Low Chai Ling *v* Singapore Medical Council
[2012] SGHC 191

Case Number	: Originating Summons No 18 of 2012
Decision Date	: 17 September 2012
Tribunal/Court	: High Court
Coram	: Chan Sek Keong CJ; Andrew Phang Boon Leong JA; V K Rajah JA
Counsel Name(s)	: Myint Soe and Daniel Atticus Xu (MyintSoe & Selvaraj) for the applicant; Tan Chee Meng SC, Josephine Choo and Maxine Ung (WongPartnership LLP) for the respondent.
Parties	: Low Chai Ling — Singapore Medical Council

PROFESSIONS – Medical profession and practice – professional conduct

17 September 2012 Judgment reserved.

V K Rajah JA (delivering the judgment of the court):

Introduction

1 This is an appeal by Dr Low Chai Ling ("the applicant") against the decision of the disciplinary committee ("the DC") constituted by the Singapore Medical Council ("the SMC") in convicting her of five out of seven charges of offering and performing aesthetic procedures that were found not to be clinically justifiable. She was charged with professional misconduct under s 45(1)(*d*) of the Medical Registration Act (Cap 174, 1998 Rev Ed) [note: 1] ("the MRA (1998)").

Background

Parties to the dispute

2 The applicant is a general practitioner ("GP") who obtained her MBBS from Guy's & St Thomas' Hospital in London in 1998, and completed a Diploma of Dermatology from the University of Wales in 2003. As a GP, she first started a GP clinic called Eastlife Medical Centre in 2000. Subsequently, she started The Sloane Clinic in 2003 and a second branch in 2005. To date, The Sloane Clinic has a total of six branches, including one in Kuala Lumpur, Malaysia. It has a website at the Internet address <http://www.sloaneclinic.com>.

3 At the material time in 2007, the applicant was the director of The Sloane Clinic, which provided both non-invasive aesthetic treatments as well as invasive plastic surgery. The applicant only performed the former type of treatments and procedures such as lasers, filler and botox, whereas accredited plastic surgeons practised the latter type of cosmetic and reconstructive surgery. The Sloane Clinic was later acquired by Healthtrends Medical Group in 2008, and the applicant has been a salaried employee of the group ever since.

4 The SMC is a statutory board which, *inter alia*, governs and regulates the professional conduct and ethics of registered medical practitioners.

Background to the disciplinary proceedings

5 While practising at The Sloane Clinic, the applicant received a letter from the Ministry of Health ("the MOH") dated 20 September 2007 [note: 2] which referred to certain advertisements on the clinic's website with regard to the following aesthetic treatments listed there: mesotherapy, mesoglow, mesolift, meso-oxygen, stem cell extract facial therapy, stem cell extract scalp therapy, sonophoresis, carboxytherapy and osmolipolysis.

6 The letter also directed the applicant's attention to Art 4.1.4 of the SMC's Ethical Code and Ethical Guidelines ("the ECEG"), which states: [note: 3]

> **4.1.4 Untested practices and clinical trials**
>
> A doctor shall treat patients according to generally accepted methods and use only licensed drugs for appropriate indications. A doctor shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial.
>
> A doctor who participates in clinical research must put the care and safety of patients first. If a doctor wishes to enter a patient into a clinical trial, he must ensure that the trial is approved by an ethics committee and conforms to the Good Clinical Practice Guidelines. In addition, informed consent must be obtained from the patient.
>
> It is not acceptable to experiment or authorise experiments or research which are not part of a formal clinical trial and which are not primarily part of treatment or in the best interest of the patient, or which could cause undue suffering or threat to the life of a patient.

7 The applicant replied to the MOH in a letter dated 25 September 2007 as follows: [note: 4]

> I refer to your letter dated 20 September 2007, we have taken steps to remove the said list of services from the "The Face clinic", "The Body clinic" and "The Skin clinic" sections of our website that details medical services.

8 In that same letter, the applicant also listed 24 other websites showing similar treatments being offered by other local medical practices as well. She then followed up with an undated letter [note: 5] which listed 13 additional websites showing similar treatments and explaining the various procedures. She added the following statement after providing the list of websites: [note: 6]

> We hope our small selection of published studies will help clarify any doubts about the treatments mentioned. We hope that our limited efforts can help our fellow colleagues avoid the same misunderstanding with MOH since all of us appear to have listed the same treatments on the websites. I understand that as with standard MOH protocol, you must be concurrently contacting all of the clinics above for similar verification, please do keep us updated on your investigations, we are committed to working closely with you as this is obviously an issue that is affecting not just clinics but hospitals, and has implications for many of our colleagues.

9 The MOH replied in a letter dated 1 October 2007 asking for detailed descriptions of the nine procedures listed in its earlier letter of 20 September 2007: [note: 7]

> I refer to your reply dated 25 September 2007 and appreciate the materials which you have forwarded to the Ministry for its reference.

2. We however note that you have not provided us with a detailed description of how you carry out the following procedures for patients in your clinic.

(a) "Mesotherapy"

(b) "Mesoglow"

(c) "Mesolift"

(d) "Meso-Oxygen"

(e) "Stem Cell Facial Therapy"

(f) "Stem Cell Scalp Therapy"

(g) "Sonophoresis"

(h) "Carboxytherapy"

(i) "Osmolipolysis"

…

10 Soon after, the applicant replied in a letter (mistakenly) dated 28 September 2007 attaching descriptions of the treatment protocols for the procedures in question. In the letter, the applicant affirmed her belief that The Sloane Clinic had complied with Art 4.1.4 of the ECEG: [note: 8]

We are glad that the ministry had drawn our attention to the said ethical code [*ie*, the ECEG] because we have managed to show:

1) *These procedures are "accepted by the general profession" as seen by the list of other clinics and hospitals offering them.* This is the list just for Singapore alone, and does not include medical profession in other countries. The websites provided reflect only clinics with a website providing the service, and does not include clinics that do not have a website but provid[e] the same services.

…

[emphasis added]

11 The applicant also raised her concerns about what she considered to be the less-than-upfront nature of the investigations against her, and suggested the possibility that the investigations could have been initiated because of professional jealousy on the part of doctors with competing practices: [note: 9]

The medical ethical code is set out to protect the patient's interests and make sure we, as medical practitioners act in the best interests of our patients. We should not let this code be abused by a handful of disgruntled doctors for petty reasons. … We should not let disgruntled doctors who in light of existing competition make false and derogatory statements, they waste the ministry's time and resources, as well as their fellow colleagues [*sic*] time and resources needed to disprove such frivolous remarks in a "guilty till proven innocent witch-hunt". …

…

We have in the past years received anonymous email threats pertaining to fake "deaths" of our patients, threats to our personal safety and others in the similar vein. … These "threatening" emails were then traced by the police to a fellow doctor's house! We dropped the matter for a simple apology from the said doctor who admitted sending intimidating emails to our clinic due to jealously, we did not bring this matter up to the medical council nor the ministry in the hope goodwill can be maintained in the profession. … *We are almost certain that a handful of doctors are behind these attacks, including the latest unsubstantiated complaint to MOH.* …

[emphasis added]

12 Soon after, an article titled "SKIN FLICK" was published in *The Straits Times* on 15 November 2007 introducing various aesthetic procedures that could purportedly "revitalise sagging, dull skin without having to undergo surgical procedures". [note: 10] The applicant was interviewed, together with several other doctors, on stem cell mesotherapy for slowing hair loss, regrowing hair and lightening age-related skin pigmentation. She was quoted as saying the following: [note: 11]

The injections are minute and done very quickly, approximately five little pricks per second. It feels like little ants crawling over your face. As anaesthetic cream is used, some patients even ask if I have started the treatment.

13 In a letter dated 15 November 2007 (the same day on which the "SKIN FLICK" article was published), Dr Harold Tan, Assistant Director (Clinical Assurance and Audit Branch) of the MOH's Health Regulation Division, issued an official complaint to the SMC against the applicant stating the following: [note: 12]

…

2 *MOH had asked Dr Low to provide evidence for her practices.* However, in our opinion, much of the evidence she had provided were either irrelevant or unsatisfactory. Dr Low's response to MOH also strongly suggested that she may be practising possibly unsubstantiated practices not limited to the list of practices shown in paragraph 1 [*ie*, the list of procedures set out in the MOH's letter to the applicant dated 1 October 2007 (see [9] above)]. A check of the website of The Sloane Clinic today showed that Dr Low has not removed any of the items listed in paragraphs 1(a)–(i) from her website since the start of our inquiry. *In addition, the article from today's The Straits Times URBAN (dated 15 Nov 2007; encl. 2)* ***suggests that Dr Low, who was interviewed*** , ***is still providing*** *stem cell injections to patients for aesthetic indications.*

3 Based on the preliminary evidence that we have obtained so far, we are concerned that Dr Low may have breached Article 4.1.4 of the [ECEG] …

4 We would therefore like to refer Dr Low Chai Ling to the Singapore Medical Council for further investigation and action where necessary.

…

[emphasis added in italics and bold italics]

14 The Complaints Committee of the SMC later sent the applicant a letter dated 14 February 2008

requesting, pursuant to s 40(7) of the MRA (1998), a written explanation in response to the complaint from the MOH. [note: 13] The applicant responded in a letter dated 19 February 2008 with some literature on the impugned procedures. [note: 14] She also highlighted the following concerns about the MOH's complaint: [note: 15]

> … There may have been a misunderstanding between MOH and us.
>
> Upon their request sometime in September 2007, we submitted to MOH some studies that have been done with regards to the following procedures …
>
> …
>
> *Our understanding was to await their reply with regards to the feasibility of continuing the above named treatments.*
>
> Furthermore, it was (and still is) most evident, in all forms of media, that plastic surgeons, dermatologists and other physicians were still offering the said treatments, and as such, we did not remove the procedures from our website as we were under the notion that these procedures did not contravene the [ECEG] that says "A doctor shall treat patients according to generally accepted methods and use only licensed drugs …" as:
>
> 1. We had showed that these procedures had studies backing them,
>
> 2. *The treatments were widely practi[s]ed by our peers.*
>
> 3. *Our colleagues had similarly continued with the treatments. Both our colleagues and ourselves had not received any directive of the banning or discontinuation of any of the above treatments*
>
> Therefore, it came as a shock to us when we received your letter.
>
> To clarify, the list of treatments above does not use any unlicensed drugs or medicines. In fact, most of them relate only to techniques which we were trying to explain to MOH but with some difficulty. We hope that we can clarify the matter better in our following paragraphs.
>
> …
>
> In relation to the treatments that we do provide, the reason why we had continued with them is because we had not received any directive concerning their ban in Singapore. We were under the impression that these treatments, being still widely practi[s]ed around the world were acceptable practices in Singapore.
>
> We further checked with our peers who are providing similar treatments, and they have not received any notification/ directive from SMC or MOH to date.
>
> Treatments are generally acceptable by their widespread use in government hospitals, specialist clinics and GP clinics[.]
>
> …
>
> *We are fully cooperative with SMC and MOH and their guidelines.* ***Should any of these***

treatments be banned in Singapore, we would appreciate it if you would notify us and our colleagues so that we can cease and remove them from our practices immediately.

In the meantime, we would also like to notify SMC that some of the treatments that have been discussed had actually been discontinued at The Sloane Clinic by our management last year. *Hence as of Dec 2007, we no longer offer meso-oxygen, mesoglow, sonophoresis and osmolipolysis*. …

[original emphasis omitted; emphasis added in italics and bold italics]

15 The applicant was subsequently sent a Notice of Inquiry ("NOI") dated 1 March 2010 from the SMC's solicitors, WongPartnership LLP. [note: 16] The NOI listed seven charges against her, and came attached with a report dated 26 February 2010 [note: 17] by Dr Goh Chee Leok ("Dr Goh"), the SMC's expert witness (see also [23] and [44] below). Out of the original nine treatments inquired about by the MOH, osmolipolysis and meso-oxygen were dropped from the list, leaving mesotherapy, mesoglow, mesolift, stem cell extract facial therapy, stem cell extract facial therapy, sonophoresis and carboxytherapy.

16 The seven charges were all framed similarly, the main difference being the particulars of the treatment in question. They were all broad allegations in relation to the applicant's alleged breach of Art 4.1.4 of the ECEG by having offered and performed the impugned treatments outside the context of a formal and approved clinical trial. The material period of misconduct stated in each charge was the period "prior and up to 20 September 2007". [note: 18]

17 Before the DC, the applicant was charged under s 45(1)(*d*) of the MRA (1998) (now s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("the MRA (2004)")), which states:

45.—(1) Where a registered medical practitioner is found or judged by a Disciplinary Committee —

(*a*) to have been convicted in Singapore or elsewhere of any offence involving fraud or dishonesty;

(*b*) to have been convicted in Singapore or elsewhere of any offence implying a defect in character which makes him unfit for his profession;

(*c*) to have been guilty of such improper act or conduct which, in the opinion of the Disciplinary Committee, brings disrepute to his profession;

(*d*) *to have been guilty of professional misconduct*; or

(*e*) to have contravened section 64, 65 or 67,

the Disciplinary Committee may exercise one or more of the powers referred to in subsection (2).

[emphasis added]

The DC's decision

18 On 12 December 2011, the DC delivered its decision and found against the applicant on five out of the seven charges against her. The DC imposed the following punishment on her in respect of these five charges: [note: 19]

(a) You [*ie*, the applicant] be fined a sum of **$10,000**;

(b) You be censured;

(c) You give a written undertaking to the SMC that you will not engage in the conduct complained of or any similar conduct; save that for the procedures now regulated by the MOH guidelines on aesthetic medicine, you can practise these procedures in compliance with the appropriate guidelines; and

(d) You pay 80% of the costs and expenses of and incidental to these proceedings, including the costs of the 2 solicitors to the Medical Council, and the Legal Assessor.

[emphasis in bold in original]

19 The DC acquitted the applicant of the remaining two charges (relating to mesolift and stem cell extract scalp therapy respectively), apparently because the DC found that there was doubt as to whether the procedures in question had indeed been performed. The results of the seven charges against the applicant were as follows:

Treatment	**Convicted**	**Acquitted**
Mesotherapy for fat deposits	✓	
Mesoglow	✓	
Mesolift		✓
Stem cell extract facial therapy	✓	
Stem cell extract scalp therapy		✓
Sonophoresis	✓	
Carboxytherapy	✓	

20 In its grounds of decision dated 12 December 2011 ("the GD"), the DC rejected the applicant's argument that "the MOH guidelines on aesthetic medicine" [note: 20] did not apply to cosmetic or beauty treatments as they could not be regarded as "treatments or management plans" [note: 21] for the purposes of Art 4.1.4 of the ECEG (reproduced at [6] above).

21 The DC also rejected the applicant's argument that the aesthetic procedures which she had carried out had "general acceptance by the medical profession" (see the GD at [13]) as they were widely practised by a large number of doctors. The DC held that extensive practice by medical practitioners was not sufficient as medical procedures had to be scientifically validated. Rather, the correct approach in determining the appropriateness of medical treatment was evidence-based medicine ("EBM") (see the GD at [14]):

> … For the last few years, the approach taken by the medical profession in determining the appropriateness of treatments is "Evidence-Based Medicine" i.e. that a treatment ought to be substantiated and validated by medical research, with benefits for the patients. The underlying purpose of paragraph 4.1.4 of the [ECEG] and evidence-based medicine is to ensure that patients

are offered competent medical treatments that are beneficial and ha[ve] scientific basis that these treatments work. …

22 The DC also referred (at [15] of the GD) to a passage from *Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 ("*Gobinathan Devathasan*"), where this court stated (at [46]):

> During the DC hearing, expert witnesses for both sides broadly agreed on the test for when a particular therapy treatment would become generally accepted. In essence, the following factors would be crucial:
>
> (a) there had to be at least "one good study";
>
> (b) the results of the study can be replicated and reproduced under the same sort of like treatment parameters and conditions;
>
> (c) the study had been written up in publications and presented at meetings;
>
> (d) the study had received peer review;
>
> (e) the study had to have "clear-cut results" and the sample had to be "statistically significant"; and
>
> (f) the study had to have some form of controls, such as randomised double-blind trials.

23 Save for criteria (f), the DC was of the view that there was no reason why the other criteria set out in the above passage could not apply to aesthetic medicine. Relying heavily on Dr Goh's expert report ("the Expert Report"), the DC found that those criteria had not been met, and that the aesthetic procedures which the applicant had carried out were not generally accepted treatments (see the GD at [38], [46], [64], [73] and [89]). Hence, the applicant was held to be guilty of professional misconduct during the period "prior and up to 20 September 2007". [note: 22]

Issues before the court

24 The issues before this court are as follows:

(a) whether the charges against the applicant were properly framed, considering:

(i) the lack of consistency between the charges and the SMC's argued case; and

(ii) the lack of particularisation in the charges;

(b) whether the applicant's conduct was correctly characterised as professional misconduct under s 45(1)(*d*) of the MRA (1998); and

(c) whether it would have been more appropriate to charge the applicant with disreputable conduct under s 45(1)(*c*) of the MRA (1998) instead.

The standard of professional responsibility in aesthetic medicine

25 Aesthetic practice is currently not regarded in Singapore as a speciality or subspecialty in medical treatment. As a preliminary point, we observe that it is clear that aesthetic medicine is still an

evolving area of medical practice where there are sometimes no clear lines that can be readily drawn between treatments that have scientific basis and those that are plain quackery. There is also, as yet, no internationally-accepted definition of "aesthetic practice". The Guidelines on Aesthetic Practices for Doctors issued by the SMC on 28 October 2008 ("the October 2008 Guidelines"), which are the guidelines currently in force, adopt the following definition by the United Kingdom Cosmetic Surgery Interspecialty Committee as a working definition: [note: 23]

> *Operations and other procedures that revise or change the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise to be within the broad range of 'normal' for that person*. [emphasis in original]

26 As observed in a 2005 article by Associate Professor Goh Lee Gan ("Assoc Prof Goh") (not to be confused with Dr Goh, the SMC's expert witness in the DC proceedings), "Aesthetic Medicine: A Professional Perspective" *SMA News* vol 37(6) (June 2005) at p 11, [note: 24] the practice of aesthetic medicine can be grouped broadly into two categories: surgical procedures and minimally-invasive procedures. The former would include procedures which require the skills of a trained surgeon, an operating theatre and anaesthesia services, whereas the latter can be done by primary care doctors. The present case is about treatments that would clearly fall into the category of minimally-invasive procedures.

27 Strikingly, the October 2008 Guidelines emphatically state that the standard of professional responsibility in the realm of aesthetic medicine is not the same as that in conventional medical practice: [note: 25]

> 7. The guiding principles in any medical treatment must be that it is effective and there is due cognizance given to patient safety. *In the context of aesthetic practice, it must go beyond the "Do No Harm" principle and* ***be seen to benefit the patient positively*** . [underlining in original; emphasis added in italics and bold italics]

28 Paragraph 7 of the October 2008 Guidelines pitches the level of responsibility which a doctor practising aesthetic medicine must observe differently from that governing the practice of conventional medicine. Medicine is ordinarily viewed as the scientific practice of the diagnosis, treatment and prevention of disease and injury to the mind and body. The foremost consideration of the medical practitioner must be the well-being of the patient. Aesthetic medicine, however, is in some respects distinct from conventional medicine not only because of its very name. It involves procedures administered to modify a patient's appearance through treatment of body structures, and does not have as its primary objective the curing of any existing illness or disease. Patients who undergo aesthetic treatments seek to enhance their overall sense of well-being and self-esteem by receiving such treatments. The treatments may be sought to diminish negative attention and/or increase positive attention from others. Often, they involve elective procedures that seek to defer or prevent the onset of the natural effects of the aging process or the gaining of excessive weight. Like any beauty treatment the psychological aspects often take centre stage in aesthetic treatments. *However, unlike beauty treatments offered by beauticians, the proper practice of aesthetic medicine must have a scientific basis because it is practised by doctors, in whom patients have implicit trust for their safety and well-being*. [note: 26] Hence, there is an added responsibility on the doctor to ensure that the treatments involved are always *safe and efficacious* in achieving the desired improvement in appearance and well-being. Aesthetic medicine does not include reconstructive surgery, although there are some kinds of treatments that can be either reconstructive or cosmetic, for example, eyelid surgery (blepharoplasty). Beauty or grooming activities that have no structural impact on body tissue are also not considered to be part of aesthetic medicine.

The inadequacy of the charges against the applicant

29 As disciplinary proceedings are quasi-criminal in nature, a disciplinary tribunal has to adopt procedures and practices which ordinarily prevail in criminal trials. It is a fundamental principle of criminal law that the charges against an accused must state clearly the precise nature of the offence, and also include sufficient particulars of the time and the place of the alleged offence so as to enable the accused to prepare his defence adequately. Indeed, this principle has long been acknowledged in Singapore as an essential aspect of due process from as far back as the mid-19th century, when it was succinctly summarised by Norris R in *Lim Beh & Ors v Opium Farmer* (1842) 3 Ky 10 at 12 as follows:

> … [I]f there be any one principle of criminal law and justice clearer and more obvious than all others, *it is that the offence imputed must be positively and precisely stated, so that the accused may certainly know with what he is charged, and be prepared to answer the charge as he best may.* [emphasis added]

30 An accused must be given adequate details of the alleged offending conduct so that he can prepare his defence with the confidence of certainty about the allegations that have to be met. Hence, the question of whether the charges brought against the applicant were adequate in this respect is a fundamental one that requires careful consideration.

Lack of consistency between the charges and the SMC's argued case

31 The charges against the applicant were all largely similar, except for the treatments stated therein, and they all began with the following statement: [note: 27]

> That you **DR LOW CHAI LING**, a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at The Sloane Clinic, 30 Raffles Place, #03-01 Chevron House, Singapore 048622 ("the Clinic"), you did, *prior and up to 20 September 2007*, through your Clinic's website (http://www.sloaneclinic.com/) …, offer to patients … [emphasis in bold in original; emphasis added in italics]

32 While the charges precisely defined the timeframe of the alleged offences as the period "prior and up to 20 September 2007", [note: 28] it was clear during the hearing before us that the SMC's counsel, Mr Tan Chee Meng SC ("Mr Tan"), identified the SMC's real grievance with the applicant as being her failure to cease the impugned treatments *after* 20 September 2007 despite having received letters from the MOH querying those treatments. In fact, when queried by us as to why the applicant was one of the very few who had been charged by the SMC when there were many other practitioners who were also conducting the same procedures at the material time, Mr Tan confirmed that it was because the others had stopped the procedures on being notified whereas the applicant had not. The SMC's stance had also been earlier made abundantly clear during the cross-examination of the applicant at the DC hearing: [note: 29]

> Q. The fact of the matter is, Dr Low, you refused to stop notwithstanding the MOH position as reflected in the Council News of May 2008 – 2007, *you also refused to stop notwithstanding the unequivocal statement by MOH that if it is not evidence based*, you should stop in their letter of 20 September 2007.
>
> A. I don't think that is fair because when you have a Council News that is not a letter directed to me. I am sure a lot of doctors cannot be expected to stop based on a letter in the Council

that they may or may not have read. *I have also received the MOH's letter, but the MOH's letter says that should these treatments not be evidence based, and as far as I know, all these treatments are evidence based, and which is why we were engaging MOH to provide them with evidence to explain that these treatments had evidence and –*

Q. Dr Low, let me now tell you, as a response to your query as to why others who had practi[s]ed were not prosecuted and why you were. The reason is *they stopped you did not*.

[emphasis added]

33 However, the applicant's "wilful" (as perceived by the SMC) refusal to stop offering and/or administering the impugned treatments after receiving letters from the MOH was patently not part of the charges against her, which explicitly referred instead to what she had allegedly done *before* receipt of the MOH's warning letters. While it is usually not fatal to a charge that the time of the offence is wrongly or imprecisely stated as long as the accused has a fairly reasonable idea of the case facing him, here, the difference between the time period specified in the charges against the applicant (*ie*, the period "prior and up to 20 September 2007") [note: 30] and the time period following the MOH's letters (*ie*, the period after 20 September 2007) is not just a matter of timing *per se*, but an altogether fundamental difference in the nature and substance of the charges against the applicant. Charges relating to the period "prior and up to 20 September 2007" [note: 31] would plainly be concerned with the practice of non-EBM procedures in itself, whereas charges relating to the period after 20 September 2007 would concern the applicant's recalcitrant (from the SMC's perspective) conduct in wilfully continuing to offer and administer the impugned procedures despite having been explicitly told to stop. Consequently, the charges against the applicant as framed could not be proved as there was no evidence as to when, prior to 20 September 2007, the MOH had actually directed her to immediately stop the impugned treatments.

34 Indeed, even if the charges had been correctly framed to reflect the SMC's case that the applicant's offence was that of continuing to offer and administer the impugned procedures *after* 20 September 2007, it is unclear if this allegation can be established. From an objective point of view, it does not appear to us that it would have been obvious to the applicant that the *appropriate* response to the MOH's letters was for her to stop the impugned procedures immediately. Throughout the correspondence between the MOH and the applicant, there were absolutely no explicit demands by the MOH that the applicant stop the impugned procedures *immediately* pending a determination by the MOH as to whether the procedures were indeed adequately evidence-based. All that the letter from the MOH dated 20 September 2007 stated was: [note: 32]

3 Please write to us by 1 October 2007 to *describe* in detail how you carry out the above practices (Paragraph 1(a)– (i)) for patients in your clinic, and *whether these practices are evidence-based*. ***If they are not evidence-based*** , ***we would advise that you stop these practices immediately*** *, unless you get approval from an Institutional Review Board to perform them on a clinical trial basis.* [original emphasis omitted; emphasis added in underlining, italics and bold italics]

35 It would be hard to read this letter as a clear directive to the applicant to stop all activities in relation to the impugned treatments. The letter did not plainly state that the applicant ought to immediately stop offering those treatments until she could satisfactorily establish that they were evidence-based. Rather, the letter appears on a reasonable reading to be an invitation for the applicant to establish satisfactorily whether or not the impugned procedures were evidence-based. The instruction was to write to the MOH to state if the procedures were evidence-based. The

applicant appeared to have believed them to be so (as can be seen from the cross-examination reproduced above at [32]), and hence complied with the MOH's request by submitting the relevant articles and websites (see also her immediate response to the SMC's letter dated 14 February 2008 (above at [14])). The applicant also stated that as a number of more senior doctors were then offering similar treatments, that in itself was good evidence that the impugned treatments were clinically acceptable. The indistinct advice to stop those treatments immediately would only have applied had the applicant subjectively known or thought that they were not evidence-based – which was *not* the case. Pertinently, the DC also made no such finding.

36 Subsequent replies from the applicant show that she believed in the evidence-based nature of the impugned procedures and, contrary to Mr Tan's allegations of defiance, evidence her willingness to co-operate with the SMC and the MOH. This is apparent from her reply to the SMC's Complaint Committee dated 19 February 2008, which stated: [note: 33]

> We are fully co-operative with SMC and MOH and their guidelines. *Should any of these treatments be banned in Singapore, we would appreciate it if you would notify us and our colleagues so that we can cease and remove them from our practices* **immediately**.
>
> In the meantime, we would also like to notify SMC that some of the treatments that have been discussed had actually been discontinued at The Sloane Clinic by our management last year. Hence as of Dec 2007, we no longer offer **meso-oxygen**, **mesoglow**, **sonophoresis** and **osmolipolysis**. …
>
> [underlining and emphasis in bold in original; emphasis added in italics]

37 We also note that when the complaint was made to the SMC, all that the MOH asserted against the applicant was that "MOH had asked [the applicant] to provide evidence for her practices" [note: 34] (see [13] above). There was no allegation about the alleged defiant behaviour that the SMC's counsel adverted to. In our view, given the absence of a clear direction to the applicant to stop the impugned treatments and the lack of evidence to show that she remained defiant in the face of such a direction, the allegation by the SMC in relation to her persistent continuation of the treatments despite a notification to stop was misconceived.

Lack of particularisation in the charges

38 The charges against the applicant were, in our view, obviously vague enough to warrant detailed particulars. Yet, the particulars supplied were hardly sufficiently *particular* enough, with crucial details missing. This is contrary to established legal procedure. It is trite that an accused, once charged, must be able to immediately begin gathering evidence in his/her defence with absolutely clarity as to the case that has to be met (see above at [29]–[30]).

39 As alluded to at [31] above, the particulars of each of the charges against the applicant were framed in largely identical bare terms, apart from the procedures and their descriptions. For instance, the particulars for the first charge on mesotherapy read as follows: [note: 35]

> (a)In your Clinic's website (http://www.sloaneclinic. com/), "Mesotherapy for *fat deposits*" was ***listed*** as one of the treatments provided in your clinic. You have described such treatment as "*mesotherapy*", a "*revolutionary and essential tool*" for patients seeking weight loss; ***and/or***
>
> (b) You ***claimed*** that Mesotherapy Treatment is also used for cellulite reduction and body

sculpting; ***and/or***

(c) The Mesotherapy Treatment involved "*microinjections into the mesodermal – or middle layer of the skin*" of vitamin C; ***and/or***

(d) You ***performed*** the mesotherapy treatments outside the context of a formal and approved clinical trial;

and that in relation to the facts alleged, you are in breach of Article 4.1.4 of the [ECEG] and guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174).

[underlining and emphasis in italics in original; emphasis added in bold italics]

40 The particulars of the other charges were all worded similarly, the only difference being the precise descriptions of the procedures. The charges all made reference to The Sloane Clinic's website, set out some details on the procedures concerned and their purported benefits, and contained a general statement that the procedures had been performed outside the context of a formal and approved clinical trial in breach of Art 4.1.4 of the ECEG. In our view, this was plainly far from sufficient in giving the applicant adequate notice of *what* she was really being charged for. Was it for the mere fact that the website of The Sloane Clinic happened to have listed and promoted the impugned treatments with their corresponding descriptions attached? That appeared to be the case based on para (a) of the first charge. But, a plain reading of that rolled-up charge indicates that there were in fact three alternative and distinct elements to the charge, namely: (a) listing mesotherapy as one of the treatments provided by The Sloane Clinic; (b) claiming benefits that flowed from mesotherapy; and, importantly, (c) performing mesotherapy outside the context of a formal and approved clinical trial. Surely, as part of its case against the applicant, the SMC had to establish what was communicated to those of the applicant's patients who underwent the impugned treatments, as well as when and how those treatments were effected on the patients? Regrettably, the SMC did not appear to have either considered or established these vital elements. Indeed, it appears to us that the SMC was rather equivocal as to what its real case against the applicant was, as can be seen from its preferring seven multi-pronged charges that were not only bereft of proper particulars, but also confusing in levelling against the applicant alternative sub-sets of allegations. Pertinently, the DC, without acknowledging this deficiency, in turn considered the different elements of the charges as *cumulative requirements* (see the GD at [30], [31], [38], [41], [43], [46], [50], [52], [55]–[59], [64], [67]–[69], [72], [76], [78], [79], [83] and [89]). Our perusal of the record of proceedings suggests that because the SMC adopted an equivocal approach about the case which it sought to establish against the applicant, the DC construed the various elements of each charge as cumulative and not as alternatives. We must add that it is not at all clear to us if this cumulative approach was indeed the intended thrust of the charges. If it was, then why were the various limbs of each charge listed as possible alternatives? These unsolvable doubts make the charges legally embarrassing.

41 Further, none of the particulars of the charges referred to the specifics of whether and/or when the applicant actually performed the impugned procedures, how many of such procedures she performed and how she performed them; neither did the particulars clearly state the *manner* in which the applicant actually offered her patients the impugned treatments, a crucial element in defining the essential ingredients of the offence under s 45(1)(*d*) of the MRA (1998). Did the applicant *in fact* both promote and administer the impugned treatments as a first-line treatment? Did she inform her patients of the nature of these treatments and the risks involved? Did her patients have to sign consent forms to acknowledge the same? Who were these patients and why did they approach her? Were the

treatments in the best interests of the patients? Did they indeed benefit from the treatments in a medical sense? All these important items of information were neither particularised nor ascertained in a satisfactory manner. In our view, the mere vague passing reference to the contents of The Sloane Clinic's website and the abstract sweeping allegation of offer and performance of the impugned treatments outside the context of a formal and approved clinical trial were neither sufficient nor satisfactory in the prevailing circumstances to conclusively point to and establish professional misconduct on the applicant's part. The SMC ought to have obtained and adduced the applicant's medical records to substantiate its allegations of professional misconduct.

Lack of clarity in the DC's reasons for convicting the applicant

42 We readily accept, based on the Expert Report by Dr Goh, the cross-examination during the proceedings before the DC and the literature submitted during those proceedings, that there is little doubt that the five procedures in respect of which the DC found the applicant guilty of professional misconduct (*viz*, mesotherapy, mesoglow, stem cell extract facial therapy, sonophoresis and carboxytherapy) have plainly not met the standards of EBM. The DC rightly rejected the applicant's argument that a medical treatment was "generally accepted" for the purposes of Art 4.1.4 of the ECEG if it was widely practised by a large number of medical practitioners (see the GD at [14]). The assessment of whether or not a particular medical treatment is generally accepted must be scientific rather than empirical. *Illegitimate or unethical practices are not legitimised merely because large numbers of doctors engage in them.* As a specialist tribunal with its own professional expertise and understanding of what the medical profession expects of its members, the DC's conclusion on this matter should be accorded a high degree of deference, especially with regards to findings of a scientific and/or medical nature. Even so, given the lack of guidance on the propriety of the impugned procedures, which were widely practised at the material time, it is unsatisfactory that any medical practitioner should be singled out and charged with professional misconduct solely for administering such procedures, which were only clearly deemed by the SMC not to be evidence-based well after the alleged transgressions. *It is a cardinal tenet of the rule of law that a person should only be punished for offending laws, regulations or professional practices that are both known and clearly established at the time of offending; no person should be punished retrospectively.* Unfortunately, the manner in which the case against the applicant was framed at the DC hearing raises troubling questions as to what she was really being punished for. What is now clear on hindsight cannot be presumed to have been present in the minds of doctors with the same clarity during the period before the regulators took a firm stand on the practice of aesthetic medicine in July 2008 with the publication of the first edition of the Guidelines on Aesthetic Practices for Doctors ("the July 2008 Guidelines").

43 More crucially, while it is important for the guidance of the medical profession to determine whether or not the five procedures set out at [42] above were in fact evidence-based treatments, in so far as the current proceedings are concerned, it should not be the primary issue, given the uncertainty prevailing at the material time about the proper practice of aesthetic medicine and the legitimacy of some of the treatments that were then widely administered. Rather, given that the charges against the applicant were for professional misconduct, what should really have been the focus of the DC was the actual conduct of the applicant apropos her patients, and whether it was so out of line with what was professionally expected of her that she should be convicted under s 45(1)(*d*) of the MRA (1998) (now s 53(1)(*d*) of the MRA (2004)). While this court would be slow to interfere with the findings of the DC, we will not defer to the DC if its decision is not in accordance with law and/or goes against the grain of established facts (see *Gobinathan Devathasan* at [29]).

44 It bears mention that when the applicant was notified of the charges against her via the NOI dated 1 March 2010, the Expert Report by Dr Goh was also annexed. [note: 36] In the Expert Report,

Dr Goh categorised the impugned treatments according to their evidence-based levels (high, moderate, low or very low) as measured against a certain "GRADE system", an international standard which has also been adopted by the SMC's Aesthetic Procedure Oversight Committee. He emphatically stated what the guidelines for offering treatments of low or very low evidence-based grades should be, namely: [note: 37]

> 21. From a professional and professional ethics points [*sic*] of view, treatment options offered to patients which are graded as *low and very low evidenced based* or off-label *should be offered to patients only under special circumstances and should be administered with caution and under the following guidelines*:
>
> a. Patient has not responded to the 1st or 2nd line treatments which are graded as very good or good or moderate evidence based.
>
> b. Patients should be informed of the low or very low evidence based or "off label" nature of treatment.
>
> c. Consent should be obtained from the patient.
>
> d. The treatment should be done under [a] clinical trial setting where close monitoring of treatment response and side effects is necessary.
>
> e. Physicians should not promote or "advertise" the treatment option as a routine procedure, as it will mislead patients into thinking that it is a standard proven and accepted treatment option.
>
> [emphasis added]

45 Dr Goh then provided his professional input on the impugned treatments in terms of the following factors: [note: 38]

a. nature of procedure,

b. procedure grade of evidence based,

c. comments on available publications to support the grades of evidence based where relevant, of the procedure,

d. comment if the procedure is considered by the profession as an accepted standard first line treatment for the specific disorder indicated,

e. comment on the expected guidelines on how the procedure should be administered when it is used.

46 In the Expert Report, Dr Goh evaluated the impugned treatments individually and eventually concluded that all of them were not accepted as a standard first-line treatment and had either low or very low evidence-based grades. Notably, for each of these treatments, he specifically referred to the guidelines set out in para 21 of the Expert Report (reproduced at [44] above) as the proper treatment guidelines to be adhered to when offering the treatments. For instance, he made the following remarks (repeated for all the other treatments) in relation to mesotherapy: [note: 39]

Guidelines when mesotherapy is offered to patients:

27. Follow treatment guidelines as set out in paragraph 21 above.

47 Yet, despite repeatedly stating abstractly in the GD that the guidelines set out in para 21 of the Expert Report had to be adhered to, no inquiries were apparently made by the DC about compliance with the relevant standards set out in those guidelines. Did the applicant's patients *in fact* respond adversely to appropriate first- and second-line treatments before undergoing the impugned treatments? Were the patients adequately informed of the nature of those treatments? Was consent obtained from the patients? Were the treatments conducted under highly-monitored settings with strict protocols in place? In what manner were the treatments misleadingly advertised as routine procedures? Unfortunately, these pertinent issues and details were neither adequately addressed by the SMC nor granularly ascertained by the DC. The GD made no reference whatsoever to any of these crucial matters.

48 Pertinently, the guidelines which Dr Goh set out in para 21 of the Expert Report (reproduced at [44] above) broadly echo the framework that the October 2008 Guidelines prescribe for treatments of low or very low evidence-based levels (see [60] below). This indicates that even the SMC's own expert witness, Dr Goh, was of the view that when the alleged transgressions took place, the impugned treatments, despite having either low or very low evidence-based grades, were not prohibited absolutely, but required careful promotion, evaluation and administration. Hence, while the Expert Report stated Dr Goh's professional opinion on what the evidence-based grades of the impugned treatments were, it was overall inconclusive as to the question of whether the actual treatments were *in fact* administered in a manner that would be in clear violation of any "[s]tandard professional approach". [note: 40]

49 It is puzzling why the DC, without giving any explanation in the GD, adopted an altogether different approach from Dr Goh in its assessment of what doctors could or could not do with regard to treatments of low or very low evidence-based levels. Instead of recognising that there could be ways of properly administering such treatments, the DC adopted an "EBM or nothing" approach by flatly condemning any treatment that failed to meet the exacting requirements of EBM, as evidenced by the following statements in the GD:

> 12 The effect of paragraph 4.1.4 [of the ECEG] is that a practitioner *cannot* offer methods of treatments that are not "generally accepted", unless it was "in the context of a formal and approved clinical trial".
>
> …
>
> 20 … [A] practitioner must be careful to *only offer treatments that had* [*sic*] *been proven to be beneficial*, and not simply offer what patients or the commercial market wanted [*sic*]. …
>
> [emphasis added]

50 In short, while Dr Goh explicitly made mention in the Expert Report of specific guidelines which should be followed when administering treatments of low or very low evidence-based levels (an approach similar to that set out in the October 2008 Guidelines), the DC rejected this approach altogether and instead found that during the material period, there was an absolute regulatory or professional prohibition on all non-EBM procedures conducted outside the context of clinical trials. We have difficulty in understanding why and how the DC arrived at this conclusion.

The essence of professional misconduct

51 In determining what constituted professional misconduct for the purposes of s 45(1)(*d*) of the MRA (1998), the DC quoted with approval (at [9] of the GD) the following passage from *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37]:

> … In summary, we accept Kirby P's suggestion in [*Pillai v Messiter (No 2)* (1989) 16 NSWLR 197] 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 second, where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner …

52 The passage above contained the concluding remarks of this court in *Low Cze Hong* after it made an extensive survey of the case law on what constituted professional misconduct under the MRA (2004). Although this court's decision in *Low Cze Hong* was not meant to be an exhaustive determination of what professional misconduct consists of, the passage above at least shows that professional misconduct ordinarily does carry with it the *severity* of sanctioning either an intentionally errant doctor who chooses to go against established conventional standards or a grossly negligent medical practitioner. In so far as the applicant is concerned, there is not even the barest hint of a suggestion that she might have either harmed or experimented on her patients (see Art 4.1.4 of the ECEG). Rather, the nub of the SMC's case was that it was inappropriate for the applicant to have administered treatments that might have no scientific validity. In short, the SMC's stance was that the impugned treatments, even if they were of positive benefit to the well-being of the applicant's patients, ought not to be offered by a doctor in a medical clinic setting.

53 Interestingly, the DC noted (at [10] of the GD) that "[n]aturally, the gravity of the departure from the [ECEG] or whether harm was caused to the patient may well be relevant considerations in determining whether there was professional misconduct", a statement which largely resonates with the passage from [37] of *Low Cze Hong* (reproduced at [51] above) in terms of prescribing a certain level of severity or intentionality for professional misconduct to be found. Yet, what the DC failed to do subsequently was to show in the GD how the applicant's conduct corresponded to its own understanding of what constituted professional misconduct. The significant leap from a breach of Art 4.1.4 of the ECEG to a finding of professional misconduct was left unexplained by the DC in the GD. Notably, the focus of the GD was largely on the nature of the procedures carried out by the applicant, which the DC analysed in worryingly abstract terms, and not on the applicant's actual manner of administering those procedures on her patients, which really ought to be the focus in any typical professional misconduct case. We will now examine the evidence on record to determine if the applicant's conduct both *prior and up to* the time of the MOH's letter dated 20 September 2007, as well as *after* that letter, was sufficiently grave to constitute professional misconduct.

Examination of the applicant's conduct

The period prior and up to 20 September 2007

54 Prior and up to 20 September 2007, there were no guidelines on the practice of aesthetic medicine. Such guidelines were only published in July 2008 (in the form of the July 2008 Guidelines), and were subsequently updated in October 2008 (resulting in the October 2008 Guidelines). As the applicant explained in her affidavit affirmed on 16 January 2012, she had only followed the lead taken by other doctors, a number of whom were prominent in the medical field, who had jumped onto the

aesthetic medicine bandwagon with considerable alacrity. [note: 41] As a rapidly-evolving area of medical practice in Singapore in 2007, aesthetic medicine at that time was unclearly regulated and monitored. Except for a brief paragraph in the "Council News" section of the Singapore Medical Association's May 2007 newsletter stating the MOH's position on mesotherapy (see *SMA News* vol 39(5) (May 2007) at p 4), there were no rulings on which aesthetic procedures were clinically validated and which were not. The aforesaid paragraph read: [note: 42]

> *The Ministry has reviewed the issue and our current position is that mesotherapy should not be considered as a medical service because of the lack of supporting evidence.* Currently, no product has been registered with Health Sciences Authority for mesotherapy. [emphasis added]

55 According to the applicant, in 2007, there were a number of courses or programmes on aesthetic procedures openly and regularly provided by private companies like the Aesthetic Dermatology Educational Group Pte Ltd (ADEG), as well as courses offered by senior local doctors through the Aesthetic Medical Pte Ltd (AMPL) Education Series, a widely-publicised series of courses helmed by a senior doctor, Dr Goh Seng Heng. [note: 43] Prominent doctors conducted the latter courses, which involved teaching procedures including, *inter alia*, mesotherapy. No steps were taken by the regulators to curtail these activities. Given this backdrop of how aesthetic procedures were introduced and taught to doctors in Singapore, it would be reasonable to say that both young and more established doctors were left in the dark as to the official and/or professional requirements for practice in this field. Mr Tan argued forcefully that doctors should not wait for the authorities to issue guidelines to know what could not be done as it was impossible to issue guidelines on everything. Rather, Mr Tan submitted, doctors should understand that they had a duty to practise medicine that was clearly EBM, and the onus rested on them to ensure that the procedures which they performed were not prohibited. There is certainly merit in Mr Tan's submissions on this point and, in substance, we, of course, agree with him on this.

56 However, in 2007, the practice of aesthetic medicine was rapidly evolving, resulting in the boundary between permissible conduct and impermissible conduct (amounting to unprofessional conduct or professional misconduct) becoming more and more hazy. No clear lines were drawn by the regulators nor were clear advisory cautions issued, save for one on mesotherapy (see above at [54]). The SMC did not move immediately to address this problematic development as it wanted to first seek and then build a consensus within the medical community as to how to approach this thorny matter. Doctors in 2007 would not have been able to discern with certainty and clarity which aesthetic procedures would be allowed and which would not. We pause to mention that of the nine original treatments complained of *vis-à-vis* the applicant, two were later dropped without explanation (see above at [15]). Further, the DC acquitted the applicant of two of the seven charges preferred against her (*viz*, the charges relating to mesolift and stem cell extract scalp therapy) apparently because there was doubt as to whether (and how) the treatments in question were in fact administered. The SMC itself was unclear during the material period as to what was permissible. While there had already been a working group formed in 2006 by the MOH to consider the practice of aesthetic medicine in Singapore, it was not until July 2008 that official guidelines (in the form of the July 2008 Guidelines) were first published. Effectively, from 2006 to July 2008, when the July 2008 Guidelines were published, there was uncertainty on the medical front as to what the official regulatory stand was in relation to the practice of aesthetic medicine and what came within its architecture. Interestingly, as will be discussed in further detail below, even within the framework of the October 2008 Guidelines (the guidelines currently applicable), which were issued after the material period stated in the charges against the applicant (*ie*, the period prior and up to 20 September 2007), there are provisions for the practice of low or very low evidence-based aesthetic procedures within certain boundaries, which, on the evidence adduced in this case, the applicant has not been clearly

shown to have crossed.

The period after 20 September 2007

57 As discussed above at [33]–[37], there was no unequivocal or unqualified directive from the MOH or the SMC to the applicant to stop the impugned treatments immediately. Furthermore, the letters from the MOH and the SMC to the applicant were clearly inquiring about her past practice in relation to the treatments. Throughout her exchanges with the MOH and the SMC, the applicant's conduct was courteous, co-operative and responsive. There was no evidence of defiance or evasiveness in her replies, which often came across as earnest and somewhat distressed by the charges brought against her. The article "SKIN FLICK" published in *The Straits Times* on 15 November 2007 quoting the applicant (see [12] above) did not show defiance in any sense on her part. In fact, a quick glance at the whole article reveals that the applicant was obviously not alone in practising aesthetic procedures which were possibly not evidence-based procedures, which again raises the question of why she was apparently singled out from the crowd for disciplinary action. It is unclear from the article whether the applicant was merely describing the intricacies of stem cell mesotherapy and in what capacity she was being interviewed.

58 In our view, the applicant's conduct, even if it was seen to be defiant by the SMC, was not plainly of sufficient gravity to constitute professional misconduct. Even her admission (via the advertisements on The Sloane Clinic's website offering the impugned treatments) that she had offered and administered those treatments would, in these circumstances, not amount to professional misconduct unless there is some evidence of the actual advice given by the applicant to her patients as to the efficacy of the treatments immediately prior to administering those treatments. Were the impugned treatments in fact first- or second-line treatments? Significantly, there was no inquiry whatsoever as to whether or not any of the treatments administered by the applicant would have met the requirements of the October 2008 Guidelines (*viz*, the guidelines currently applicable) had they been in force during the period covered by the charges against the applicant. We now turn to examine the October 2008 Guidelines.

The October 2008 Guidelines

59 Not long after a flurry of media reports and letters from members of the public were published in *The Straits Times* in early 2008 discussing the appropriateness of and the need for regulation of aesthetic medicine, the October 2008 Guidelines were released on 28 October 2008. These guidelines were a revision of the July 2008 Guidelines, and were based on a report produced by the MOH in consultation with the College of Family Physicians, Singapore ("the CFPS"), the Academy of Medicine, Singapore ("the AMS"), the Society of Aesthetic Medicine (which had been formed only in 2005) and the SMC. The October 2008 Guidelines were then jointly implemented by the AMS, the CFPS and the SMC with effect from 1 November 2008.

60 Within the October 2008 Guidelines, aesthetic procedures were largely separated into either "List A" or "List B" procedures. List A contained evidence-based procedures, whereas List B contained those of low or very low evidence-based levels. For List A treatments, medical practitioners would be allowed to perform them if they possessed a track record of performing a requisite number of those procedures and had a minimum level of competence. For List B treatments, the following framework was spelt out: [note: 44]

> 15. List B contains aesthetic treatments and procedures that are currently regarded as having low / very low level of evidence and / or being neither well established nor acceptable. These are:

(a) Mesotherapy;

(b) Carboxytherapy;

(c) Microneedling dermaroller:

(d) Skin whitening injections;

(e) Stem cell activator protein for skin rejuvenation;

(f) Negative pressure procedures (e.g. Vacustyler); and

(g) Mechanised massage (eg. "slidestyler", "endermologie" for cellulite treatment).

16. There will be circumstances in which *doctors may wish to practise such low-evidence procedures on patients*. In general, these circumstances are:

(a) *All other conventional and sound-evidence based treatments / procedures have been attempted* on the patient and have not been shown to produce the desired outcomes;

(b) The procedure has on the available evidence *not been shown to carry any risk of significant adverse effects or harm* to any patient;

(c) The patient is *aware that the procedure is low-evidence in nature* and only offered in view of the lack of efficacy of conventional and sound-evidence based treatments and gives specific consent to this, on a consent form.

17. Having satisfied all the above circumstances and documentations, it is still required of doctors to practise List B aesthetic procedures only under *highly monitored conditions* that enable *the efficacy or lack thereof of such procedures to be objectively demonstrated. The objectives, methodology, analysis and findings obtained through such treatments must be of sufficient scientific validity to establish efficacy or otherwise.* In addition, patient response should be *documented and retained*, alongside all case records of such treatments.

18. In the event the procedure yields adverse or neutral outcomes, the practice of the procedure(s) must be terminated.

…

20. It is important for the doctor to understand that the provisions of the [EGEG] apply to all doctors who wish to practise List B aesthetic procedures. *A doctor must ensure that he / she practises in the best interests of his / her patients and that any procedure is clinically justifiable if challenged*.

21. *No doctor shall advertise that he / she is performing the aesthetic procedures in List B*.

[emphasis added]

61 With regard to the practice of List B procedures, one change made in the October 2008 Guidelines from the July 2008 Guidelines was a significant relaxation of the criteria for practising List B procedures. Whilst, under the July 2008 Guidelines, doctors could only perform List B procedures

"under a research framework" [note: 45] either as "a clinical trial" [note: 46] or as "a series of before-and-after studies with sufficient scientific rigour to produce evidence of the [procedures'] effectiveness and safety", [note: 47] under the October 2008 Guidelines, List B procedures could be practised, *inter alia*, under "highly monitored conditions that enable[d] the efficacy or lack thereof of such procedures to be objectively demonstrated". [note: 48] It is therefore evident that the October 2008 Guidelines envisaged the possibility of a doctor performing low or very low evidence-based procedures on patients as long as they were performed in accordance with the standards listed in paras 16 and 17 of these guidelines. The absolute prohibition on advertising of List B procedures was for the first time also *clearly* spelt out in the July 2008 Guidelines and the October 2008 Guidelines.

62 Given that four out of the five charges which the applicant was found guilty of relate to procedures under List B (*viz*, mesotherapy, mesoglow, stem cell extract facial therapy and carboxytherapy), the October 2008 Guidelines would have been relevant in the applicant's case had they been in operation at the material time, *ie*, during the period prior and up to 20 September 2007. Paradoxically, if the October 2008 Guidelines had been in operation at the material time, the SMC would not have been able to clearly establish (on the basis of the evidence on record) that the applicant had violated these guidelines, except in so far as she had promoted the impugned treatments on The Sloane Clinic's website. Assuming that the applicant had administered the impugned treatments with full disclosure to her patients that the treatments were of a low or very low evidence-based nature and were not being offered as first-line solutions, and assuming that her patients objectively benefited from the treatments, the applicant may not have been in breach of the October 2008 Guidelines.

63 What must be emphasised here is that it would be plainly unjust for the applicant to be sanctioned for professional misconduct based on standards *higher* than the applicable standards today (which are the standards set out in the October 2008 Guidelines) when there was a patent lack of clarity as to what were appropriate practices at the material time. By bringing the charges against the applicant, what the SMC was effectively contending was that there was at the material time an absolute prohibition against *any* practice of low or very low evidence-based procedures. This is a much stricter approach than what even the October 2008 Guidelines actually set out, and is also contrary to the MOH's own regulatory approach, as stated in its press release "MOH Clarifies Position on Aesthetic Treatment" of 24 March 2008, which was against strict bans: [note: 49]

> **Regulating this business [of aesthetic treatment] is particularly challenging as often scientific evidence is missing or inconclusive. A hard regulatory approach must mean *the prohibition of many procedures* but *this is not practical* . And *this is not what MOH is advocating* .**
>
> …
>
> *As for the other aesthetic* [*ie*, not highly invasive] *procedures, the Academy of Medicine and the College of Family Physicians are jointly formulating guidelines which will govern the ethical practice of such procedures.* They will consult widely and learn from other countries with similar guidelines. MOH supports such a responsible way of self-regulation by the profession. …
>
> [emphasis added in bold, in italics and in bold italics]

64 Even within the October 2008 Guidelines, we might add, there exists uncertainty in some areas. For instance, the following definition of List B procedures is unhelpfully vague: [note: 50]

- List B – Low or very low level of evidence; and / or *Local medical expert consensus that procedure is neither well-established nor acceptable*

[emphasis added]

65 It is puzzling why the DC, in the GD, defined the phrase "generally accepted" in Art 4.1.4 of the ECEG (in relation to the practice of aesthetic medicine) to mean that a procedure must fall within the confines of EBM before it can be regarded as "generally accepted", when the October 2008 Guidelines separates general acceptance from evidence level, suggesting that evidence level and local medical expert consensus are two different issues. In the light of the DC's decision, which effectively equated "generally accepted" in Art 4.1.4 of the ECEG with EBM, it is unclear what the phrase "[l]ocal medical expert consensus" [note: 51] in the October 2008 Guidelines should mean beyond the standard of EBM. In short, the lack of clarity both inherent in the October 2008 Guidelines themselves and on the question of whether the applicant's conduct would have been in breach of these guidelines had they been applicable at the material time further points to the injustice of convicting the applicant of professional misconduct for what she is alleged to have done.

66 As a point of interest, while this issue is not the subject of our current case, the following paragraph of the October 2008 Guidelines raises an important consideration in the regulation of aesthetic medicine: [note: 52]

> 19. The patients must not be charged *highly profitable fees* for such procedures of low-evidence, but a *fair fee* representing the cost of the procedures plus the cost of providing and administering them. Financial documents relating to these procedures must also be retained for the purpose of audit when required. [emphasis added]

The injunction to doctors that they must not charge "highly profitable fees" [note: 53] for low evidence-based procedures is, in our view, an unsatisfactorily vague measure of ethical or professional conduct. Self-esteem and contentment in having physical beauty and grace cannot be measured in monetary terms. Paragraph 19 of the October 2008 Guidelines seems to imply that even for low evidence-based procedures, charging substantial (as opposed to "highly profitable") [note: 54] fees is not objectionable. In principle, while it can be confidently said that no professional should overcharge or be allowed to overcharge, aesthetic medicine is an area of medical practice where the effectiveness of treatment cannot be measured quantitatively and, hence, can be a trap for the unwary. Patients who seek aesthetic treatments are usually prepared to pay for such services. The patient's desire and finances determine the treatment eventually administered. With an increasingly affluent and aging population, the demand for aesthetic medicine will continue to grow. Hence, if the SMC desires to regulate the proper charging of aesthetic services, it should come up with some better and more precise guidelines on permissible charging and full disclosure in relation to specific types of low evidence-based procedures.

Sanctioning the applicant for professional misconduct as opposed to disreputable conduct

67 In the present case, the applicant was charged with professional misconduct for offering and performing aesthetic procedures that had no support in EBM. It is quite telling that the October 2008 Guidelines state the following: [note: 55]

> 25. Any doctor who performs any aesthetic procedure that is not in accordance with these guidelines or with any requirements set by the SMC or MOH will be deemed by the medical profession as unethical and ***bringing disrepute to the profession*** **.** Such a doctor may be liable

for disciplinary action by the SMC. [emphasis added in bold italics]

68 In the light of this passage, it is puzzling that the SMC chose to discipline the applicant for professional misconduct rather than for bringing the medical profession into disrepute. The above passage reveals what the SMC really considers to be the true mischief that the October 2008 Guidelines are meant to target: *viz*, conduct that brings disrepute to the medical profession. This kind of misconduct is quite different from professional misconduct, which is the type of misconduct that the applicant was charged with. The dissimilarity is also acknowledged by s 45(1)(*c*) of the MRA (1998) (now s 53(1)(*c*) of the MRA (2004)), which distinctly refers to:

> (*c*) … such improper act or conduct which, in the opinion of the Disciplinary Committee, *brings disrepute to his profession* … [emphasis added]

69 There is indeed a conceptual difference between the offence under s 45(1)(*d*) of the MRA (1998) ("the professional misconduct offence") and the offence under s 45(1)(*c*) ("the disreputable conduct offence"), although there may be circumstances where it would be difficult to characterise whether the offending conduct falls under s 45(1)(*d*) or s 45(1)(*c*). The former offence (*ie*, the professional misconduct offence) is often more serious than the latter (*ie*, the disreputable conduct offence), and is always committed in a professional capacity (*ie*, while acting as a doctor), whereas the latter is usually committed in a non-professional capacity (*ie*, while acting in a personal capacity). An example of the latter would be involvement in criminal syndicates. At this point, it may be useful to draw a parallel with the legal profession. Section 83(2) of the Legal Profession Act (Cap 161, 2009 Rev Ed) ("the LPA") states a list of causes for which a lawyer may be suspended, struck off the roll, fined or censured. In particular, s 83(2)(*b*) and s 83(2)(*h*) of the LPA, which roughly mirror s 45(1)(*d*) and s 45(1)(*c*) respectively of the MRA (1998), read as follows:

> (2) Such due cause [for sanctioning an advocate and solicitor] may be shown by proof that an advocate and solicitor —
>
> …
>
> (*b*) has been guilty of fraudulent or grossly improper conduct in the discharge of his professional duty or guilty of such a breach of any usage or rule of conduct made by the Council under the provisions of this Act as amounts to improper conduct or practice as an advocate and solicitor;
>
> …
>
> (*h*) has been guilty of such misconduct unbefitting an advocate and solicitor as an officer of the Supreme Court or as a member of an honourable profession …

70 In differentiating between s 83(2)(*b*) and s 83(2)(*h*) of the Legal Profession Act (Cap 161, 1997 Rev Ed) (the then equivalent of the LPA), the High Court in *Law Society of Singapore v Ng Chee Sing* [2000] 1 SLR(R) 466 observed at [40]:

> Section 83(2)(*h*) of the Legal Profession Act is a catch-all provision which can be invoked when the conduct does not fall within any of the other enumerated grounds but is nevertheless considered unacceptable. It was stated in *Law Society of Singapore v Khushvinder Singh Chopra* [[1998] 3 SLR(R) 490] that unlike "grossly improper conduct" in s 83(2)(*b*), "conduct unbefitting an advocate and solicitor" is not confined to misconduct in the solicitor's professional capacity but also extends to misconduct in the solicitor's personal capacity. *It follows that the standard of*

> *unbefitting conduct is less strict* and, as stated in *In re Weare, a Solicitor; In re The Solicitors Act, 1888* [1893] 2 QB 439, a solicitor need only be shown to have been guilty of "such conduct as would render him unfit to remain as a member of an honourable profession". [emphasis added]

71 This distinction is similar to the difference between the professional misconduct offence and the disreputable conduct offence under the MRA (1998) (as well as under the MRA (2004)). Where the offending conduct has been carried out in the course of a doctor's professional duties, the charge would usually be for professional misconduct instead of for disreputable conduct. We can also illustrate the difference by making reference to some recent disciplinary cases involving doctors. In the case of Dr Tan Teck Hong, [note: 56] the offence concerned the doctor's failure to take due care in the management of patients in relation to the prescription of certain medication. The disciplinary proceedings against Dr Saifuddun bin Sidek [note: 57] involved, *inter alia*, prescribing medication without carrying out a clinical review of the patient. Dr Chee Yew Wen's case [note: 58] involved carrying out a procedure which was deemed not to be the appropriate treatment for the patient. In Dr Ng Chee Keong's case, [note: 59] it was the failure to exercise due care by inappropriately prescribing medication. In all of these cases, the doctors were charged with the *professional misconduct* offence as their offending conduct all related to the professional medical duties of a doctor.

72 In contrast, the disciplinary proceedings against Dr Ho Mien [note: 60] were based on two charges for the *disreputable conduct* offence instead. This case involved a house officer making claims for monetary compensation for two night calls despite having swopped those night calls with another doctor. The DC in that case held that the house officer's acts had in fact brought disrepute to the medical profession as it would have a significant impact on the training of doctors and would eventually erode the integrity of the training system in place. In its decision dated 16 December 2011, the DC stated (at [20]) that it was "concerned with the wrong message that would be sent to doctors under training if [it] were to condone the Respondent's acts". This case illustrates that the primary concern underlying the disreputable conduct offence is the protection of the medical profession's integrity and good name. Would public confidence in the medical profession be damaged by the offending conduct? What message would such conduct send to the public at large about doctors? This is an objective inquiry, which relates to the question of how a reasonable layperson would perceive the offending doctor's conduct and, hence, the entire medical profession as a result. The High Court in *Wong Kok Chin v Singapore Society of Accountants* [1989] 2 SLR(R) 633 at [17] also relied on this standard (albeit in the context of accountants):

> A practical test could have been if reasonable people, on hearing about what [the errant accountant] had done, would have said without hesitation that as an accountant he should not have done it.

73 In the article by Assoc Prof Goh referred to at [26] above, it was suggested that: [note: 61]

> The turf that belongs to the beautician should be left to the beautician. Aesthetic medicine/surgery should therefore exclude beauty or grooming activities that have no structural impact on body tissue, ear or body piercing or tattooing.

Presumably, what Assoc Prof Goh is suggesting is that doctors who choose to practise as beauticians should not hold themselves out as doctors. Whether, if such doctors so hold themselves out, it would bring the medical profession into disrepute is a matter on which we express no opinion as this is really a matter for the SMC to prescribe or regulate. However, with respect to the practice of aesthetic medicine, we are of the view that doctors can still hold themselves out as doctors provided they

follow the October 2008 Guidelines; otherwise, they would be deemed to be unethical and/or to bring disrepute to the medical profession.

74 In our view, tolerance for errant doctors who visibly depart from the October 2008 Guidelines by offering and performing dubious aesthetic treatments will first corrode and then erode the sterling reputation that the medical profession now enjoys for competence and integrity. Patients are entitled to have an anticipatory confidence that all doctors are both competent and ethical. This has been rightly underscored in the introduction to the ECEG, which states: [note: 62]

> *The medical profession has always been held in the highest esteem by the public, who look to their doctors for the relief of suffering and ailments.* In modern medical practice, patients and society at large expect doctors to be responsible both to individual patients' needs as well as to the needs of the larger community. Much trust is therefore endowed upon doctors to do their best by both. *This trust is contingent on the profession maintaining the highest standards of professional practice and conduct.* [emphasis added]

75 The key question is: where and how should the boundaries of medical practice be clearly drawn for the wider common good? We note that the applicant, in her written closing submissions to the DC, argued alternatively that "the cosmetic or beauty treatments performed by doctors like [the applicant] cannot be regarded as treatments or management plans within the meaning of Article 4.1.4 [of the ECEG] regarding medical treatments to patients". [note: 63] Her argument was that if there was no medical treatment in the first place, the ECEG did not apply. We wish to make some observations on this argument as it is not without some intrinsic merit. There is no health or medical reason why a doctor may not provide beauty treatment to his/her patients if they ask for it. The only reason why he/she should not be doing so is that he/she may thereby be bringing the medical profession into disrepute. If a doctor wants to be a beautician, he/she should, perhaps, deregister himself/herself as a doctor, as Assoc Prof Goh appears to be suggesting (see above at [73]). (As an aside, it is not clear that para 25 of the October 2008 Guidelines (reproduced at [67] above) applies to such a situation as it expressly refers to the practice of aesthetic medicine.) Nevertheless, if there is full disclosure to the patient about the lack of clinical validity about certain aesthetic treatments and informed consent to those treatments is given by the patient, it would be difficult to argue that such treatments would not be better administered by doctors as compared to beauticians. In the practice of aesthetic medicine, the primary concern of the SMC must be that there should be no quackery that could cause harm to patients. The fact that this area of practice may prove to be lucrative for certain medical practitioners should not be the basis for professional disapproval. There are other means of addressing that particular concern (see [66] above). Unless this vexing issue is addressed decisively and the boundaries are clearly drawn by the relevant regulators, doctors who practise aesthetic medicine will continue to be left in a state of uncertainty as to their standing in the medical profession.

76 Be that as it may, what we can say with certainty is that in the present case, the DC was wrong to literally apply Art 4.1.4 of the ECEG to the applicant's practice of aesthetic medicine during the material period. This was akin to forcing the central ethical issues into an ethical Procrustean bed. The October 2008 Guidelines make it plain that there are certain medical modalities that critically distinguish the practice of aesthetic medicine from the practice of conventional medicine (see [27] above). The DC overlooked this in convicting the applicant based on vague charges that failed to adequately factor in the then prevailing uncertainty about the proper procedures to be observed in the practice of aesthetic medicine. That ethical hiatus was only resolved after the formulation of, first, the July 2008 Guidelines and, subsequently, the October 2008 Guidelines (see [56] and [59] above). Indeed, the fact that it was eventually considered necessary by the regulators to *clarify and*

narrow the broad embrace of Art 4.1.4 of the ECEG (after an extensive consultation exercise) and specifically provide for the practice of aesthetic medicine through (*inter alia*) the October 2008 Guidelines ought to have been seen by the DC as a pivotal consideration in assessing the viability of the charges against the applicant. In the light of all that uncertainty, it would be unjust, on the facts of this case, to punish the applicant by rigidly applying Art 4.1.4 of the ECEG to "offending" conduct that took place prior to the issuance of the October 2008 Guidelines (see [49]–[50] above). The apparent unjustness of sanctioning the applicant becomes even more plain when the prevalence of the practice of the impugned treatments by many of her contemporaries (some more prominent than her, none of whom has been taken to task) is taken into account (see [54]–[55] and [57] above). *We would add that had a clear cease-and-desist directive by the regulators been served on the applicant, the outcome of the case against her might then justifiably have been different (see [33] above).*

Summary

77 In summary, we make the following findings:

(a) During the period stated in the charges against the applicant (*ie*, the period "prior and up to 20 September 2007"), [note: 64] there were no established standards or official standards prescribed by either the MOH or the SMC for the practice of aesthetic medicine (see [54]–[56] above). The ethical parameters for the practice of conventional medicine and those for the practice of aesthetic medicine do not coincide in all respects (see [27]–[28] above). It would therefore be inappropriate to invariably and/or rigidly apply Art 4.1.4 of the ECEG to the practice of aesthetic medicine (see [76] above).

(b) The appropriate standards to regulate the practice of aesthetic medicine were first established by the July 2008 Guidelines and subsequently updated via the October 2008 Guidelines (see [56] and [59] above). It is reasonable to assume that the same standards (if at all) would have applied during the time period stated in the charges against the applicant. It would be unjust, considering the uncertainty prevailing during the material period, to impose on the applicant more exacting standards of professional conduct in relation to her practice of aesthetic medicine than the standards which apply today, which are the standards set out in the October 2008 Guidelines. Assuming that the October 2008 Guidelines had been applied to the applicant's aesthetic practice as advertised by The Sloane Clinic, it was not unequivocally established whether she had breached those guidelines with respect to the impugned treatments (see [62]–[65] above).

(c) The applicant was not being defiant when she did not immediately cease offering the impugned treatments via The Sloane Clinic's website (see [57] above). No clear directive to do so was served on her.

(d) Given the uncertainty that prevailed at the material time in relation to the boundaries of the proper practice of aesthetic medicine until the issuance of, first, the July 2008 Guidelines and, subsequently, the October 2008 Guidelines, it would be unjust to sanction the applicant on the basis of the decidedly vague charges that were preferred against her (see above at [38]–[41], [54], [56] and [63]).

Conclusion

78 Accordingly, we set aside the decision of the DC *vis-à-vis* the five charges which it convicted the applicant of and allow the applicant's appeal. As the SMC was discharging its statutory role in

these proceedings, we direct that there be no order as to costs here as well as for the proceedings before the DC.

[note: 1] Now s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed).

[note: 2] Record of Proceedings ("ROP") Vol V, p 4857.

[note: 3] ROP Vol V, p 4987.

[note: 4] ROP Vol II, p 193.

[note: 5] ROP Vol II, p 195.

[note: 6] *Ibid*.

[note: 7] ROP Vol V, p 4860.

[note: 8] ROP Vol II, p 199.

[note: 9] ROP Vol II, p 200.

[note: 10] ROP Vol II, p 208.

[note: 11] ROP Vol II, p 209.

[note: 12] ROP Vol V, pp 4861–4862.

[note: 13] ROP Vol V, p 4878.

[note: 14] ROP Vol V, pp 4880–4924.

[note: 15] ROP Vol V, pp 4880–4884.

[note: 16] ROP Vol V, pp 4826–4838.

[note: 17] ROP Vol V, pp 4926–4943.

[note: 18] See, *inter alia*, ROP Vol V, p 4828.

[note: 19] ROP Vol I, p 44.

[note: 20] *Ibid*.

[note: 21] ROP Vol III (Part F), p 2163.

[note: 22] See, *inter alia*, ROP Vol V, p 4828.

[note: 23] ROP Vol V, p 4967.

[note: 24] ROP Vol II, p 323.

[note: 25] ROP Vol V, p 4968.

[note: 26] ROP Vol V, p 4982.

[note: 27] See, *inter alia*, ROP Vol V, p 4828.

[note: 28] *Ibid*.

[note: 29] ROP Vol III (Part D), pp 1733–1734.

[note: 30] See, *inter alia*, ROP Vol V, p 4828.

[note: 31] *Ibid*.

[note: 32] ROP Vol V, p 4857.

[note: 33] ROP Vol V, p 4884.

[note: 34] ROP Vol V, p 4861.

[note: 35] ROP Vol V, p 4829.

[note: 36] ROP Vol V, pp 4926-4943.

[note: 37] ROP Vol V, p 4932.

[note: 38] ROP Vol V, p 4933.

[note: 39] ROP Vol V, p 4935.

[note: 40] ROP Vol V, p 4928.

[note: 41] See paras 11–12 of the applicant's affidavit of 16 January 2012 (ROP Vol II, p 64).

[note: 42] ROP Vol V, p 4945.

[note: 43] See paras 14–17 of the applicant's affidavit of 16 January 2012 (ROP Vol II, pp 65–66).

[note: 44] ROP Vol V, pp 4971–4972.

[note: 45] ROP Vol IV (Part G), p 4292.

[note: 46] *Ibid*.

[note: 47] *Ibid*.

[note: 48] ROP Vol V, p 4971.

[note: 49] ROP Vol V, p 4947.

[note: 50] ROP Vol V, p 4968.

[note: 51] *Ibid*.

[note: 52] ROP Vol V, p 4971.

[note: 53] *Ibid*.

[note: 54] *Ibid*.

[note: 55] ROP Vol V, p 4972.

[note: 56] See the SMC's Published Grounds of Decision for the Disciplinary Committee Inquiry apropos Dr Tan Teck Hong held on 11 October 2011.

[note: 57] See the SMC's Published Grounds of Decision for the Disciplinary Committee Inquiry apropos Dr Saifuddin bin Sidek held on 1 and 2 February 2012.

[note: 58] See the SMC's Published Grounds of Decision for the Disciplinary Committee Inquiry apropos Dr Chee Yew Wen held on 20–22 October 2010, 27–28 October 2010, 3 January 2011 and 27–28 June 2011.

[note: 59] See the SMC's Published Grounds of Decision for the Disciplinary Committee Inquiry apropos Dr Ng Chee Keong held on 10 June 2011.

[note: 60] See the SMC's Published Grounds of Decision for the Disciplinary Committee Inquiry apropos Dr Ho Mien held on 21 July 2010, 15 August 2011, 22 August 2011 and 16 December 2011.

[note: 61] ROP Vol II, p 323.

[note: 62] ROP Vol V, p 4980.

[note: 63] ROP Vol III (Part F), p 2163.

[note: 64] See, *inter alia*, ROP Vol V, p 4828.