

Lee Kim Kwong v Singapore Medical Council
[2014] SGHC 151

Case Number : Originating Summons No 1177 of 2013
Decision Date : 30 July 2014
Tribunal/Court : High Court
Coram : Sundaresh Menon CJ; Andrew Phang Boon Leong JA; Quentin Loh J
Counsel Name(s) : Lek Siang Pheng, Lim Xiu Zhen and Ang Yi Rong (Rodyk & Davidson LLP) for the appellant; Tan Chee Meng SC, Chang Man Phing, Ng Shu Ping and Jocelyn Ngiam (WongPartnership LLP) for the respondent.
Parties : Lee Kim Kwong — Singapore Medical Council

Professions – Medical profession and practice – Professional conduct

30 July 2014

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

1 Dr Lee Kim Kwong (“the Appellant”) is a medical practitioner who has been registered since 1998 as a specialist in obstetrics and gynaecology with the Singapore Medical Council (“the Respondent”). Following a complaint by a patient of the Appellant (“the Complainant”) in relation to a caesarean section that he performed on her on 17 August 2010, a single charge of professional misconduct was preferred against him. The allegation of misconduct contained in the charge was that he had commenced the caesarean section by making an incision on the Complainant’s abdomen without having first tested if the anaesthetic earlier administered to her had taken full effect; and that, even though the incision caused the Complainant to scream in pain, he continued with the procedure anyway. The charge against the Appellant itself reads as follows:

That you, Dr LEE KIM KWONG, a registered medical practitioner under the Medical Registration Act (Cap. 174), on 17 August 2010 at Mount Alvernia Hospital located at 820 Thomson Rd, Singapore 574623, did perform a lower segment caesarean section (“the Procedure”) on your patient, [the Complainant], without ensuring that the anaesthesia had taken full effect, thereby causing pain and distress to the [Complainant].

Particulars

- a. The [Complainant] was administered with an epidural injection of local anaesthetic to the epidural space of the [Complainant] by Dr Lim Eng Siong at about 8.10 a.m.
- b. You commenced the Procedure on the [Complainant] by making an incision before testing if the anaesthetic had taken full effect.
- c. The incision you made on the [Complainant] caused the [Complainant] to scream in pain. Despite this, you proceeded with the Procedure.

and that in relation to the facts alleged you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) and in breach of Article 4.1.1.5 of the Singapore Medical Council’s Ethical Code and Ethical Guidelines.

2 The Disciplinary Committee ("DC") of the Respondent found the Appellant guilty of professional misconduct. It ordered that the Appellant be suspended from practice for nine months and that he pay a financial penalty of \$10,000 as well as costs. By the present originating summons the Appellant sought to set aside the entirety of the DC's order. Broadly speaking, this was an appeal against both conviction and sentence. The Appellant asked that this court set aside the DC's guilty verdict on the charge of professional misconduct against him, and in the event that we did not, he asked that the nine-month period of suspension from practice imposed on him be set aside or reduced. At the conclusion of the hearing of the appeal we dismissed the appeal against conviction but, allowing the appeal against sentence, we ordered that the period of suspension imposed be reduced from nine to five months. We set out now the detailed grounds for our decision.

Agreed facts

3 An agreed statement of facts was tendered before the DC and we can do little more than to reproduce most of its contents here. The Complainant first saw the Appellant in 2008 for the management of her first pregnancy. The Appellant safely delivered her first child via lower segment caesarean section under epidural anaesthesia ("EA") on 6 January 2009 due to failure to progress in labour.

4 The events giving rise to the charge of professional misconduct against the Appellant arose out of the Complainant's second pregnancy. She was scheduled to undergo a lower segment caesarean section performed by the Appellant on 17 August 2010 at 8.00am at Mount Alvernia Hospital. At 5.25am on that day, she arrived at the hospital and she elected to undergo the procedure under EA. She was wheeled into the operating theatre sometime before 7.30am. Dr Lim Eng Siong ("Dr Lim"), a medical practitioner with a registered specialty in anaesthesiology, conducted a pre-anaesthetic assessment on the Complainant. Following completion of this assessment, Dr Lim administered EA. It takes at least 15 to 20 minutes for the EA to take effect. After the Appellant entered the operating theatre, the Complainant informed him that she still had some feeling in her leg. The Appellant acknowledged this.

5 Around 8.20am, the Appellant made a slit (or cut) on the Complainant's abdomen; it was indicated in the agreed statement of facts that parties disputed whether this was properly to be termed a "slit" or a "cut". This slit (or cut) caused the Complainant to express pain. Hearing this, Dr Lim immediately administered a gas mixture of oxygen and nitrous oxide for about a minute by face mask to sedate the Complainant. The operation ended around 8.45am and the Complainant delivered a baby girl.

The different versions of events

6 The agreed facts are silent as to what happened between the time that the Complainant was wheeled into the operating theatre sometime before 7.30am and the time that the Appellant made the slit (or cut) on her abdomen around 8.20am. Unsurprisingly, different versions of events were advanced by the Appellant and the Respondent before the DC.

7 The Appellant's version was that Dr Lim, the anaesthetist, administered EA to the Complainant by 8.00am. The Appellant was informed that the EA had been administered and he entered the operating theatre shortly after 8.00am. He greeted the Complainant and it was at this juncture that she informed him that she still had feeling in her leg. He acknowledged this and told her to wait, and he then left to scrub up thoroughly. He returned five minutes later and proceeded to insert a Foley's catheter into the Complainant for the purpose of urine management during the operation. Thereafter he changed his gown and gloves. He painted the Complainant's abdomen with an antiseptic solution,

and draped sterile cloth over the parts of her body other than the abdomen. The Appellant's position is that when an anaesthetist such as Dr Lim allows a surgeon such as himself to drape sterile cloth over the patient, the presumption is that the anaesthetist is satisfied with the EA. The Appellant said "Let's start", to which Dr Lim, who was busy writing notes, nodded his head. It was 8.20am at this point. The scalpel was handed to the Appellant and he gently made a short superficial slit on the incision site to test if the EA had taken effect. Elsewhere, he called this a "scratch test". This caused the Complainant to express pain in a short loud scream. The Appellant stopped immediately, and Dr Lim at once gave nitrous oxide to the Complainant. She was unconscious within a minute or two and Dr Lim asked the Appellant to carry on. On that instruction, the Appellant continued with the procedure and delivered the Complainant's baby.

8 The Appellant's version of events was supported by the evidence of Florence Quan, a nurse from his clinic who was in the operating theatre assisting him during the caesarean section procedure. She testified that the Appellant had done no more than to make a test scratch – a "nick on the skin" – measuring between 1 and 1.5cm in length, and that it was this test scratch that caused the Complainant to scream.

9 The Respondent's version of events, on the other hand, was that Dr Lim administered EA to the Complainant at 8.10am and not 8.00am. The Appellant was informed that EA had been administered and he entered the operating theatre. He attended to the Complainant and carried out the pre-operation procedures, including scrubbing and inserting the Foley's catheter into the Complainant. After the Appellant had scrubbed and gowned and was ready to commence the operation, Dr Lim told him that he should wait about ten more minutes before proceeding with the caesarean section to give the EA time to take effect. Nonetheless, at 8.20am, the Appellant began the procedure by making an incision on the Complainant's abdomen. The Complainant expressed pain but the Appellant continued with the procedure regardless.

10 The Respondent's version of events was based on the evidence of the Complainant and Dr Lim as well as two other persons who were also present in the operating theatre during the caesarean section procedure, namely, the scrub nurse Sarah binte Abdul Aziz ("Nurse Sarah") and the anaesthetic assistant Victness s/o Ayasamy. The testimony of Nurse Sarah was particularly significant. She stated that while engaged in certain tasks she heard the Complainant scream, and that when she turned and looked, she saw that an incision had been made on the Complainant's abdomen. This, said Nurse Sarah, was an incision that exposed the fat layer, and it was a full caesarean incision in the sense that there was no need to lengthen it thereafter in delivering the baby.

Findings of the DC

11 The DC rejected the Appellant's version of events and gave its reasons in written grounds of decision ("the GD"). It noted the existence of disagreement as to the exact time at which the EA was administered – 8.00am or 8.10am – but ultimately took the view that the exact time did not affect its decision as to whether the charge of professional misconduct had been made out. The reason why the exact time was irrelevant was that, regardless of when the EA was administered, the Appellant had an obligation to test if the EA had taken full effect before commencing the caesarean section (see the GD at [50]). However, the DC nevertheless proceeded to add that, in its judgment, the evidence would support the fact that the EA had been administered "at about" 8.10am (see the GD at [52]).

12 The DC then found beyond a reasonable doubt that, when the Complainant expressed pain, it was occasioned by an incision made by the Appellant rather than a test scratch as he claimed (see

the GD at [64]–[65]). In particular, the DC said that the evidence of Nurse Sarah was “compelling” (see the GD at [56]). The DC held that an incision of that nature could not amount to an appropriate test of whether the EA had taken full effect (see the GD at [66]). The DC opined that, speaking generally, whilst the anaesthetist has a responsibility to check whether the EA has taken effect, the surgeon has the “ultimate responsibility and primary obligation” to ensure that the EA is effective before he begins carrying out the surgery (see the GD at [70]). Moreover, the DC found beyond a reasonable doubt that, in response to the Complainant’s expression of pain, the Appellant did not stop but simply proceeded with the caesarean section after the initial incision (see the GD at [76]). The DC considered this to be “completely unacceptable” given that the caesarean section was not an emergency procedure (see the GD at [78]–[80]).

13 In the light of these findings of fact, the DC held that the actions of the Appellant amounted to professional misconduct on either of the two limbs set out by this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 (“*Low Cze Hong*”). In that case it was said (at [37]) that professional misconduct can be made out “in at least two situations”: first, where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and secondly, where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner. We will return to these two limbs in *Low Cze Hong* later in this judgment (see below at [41]–[44]).

The appeal against conviction

14 We address first the appeal against conviction. In our view, the appropriate starting point was the DC’s determination that the surgeon has the “ultimate responsibility and primary obligation” to ensure that the EA is effective before commencing surgery. We did not think that this determination could be impugned. This was because a finding “relating to any issue of medical ethics or standards of professional conduct” is one which this court is obliged to accept as final and conclusive unless it is “unsafe, unreasonable or contrary to the evidence”, pursuant to s 55(11) of the Medical Registration Act (Cap 174, 2004 Rev Ed). We could not see how the DC’s determination was “unsafe, unreasonable or contrary to the evidence”, and indeed the Appellant did not even challenge its correctness. On the contrary, we thought that there was very good reason for this: as the DC pointed out at [70] of the GD, given the different physiologies of patients and the different responses that they have to various drugs, the anaesthesia may fail completely or may not work at its optimum level.

15 Two related consequences followed from this. The first was that the appeal against conviction could be narrowed to the single issue of whether the Appellant tested the effectiveness of the EA prior to commencing the caesarean section on the Complainant. The second was that everything else became of secondary importance, in particular, the contested question of whether the EA was administered by Dr Lim at 8.00am or 8.10am. Whatever the exact timing of this might have been, had the Appellant made an incision without first testing if the EA had taken effect, he would have been in breach of his obligation to ensure the effectiveness of the EA, and that in itself could amount to professional misconduct.

16 The evidence on this particular issue with regard to the appeal against conviction was entirely oral; the documentary evidence did not shed any light on whether the Appellant tested the effectiveness of the EA before commencing surgery on the Complainant. It was, in essence, the testimony of Nurse Sarah and, to a smaller extent, Dr Lim, against that of the Appellant and Florence Quan. Having had the advantage of hearing and observing all the witnesses, the DC unequivocally preferred the evidence of Nurse Sarah. Before us, the Appellant argued that Nurse Sarah’s testimony was unreliable. In written submissions supplemented by oral argument, the Appellant attacked

Nurse Sarah's account on three grounds. None of these arguments was convincing, as we now explain.

17 First, the Appellant pointed to Nurse Sarah's inexperience, *ie*, the fact that she became a scrub nurse only in 2010, and argued that this therefore called into question the reliability of her perception of the length and depth of the alleged incision made by the Appellant and the amount of blood that was visible. However, we failed to see how such inexperience would have made her more likely to report having seen fat where none was visible. Nor could we see how it would cast doubt on her testimony that the incision did not need to be lengthened further in the course of the operation.

18 Secondly, the Appellant took issue with a portion of Nurse Sarah's testimony concerning her handing to the Appellant the scalpel used to make the incision, as follows:

MS E ENG [member of the DC]: Okay. When you mentioned that you heard the patient screamed and the incision was already made, who supposed to be the person who passed to the surgeon the knife or the scalpel? Yourself or the assisting nurse?

A. Sorry. Before or after?

MS E ENG: Because you said when you fits up the suction --

A. Mm-hm.

MS E ENG: -- the diathermy, you already heard the patient screamed.

A. Yes.

MS E ENG: So when you look at it --

A. I was the one --

MS E ENG: -- incision --

A. -- who passed the knife. I -- I -- I was the one who put the knife and the forceps there.

We understood the Appellant to argue that this passage demonstrated Nurse Sarah's evasiveness, in that she testified that she put the scalpel "there" rather than that she handed it to the Appellant, when the latter, it was said, would have been the "textbook" thing to do. But we could not see how an inference of evasiveness could be drawn from this passage, nor did we think it was at all a material point whether the scalpel was handed to the Appellant or placed in some undefined locale "there", for it was beyond dispute that the Appellant eventually took hold of the scalpel and used it.

19 Thirdly, the Appellant argued that, since by her own account, Nurse Sarah was engaged in some tasks when she heard the Complainant scream, she might have missed seeing certain things that would exonerate the Appellant. The Appellant claimed support for this particular argument from the following portion of Nurse Sarah's cross-examination:

Q. So can you maybe help us again by telling us what you recall seeing?

A. Because what I recall is once I'm done with my diathermy and my sucker, right, when I turn back, patient was already screaming and there was already incision already made.

Q. Yes. The incision -- how was the incision made?

A. Meaning, I can see the fat layer already.

Q. You can see the fat layer?

A. Yes.

Q. Okay. At this -- at that moment, was the gas already given?

A. When again, sorry?

Q. Was the gas already given at that moment when you saw the incision and the fat layer?

A. I only remember gas was given after patient screamed.

The last few lines of this exchange, the Appellant submitted, demonstrated that Nurse Sarah looked at the Complainant's abdomen only after Dr Lim had administered the gas mixture of oxygen and nitrous oxide following the Complainant's scream. This would mean a period of at least half a minute between the Complainant's scream and Nurse Sarah's earliest sight of the Complainant's abdomen, during which period the Appellant could have lengthened what was initially a test scratch into a full caesarean incision that did not need to be lengthened further. In other words the Appellant argued that Nurse Sarah's evidence did not rule out the following sequence of events: the Appellant making a test scratch, the Complainant screaming in pain as a result, Dr Lim administering the gas mixture, the Appellant lengthening the test scratch into a full caesarean incision, and finally, only then, Nurse Sarah looking at the Complainant's abdomen and the incision made thereon. We rejected the argument without hesitation. In the first place, we could not see how the portion of Nurse Sarah's testimony quoted above constituted an acknowledgement that she looked at the Complainant's abdomen only after Dr Lim had administered the gas mixture. Moreover, we thought it highly improbable that Nurse Sarah would not turn to look immediately upon hearing the Complainant scream.

20 For these reasons, we did not think that the Appellant's attempt to call into question the reliability of Nurse Sarah's evidence met with any success at all. It seemed to us that all the Appellant could do was to chip away at the edges of her testimony without going anywhere near the core of it. Since Nurse Sarah's testimony formed the foundation of the DC's finding that the Appellant made an incision on the Complainant's abdomen without having tested the effectiveness of the EA, and since this foundation remained undisturbed, we took the view that there was no basis for interfering with that finding of the DC.

21 Another significant finding of fact made by the DC was that the Appellant did not stop the procedure following the Complainant's scream but simply continued with it. The DC appeared to have based this finding on Dr Lim's testimony as well as the fact that the baby was delivered at 8.23am, a mere three minutes after the incision was made (see the GD at [74]–[75]). To this might be added Nurse Sarah's testimony that if the Appellant stopped at all it was for less than a minute. Likewise, we did not think that we could interfere with this finding of the DC. It was a matter of oral evidence and the DC had the benefit we did not have of hearing and observing all the witnesses as they gave their testimony.

22 The Appellant argued in written submissions that "stoppage of any length of time is stoppage". But in our judgment that missed the point. The DC's view at [77] of the GD was that acceptable

medical practice “would dictate that the [Appellant] immediately stop the [p]rocedure and carefully consider all circumstances”. This seemed to us to be another finding relating to standards of professional conduct such as this court must accept as final and conclusive unless it was “unsafe, unreasonable or contrary to the evidence”, which, in our view, it was not. It was therefore not a merely technical question of whether there was stoppage or not, but a broader one of whether the Appellant “carefully consider[ed] all circumstances” following the scream, including the Complainant’s physical and mental well-being. The DC found that the Appellant’s attitude was quite the opposite; it was one of single-minded determination to complete the procedure in the quickest possible time with little, if any, regard to considerations other than pure efficiency. This was, in the opinion of the DC, “completely unacceptable”, and we had no reason to depart from that judgment.

23 For the sake of completeness, we note that the Appellant’s claim before this court was that he merely did a scratch test, and that it was this scratch test rather than any more substantial cut or incision which caused the Complainant to cry out in pain. It should be implicit, in our analysis above, that we rejected this argument, but since it was a contention vigorously advanced by the Appellant, we deal with it head on. For this, we need only express our complete agreement with the DC. The DC had (correctly, in our view) rejected this particular argument, relying, in the main, on Nurse Sarah’s evidence (see the GD at [56]), which we have already touched on above. It concluded (again, correctly in our view) thus (see the GD at [64]):

It cannot be disputed that the [Complainant] did in fact scream and was certainly in a lot of pain as evidenced in the sudden increase in her vital parameters at that particular time. It also cannot be disputed that the cut made by the [Appellant] penetrated the epidermis and the dermis (which contained the nerves, thus the pain, and which contained the blood vessels, thus the bleeding) and so exposing the subcutaneous fat. We can find no reason to doubt the veracity of the [Complainant’s] evidence as to the pain and anguish she suffered at the time of the incision. The Committee also finds the evidence of Nurse Sarah as truthful. The above facts and evidence point to the inescapable conclusion that the [Appellant] neither did a scratch or a superficial slit. It was a c-section incision which did not need to be lengthened.

24 We may summarise our conclusions on the appeal against conviction as follows. The Appellant had the obligation to test the effectiveness of the EA before carrying out the caesarean section on the Complainant. This, he did not do. The Complainant having screamed, the proper response on the Appellant’s part would have been to stop and carefully consider all the circumstances, especially the Complainant’s well-being, before proceeding any further. This, he also did not do. The Appellant’s claim that he had merely performed a scratch test is also without merit. We thought that the Appellant’s conduct fell at least within the second limb of professional misconduct as defined in *Low Cze Hong*, which is to say, we thought that there had been such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. Therefore, we upheld the DC’s guilty verdict on the charge of professional misconduct against the Appellant.

The appeal against sentence

The Appellant’s conduct of his defence as an aggravating factor

25 There remained the appeal against sentence. Before we discuss the sentencing precedents that the Appellant and Respondent cited before us, we address an aggravating factor identified by the DC at [85(b)] of the GD. This aggravating factor concerned the manner in which the Appellant conducted his defence. The DC found at [40]–[41] of the GD that the Appellant had, in effect, tampered with the nursing record for the caesarean section that he performed on the Complainant, and it said that it

was "dismayed and appalled" by what he had done. This nursing record contains information such as the operation start time and the type of anaesthesia administered, and the material point for our purposes is that it indicated that the start time of the procedure was "0800".

26 What the Appellant did was this. In the course of preparing his defence, he took a photocopy of the nursing record and met the operating theatre manager of Mount Alvernia Hospital, one Ms Roslinda. Ms Roslinda wrote the words "Patient is in supine position after Epidural Anaesthesia at 0800 hrs" on that copy of the nursing record and signed beside it. She testified that these were not her own words; she had not been present in the operating theatre during the caesarean section on the Complainant, and she did not make enquiries of those nurses who had been present. Rather, those were the Appellant's words and she wrote them at his request. The Appellant did not dispute this. But he explained that his only intention was to get Ms Roslinda to clarify what a start time of "0800" meant, since that was susceptible to more than one interpretation. It could mean the time at which the EA was administered, or the time at which the Complainant was ready for surgery, or the time at which the scalpel was actually applied to the skin. He thought that Ms Roslinda would be able to tell him what the practice was at the hospital, *ie*, what the start time on its nursing records was generally understood to mean. He argued that there was no attempt to deceive or mislead the DC; he had never denied that Ms Roslinda's annotations were made after the event and were not part of the original nursing record. He was merely seeking to resolve the ambiguity on the face of the nursing record.

27 Unfortunately, we did not find this benign construction that the Appellant placed on his own conduct convincing. The fact is that the Appellant chose to tender before the DC the copy of the nursing record containing Ms Roslinda's annotations. This would not have been necessary if the Appellant had truly wanted nothing more than to clarify the nursing record, for the Appellant could simply have shown the nursing record to Ms Roslinda in the witness box and asked her what was meant by a start time of "0800". The picture became clearer when we had regard to the report of one Dr Boey, the anaesthetist whom the Appellant called to give evidence as an expert before the DC. In this report, Dr Boey opined that it was likely that the EA had been administered by 8.00am. One of his stated reasons for holding such an opinion was that the timing of 8.00am "seems to have been borne out by the [nursing record], which documented that the [Complainant] was supine and ready for surgery at 0800Hrs". Dr Boey observed that "[t]here is also a note made by [Ms Roslinda] signed and dated as 13/10/11 that the epidural injection had been given and the [Complainant] was in the supine position at 0800Hrs". This suggested to us that Dr Boey did not know that Ms Roslinda's annotations were in fact the Appellant's words. Nor did Dr Boey think that her annotations merely explained what nursing records generally meant at Mount Alvernia Hospital. That, in turn, suggested that the Appellant presented the annotations to his own expert witness not as his own words, and not as a statement of general hospital practice, but as objective evidence of the fact that the EA had been administered by 8.00am.

28 The inescapable inference was that the Appellant offered the modified nursing record as evidence that the EA had been administered by 8.00am despite knowing full well that it could not be evidence of that since it was something that he had instructed Ms Roslinda to write, and since Ms Roslinda would not have been in any position to verify the truth of what she had written. He sought to create the impression that an independent party had given her stamp of approval to the interpretation of the nursing record most favourable to him, in order that Dr Boey and the DC would subscribe to that interpretation. In short, we thought that this was in fact an attempt to mislead the DC, albeit one that was somewhat transparent in nature and (hence) unpersuasive. Hence, we agreed with the DC that this should be an aggravating factor to be taken into account in determining the appropriate sanction to impose on the Appellant.

Sentencing precedents

29 We turn now to the sentencing precedents. Among these were three that might appear to assist the Appellant, for in all of them, the medical practitioner found guilty of professional misconduct did not have any period of suspension from practice imposed on him. In our view, however, all three precedents were not helpful to the Appellant because the comparatively lenient sanctions in those cases could be explained by certain factors unique to them which do not feature on the facts in the present case.

30 The first precedent is the case of Dr Koh Gim Hwee. Dr Koh, an obstetrician and gynaecologist, was found guilty of two charges of professional misconduct. One was for performing a procedure not within the norms of acceptable medical practice when he used an instrument known as a Hegar dilator to effect forcible opening of his patient's cervix for induction of labour. For a woman to achieve natural delivery of a baby, the cervix has to ripen via chemical changes; Hegar dilators, by contrast, dilate the cervix mechanically and are thus inappropriate for that purpose. The other charge was for failing to ensure that his patient was adequately informed about her medical condition and options for treatment. Dr Koh was censured and ordered to pay a financial penalty of \$10,000. The distinctive aspect of this precedent is that the DC in that case expressly found that Dr Koh had acted "at all times in good faith", *ie*, out of an "honest but ultimately misguided desire" to give effect to his patient's preference for vaginal birth over a caesarean section; he had unfortunately "overlook[ed]" the fact that in expressing this preference, his patient "was not indicating an intention to overrule his clinical judgment". In contrast, the Appellant in the present case did not demonstrate any similar concern for the interests of the Complainant.

31 The second precedent is the case of Dr S. He failed to take adequate steps to find a long tonsil swab that he had inserted into the trachea of his patient but had not retrieved immediately after use, despite having been told by a nurse after the operation that the swab was missing. He was censured, even though it appears that swab might have led to his patient's death – that causal connection is not apparent from the written grounds of decision, but in a newspaper article enclosed by the Appellant, it is said that the swab blocked the airway into the patient's right lung, and the patient "died after her lungs collapsed". The relatively light touch employed in sanctioning Dr S can be explained by three peculiar factors that the Medical Council took into account: one, the fact that the medical procedure involved – reconstructive surgery of the larynx to convert a sub-glottic stenosis – was a "very complicated" one; two, the "immense contribution" that Dr S had made to medical students, the National University of Singapore and the profession generally; and three, the fact that the case had taken nearly ten years to come before the Medical Council, meaning that Dr S had had to "bear with the strain" for an "inordinate period". We saw no similarly exceptional circumstances in the instant case.

32 The third is the case of Dr K. He was consulted by a nine-year-old patient, accompanied by his father, who complained of acute abdominal pain. Dr K concluded that the boy had gastroenteritis. But, in fact, he had appendicitis and passed away three weeks later. Dr K was found guilty of failing to assess adequately the medical condition of his patient, as well as failing to keep proper medical records. He was fined \$10,000 and censured. This sanction imposed by the DC in that case was probably influenced by its appreciation of the fact that "it is often very difficult to make a diagnosis of appendicitis in children, especially in obese children such as the Patient". There was in the present case no comparable difficulty such as would render less culpable the Appellant's failure to test the effectiveness of the EA before commencing surgery.

33 These three sentencing precedents did not suggest that no period of suspension should be

ordered in the instant case. On the other hand, we thought that there were three other sentencing precedents that were closer to the present case. The periods of suspension imposed on the medical practitioners in those cases ranged from three to six months, without any financial penalty. We turn now to consider these precedents.

34 The first precedent is *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745, in which this court affirmed Dr Gan's conviction on a charge of wilful neglect of his duties and gross mismanagement of the post-operative treatment of his patient. Dr Gan performed a procedure on his patient which failed. One of the known complications of this failed procedure was perforation of the duodenum, *ie*, the small intestine. As it turned out, the patient's duodenum was perforated and he passed away about eight weeks later. Dr Gan performed the procedure on the afternoon of 6 December 2005; later in the afternoon, the patient complained of abdominal pain, and Dr Gan had an "inkling" that something might be wrong. However, instead of personally examining his patient, he went home for the day and left matters to the on-call Registrar. He examined the patient personally only on the following morning. This, as well as Dr Gan's failure to order a CT scan – which would have shown the perforation – in a sufficiently timely manner, was held to be professional misconduct. Dr Gan was suspended from practice for six months and censured.

35 The second precedent is the case of Dr L E. He was found to have been grossly negligent in failing to refer an infant under his care to a consultant paediatric ophthalmologist for screening of the infant's retina. This infant was born at 25 weeks' gestation, and Dr L E diagnosed her as having intrauterine growth retardation, prematurity and extremely low birth weight. The medical practice was to refer infants with extremely low birth weight for retina screening at four to six weeks' postnatal age or 31 to 34 weeks' gestational age, whichever was later; retina-related complications were very common in these infants but could be prevented through early diagnosis and intervention. By the time Dr L E made the referral, however, the infant was seven months old. This was five months later than what medical practice required. As a consequence, the infant lost all useful vision in the left eye. Dr L E was suspended for three months and censured.

36 The third precedent is the case of Dr T. He pleaded guilty to two charges. One was for failing to check his patient's Hepatitis B status prior to his patient's chemotherapy, the context being that chemotherapy is a well-known cause of reactivation of Hepatitis B. The other was for discharging his patient without discussing the option of consultation with a hepatologist, even though the patient's Hepatitis B had in fact been reactivated. The DC in that case took into account Dr T's unblemished 44-year record and testimonials from his colleagues. Dr T was suspended for three months and censured.

37 It is apparent that the facts in these three precedents are not at all similar to those in the present case. Nevertheless, we thought that the precedents provided a degree of assistance because they all involved serious harm to patients and a negligent failure on the part of the medical practitioner to do something that he ought to have done which would have avoided that harm or at least reduced the likelihood of its occurrence. We were of the view that, as far as it is possible to measure these things, the culpability of the Appellant was closer to that of Dr L E and Dr T than that of Dr Gan. There were two factors in Dr Gan's case that made his conduct especially blameworthy and which thus set it apart from the Appellant's. The first was his knowledge. He had an "inkling" that something was not right with his patient, and he was informed by the on-call Registrar later that evening that the patient looked unwell; yet, despite his cognisance of the potential dangers, he decided not to see the patient until the following morning. The second factor was that the patient lost his life.

38 It might be argued that, in the present case, the Appellant must have at least had a similar

“inking” that the EA had not yet taken effect when he made the incision on the Complainant’s abdomen. After all, the anaesthetist, Dr Lim, testified that he had advised the Appellant to wait ten more minutes before commencing the caesarean section. We thought it noteworthy, however, that no one else in the operating theatre heard Dr Lim say this, and we thought that this generated a reasonable doubt as to whether Dr Lim did in fact give the Appellant that warning. This, of course, is not to ascribe duplicity to Dr Lim; he may simply have been mistaken. But the material point is that it cannot be said with certainty that when the Appellant made the incision on the Complainant’s abdomen, he had in his mind the possibility that the EA may not yet have taken effect. It could be that this simply did not occur to him, and we considered that we should give him the benefit of the doubt.

The appropriate sanction

39 As noted above, the sentencing precedents suggested a starting point in the region of three months’ suspension from practice. On the facts of the instant case, however, we were particularly perturbed by two things. The first was that the Appellant’s misconduct took place in circumstances very far from those of an emergency. The DC made a comment to that effect at [78] of the GD. It looked to be nothing more than a routine caesarean section; this was not a case in which surgeon had to act quickly in an emergency situation in order to avert serious harm to a patient. Given this context, we considered the Appellant’s haste in carrying out the procedure to be particularly unacceptable. The second was the manner in which the Appellant conducted his defence – his getting Ms Roslinda to annotate a copy of the nursing record and then putting forward those annotations as evidence in support of his version of events. As we have said, this want of probity on the Appellant’s part was something properly to be regarded as an aggravating factor.

40 Taking all these matters in the round, we were of the view that the nine months’ suspension from practice handed down by the DC was manifestly excessive. We thought that the appropriate period of suspension to impose on the Appellant was five months. We did not see fit to alter the other parts of the sentence handed down by the DC such as the financial penalty of \$10,000 that the Appellant was ordered to pay. Accordingly, we affirmed the sentence set out at [87] of the GD save only that we reduced the period of suspension from nine months to five months.

Concluding observations

41 We conclude these grounds of decision with some observations of a general nature on the jurisprudence of sentencing in disciplinary cases against medical professionals. There are broadly two points that we would make. The first pertains to the two limbs of professional misconduct in *Low Cze Hong*. The second concerns the continued relevance of sentencing precedents that are of some vintage.

42 On the first point, we think that a distinction ought always to be drawn in individual cases between the two limbs of professional misconduct in *Low Cze Hong*. In the present case, the position taken by the Respondent before the DC was that it would be proceeding under the first limb only. The DC was of the view that professional misconduct had been made out not only under the first limb but also under the second. On our part, we thought that it had been made out under the second limb, but we could not be sure beyond a reasonable doubt it had been made out under the first. As we have observed earlier, we did not think it incontrovertible that the Appellant was conscious of the possibility that the EA may not yet have taken effect when he commenced the caesarean section on the Complainant; hence, there was some doubt as to whether the Appellant was guilty of an “intentional” or “deliberate” departure from approved medical standards.

43 Thus, the distinction between the first and second limbs in *Low Cze Hong* was maintained in the instant case. However, in contrast, the distinction was not apparently borne in mind in many other cases subsequent to *Low Cze Hong*. We are of the view that, for clarity of analysis, the distinction should always be drawn in future cases. This would facilitate comparison of like cases with like: cases under the first limb would draw from sentencing precedents in which that particular limb was invoked, as would similarly be the approach for cases under the second limb. In the criminal law there is a general boundary drawn between intentional wrongdoing and negligent wrongdoing. So should it be in the medical disciplinary context.

44 However, that is *not* to say that cases under the first limb, *ie*, those that involve an intentional or deliberate departure from medically-accepted standards, will *invariably* attract *heavier* sanctions than cases under the second limb, which involve serious negligence. For instance, an intentional departure from medically-approved standards may be motivated by a genuine but mistaken concern for a patient's interests, for example, where a doctor believes that his patient's condition is beyond the administering of any accepted treatment and that the only hope for a solution lies in a novel or experimental method which the medical profession has not yet endorsed. On the other hand, serious negligence may demonstrate precisely a lack of such concern for the patient's interests. Where this is so, negligent wrongdoing may be deserving of greater punishment than intentional wrongdoing. Put simply, the precise fact situation would be of the first importance.

45 The second broad point we would make is this. In the present case, it was to achieve a measure of consistency with the sentencing precedents that we reduced the period of suspension imposed on the Appellant to five months from the nine months handed down by the DC. But we would emphasise that fidelity to precedent ought not to lead to ossification of the law. For circumstances change: the way medicine is practised now may be different in many respects from the way it was practised, say, a decade ago, and it may well be rather different from the way it will be practised a decade from today. A corollary of this is that, given two similar cases separated in time by a substantial number of years, the sentence that was appropriate in the earlier case may not necessarily be appropriate in the later.

46 All we would say is that it is open to the Respondent in future cases to persuade the DC or this court that relevant sentencing precedents are no longer a helpful guide to the appropriate sanction that ought to be imposed because prevailing circumstances are materially different from those at the time when those precedents were decided. For example, from a cursory examination of the published grounds of decision of DC cases available on the Respondent's website, we note that it is very rare for periods of suspension to exceed six months. There are two cases in which three years' suspension was imposed, one involving gross overcharging of a patient and the other involving a sexual relationship lasting more than a decade between a medical professional and a patient who had psychiatric problems, but it would seem that these are exceptional.

47 Indeed, the Respondent itself, in its written submissions, referred at least twice to the fact that the precedent concerned was dated, observing that the case of Dr S (discussed above at [31]) "took place almost 15 years ago and would not [be] reflective of the needs of the profession and the public today", as well as observing that as two other cases "are very old precedents from almost 20 years ago, the DC is entitled to take the view that the benchmark should be moved in light of the prevailing circumstances today". But it is not enough to state that sentencing precedents should not be followed simply because they are from another era; some more concrete difference between the circumstances then and the circumstances now that calls for correspondingly different approaches or benchmarks should be demonstrated. Should the Respondent on some future occasion take the view that the sentencing tariffs have up to that point in time been set too low, whether generally or in respect of a particular type of case, this is something it should bear in mind when it makes the

argument before the relevant adjudicatory body.

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