient's welfare because (a) he had advised surgery without having first evaluated her condition using any acceptable guidelines and (b) he had removed her ovary even though he knew that she did not want any part of her womb to be removed because of her fertility concerns (GD at [54(e)]).

162 Dr Jen argues that he was not indifferent to the Patient's interests because there was a risk that the Patient's mass was malignant. We accept that the risk of malignancy could not entirely be ruled out. We further accept that Dr Jen was concerned to address the presence of the mass as seen on the MRI, and to that extent, he had demonstrated a concern for the Patient's welfare. However, as against that, there are number of features of this case which we find extremely troubling.

163 First, there was a lack of care in the way that Dr Jen addressed the Patient's condition. As the DT noted, Dr Jen assessed the mass to be malignant without applying any malignancy guideline, such as the widely-accepted RMI (GD at [54(c)]). In fact, Dr Jen admitted that he was not familiar with any relevant guidelines. The DT noted that his lack of knowledge of such guidelines,

and failure to apply them, demonstrated an "egregious failure in keeping up to date with medical knowledge and failure to evaluate with appropriate investigations and with acceptable guidelines in medical practice before commencing treatment" (GD at [54(c)]. Dr Jen does not challenge this assessment made by the DT. It is not, we would add, an insignificant consideration given that this court has emphasised the importance of a doctor's "professional responsibility to keep abreast of medical knowledge" (see *Low Cze Hong* at [73]).

164 Second, and more importantly, he had never made known to the Patient that he had removed her ovary. Dr Jen concluded the operation by telling the Patient that the mass was benign. However, Dr Jen did not update the Patient to the effect that he had also removed her ovary together with the mass. This was despite his knowledge that the Patient did not want any part of her reproductive organs to be removed. Why he did not broach the topic with her remains unknown. But what is clear is that in effect, he left it to another gynaecologist to reveal that a core part of the Patient's reproductive system had been removed. We have immense difficulty seeing this as the conduct of a responsible medical practitioner. It demonstrates a grave disregard for the interests of a patient. We therefore think such conduct calls for a sufficiently deterrent sentence in this case.

165 As for the second aggravating factor, namely, a lack of remorse, the DT found that Dr Jen had not shown any remorse and had in fact "callously suggested that he had improved her fertility" (GD at [54(e)]). We agree that Dr Jen demonstrated a lack of remorse. This was especially true in relation to the second charge. His attempt to disclaim his responsibility for ensuring that the Patient understood the nature of an oophorectomy is telling: in his letter to

the SMC he said that "[i]gnorance of medical terminology is no longer a valid excuse since these are freely available and explained over the internet and accessible anywhere and anytime with the use of a mobile smartphone". He maintained this position during the inquiry – his counsel asked the Patient, in cross-examination, if she or her husband had "Google[d]… the meaning of oophorectomy". This shows a persistent refusal to acknowledge that he had the duty to explain the nature of the procedure to the Patient.

166 Having considered the aggravating factors, we will now consider the extent to which Dr Jen's sentence should be reduced on account of SMC's inordinate delay in the prosecution of his case, before deciding on whether there are any grounds for disturbing the DT's sentence in this case.

Inordinate delay

167 We agree with Dr Jen that the sentence should be reduced on account of SMC's inordinate delay in prosecuting his case. In a recent decision, *Ang Peng Tiam*, this court held (at [115]) that mental anguish, anxiety and distress suffered by an offender in having a charge hanging over his head during the period of delay is prejudice that might warrant a reduction in sentence. In that case, this court was prepared to accept, "as a matter of natural inference", that the doctor had suffered anxiety and distress as a result of a three-year delay between the time the doctor was informed that the complaint would be referred for a formal inquiry and the time the Notice of Inquiry was issued (see [10] and [123]). The court also noted that a total of four-and-a-half years had passed between the SMC receiving the Patient's complaint and the time the doctor was issued with the Notice of Inquiry. By the time the DT delivered its verdict on conviction and sentence, more than five-and-a-half years had passed since the

complaint was lodged. The court imposed a term of suspension of 16 months but halved it, on account of the inordinate delay, to eight months (see [128]).

168 Most recently, in *Leslie Lam* (a decision that, as already mentioned above at [146], was handed down after an initial draft of this judgment had been prepared), this court observed (despite setting aside the doctor's conviction therein) that the complaint there took about six years to reach the court and that this appeared, on its face, to be an inordinately long time to dispose of such a matter (at [84]). The patient in that case had lodged a complaint with the SMC on 17 August 2011 (see [9]), while the Notice of Inquiry was issued over four years later.

169 The SMC's delay in prosecuting Dr Jen's case is comparable to the delay in both *Ang Peng Tiam* and *Leslie Lam*. Here, the Patient had lodged a complaint on 12 December 2011. The SMC then sent a Notice of Complaint to Dr Jen on 17 July 2012, after which Dr Jen sent his Response to the Notice of Complaint on 2 August 2012. The SMC waited nearly three years thereafter to issue a Notice of Inquiry – only doing so on 8 July 2015. That is similar to the three-year delay between the time Dr Ang Peng Tiam was notified that the complaint would be referred for a formal inquiry and the time the Notice of Inquiry was issued. Moreover, on the whole, it took about six years for this case to reach this court (from the date of the Patient's complaint to the date of the hearing of this appeal), which is similar to the length of the delay in *Leslie Lam*. On the basis of these decisions, we think that the sentence here should also be reduced on account of inordinate delay.

170 We now turn to the arguments Mr Kronenburg made. First, whilst we acknowledge some merit in Mr Kronenburg's explanation about the time it took

to find an expert and the time it might have taken to draft the charges, we did not think it justified as long as a three-year delay between the date Dr Jen sent his Response to the Notice of Complaint and the date the Notice of Inquiry was issued against him. We understand that it may take time to find and brief an expert witness given that the available pool of potential experts may be small and not every potential witness may be willing to testify. Still, we are of the view that a delay of three years is overly lengthy by any reasonable measure. To place that length of time in context, three years is the maximum period of suspension that could be imposed on any doctor pursuant to s 53(2)(*c*) of the Act. For the avoidance of doubt, we are not stating that a length of delay of fewer than three years is necessarily tolerable. The point is that the delay in this case was clearly unacceptable even if one factored in the time it might reasonably take to prepare the case. Each case must obviously depend on its precise facts and circumstances.

171 Second, although the DT was asked to take delay into account (see [153(c)] above), it is not apparent from its GD that the DT considered the inordinate delay in arriving at the term of suspension it imposed.

Conclusion on sentence

172 Having considered the matter in the round, we think that there is no basis for disturbing the term of suspension imposed by the DT. We acknowledge that the appropriate suspension to be imposed on Dr Jen should in principle be reduced on account of the inordinate delay in the SMC's prosecution of his case. However, the appeal is brought by Dr Jen and it is incumbent on him to establish that the sentence was manifestly excessive or wrong in principle. We do not think it was even if this is so for slightly different reasons than those given by

the DT. To begin with, we think that the term of suspension that the DT imposed was on the low side.

173 Further, based on the presence of the peculiar aggravating considerations we have mentioned, we consider that it would have been justified to impose a term of suspension of eight months for each charge, with both to run consecutively, making an aggregate of 16 months' suspension. On the other hand, we think the inordinate delay in this case would have warranted halving that term of suspension, with the result that the term of suspension to be imposed on Dr Jen would remain at eight months. Both these sentencing considerations balance each other out, and accordingly, in all the circumstances, we see no reason to disturb the term of suspension imposed by the DT. We also see no reason for disturbing the $10,000 fine imposed on Dr Jen as well as the written undertaking he is required to give.

Conclusion and orders

174 For the reasons given, we uphold the DT's conviction on both charges. Further, the orders made by the DT with regard to sentence, as set out at [4] above, are to stand. Dr Jen's appeal against his conviction and sentence is dismissed. The eight-month term of suspension imposed on Dr Jen will commence one month from the date of this judgment.

175 Unless the parties are able to come to agreement as regards the costs of this appeal, they are to file, within 14 days, written submissions limited to seven pages each on the appropriate costs order and the quantum of costs. The costs orders in the proceedings below are to remain.

Andrew Phang Boon Leong	Judith Prakash	Steven Chong
Judge of Appeal	Judge of Appeal	Judge of Appeal

N Sreenivasan SC, Lim Min (Straits Law Practice LLC) (instructed), Charles Lin and Tracia Lim (Myintsoe & Selvaraj) for the appellant; Edmund Jerome Kronenburg, Kevin Ho, Lynette Zheng and Tan Tien Wei (Braddell Brothers LLP) for the respondent.
