IN THE COURT OF THREE JUDGES OF THE REPUBLIC OF SINGAPORE

[2023] SGHC 254

Originating Application No 3 of 2023

Between

Ho Tze Woon

… *Appellant*

And

Singapore Medical Council

… *Respondent*

GROUNDS OF DECISION

[Professions — Medical profession and practice — Professional conduct]

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Ho Tze Woon
v
Singapore Medical Council

[2023] SGHC 254

Court of Three Judges — Originating Application No 3 of 2023
Judith Prakash JCA, Tay Yong Kwang JCA and Steven Chong JCA
7 August 2023

11 September 2023

Steven Chong JCA (delivering the grounds of decision of the court):

Introduction

1 This was an appeal against the decision of the Disciplinary Tribunal (the "DT") in *Singapore Medical Council v Dr Ho Tze Woon* [2023] SMCDT 1 (the "Decision") to convict Dr Ho Tze Woon, the appellant, on one charge under s 53(1)(*e*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) (the "MRA") for failing to provide professional services of the quality that was reasonable to expect of him, and to impose a suspension of nine months.

2 We heard and dismissed the appeal against conviction on 7 August 2023. In our view, the DT's decision to convict the appellant, on the evidence before the court, was eminently correct. The appellant's arguments on appeal did not persuade us otherwise. However, we allowed the appeal against sentence and reduced the suspension from nine months to three months. We now provide

detailed grounds to explain our decision to uphold the DT's conviction but to reduce the period of suspension imposed.

3 In arriving at the sentence, the DT applied a sentencing framework which had been developed to deal with a different disciplinary offence from that which the appellant was convicted of. While the framework could, in theory, have applied to the appellant's disciplinary conviction, given the inherent overlap in the different disciplinary offences, care had to be taken to properly examine the factual matrix of the appellant's disciplinary conduct in order to determine whether the framework should have applied in sentencing the appellant.

4 Ultimately, in the same way that a sentence must always fit the crime, the suspension of a medical practitioner must fit the nature of the disciplinary offence. This is the main point which we will address below.

Material background facts

The incident

5 On 14 January 2017 at about 8.05pm, Mr Ng Cheng Sea Sheares (the "Patient") visited Central 24-Hr Clinic (Yishun) (the "Clinic"), complaining of breathlessness. The Patient had a long history of severe asthma and was 45 years old at the time. He was accompanied by a friend, Ms Liu Jiyun: the Decision at [2].

6 The appellant was the locum doctor on duty in the Clinic. He assessed the Patient to be having an asthma attack, prescribed him some medicine, and then instructed a clinic assistant, Mr Perry Brandon Charles ("Mr Charles"), to administer nebulisation treatment to the Patient. Mr Charles commenced

nebulisation treatment at about 8.08pm in a treatment room (the "Treatment Room"). The Patient was seated in a chair while the nebulisation treatment was being administered. At some point during the nebulisation treatment, the Patient's face turned purple and he began to lose consciousness. Mr Charles shouted for the appellant who was in the adjacent consultation room at the time: the Decision at [3]–[5].

7 The appellant found the Patient pulseless and unconscious and assessed that the Patient was in cardiac arrest. The appellant immediately began performing cardiopulmonary resuscitation ("CPR") on the Patient. This was at around 8.13pm. The Patient remained seated in the chair, unconscious, while the appellant performed CPR on him. Mr Charles continued to hold the nebuliser mask as the appellant performed CPR. The appellant instructed another clinic assistant, Ms Patsy Danker, to call the Singapore Civil Defence Force ("SCDF"). She made the first call to the SCDF at around 8.14pm.

8 The appellant continued performing CPR on the Patient until the paramedics arrived sometime between 8.23pm and 8.25pm. All this while, the Patient remained in the same seated position on the chair. The paramedics examined the Patient and found him to be pulseless and not breathing. They moved the Patient from the chair to the floor, laying him down in a supine position, before performing manual CPR. Subsequently, the paramedics switched to using a LUCAS mechanical chest compression machine. The paramedics also fitted the Patient with a laryngeal mask airway to keep his airway open, and administered adrenalin intravenously: the Decision at [10]–[11].

9 At about 8.37pm, the paramedics transported the Patient from the Clinic to Khoo Teck Puat Hospital ("KTPH") while efforts continued to resuscitate

him. At about 8.41pm, upon arrival at KTPH, the Patient was intubated and there was a return of spontaneous circulation. He was assessed to have suffered from a severe near fatal asthma attack: the Decision at [12].

10 Later, the Patient was transferred to the intensive care unit of KTPH. On 21 January 2017 at 10.48am, the Patient was declared brain dead and passed away while still on life support. The cause of death was status asthmaticus: the Decision at [13].

11 On 10 March 2017, the Patient's sister filed a complaint with the respondent, the Singapore Medical Council ("SMC"), alleging that the appellant had failed to correctly perform CPR on the Patient: the Decision at [14].

The disciplinary proceedings

12 Before the DT, the appellant faced a single charge under s 53(1)(*e*) of the MRA for failing to provide professional services of the quality that was reasonable to expect of him.

13 SMC argued that the appellant should have repositioned the Patient from a seated position to a supine position on the floor before starting to perform CPR. SMC argued that the appellant's failure to do so constituted a failure to meet the "minimum standards of acceptable care derived from the expectations of reasonable medical practitioners": the Decision at [16].

14 The appellant's response was that there was no requirement for him to reposition the Patient to a supine position before performing CPR, as this was not taught in the Basic Cardiac Life Support ("BCLS") course: the Decision at [17]. At the time of the incident, the appellant held a BCLS certification which was valid from 27 August 2015 to 27 August 2017: the Decision at [3]. The

appellant argued that, even if he had needed to reposition the Patient to meet the minimum acceptable standard of care, his failure to do so was justifiable because:

(a) There was insufficient space to transfer the Patient to the floor in the treatment area.

(b) Neither he nor the persons in the Clinic were trained to effect the transfer.

(c) An indeterminate amount of time would be required to reposition the Patient.

(d) There was a possibility of injuring the Patient and/or the persons assisting with the repositioning.

15 In these circumstances, the appellant submitted, it was not unreasonable for him to administer CPR on the Patient in a seated position without first attempting to reposition him: the Decision at [17].

16 SMC called two experts to assist the DT: (a) Professor Heng Wei Jian Kenneth ("Prof Heng"), who is a senior consultant of the Emergency Department at Tan Tock Seng Hospital and the chief instructor of the BCLS course accredited by the Singapore Resuscitation and First Aid Council; and (b) Dr Eng Soo Kiang ("Dr Eng"), who is a family physician practicing at CCK Family Clinic Pte Ltd. In response, the appellant called Dr Lim Swee Han ("Dr Lim"), who is a senior consultant of the Department of Emergency Medicine at the Singapore General Hospital. Dr Lim was initially asked by SMC to provide an expert opinion for the purpose of the disciplinary inquiry and he did so on 11 March 2020. Later, SMC decided that it would not be calling Dr

Lim as an expert witness. The appellant then decided to call Dr Lim as his own witness, and Dr Lim provided a further report on 14 September 2021: the Decision at [19].

The DT's decision

17 The DT convicted the appellant on the charge and sentenced him to a nine-month suspension, along with the usual accompanying orders.

18 In coming to its decision to convict the appellant, the DT first considered whether the appellant would know that a patient should generally be repositioned to a supine position before CPR is administered. The DT noted Prof Heng's evidence that it was emphasised during the BCLS course that a patient should be lying on a firm flat surface for CPR to be effective: the Decision at [22]. The DT also noted that Dr Lim accepted that CPR should be performed with patients lying on their back on a firm flat surface as a general rule: the Decision at [24]. The DT concluded that the appellant ought to have known that administering CPR on the Patient in a seated position was not an effective way to resuscitate him, in accordance with his BCLS training: the Decision at [27]. The DT rejected the appellant's suggestion that he should not be expected to know that he needed to reposition the Patient from a seated position to a supine position because this was not specifically taught in his BCLS course. In the DT's view, the BCLS course taught the principles of effective CPR and it would be reasonable to expect a medical practitioner to be able to apply these principles and react accordingly in the given circumstances: the Decision at [28].

19 The DT then considered whether the appellant's failure to reposition the Patient to a supine position was justifiable in the circumstances of this case. All the experts acknowledged that, while the general rule was for CPR to be

performed on a patient in a supine position, there were exceptional circumstances where this could not be done: the Decision at [31].

20 Prof Heng and Dr Eng were of the view that, even though the space in the Treatment Room was limited, CPR could have been administered with the Patient lying supine on the floor and the appellant kneeling next to him: the Decision at [47]. Dr Lim agreed that this was possible, but qualified that it would not have been optimal: the Decision at [48]. The DT concluded that the Treatment Room was big enough for the Patient to be laid in a supine position while the appellant performed CPR on him: the Decision at [49]–[50].

21 On the issue of manpower to effect the transfer, Prof Heng and Dr Eng opined that a patient transfer could be done safely by three, or even two, persons. Their view was that patient transfer did not need to be explicitly taught in the BCLS course because it would be reasonable to expect the rescuer to mobilise help to safely lower the patient onto the floor. Further, they thought that it was not necessary for the persons assisting to be trained or experienced in patient transfer: the Decision at [55]–[58]. Dr Lim, however, gave evidence that the appellant faced manpower constraints that prevented him from transferring the Patient to a supine position. He explained that the appellant was not trained in the mechanics of patient transfer, and that the other people in the Clinic had even less training as they had not attended any BCLS course. Even if everyone at the Clinic had the requisite training, they were of small build and were unlikely to have had enough strength to transfer the Patient. Dr Lim's evidence was that if the appellant had thought through the situation and made a subjective assessment that a transfer was not feasible, he should continue to do chest compressions on the Patient in a seated position without attempting a transfer: the Decision at [60]. The DT rejected this proposition, noting that the appellant had to meet *objective* minimum standards. The DT concluded that there were

no manpower constraints which could have justified not attempting to reposition the Patient: the Decision at [62]–[64].

22 In respect of the time required to reposition the Patient, Dr Lim emphasised the importance of uninterrupted or continuous chest compressions. He noted that chest compressions could not be performed while transferring a patient. This supported the appellant's argument that he was justified in commencing CPR immediately instead of repositioning the Patient first. Prof Heng and Dr Eng disagreed with Dr Lim's analysis. Dr Eng's view was that ineffective CPR was as good as no CPR: the Decision at [65]–[66]. Ultimately, the DT did not accept the appellant's argument. The DT found that delayed *effective* CPR on the Patient would have given him a better chance of survival as compared to immediate but futile and ineffective CPR: the Decision at [69]–[70].

23 Finally, Dr Lim gave evidence that the safety risk of moving the Patient would have been higher due to his relatively large build as compared to the appellant and his clinic assistants. The DT found this risk to be overstated. The DT also found that the benefit of administering potentially life-saving CPR on the Patient would outweigh the risk of any injury to him in the course of transfer: the Decision at [71]–[73].

24 Accordingly, the DT found that, in order to provide professional services of the quality reasonably expected of him, the appellant should have attempted to transfer the Patient to a supine position before commencing CPR, and convicted him of the charge: the Decision at [74]–[75].

25 On sentencing, the DT agreed with SMC's submission that the sentencing framework set out in *Wong Meng Hang v Singapore Medical*

Council and other matters [2019] 3 SLR 526 ("*Wong Meng Hang*") at [29]–[44] and the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* dated 15 July 2020 (the "*Sentencing Guidelines*") at paras 47–72 was applicable to offences under s 53(1)(*e*) of the MRA: the Decision at [78].

26 Applying the framework and the *Sentencing Guidelines*, the DT found the appellant's offence to have caused harm on the high-end of the "moderate" range. It found it inappropriate to classify this case as involving slight harm because this would imply that the offence did not cause actual personal injury or that the offence did not undermine public confidence in the medical profession: the Decision at [93]. The DT found that the appellant's failure to provide effective CPR had a direct adverse effect on the chances of survival for the Patient and that permanent and irreversible harm was done to the Patient: the Decision at [94]. Further, the appellant's failure to deliver elementary clinical care by providing CPR in a proper manner would undermine public confidence in the medical profession: the Decision at [100]. The DT found the appellant's culpability to fall slightly above the middle of the "low" range. It noted that based on the *Sentencing Guidelines*, a doctor would be more culpable if he failed to uphold the most basic and elementary professional standards. While the DT was prepared to give weight to the urgency and rarity of the situation faced by the appellant, it did not think that this would significantly lower the appellant's culpability: the Decision at [101]. The DT thus concluded that an eight-month suspension would be the appropriate starting point for the appellant's sentence: the Decision at [102].

27 The DT then noted the appellant's lack of remorse, which was an aggravating factor as per the *Sentencing Guidelines* at para 69. On this basis, the DT increased the suspension to nine months: the Decision at [103]. The DT

concluded that there were no mitigating factors which warranted any reduction in the sentence: the Decision at [108].

Issues to be determined

28 There were four issues which we had to decide in the appeal. The first two issues related to the appeal against conviction and the latter two issues related to the appeal against sentence:

(a) What is the applicable test in cases involving s 53(1)(*e*) of the MRA?

(b) Did the appellant fail to provide professional services of the quality which was reasonable to expect of him?

(c) Was the *Wong Meng Hang* sentencing framework applicable in this case?

(d) What was the appropriate sentence in this case?

What is the applicable test in cases involving s 53(1)(*e*) of the MRA?

29 Under s 53(1)(*e*) of the MRA, a medical practitioner may face disciplinary action where he has "failed to provide professional services of the quality which is reasonable to expect of him".

30 In *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 ("*Peter Yong*") at [11], the court explained that a charge under s 53(1)(*e*) "involves an objective assessment of standards of medical care which can be reasonably expected of medical practitioners". This assessment "calls for a consideration of what reasonable medical practitioners would expect of their peers in delivering medical care". These standards "may be regarded as the

minimum standards of acceptable care derived from the expectations of reasonable medical practitioners". This is the standard that the DT applied (see the Decision at [16]).

31 In our view, the test to be applied in s 53(1)(*e*) cases is stated clearly in the text of the MRA. The remarks in *Peter Yong* are useful in explaining how this test is to be applied. On appeal before us, the appellant sought to argue that the applicable test should be slightly different. We rejected these arguments because they were premised on the appellant's selective citing of *dicta* from various cases that were not applicable in the present context.

32 First, the appellant suggested that a medical practitioner only falls foul of s 53(1)(*e*) where he has shown a serious disregard of or a persistent failure to meet minimum and elementary clinical standards. Where there is serious disregard of or a persistent failure to meet minimum standards, undoubtedly, the medical practitioner would fall foul of s 53(1)(*e*). However, it is entirely erroneous to suggest that a conviction under s 53(1)(*e*) is *only* warranted where such serious disregard or persistent failure is established. As mentioned, the text of the statute is clear and there is no requirement that the failure to provide adequate professional services must be serious or persistent. In *Peter Yong*, the court did not suggest that there had to be a serious disregard of or persistent failure to meet minimum standards for there to be a breach of s 53(1)(*e*).

33 In support of his point, the appellant cited *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739 (*"Lim Lian Arn*") at [34] where the court explained that while doctors are expected to adhere to the standards prescribed in the Ethical Code and Ethical Guidelines (2002) ("ECEG"), it is only serious disregard of or persistent failure to meet these standards that may lead to disciplinary proceedings. The appellant's reliance on this case was misplaced.

In *Lim Lian Arn*, the court was considering the scope of professional misconduct for the purposes of s 53(1)(*d*) of the MRA (see *Lim Lian Arn* at [26]). The court rejected an argument that a breach of a basic principle of the ECEG amounted to professional misconduct. The court clarified that a departure from the standards prescribed in the ECEG does not itself lead to the conclusion that there has been professional misconduct. It was in this context that the court identified the need for a serious disregard of or persistent failure to meet the ECEG standards (at [33]). As is common ground between both sides, s 53(1)(*e*) does not necessarily involve professional misconduct and this case in particular did not involve professional misconduct. A charge that involves professional misconduct is quite different from a charge which simply involves a failure to provide professional services of a reasonably expected quality (we return to this at [65]–[67] below). The court's remarks in *Lim Lian Arn* were inapplicable to s 53(1)(*e*) and therefore did not assist the appellant.

34 Second, the appellant suggested that there must be a failure to meet *elementary* clinical standards for there to be liability under s 53(1)(*e*). In so far as the word "elementary" connoted standards that are lower than standards "reasonably expected" of a practitioner (*ie*, standards that are easier for a practitioner to meet), it did not form part of the test. This argument once again did not accord with the text of the statute.

35 To advance this argument, the appellant relied on *Peter Yong* at [11] where the court held:

> … In the case before us, Dr Yong has accepted that he failed to meet these standards in relation to the third charge and this is unsurprising given that the DT found his conduct in this regard fell short of *elementary* clinical standards. [emphasis in original]

36 This passage did not support the appellant's argument. When the court noted that the doctor *in that case* had fallen short of elementary clinical standards, it did not hold that a breach of elementary clinical standards was a necessary ingredient of a breach of s 53(1)(*e*). A failure to meet elementary clinical standards will undoubtedly be a failure to meet minimum acceptable standards. The converse, however, is not true.

37 We therefore rejected the appellant's attempts to recharacterise the applicable test in determining whether a medical practitioner has committed a disciplinary offence under s 53(1)(*e*) of the MRA. We found that the test was best articulated using the words of the MRA itself. A medical practitioner has committed a disciplinary offence when he has failed to provide professional services of the quality which is reasonable to expect of him.

Did the appellant fail to provide professional services of the quality which was reasonable to expect of him?

38 We found that the DT's conclusion that the appellant failed to provide professional services of the quality which was reasonable to expect of him was entirely justified.

39 There were two points which we found strongly supported the DT's conclusion that it would be reasonably expected that a medical practitioner reposition a patient to a supine position, if possible, before performing CPR.

40 The first point was that there was a consensus between the experts that effective CPR requires the patient to be lying flat on his back on a firm surface.

41 The appellant's expert, Dr Lim, explained that during chest compressions, the heart is squeezed between the sternum and the spine, and this

causes blood to flow from the heart to various parts of the body, including the brain. For chest compressions to be effective, the rescuer must push hard and fast. When the patient is in a supine position, the rescuer can keep his shoulders directly above the patient's sternum and use his body weight to compress the sternum. This reduces fatigue for the rescuer. Further, when the patient is in a supine position, blood from the heart does not need to flow against gravity to reach the brain. In cross-examination, Dr Lim agreed that another advantage of the patient being in a supine position was that there would be a stronger counterforce provided by the firm ground against the spine.

42 Prof Heng explained that the patient should be lying supine on a firm, flat surface which offers counterforce and enables the blood to be squeezed out of the heart. Also, the rescuer's shoulders should be directly over the patient, with his weight directly over his clasped hands placed on the patient's lower sternum. Dr Eng's evidence was that a hard surface is required under the patient to provide uniform force and sternal counter pressure.

43 The expert evidence thus made clear that there were three key reasons why a patient must be in a supine position for CPR to be effective:

(a) so that there is a strong, uniform counterforce from a firm, flat surface;

(b) so that greater force can be exerted by the rescuer by using his body weight; and

(c) so that there is no need for the patient's blood to work against gravity to travel from the heart to the brain.

44 It followed from the above that the administration of CPR in a seated position would be ineffective due to the absence of those three factors. In cross-examination, Dr Lim accepted that this was the case for the Patient because: (a) the chair provided reduced counterforce (the backrest or the chair would rock back and forth during compressions); (b) the appellant was not able to position himself directly above the Patient and perform the compressions using his body weight to achieve the necessary depth of compressions and reduce fatigue; and (c) the blood from the Patient's heart would have to flow against gravity to reach the brain. This echoed what Prof Heng noted in his report. According to Prof Heng, CPR on the Patient in the seated position for nine minutes would have been so ineffective that it would have decreased the Patient's chances of survival by 90%.

45 The second point was that Step 4 of CPR as taught in the BCLS course explicitly states that, for CPR to be effective, the patient must be lying on his or her back on a firm, flat surface. We reproduce what the BCLS manual states at Step 4:

> For CPR to be effective, the casualty must be lying on his/her back on a firm, flat surface. If the casualty is lying face down, or on his/her side, the rescuer will need to roll the casualty over onto his/her back. Do take care that the head, neck and body are supported and turned simultaneously during repositioning, to avoid aggravating any potential cervical spine injury.

It would therefore be clear to anyone, more so a medical practitioner, who had attended and passed the BCLS course that it is important to place the patient in a supine position on a firm, flat surface for CPR to be effective.

46 On these two points, it was relatively clear that it would be reasonable to expect a medical practitioner who had gone through the BCLS course and administered CPR before to reposition a patient to a supine position, if possible,

before performing CPR. The appellant argued that the DT's decision was tantamount to imposing an absolute rule on medical practitioners to reposition patients to a supine position before performing CPR in all circumstances. However, this was not what the DT decided. The DT acknowledged that there may be exceptional situations in which repositioning a patient would not be possible and that consequently there would be no expectation on the doctor to reposition the patient. The DT's focus was on whether, on the facts of this case, there were such exceptional circumstances. The DT found that there were not, and that it was possible for the appellant to reposition the Patient to a supine position before starting CPR.

47 We now turn to the question of whether, given the circumstances of this case, it was reasonable to expect the appellant to reposition the Patient before performing CPR.

48 We agreed with the DT that it was possible for the appellant to have repositioned the Patient to a supine position on the floor before starting CPR. There was clearly enough space given that the paramedics were eventually able to place the Patient on the floor, albeit with part of his body outside the Treatment Room, and perform CPR on him: the Decision at [51]. In Dr Lim's reports, he was overly focused on whether there was sufficient space *in the Treatment Room* for CPR to be performed on the Patient in a supine position. He did not consider properly the possibility of moving items out of the Treatment Room, or whether there was enough space for the appellant to perform CPR on the Patient laid supine partially outside the Treatment Room. It is not clear why Dr Lim assumed that items could not have been moved out of the Treatment Room, or that the Patient could not have been placed on the floor with his body partially outside the Treatment Room.

49 There was also clearly enough manpower for the appellant to reposition the Patient. There were three other individuals in the Clinic that could have assisted the appellant. It was not the appellant's evidence that he had asked any of these individuals to help him move the Patient and that they had refused or told him that they were not able or willing to do so. After all, repositioning the Patient in this case involved the relatively simple manoeuvre of placing the Patient onto the floor from a chair. There were no obstacles to impede or prevent the appellant from repositioning the Patient with the assistance of the others in the Clinic.

50 At the hearing before us, the appellant's counsel emphasised that: (a) the BCLS manual did not specifically state that a patient should be repositioned from a sitting position to a supine position before CPR was performed; (b) the appellant was faced with a chaotic emergency situation; and (c) the appellant could not have reasonably known that repositioning the Patient was possible, or how long it would have taken. None of these three contentions changed our conclusion.

51 On the first point, we were troubled by the suggestion that a medical practitioner would only be reasonably expected to do what was explicitly stated in the BCLS manual. Even the appellant's expert agreed that the appellant should have known that, as a general rule, he should place a patient in cardiac arrest in a supine position before administering CPR, unless there were manpower or spatial constraints preventing him from doing so. To us, the important point was that the BCLS manual did not contain anything which suggested that moving a patient in cardiac arrest was dangerous, and therefore prohibited or advised against. There was no evidence before the DT that there were medical reasons why the Patient should not have been moved.

52 On the second point, we did not see how the fact that the appellant was faced with an emergency could be a relevant consideration in this context. After all, the very issue concerned what was reasonably expected of a doctor when performing CPR. All cases where a doctor is required to perform CPR will be emergencies. In such situations, doctors are expected to provide emergency care. Of course, as explained in *Noor Azlin bte Abdul Rahman v Changi General Hospital Pte Ltd and others* [2019] 1 SLR 834 at [68], the court is cognisant that a doctor dealing with a medical emergency will not have the "luxury of long and mature consideration" of what the appropriate step to take is. That said, there is nothing onerous about expecting a doctor to reposition a patient into a supine position in an emergency. All that the DT found was expected of the appellant was to *attempt* to transfer the Patient: the Decision at [74]. Making the decision to do this would not need long and mature consideration. The appellant could have just attempted repositioning the Patient and then, if his attempts were not successful, considered whether it was feasible or possible to continue.

53 This leads us to our final point. Even if the appellant could not reasonably have known whether it was possible to move the Patient or how long it would have taken to do so, one would reasonably expect him to have had at least made an attempt before concluding that it was not possible and would have taken too long. This is especially the case considering how important it is for a patient to be in a supine position, as explained by the experts (see [43] above). As explained above, in the Patient's seated position, none of the three advantages of a supine position for the purposes of effective CPR were present.

54 We therefore agreed with the DT's conclusion that the appellant failed to provide professional services of a quality reasonably expected of him and we dismissed his appeal against conviction.

Was the *Wong Meng Hang* sentencing framework applicable in this case?

55 In arriving at the nine-month suspension that it imposed on the appellant, the DT used the sentencing framework that was set out in *Wong Meng Hang*. Before the DT, and before us on appeal, the appellant argued that the *Wong Meng Hang* framework was not applicable to his case. His argument was essentially that the *Wong Meng Hang* framework was developed in relation to cases of professional misconduct under s 53(1)(*d*) of the MRA and accordingly it would be inappropriate to apply the framework to cases involving s 53(1)(*e*) of the MRA. We agreed with the appellant's argument in part. While we considered that it was possible for the *Wong Meng Hang* framework to apply to some cases under s 53(1)(*e*) of the MRA, we did not consider that it could apply to all such cases. Whether or not the framework could be applied to a s 53(1)(*e*) case would depend on the specific factual matrix of the case. We now explain why, on the facts of this case, we had some hesitation about applying the *Wong Meng Hang* framework.

56 In *Wong Meng Hang* at [29]–[44], we set out a systematic approach to sentencing that is to be adopted in "cases where the misconduct of a medical practitioner has caused harm to the patient". At the first step of the inquiry, the court is to evaluate the seriousness of the offence, having regard to the two principal parameters of harm and culpability (at [30]).

57 At the second step, the court is to identify the applicable indicative sentencing range based on the relevant levels of harm and culpability. For the purposes of this exercise, we set out the following sentencing matrix at [33]:

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

58 We then clarified at [36] of *Wong Meng Hang* that the above sentencing matrix was only applicable to cases where deficiencies in a doctor's clinical care caused harm to a patient. It was not applicable to cases involving other forms of medical misconduct such as "overcharging, falsification of medical documents, inappropriate relations with a patient, or conduct which lies outside the ambit of a doctor's professional responsibilities to his patient but which leads to a

conviction for a criminal offence implying a defect of character that renders the doctor unsuitable for registration as a medical practitioner".

59 At the third step, the court is to identify the appropriate starting point within the relevant indicative sentencing range from the matrix above (at [42]). At the fourth step, the court is to make adjustments to the starting point to take into account offender-specific factors which do not relate directly to the commission of the particular offence, but may nonetheless be sufficiently aggravating or mitigating so as to warrant an adjustment in the sentence (at [43]).

60 Following *Wong Meng Hang*, the Sentencing Guidelines Committee appointed by SMC published the *Sentencing Guidelines*. The *Sentencing Guidelines* noted that the *Wong Meng Hang* framework was broad enough to apply to other forms of harm (*eg*, emotional or psychological distress, potential harm, harm caused to public confidence in the medical profession, *etc*.), and that it could therefore be extended to cover non-clinical care offences (para 44 of the *Sentencing Guidelines*). It was also suggested that the *Wong Meng Hang* framework could apply not only to cases involving professional misconduct under s 53(1)(*d*) of the MRA but to all five limbs under s 53(1) of the MRA (para 45 of the *Sentencing Guidelines*).

61 In *Ong Kian Peng Julian v Singapore Medical Council and other matters* [2023] 3 SLR 1756 ("*Julian Ong*"), this court dealt with two practitioners who were charged with offences under s 53(1)(*c*) of the MRA. The parties in that case did not dispute that the *Wong Meng Hang* framework applied to sentencing even though the offences did not involve the doctors' deficiencies in clinical care causing harm to their patients (at [60]). There, we recognised the logic of the suggestion in the *Sentencing Guidelines* that the *Wong Meng Hang*

framework could be extended to other forms of wrongdoing, but emphasised the importance of bearing in mind the nuances of each case (at [62]). We then applied the *Wong Meng Hang* framework to determine the appropriate sentence for the medical practitioners.

62 To summarise, the *Wong Meng Hang* framework was first formulated to apply to clinical cases of professional misconduct under s 53(1)(*d*) of the MRA. It has since, in *Julian Ong*, been extended to apply to non-clinical cases where the doctor is "guilty of such improper act or conduct which, in the opinion of the Disciplinary Tribunal, brings disrepute to his profession" under s 53(1)(*c*) of the MRA. While the *Sentencing Guidelines* contain a suggestion that the *Wong Meng Hang* framework *can* apply to all the limbs under s 53(1) of the MRA, this court has not yet considered this suggestion in depth. There is also no case thus far in which this court has applied the *Wong Meng Hang* framework to a s 53(1)(*e*) offence.

63 The DT considered that the *Wong Meng Hang* framework was applicable to this case because the court in *Wong Meng Hang* intended it to apply to cases where there were deficiencies in a doctor's clinical care that caused harm to a patient. The DT found this to be broad enough to include disciplinary offences under s 53(1)(*e*): the Decision at [78]. Further, the DT noted the suggestion in the *Sentencing Guidelines* that the framework could be extended to non-clinical offences and to all the limbs of s 53(1). The DT also considered the fact that, in *Julian Ong*, the *Wong Meng Hang* framework was applied to a limb of s 53(1) other than s 53(1)(*d*). The DT thus concluded that the *Wong Meng Hang* framework was not limited to offences under s 53(1)(*d*) of the MRA and that the factors laid out in the framework would remain relevant for offences under other limbs of s 53(1). The DT then determined the relevant

level of harm and culpability in the appellant's case before utilising the matrix at [57] above to reach its sentence of a nine-month suspension.

64 While we accepted that the *Wong Meng Hang* framework *could* apply to certain cases involving offences under s 53(1)(*e*), we did not agree that it was appropriate to utilise the framework in this case.

65 The *Wong Meng Hang* framework was developed to deal with cases under s 53(1)(*d*) of the MRA. These cases involve professional misconduct. In *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37], this court observed that professional misconduct can be made out in at least two situations:

(a) where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; or

(b) where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

It has been made abundantly clear in multiple cases that professional misconduct entails more than mere negligence, professional incompetence or an error of judgment (see *Lim Lian Arn* at [37], *Chia Foong Lin v Singapore Medical Council* [2017] 5 SLR 334 at [60]–[61]). While negligence can sometimes amount to professional misconduct, it is only cases involving gross negligence that will fall within the second category of misconduct described in *Low Cze Hong*.

66 For an offence under s 53(1)(*e*) to be made out, there is no need for the doctor involved to have been guilty of professional misconduct. Returning to the test from *Peter Yong*, an offence under s 53(1)(*e*) is made out as long as there has been a failure by the doctor to meet the minimum standards reasonably expected of him. There is no requirement that this failure to meet the minimum acceptable standards must be deliberate, intentional or so serious that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

67 There is therefore an overlap between clinical cases of professional misconduct under s 53(1)(*d*) and offences under s 53(1)(*e*) of the MRA. In all cases where the conduct of a medical practitioner satisfies either limb from *Low Cze Hong*, the medical practitioner will undoubtedly have failed to provide professional services of the quality reasonably expected of him. The converse, however, is not true. There will be many cases where a medical practitioner has failed to provide professional services of the quality reasonably expected of him, but where his conduct does not satisfy either limb from *Low Cze Hong*. This case was a good illustration of this. It was common ground between SMC and the appellant that the present case did not involve professional misconduct. Nonetheless, we had no doubt that the appellant had failed to provide professional services of the quality reasonably expected of him and we agreed with his conviction under s 53(1)(*e*).

68 When we set out the framework in *Wong Meng Hang*, we emphasised that the above sentencing matrix was not an appropriate reference for cases involving other forms of misconduct (*ie*, non-clinical misconduct) because "the types of harm caused by those forms of misconduct may be markedly different in nature to that which is caused by misconduct in the form of deficient clinical care" (at [36]). While the harm in s 53(1)(*d*) cases involving misconduct of a

clinical nature would not be markedly different from the harm involved in s 53(1)(*e*) cases, the culpability involved would be. As demonstrated by the overlap between the two subsections, s 53(1)(*e*) covers a much wider range of culpability than s 53(1)(*d*). It also has a much lower minimum threshold of culpability. We therefore did not agree that the *Wong Meng Hang* framework should be applicable as a default for all cases under s 53(1)(*e*). If it were applicable to *all* cases under s 53(1)(*e*), it would apply to some cases where there was no professional misconduct and the medical practitioner's culpability fell far short of even the minimum culpability contemplated when the framework was developed. In our view, this could not be the correct position.

69 When we made the decision in *Julian Ong* to extend the *Wong Meng Hang* framework to a case under s 53(1)(*c*), we did not hold that the framework was to apply as a default to all cases under s 53(1)(*c*). In fact, we stressed the importance of bearing in mind the nuances of each case (*Julian Ong* at [62]). Our decision to apply the framework in that case must be seen in light of the nature of the conduct involved. In this regard, we found that one of the medical practitioners had demonstrated a "callous and an intentional departure from the conduct reasonably expected" of him as a medical practitioner (*Julian Ong* at [71]).

70 Once again, we recognise the logic of the recommendation in the *Sentencing Guidelines* that the *Wong Meng Hang* framework can apply to all other limbs under s 53(1). The *Wong Meng Hang* framework can provide a useful analytical guide in sentencing for many cases across all limbs of s 53(1). However, there will be certain cases under s 53(1) where the *Wong Meng Hang* framework is not applicable. The *Wong Meng Hang* framework was developed to deal with instances of professional misconduct. Professional misconduct is a serious charge, and it carries a much higher threshold than, for example, failing

to provide professional services of the quality reasonably expected. It is not appropriate to apply the *Wong Meng Hang* framework to cases where there is no proof of misconduct, bearing in mind the contours of "misconduct" as set out in *Low Cze Hong*. Before the *Wong Meng Hang* framework is applied to any case under s 53(1), care must be taken to analyse the facts and determine if the medical practitioner's conduct is, or is at least comparable to, professional misconduct.

71 In the present case, it was common ground that the appellant's wrongdoing did not amount to professional misconduct. We therefore had reservations about the DT's decision to use the *Wong Meng Hang* framework to determine the appellant's sentence.

What was the appropriate sentence in this case?

72 Having concluded that it was not appropriate to use the *Wong Meng Hang* framework in this case, we then had to decide what the appropriate sentencing approach was. The appellant proposed that we utilise the *Wong Meng Hang* framework but apply a one-third reduction to the prescribed sentence range in the sentencing matrix. We did not agree with this approach because there was no principled basis for the proposed one-third reduction. We also did not consider that this was an appropriate case to set out a new sentencing framework for s 53(1)(*e*) offences not involving professional misconduct given that there had only been two prior cases involving this limb of s 53(1). We determined that the appropriate sentence for the appellant should be a suspension of three months by comparing the facts of the present case to those of the two precedents under s 53(1)(*e*).

73 In *Peter Yong*, the doctor failed to adequately explain to his patient the nature of a trigger finger release surgery, including possible complications. He

then carried out this surgery on the consultation table at his clinic. Following the surgery, the doctor did not keep clear or complete records in respect of what, if anything, was conveyed to the patient in terms of advice or explanation, the patient's response to any such communications and his physical findings upon assessment of the patient. The patient subsequently sought a second opinion and was diagnosed with numbness over his radial aspect left middle finger and a poorly healing wound post the trigger finger surgery. He had to undergo further medical treatment and consultations. The doctor faced two charges of professional misconduct under s 53(1)(*d*) in respect of his failure to obtain informed consent and failure to keep clear and accurate medical records respectively. He faced a third charge under s 53(1)(*e*) in respect of his carrying out the trigger finger release surgery on the consultation table instead of in a procedure room or an operating theatre. The doctor pleaded guilty to all three charges. He was sentenced to six months' suspension and a $10,000 fine.

74 In the case of *In the Matter of Dr Fernandes Mark Lee* [2017] SMCDT 2 ("*Fernandes Mark Lee*"), the doctor failed to accurately inform his patient of his test results. Following a health screening, the doctor sent his patient a medical report which indicated on its summary page that the cancer markers were "normal" even though the laboratory results that were annexed to the medical report stated that the patient's Carcino-Embryonic Antigen level was 16.5ng/ml which was an "abnormal" result. The doctor was given a fine of $10,000.

75 We considered that the appropriate sentence for the appellant should not exceed that given to the doctor in *Peter Yong.* First, the sentence in *Peter Yong* was given in respect of *three* charges, two of which were for professional misconduct. As explained earlier, professional misconduct is a serious allegation and it was common ground that there was no professional misconduct

here. Second, the doctor in *Peter Yong* had relevant antecedents which demonstrated to the court that he had "failed to mend his ways but had gone on to commit *similar* and *more serious* breaches of his duty" [emphasis in original] (*Peter Yong* at [13]). That was not the case for the appellant.

76 While we did accept that the harm in this case was certainly higher than that in *Peter Yong* where no harm was caused to the patient (*Peter Yong* at [12]), we were careful not to place too much weight on the fact that the Patient unfortunately passed away (we return to this at [79]–[81] below).

77 At the same time, we did not consider that a fine, like the sentence in *Fernandes Mark Lee*, was appropriate. The appellant's failure to provide vital emergency care was a far greater failure to provide acceptable professional services than simply misinforming a patient of test results. We therefore concluded that a three-month suspension for the appellant would be appropriate.

78 In any event, had we applied the *Wong Meng Hang* framework, we would have arrived at the same sentence. We similarly found that the appellant's culpability was in the middle range of the low band. As for harm, we were of the view that it was on the lower-end of the moderate band. We did not agree with the DT's finding that harm was on the high-end of the moderate band for the following reasons.

79 It is key that, in this case, there was no suggestion that the appellant caused the Patient's death, whether by act or omission. This is because the appellant's failure to properly administer CPR to the Patient did not cause the Patient's death. Rather, the appellant's failure constituted an omission to provide care which could potentially have saved the Patient's life, or at the very

least increased his chances of survival. The importance of this distinction was explained by this court in *Wong Meng Hang* at [83]–[84]:

> 83 Dr Wong's submissions approach the question of harm solely as a question of *injury*. But that is not correct. The focus should first be on what harm was *directly caused* by the doctor's misconduct. In our judgment, neither *Ang Peng Tiam* nor *Eric Gan* even approaches the gravity of the harm that was caused by Dr Wong. In *Ang Peng Tiam*, the misconduct of the oncologist did not *cause* the patient's death. The patient was already suffering from life-threatening cancer. What the oncologist did improperly was to present an unduly optimistic prognosis to the patient without having tested for a particular mutation, when his prognosis would only have been justified had the patient tested positive for that mutation. And in *Eric Gan*, the patient succumbed to a known complication of surgery. The surgeon did not cause the complication by his misconduct. Instead, the misconduct arose from the surgeon's failure to discover that the complication had set in.
>
> 84 In contrast, the present case did not involve a mere omission to provide lifesaving treatment, a loss of chance of survival, or any pre-existing risk inherent in the nature of the patient's medical condition or in the medical procedure undergone by the patient. In such situations, due regard should be had to the occupational risks faced on a daily basis by medical practitioners. …
>
> [emphasis in original]

80 The DT's finding was simply that the appellant's conduct directly affected the Patient's chances of survival. In our view, this finding was insufficient to support the conclusion of high-moderate harm because it was not accompanied by a finding of *how much* the appellant's breach affected the Patient's chances of survival. SMC stressed that the harm in this case was serious because the ultimate consequence for the Patient was death, and the appellant's actions had increased the chances of this happening. We did not agree with this reasoning. As is clear from the passage from *Wong Meng Hang* above, harm is a function of both the injury to the patient and the degree of connection between the doctor's conduct and that injury. Where a doctor's

actions were connected to a patient's death only in that they increased the chances of death by a small percentage, we would not consider it fair to conclude that there was moderate-high harm.

81 In this case, there was little evidence regarding the extent of the adverse effect of the appellant's conduct on the Patient's chances of survival. The experts' evidence was mainly directed at whether, generally, a delay in effective CPR decreased a patient's chance of survival. Prof Heng's conclusion that the appellant's actions decreased the Patient's chances of survival by 90% did not assist because the evidence indicated that the Patient's chances of survival were not high to begin with. 90% of a small fraction is still a small fraction. To justify the DT's conclusion there would have needed to be clearer evidence of how much the appellant's conduct decreased the Patient's chances of survival.

82 Thus, regardless of the sentencing approach used, we arrived at a sentence of a three-month suspension for the appellant.

Conclusion

83 For these reasons, we dismissed the appellant's appeal against his conviction but reduced his nine-month suspension to a three-month suspension. Because the appellant only succeeded partially in the appeal, we ordered that the costs order made by the DT was to stand and that each party was to bear their own costs in respect of the appeal.

Judith Prakash
Justice of the Court of Appeal

Tay Yong Kwang
Justice of the Court of Appeal

Steven Chong
Justice of the Court of Appeal

Cai Enhuai Amos, Teo Ying Ying Denise, Tian Keyun and Kieran Jamie Pillai (Yuen Law LLC) for the appellant.
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