IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2015] SGHC 227

C3J/Originating Summons No 1 of 2015

Between

SINGAPORE MEDICAL COUNCIL

… *Applicant*

And

KWAN KAH YEE

… *Respondent*

GROUNDS OF DECISION

[Administrative Law] — [Disciplinary tribunals] — [Disciplinary proceedings]

Version No 1: 11 Jan 2022 (19:48 hrs)

This judgment is subject to final editorial corrections approved by the court and/or redaction pursuant to the publisher's duty in compliance with the law, for publication in LawNet and/or the Singapore Law Reports.

Singapore Medical Council
v
Kwan Kah Yee

[2015] SGHC 227

Court of Three Judges — Originating Summons No 1 of 2015
Sundaresh Menon CJ, Chao Hick Tin JA, Andrew Phang Boon Leong JA
6 July 2015

31 July 2015

Sundaresh Menon CJ delivering the grounds of decision of the court:

Introduction

1 This appeal was brought by the Singapore Medical Council ("the Applicant") against the sentence imposed on Dr Kwan Kah Yee ("the Respondent") by the Disciplinary Tribunal ("DT") after the Respondent pleaded guilty to two charges of wrongfully certifying the cause of death. In this judgment, the charges will be referred to separately as the "First Charge" and "Second Charge", and collectively as the "Charges". In relation to both Charges, it was not only determined that the Respondent issued false death certifications, but also that he misled the investigators in an attempt to cover up his wrongdoing in the Second Charge. While the DT acknowledged the gravity of the offences, it imposed a sentence on the Respondent that struck us as manifestly inadequate. The DT decided that the Respondent should:

Version No 1: 11 Jan 2022 (19:48 hrs)

(a) have his registration as a medical practitioner suspended for a period of three months on each charge, these to run concurrently;

(b) be censured;

(c) undertake in writing that he would henceforth not engage in the conduct complained of or any similar conduct; and

(d) pay half of the costs and expenses of and incidental to the proceedings, including the costs of the Applicant's solicitors.

2 The DT's grounds were also to be published with the necessary redactions made to the patients' details.

3 The Applicant considered that the individual sentences as well as the total sentence were too lenient and accordingly appealed. At the conclusion of the oral submissions, we allowed the appeal and gave brief reasons for doing so. We now set out the detailed grounds for our decision.

Background

4 The Respondent is a medical practitioner, against whom two complaints were made alleging professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("MRA 2010") for erroneously certifying the cause of death of two patients. The First Charge related to Patient A, and the Second Charge related to Patient B. Before the Respondent committed the acts that led to the Charges, he was already being investigated for acts committed on 16 October 2009[1] leading to a prior charge

[1] Record of Proceedings ("ROP") vol 4 at Tab 3, p 19, para 1.

Version No 1: 11 Jan 2022 (19:48 hrs)

("the Prior Charge") being brought against him under the former Medical Registration Act (Cap 174, 2004 Rev Ed) ("the MRA 2004"). This is an important point to which we shall return.

5 The Disciplinary Committee ("DC") held its inquiry into the Prior Charge on 5 and 6 April, 1 June, and 12 July 2011.[2] At the end of its inquiry, the DC found that the Respondent's bases for the death certification were unsubstantiated, and that the Respondent ought to have declined to issue the death certificate as he had insufficient information.[3] Additionally, he had gained access to confidential medical records through his own contacts, an act in violation of the patient's confidentiality and which would in itself have warranted disciplinary proceedings.[4]

6 The Applicant raised a number of aggravating factors in relation to the Prior Charge:[5] (a) the hardship caused to the deceased's family; (b) the Respondent's lack of remorse or regret; (c) the totally unjustified basis for stating that the patient had allegedly been suffering from Ischaemic Heart Disease ("IHD") for six years; and (d) his misleading the DC. In mitigation, the DC considered and accepted as a mitigating factor the Respondent's offer to assist the family with amending the death certificate.[6]

---

2 ROP vol 4 at Tab 3, p 19.

3 ROP vol 4 at Tab 3, pp 26–27, paras 35–36.

4 ROP vol 4 at Tab 3, p 27, para 37.

5 ROP vol 4 at Tab 3, pp 27–28, para 41.

6 ROP vol 4 at Tab 3, p 28, para 42.

Version No 1: 11 Jan 2022 (19:48 hrs)

7 In the circumstances, the Respondent was sentenced some time in or after July 2011 as follows in respect of the Prior Charge:[7]

(a) suspension of his registration as a medical practitioner for a period of three months;

(b) a fine of $5,000; and

(c) a censure.

He was also ordered to give a written undertaking to the Applicant that he would no longer engage in such conduct, and within 30 days, to provide assistance to the patient's family in respect of any necessary application to the Registry of Births and Deaths to rectify the death certificate, and to pay the costs and expenses of the proceedings. The DC further ordered that its decision be published.[8]

8 In the midst of the disciplinary proceedings relating to the Prior Charge, the complaints leading to the Charges were made. This fact will become relevant as it formed one of the bases for the sentence that was eventually imposed by the DT. We now turn to the facts relating to the two Charges which were at the crux of the present appeal.

---

7 ROP vol 4 at Tab 3, p 28, para 43; Affidavit of Mohamed Faizal s/o Mohamed Abdul Kadir ("Affidavit of Mohd Faizal") at p 6, para 18.

8 ROP vol 4 at Tab 3, p 28, paras 43 & 45.

Version No 1: 11 Jan 2022 (19:48 hrs)

The First Charge

9 Patient A passed away on 29 March 2010.[9] He was 26 years old.[10] His death was certified by the Respondent, who stated in the death certificate that the cause of death was bronchiectasis for three days with chronic obstructive airway disease ("COAD") for a period of three months as an antecedent cause.[11] By a letter dated 18 November 2010, the Ministry of Health, acting on feedback, wrote to the Applicant stating that the Respondent had referred to an alleged chest X-ray from the Singapore Anti-Tuberculosis Association ("SATA") dated 13 December 2009 which showed "radiological evidences of [Patient A's] chronic obstructive airway disease" as the basis for his certification.[12] The Ministry further informed the Applicant that based on expert advice it had sought, there was no trace of Patient A having had COAD or bronchiectasis. The Respondent was therefore referred to the Applicant for investigation.[13]

10 Investigations revealed that indeed there was no such X-ray and further that 13 December 2009 was a Sunday, a day on which SATA was not open.[14]

11 The Respondent was given until 12 October 2011 to explain his certification of Patient A's death.[15] On 4 October 2011, he admitted his

---

9 ROP vol 5 at Tab 1, p 19.

10 ROP vol 5 at Tab 1, p 19.

11 ROP vol 5 at Tab 1, p 19.

12 ROP vol 5 at Tab 1, p 4.

13 ROP vol 5 at Tab 1, p 4.

14 ROP vol 5 at Tab 1, p 13.

15 ROP vol 5 at Tab 1, p 6, para 3.

Version No 1: 11 Jan 2022 (19:48 hrs)

wrongdoing and pleaded for leniency.[16] On 1 August 2013, the Health Sciences Authority ("HSA") issued a letter at the request of the Applicant's lawyers, opining as follows:[17]

> … Dr Kwan Kah Yee had more than erroneously certified the above decedent's cause of death. *There was an attempt to deceive and undermine the whole process of death certification because:*
>
> *a) Dr Kwan did not show evidence that the decedent was his patient before his death.*
>
> *b) There were no records of the decedent's patient records and X-ray films from SATA, contrary to what was alleged by Dr Kwan.*
>
> *c) Under the circumstances, this decedent's death should have been reported to the State Coroner and an autopsy conducted to determine the exact cause of death.*
>
> 5 The medical practitioner is duty bound to create a medical record when he sees a patient for the first time and to maintain it for some years. It is the duty and a requirement of the attending doctor to maintain the clinical notes of his patients. This includes the diagnoses and management of his patient.
>
> 6 The medical record is both a medical and a legal document. Recording and communicating information pertinent to the patient's condition is important for patient care, but in the event of a bad outcome, it is equally important legally as evidence of the care received. A thorough and accurate medical record is evidence that the doctor provided appropriate care and can be strong evidence that the physician complied with the standard of care.
>
> 7 A doctor would be guilty of *making a false statement if he states expressly that a doctor-patient relationship existed* between him and the deceased when none existed, or if he represented himself as being the medical practitioner who attended to the deceased during the deceased's last illness when in fact he did not do so.

---

16 ROP vol 5 at Tab 1, p 10.

17 ROP vol 5 at Tab 1, pp 24–25.

Version No 1: 11 Jan 2022 (19:48 hrs)

[emphasis added]

12 The Respondent was charged with the wrongful certification of Patient A's death on 14 October 2014.[18] The HSA letter was admitted into the Agreed Bundle for the purposes of the First Charge.

The Second Charge

13 Patient B passed away on 29 March 2011. She was 32 years old.[19] The Respondent certified her cause of death as IHD.[20] According to Patient B's sister ("C"), who wrote a letter of complaint to the Applicant, the Respondent had certified Patient B's cause of death as IHD based on nothing but a complaint of chest pain that Patient B had made to a general practitioner or a doctor at a nearby polyclinic.[21] She said that due to the Respondent's actions, her family was unable to have an autopsy done and would therefore never know Patient B's true cause of death.[22] C's letter also stated that when she called the Respondent and asked for an explanation, the Respondent informed her that even 17-year-old girls have died from heart disease. When she pressed further and enquired whether that had any bearing on how her sister's cause of death was established, the Respondent defended himself by rattling off a string of qualifications which, she said, was useless to her especially in the light of the grief that he had caused to her and her family.[23]

---

18 ROP vol 5 at Tab 1, pp 27–29.

19 ROP vol 5 at Tab 2, p 43.

20 ROP vol 5 at Tab 2, p 43.

21 ROP vol 5 at Tab 2, p 40.

22 ROP vol 5 at Tab 2, pp 40.

23 ROP vol 5 at Tab 2, p 41.

Version No 1: 11 Jan 2022 (19:48 hrs)

14 Following C's complaint, the Applicant served the Respondent with a notice of complaint on 28 November 2011. The Respondent was asked to explain: (a) the allegations put forth by C; (b) whether he had been involved in caring for Patient B before her death and if not, where he obtained her medical history before diagnosing her cause of death; (c) whether he examined the deceased and ruled out foul play before certifying her death; and (d) what he had communicated to C in their phone conversation as mentioned at [13] above.[24]

15 The Respondent replied on 11 December 2011, stating that:[25]

(a) C was neither Patient B's sister nor present with her at her death, and she had a record of making false accusations and misrepresentations of fact against various members of the community;

(b) Patient B's family members were all satisfied with his services;

(c) an investigation team of police and forensic officers was present at the scene of Patient B's death and accepted the death certificate as satisfactory;

(d) based on medical records obtained from various polyclinics and general practitioners (her medical records showed that she was previously admitted to KK Women's and Children's Hospital ("KK Hospital")), Patient B had been treated for IHD for many years, and the approximate interval between the onset of the disease and her death was three years and ten months., This conclusion was based on

---

[24] ROP vol 5 at Tab 2, pp 45–46.

[25] ROP vol 5 at Tab 2, pp 49–50.

Version No 1: 11 Jan 2022 (19:48 hrs)

"clinical history, physical examination and investigations including the result of abnormal ECGs and abnormal blood tests on several occasions";

(e) his diagnosis was consistent with the victim's medical history; and

(f) in the light of the natural cause of death, he did not consider it necessary to report the case to the Coroner.

16 The Respondent also attached what purported to be a letter from Patient B's husband ("D"), in which it was stated that C: (a) was not Patient B's sister; (b) did not stay with Patient B; (c) did not know her medical conditions; and (d) was not with her at the time of her death. In the letter, D appears to have asked for the investigations against the Respondent to be stopped, and stated that Patient B had been treated for IHD since May 2007.[26] Despite the request purportedly made by D, the Applicant continued with its investigations and made inquiries with the following medical institutions which Patient B had apparently consulted previously: (a) KK Hospital; (b) Choa Chu Kang Polyclinic; and (c) Changi General Hospital ("CGH").[27] The following emerged, contrary to the Respondent's earlier contentions:

(a) On 19 June 2013, Choa Chu Kang Polyclinic confirmed that it did not have any medical records of Patient B having attended the clinic.[28]

---

26 ROP vol 5 at Tab 2, p 51.

27 ROP vol 5 at Tab 2, p 82.

28 ROP vol 5 at Tab 2, p 78.

Version No 1: 11 Jan 2022 (19:48 hrs)

(b) On 28 June 2013, KK Hospital confirmed that Patient B never consulted or sought treatment from them for IHD.[29]

(c) On 29 July 2013, CGH said that its records which had been transmitted to KK Hospital did not show that Patient B had IHD.[30]

17 Consistent with this, on 30 March 2012, the Respondent had confirmed that he did not in fact have *any* medical reports of Patient B from any polyclinic or general practitioner or from KK Hospital.[31]

18 At the request of the Applicant's lawyers, the HSA reported on 1 August 2013 that:[32]

> … Dr Kwan, in a letter to Vicent Cheong of the SMC dated 11 December 2011 [at] Para 4 [stated] that "the earliest time when symptoms of [IHD] was traced back to May 2007 when the patient complained of chest pain of seven days, consistent with Angina Pectoris. **Subsequent medical examination and investigation confirmed the diagnosis.**"
>
> 4 *There were no case notes (inclusive of ECGs or laboratory results) or medical reports to substantiate that [Patient B] was a patient of Polyclinics, various GPs and Medical specialists, and indeed, of her diagnoses of [IHD] by the doctors.* In 2001, she was discharged from CGH for further treatment at KKH. However, the discharge summary from CGH and her medical records do not show that the patient, [Patient B] was suffering from [IHD].
>
> 5 It is my opinion that Dr Kwan Kah Yee had more than erroneously certified the above decedent's cause of death. *There was an attempt to deceive and undermine the whole process of death certification because:*

---

29 ROP vol 5 at Tab 2, p 80.

30 ROP vol 5 at Tab 2, pp 80–106.

31 ROP vol 5 at Tab 2, p 55.

32 ROP vol 5 at Tab 2, pp 111–112.

Version No 1: 11 Jan 2022 (19:48 hrs)

> *a) Dr Kwan did not show evidence that the decedent was his patient before her death. Though he did say that [C] was his patient (Paragraph 1 of his statement dated 11 December 2011), he did not submit documentary proof of a doctor-patient relationship. In this matter of a doctor-patient relationship, the husband of the deceased has stated that he was satisfied with the "professional service of Dr Kwan Kah Yee" in the Notice of Complaint letter of 10th December 2011, implying that there was a doctor-patient relationship.*
>
> *b) Nor did Dr Kwan give any documentary evidence that decedent was a patient of Polyclinics, various GPs and Medical Specialists. …*
>
> 6 The medical record is both a medical and a legal document. Recording and communicating information pertinent to the patient's condition is important for patient care, but in the event of a bad outcome, it is equally important legally as evidence of the care received. A thorough and accurate medical record is evidence that the doctor provided appropriate care and can be strong evidence that the physician complied with the standard of care.
>
> 7 It is the duty and a requirement of the attending doctor to maintain the clinical notes of his patients. This includes the diagnoses and management of his patient.
>
> [emphasis in original in bold; emphasis added in italics]

19 The Respondent was charged with the wrongful certification of Patient B's death on 14 October 2014.[33] The HSA letter was admitted into the Agreed Bundle for the purposes of the Second Charge.

The decision below

20 The Respondent pleaded guilty to the Charges on 31 October 2014.[34] The DT then had to deal with the sentence to be imposed and it concluded that:

---

[33] ROP vol 5 at Tab 2, pp 115–117.

Version No 1: 11 Jan 2022 (19:48 hrs)

(a) the Respondent was *strictly speaking* not a repeat offender as the subject matter of the Charges were acts that had been committed before he was *sentenced* for the Prior Charge;[35]

(b) the Respondent had, despite knowing about the potential consequences, continued with his wrongful actions even though he had received notice of the Prior Charge on 2 February 2010 informing him that he was facing a complaint for an instance of erroneous death certification. *As the acts involved dishonesty and false documents,* a suspension was warranted;[36]

(c) the Respondent had claimed trial to the Prior Charge but elected to plead guilty to the Charges. On the basis of parity, the sentence should not be more severe than had been imposed for the Prior Charge, which was a suspension for a period of three months with a $5,000 fine; and since he had elected to plead guilty at the earliest instance, a monetary penalty was not considered necessary;[37]

(d) had proper steps been taken, the proceedings for the Prior Charge could have been consolidated with the First Charge, and since unfairness was caused to the Respondent by him having to stand "trial" twice, the suspension sentences were to run concurrently;[38]

---

34 ROP vol 4 at Tab 5, p 37; ROP vol 2 at Tab 2, p 29, para 20; ROP vol 3 at Tab 1, p 7, line 99 and p 8, line 137.

35 ROP vol 2 at Tab 2, p 30, para 25(a).

36 ROP vol 2 at Tab 2, p 30, para 25(b).

37 ROP vol 2 at Tab 2, p 31, para 25(c).

38 ROP vol 2 at Tab 2, p 31, para 25(d).

Version No 1: 11 Jan 2022 (19:48 hrs)

(e) the Respondent had complied with his 1 August 2011 undertaking given upon his conviction for the Prior Charge that he would not engage in the conduct complained of or any similar conduct, and credit should be given for that;[39] and

(f) since the First Charge should have been dealt with together with the Prior Charge, the Respondent should not pay any of the Applicant's costs in relation to the First Charge.[40]

21 On the basis of credit being given for the Respondent's cooperation with the authorities and his early plea of guilt to the Charges, the DT determined that the Respondent should be:[41]

(a) suspended for three months on each charge with the sentences to run concurrently;

(b) censured;

(c) made to furnish a written undertaking to the Applicant that he would not engage in the conduct complained of or any similar conduct; and

(d) made to pay half the costs and expenses of the proceedings, including the costs of the Applicant's solicitors.

---

39 ROP vol 2 at Tab 2, p 32, para 25(e).

40 ROP vol 2 at Tab 2, p 32, para 25(f).

41 ROP vol 2 at Tab 2, p 32, para 27.

Version No 1: 11 Jan 2022 (19:48 hrs)

22 The publication of the grounds of decision with the necessary redaction was also ordered.[42]

The parties' contentions on appeal

23 The Applicant believed that the sentence was far too lenient and appealed. The Applicant sought a sentence of 12 months for each offence, these to be served consecutively, and for an order of costs that was not limited to half the costs as had been ordered by the DT. First, the Applicant submitted that the court should depart from the sentencing precedents relating to wrongful certification of death. The Applicant had not been able to take this point in past cases because it had no right of appeal in respect of proceedings brought under the MRA 2004, even if it was of the view that some of the sentences imposed in the past had been manifestly inadequate. Furthermore, the DT's powers of sentencing had been enhanced following the 2010 amendments to the MRA 2004.

24 Second, it submitted that a significantly heavier sentence was called for in this case because of the Respondent's dishonesty. The three-month suspension for each charge was manifestly inadequate because:

(a) the DT had failed to give sufficient weight to the fact that the Charges related to improper death certifications and involved fraud, dishonesty and the falsification of documents;[43]

---

42 ROP vol 2 at Tab 2, p 32, para 28.

43 Affidavit of Mohd Faizal at p 14, para 42(a).

Version No 1: 11 Jan 2022 (19:48 hrs)

(b) the DT had failed to give sufficient weight to the fact that there were very severe consequences for a wrongful certification of death, including the perversion of justice;[44] and

(c) the DT had placed undue weight on the sentence imposed on the Respondent for the Prior Charge.[45]

25 Third, while the Applicant acknowledged that the Respondent had not yet been sentenced for the Prior Charge at the time he committed the most recent acts of misconduct, he was undoubtedly already aware then that he was being investigated. Yet he had brazenly proceeded to commit the offences, and this should be an aggravating factor.

26 Finally, the DT erred in law in finding that the subject matter of the Prior Charge could have been consolidated with the hearing for the First Charge if proper steps had been taken by the Applicant.[46] Section 41(6) of the Medical Registration (Amendment) Act 2010 (No 1 of 2010) ("the Amendment Act") read with s 41(3) of the same meant that Part VII of the MRA 2010 did not apply to the Prior Charge. The Prior Charge was to be dealt with under the MRA 2004, and given that the MRA 2004 and the MRA 2010 were different regimes, it was not possible for the Prior Charge proceedings to be consolidated with the First Charge proceedings.[47] Flowing from the DT's error, the sentences for the Charges should have been ordered to run

---

44 Affidavit of Mohd Faizal at p 14, para 42(b).

45 Affidavit of Mohd Faizal at p 15, para 42(c).

46 Affidavit of Mohd Faizal at p 12, para 33.

47 Affidavit of Mohd Faizal at p 12, para 38.

Version No 1: 11 Jan 2022 (19:48 hrs)

consecutively, and the Respondent should be made to pay the full costs and expenses of and incidental to the disciplinary proceedings.[48]

27 The Respondent appeared in person and did not tender any written submissions to state his position. Before us, however, he denied being dishonest and said as follows:

(a) He was a hospice doctor untrained in certifying deaths, and only certified deaths on the request of his patients. As these patients would by definition already be dead, we assumed he meant at the request of the next-of-kin.

(b) With respect to Patient A, he claimed that he had seen the SATA X-ray, and the only reason it had not later been produced was because SATA had different departments and the Applicant had approached the wrong department in requesting the relevant information. He did not explain why he himself had not obtained the X-ray.

(c) With respect to Patient B, his certification had not been made without basis. KK Hospital had not released her full medical records to the court and these allegedly contained evidence as to her cause of death. Second, he said that she was his patient because her husband was his patient. He claimed that any family member of a person he treated would also be his patient. No basis was put forward for this curious proposition. Third, he said that he had certified her death at the request of her husband even though he had never examined Patient B

---

48 Affidavit of Mohd Faizal at p 14, para 40.

Version No 1: 11 Jan 2022 (19:48 hrs)

before and saw her medical records *only* after he had certified her death.

Virtually none of these grounds had been advanced by him before the DT;[49] only the second ground (at [27(b)] above) was orally referred to in a tangential way at the hearing below, though even then he agreed that he was guilty.[50] Our impression was that his position before us seemed to contradict what he had said before the DT.

Our decision

28 We had no hesitation in allowing the appeal. In a nutshell, the issue before us was whether the sentences imposed by the DT were manifestly inadequate, and they undoubtedly were. In our judgment, the imposition of a three-month suspension was a manifestly inadequate sentence considering both the nature of the harm as well as the Respondent's dishonest and evasive conduct. We now elaborate on the reasons, and also address certain key legal aspects in which the DT erred.

The analogy to improperly certifying medical certificates

29 We begin by observing that the sentence for the Prior Charge was indefensibly light. In any case, we consider it appropriate to re-visit the benchmark sentence where death certificates are improperly certified. Indeed, this was the sort of situation for which the legislative changes were effected in the MRA 2010, and as a result of which the Applicant is now able to bring

---

49 ROP vol 4 at pp 37–45.

50 ROP vol 3 at pp 40–41, lines 901–920.

Version No 1: 11 Jan 2022 (19:48 hrs)

appeals against sentences imposed by the DT which it considers unduly lenient. In *Singapore Parliamentary Debates*, *Official Report* (11 January 2010) vol 86 ("*the 11 January 2010 Debate*") at cols 1898–1899, the then Minister for Health, Khaw Boon Wan, said:

> The new section 55 sets out the framework for the SMC or an aggrieved complainant to appeal to the High Court against the Disciplinary Tribunal's decisions. Currently, only the defendant doctor is allowed to appeal to the High Court on the decision of the Disciplinary Committee. This is not necessarily fair to the public or the complainant. This section allows the SMC to appeal when the Council is not in agreement with its independent Tribunal's orders. …

30 Pursuant to the legislative changes, the court's role is to correct the DT's decisions where appropriate. This may require us from time to time to recalibrate the sort of sentence that should be considered for certain types of misconduct. The observations of Andrew Phang Boon Leong JA in *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 ("*Lee Kim Kwong*") at [45]–[47] are apposite and bear reproducing at some length:

> … [W]e 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

Version No 1: 11 Jan 2022 (19:48 hrs)

> 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.*
>
> [emphasis added]

31 The English experience has been similar; historically, decisions by the Fitness to Practise Panel ("FPP") and their predecessors were final subject only to limited rights of appeal by the doctor. Concerns were expressed about this limitation, and the Council for the Regulation of Health Professions (subsequently renamed the Council for Health Regulatory Excellence) was created in 2002. One of its functions was to appeal against decisions of the General Medical Council which it considered were unduly lenient. The courts would approach such appeals by considering whether the sentences imposed fall outside the reasonable range of sanctions available to the sentencing court in the circumstances: Mark Davies, *Medical Self-Regulation: Crisis and Change* (Ashgate, 2007) at p 327. In *Council for the Regulation of Health Care Professionals v General Medical Council and another* [2004] 1 WLR 2432, Leveson J observed at [14]:

Version No 1: 11 Jan 2022 (19:48 hrs)

> Miss Morris argued that there is a clear distinction between the criminal and disciplinary jurisdictions because criminal sentencing is concerned with punishment and disciplinary sanction with protection of the public. As I have just accepted, I agree that there is a very real difference between the two, but that difference is not to the point in relation to the proper construction of this provision. *The context in which undue lenience must be considered may be different for criminal cases (concerned with retribution, deterrence and rehabilitation) and disciplinary cases (concerned with the protection of the public and the reputation of the profession) but the relevant question remains the same, namely, whether, having regard to the purposes of the particular sanction being imposed (whether criminal or disciplinary), this particular sanction is outside the range of sanctions which the sentencing tribunal, applying its mind to all the factors relevant to its jurisdiction, could reasonably consider appropriate.* [emphasis added]

32 In its submissions, the Applicant pointed us to the disparity in sentencing between doctors who were found guilty of improperly certifying deaths, and those found guilty of improperly issuing medical certificates. To begin with, we do not think the two are even analogous. Medical certificates are generally issued to and used by patients to justify their taking medical leave from work, or for them to be excused from certain responsibilities. While the issuance of a false medical certificate is a serious matter, the fact remains that in general, the only direct harm that will result from this is a loss of money or productivity. Far more severe consequences can result from improper death certifications as will be seen at [52]–[53] below. We therefore considered that the analogy between improperly issuing medical certificates and improperly issuing death certificates is an inappropriate one for purposes of sentencing.

33 We noted that doctors found to have improperly granted a medical certificate had been suspended for up to 12 months, especially in instances where the doctor concerned had attempted to cover up his or her actions. In that light, the sentences imposed for improper death certifications appeared

Version No 1: 11 Jan 2022 (19:48 hrs)

grossly and disproportionately light. The Applicant tendered the following precedents relating to improper death certifications before us:

(a) Dr X was charged with improperly certifying three causes of death. He pleaded guilty and cooperated fully with the authorities. The police excluded any foul play. Dr X also stopped providing death certifications in ad-hoc cases. He was censured, fined $3,000, and ordered to pay the Applicant's legal costs and expenses.[51]

(b) Dr Y was charged with improperly certifying several counts of death (there were three charges of professional misconduct and three charges of associating with a person not qualified to provide medical care or generally accepted support services) and claimed trial to all of them. He was found guilty on three charges, and was censured and ordered to pay the Applicant's legal costs and expenses.[52]

(c) The third case concerned the Prior Charge and has been summarised at [4]–[8] above.

34 The precedents revealed that the sentences meted out for improper death certification have thus far been exceedingly and inexplicably lenient considering the extensive negative consequences that may flow from an improperly certified death. While the facts in the cases of Dr X and Dr Y were not before us, the facts on which the Respondent was sentenced for the Prior Charge were, and we observed that the sentence imposed by the DC there was unduly lenient. The Respondent had in the Prior Charge falsely certified the

---

[51] ROP vol 4 at Tab 2, p 16.

[52] ROP vol 4 at Tab 2, p 16.

Version No 1: 11 Jan 2022 (19:48 hrs)

death of the patient, who had passed away on 16 October 2009.[53] It was only when the patient's family dealt with an insurance claim that they realised that the Respondent had certified the patient as having IHD for the last six years, which was untrue as far as they had been aware.[54] When the family confronted the Respondent, he was reportedly unhelpful. And when the Respondent was charged, he contested it.[55]

35 First, the DC found that: (a) there was no evidence that the cause of death was congestive cardiac failure as the patient had not been diagnosed with IHD; (b) there was no medical record that could support the Respondent's certification of congestive cardiac failure and IHD; and (c) expert evidence was to the effect that the available medical records could not support the Respondent's reasons for the certification of death.[56] All that could be derived from the patient's medical records was that she was suffering from hypertension, and the DC concluded that the Respondent had no basis to arrive at his conclusion of congestive cardiac failure as the cause of death. Additionally, the evidence was clear that congestive cardiac failure could only be a mode of death, not a cause of death.[57]

36 Second, the DC found that there was no factual basis for the Respondent's conclusion that the patient had IHD for six years prior to her death. He said that he had received a call from a "reliable source" who informed him that the patient had developed IHD six years prior to her demise.

---

53 ROP vol 4 at Tab 3, p 21, para 20(c).

54 ROP vol 4 at Tab 3, p 19, para 2.

55 ROP vol 4 at Tab 3, p 20, para 5.

56 ROP vol 4 at Tab 3, p 21, para 22(b).

57 ROP vol 4 at Tab 3, p 23, para 26.

Version No 1: 11 Jan 2022 (19:48 hrs)

This evidence was found to be weak, not credible, and false.[58] Therefore, the DC concluded that the charge was proved against the Respondent and his defence was found to be unsubstantiated.[59] The aggravating and mitigating circumstances and the eventual sentence imposed have been discussed at [6]–[7] above.

37 In our judgment, the sentence meted out by the DC was unduly lenient in the circumstances. He had claimed trial and sought to justify his actions during the proceedings despite the evidence against him plainly demonstrating his lack of remorse or regret. Moreover, the DC had found that the Respondent had misled them in the conduct of his defence,[60] and had caused hardship to the family of the deceased.[61]

38 We turn now to the position in England, where heavier penalties for improper death certifications than what has traditionally been meted out by DTs in Singapore have consistently been imposed. In Joanna Glynn and David Gomez, *The Regulation of Healthcare Professionals: Law, Principle and Process* (Sweet & Maxwell, 2012) the authors note at paras 29–014–29–015:

> Sir Donald Irvine, President of the GMC from 1995 to 2002, has expressed the view that the starting point for the GMC's consideration of cases involving dishonesty must be that dishonesty amounts to a dereliction of a basic duty and constitutes *serious professional misconduct*; *in the absence of remarkably good reasons in mitigation, it should lead to the erasure of the doctor's name from the medical register.*
>
> …

---

58 ROP vol 4 at Tab 3, p 23, para 30.

59 ROP vol 4 at Tab 3, p 26, para 35.

60 ROP vol 4 at Tab 3, p 27, para 41(d).

61 ROP vol 4 at Tab 3, p 28, para 41.

Version No 1: 11 Jan 2022 (19:48 hrs)

> Not every case of dishonesty will result in expulsion from the profession. In accordance with basic principles, expulsion may not arise where such a direction would be unduly harsh and disproportionate and not in the public interest.
>
> [emphasis added]

39 Similarly, General Medical Council, "Good Medical Practice" (25 March 2013) <http://www.gmc-uk.org/Good_medical_practice___English_0914.pdf_51527435.pdf> (accessed 31 July 2015) at paras 65–67 speaks of *honesty and integrity as an indispensible characteristic of a doctor*. General Medical Council, "Sanctions Guidance" (April 2009) <http://www.gmc-uk.org/Sanctions_Guidance_28443340.pdf> (accessed 31 July 2015) at para 82 states:

> Erasure may well be appropriate when the behaviour involves **any** of the following factors (this list is not exhaustive):
>
> a particularly serious departure from the principles set out in *Good medical practice* i.e. behaviour fundamentally incompatible with being a doctor
>
> b a reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
>
> …
>
> h dishonesty, especially where persistent and/or covered up …
>
> [emphasis in original in bold]

40 We pause here to observe first that the sentencing powers of the FPP in England and the DT in Singapore are not the same. Under s 35D(2)(b) of the Medical Act 1983 (c 54) (UK) ("the Medical Act"), the FPP is empowered to suspend the doctor's registration for a period not exceeding 12 months at any one time, although under s 35D(5)(a), it also has the power, if appropriate, to extend the period of suspension from the time when it would otherwise expire. Under s 41A(1)(a) of the Medical Act, the Interim Orders Panel ("IOP") is authorised to suspend a doctor for up to 18 months in the interim if it is

Version No 1: 11 Jan 2022 (19:48 hrs)

satisfied that it is necessary for the protection of the public or it is otherwise in the public interest to do so. In comparison, the DT's sentencing jurisdiction is found in s 53(2)(*b*) of the MRA 2010, where it can suspend the doctor's registration for not less than three months and not more than three years. These differences are relevant to our discussion on sentencing considerations at [46]–[60] below, and we took this into account when we considered the length of suspension that should be imposed on the Respondent. But conscious of the relevant differences, we turn first to three English cases which dealt with falsely certified deaths.

41 The first case is *Jasinarachchi v General Medical Council* [2014] EWHC 3570 (Admin) ("*Jasinarachchi*"), where a trainee doctor, because of his desire to catch a flight, had falsely declared that he had seen the patient's body and conducted an external examination on her. He completed the cremation certificate and also lied to the Funeral Directors that he had seen the patient's body after her death. He then flew off to Australia for two weeks. It subsequently became apparent that the doctor had not attended to the patient at all. The cremation certificate could not be used, and as a result, the patient's planned cremation was delayed. A family member had to identify the body, and a post mortem was performed on the patient (at [15]). The doctor was punished with a six-month suspension. In meting out this punishment, the FPP noted that the dishonesty in this instance was *not premeditated* and was in fact an uncharacteristic reaction to his circumstances. It was said to be a "single episode in an otherwise unblemished career" (at [18]). The FPP also considered the following mitigating factors: (a) the absence of any repetition of his misconduct; (b) his developing maturity as a doctor; (c) the lack of financial gain behind his actions; and (d) his apology made to the patient's family which they accepted. It was in such circumstances that the FPP considered a suspension to be sufficient to warn the wider profession that such

Version No 1: 11 Jan 2022 (19:48 hrs)

dishonest behaviour was unacceptable, and fell short of the standards expected of a doctor (at [23]).

42 The second case is the decision of the FPP of the Medical Practitioners Tribunal Service in the case of Dr Amit Pramanik (16 May 2013) ("*Amit*"), where the doctor was charged with five counts of making false statements that he had examined deceased patients' bodies. The acts of dishonesty were not isolated and greatly undermined the fundamental tenets of the profession as his misconduct consisted of "a significant number of individual acts, committed over a number of months." It was held at p 9 that:

> The Panel noted that you have been convicted of [falsely certifying a death certificate] and that your misconduct consisted of a significant number of individual acts, committed over a number of months. *You undermined an important system of death certification and cremation and abused the trust of the medical referee.* [emphasis added]

43 Despite the gravity of his actions, the doctor in *Amit* was eventually given a six-month suspension after the FPP took into account the mitigating factors in his favour. These included his admission of wrongdoing immediately after being questioned about his misconduct, his issuance of an apology letter and acts of remorse, the high quality of his reflective notes with respect to his Continuous Professional Development, and the positive testimonies about his clinical skills and good character.

44 The third case is *Martin Sandler v General Medical Council* [2010] EWHC 1029 (Admin) ("*Sandler*"), where the doctor received an interim 18-month suspension from the IOP pending his hearing before the FPP (at [1]). He sought to terminate the suspension order so that he could work. The IOP held that as the doctor had apparently wilfully signed false certificates on at least 116 occasions, the reputation of the profession could be adversely

Version No 1: 11 Jan 2022 (19:48 hrs)

affected if he were allowed to continue practising (at [10]). His application to lift the interim suspension order was denied. Nicol J considered that the reputation of the medical profession would be adversely affected if his suspension was lifted and thus declined to lift his interim suspension (at [23]).

45 The three English decisions show that dishonesty is taken seriously by the English medical profession. The doctors in *Jasinarachchi* and *Amit* were given suspensions only because in the former case, it appeared to be an isolated incident motivated by the doctor's personal convenience and in the latter because it was mitigated by the general high regard for the doctor within the medical practice, and his clear remorse for his actions. The strong attitude against dishonesty is better exemplified in *Sandler*, where Nicol J declined to terminate the doctor's interim suspension order in the interests of upholding the reputation of the medical profession.

46 We bore in mind that the English decisions were decided in the context of the English framework, where the maximum term of suspension that could be imposed on errant doctors is 12 months, whereas our sentencing framework empowers the DT as well as the court to suspend an errant doctor for up to three years. Even then, and despite the presence of mitigating factors, the sentences imposed in England have been consistently higher than they have been here. In our judgment, it would be appropriate to use the full range of the sentencing powers to ensure that these are commensurate with the gravity of the offence, and there is no reason to shy away from exercising this power where necessary. Indeed, the 2010 legislative changes envisage this and they were crafted to achieve this end. *The 11 January 2010 Debate* at cols 1899–1901 reads:

> Second, we propose to expand the range of orders for SMC, its Complaints Committees, Disciplinary Tribunals and Health

Version No 1: 11 Jan 2022 (19:48 hrs)

> Committees so as to grant them more powers to be able to deal more effectively and appropriately with errant doctors.
>
> …
>
> Under the current Medical Registration Act, the Disciplinary Committee can impose a financial penalty not exceeding $10,000 on a medical practitioner who is convicted. The next level of penalty is a suspension of between three months and three years. There is, therefore, a significant gap in the range of penalties in the current Act.
>
> The new section 53 will allow the Tribunal to impose a fine of up to $100,000, thereby enabling the Tribunal to mete out a penalty that is appropriate to the severity of the case. This section will also allow the Disciplinary Tribunal to impose other orders … The SMC … can thus impose appropriate conditions or restrictions on the practitioner. … All this enhances the powers of the Tribunal by expanding the array of possible orders.

47 Hence, while the English cases can be a guide, sentencing in our context must be developed with due reference to the applicable framework here. Aside from this, however, we note that the same attitude abhorring dishonest practice may be found in Singapore. The Applicant's Ethical Code and Ethical Guidelines ("the Code"), which are to be used by doctors as a "yardstick for their own conduct and behaviour" (see part 3 of the Code), states that a doctor is expected to "[m]aintain the highest standards of moral integrity and intellectual honesty" and "[t]reat patients with honesty, dignity, respect and consideration".

48 Similarly, in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [36] and [88], V K Rajah JA remarked:

> 36 In the same vein, this approach applies with equal force to the medical profession under the supervision of the SMC. The importance of maintaining the highest level of professionalism and ethical conduct has been duly acknowledged by the SMC in the Introduction section of the SMC Ethical Code (at p 1):

Version No 1: 11 Jan 2022 (19:48 hrs)

> 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.*
>
> …
>
> 88 *The medical profession is a historically venerated institution. Its hallowed status is founded upon a bedrock of unequivocal trust and a presumption of unremitting professional competence.* The basic premise underpinning the doctor and patient relationship is that all medical practitioners will infallibly discharge their duties in the time-honoured and immaculate traditions of this singularly noble profession … [E]rrant conduct must be painstakingly policed and *effectively deterred* if the medical profession is to continue to rightfully occupy its unique position in society. All it needs is a few recalcitrant practitioners to diminish the stature and standing of a revered and respected institution. The SMC plays a pivotal role in ensuring that it does not. …
>
> [emphasis added]

49 In our judgment, the improper issuance of a false death certificate based on non-existent medical records goes against the very essence of these standards and constitutes a very serious breach of the Code. This is seriously aggravated if the doctor then fabricates or conjures up records in an attempt to justify the false certification. In this case, the element of dishonesty was scarcely accounted for by the DT when it held that it led to the crossing of the threshold from a mere censure or a fine to a suspension.[62] This was overly lenient to the point of being wrong in principle. It is out of line with Sir Donald Irvine's suggested approach of erasure from the medical register as a

---

62 ROP vol 1 at Tab 1, p 10, para 25(b).

Version No 1: 11 Jan 2022 (19:48 hrs)

starting point before adjusting for proportionality (see [38] above). It is also out of line with the approach we take to dishonest lawyers who are invariably struck off the rolls regardless of the mitigating circumstances: *Law Society of Singapore v Manjit Singh s/o Kirpal Singh and another* [2015] 3 SLR 829 at [77]. Additionally, the Respondent displayed his lack of contrition and repentance before us at the oral hearing, when he continued to justify his improper certification of Patient A and B's deaths despite the overwhelming evidence against him (see [27] above).

50 In *Cheatle v General Medical Council* [2009] EWHC 645 (Admin) at [33], which followed *Bolton v Law Society* [1994] 1 WLR 512, it was held that sanctions in medical disciplinary proceedings serve two functions: first, to ensure that the offender does not repeat the offence; and second, to uphold the standing of the medical profession. With respect to the former, we considered that the ultimate aim is to ensure that the public is protected from the potentially severe outcomes arising from the actions of errant doctors (see *Council for the Regulation of Health Care Professionals v General Medical Council and Ruscillo* [2005] 1 WLR 717 at [60]). We take this opportunity to lay down some principles as to the basis on which we imposed the sentence on the Respondent, and trust that they will guide future DTs in sentencing.

51 We begin with the observation that the concept of public interest which guides sentencing of medical misconduct extends further than just the danger which the doctor may pose to his patients. In *Dr Samuel Nwogbo v General Medical Council* [2012] EWHC 2666 (Admin) ("*Nwogbo*"), Davies J when considering the FPP's observations said at [76]:

> It is clear from the determination of the panel that they had proper regard to the guidance contained in the indicative guidance sanctions promulgated by the GMC in 2009. They recorded, correctly, that the purpose of sanction is protection,

Version No 1: 11 Jan 2022 (19:48 hrs)

> not punishment, and that there has to be a proportionate balancing of the interests of the public with those of the doctor. They accepted, correctly, that this was not a case where the appellant posed a risk to patients, but *they also observed, rightly, that the public interest is wider than the protection of patients and extends to other matters as well.* [emphasis added]

52 In our judgment, public interest considerations weighed heavily in favour of imposing a stern sentence in this case. The issuance of a false death certificate is a very grave breach of a doctor's ethical and professional duties. The Coroners Act (Cap 63A, 2012 Rev Ed) requires that certain types of unexplained deaths be inquired into by the Coroner. This requirement serves several important functions. From a legal standpoint, it is a vital safeguard against the possibility of homicides being covered up. It may also be important in determining liability in civil lawsuits – in cases of malpractice, for instance – or for the settlement of certain kinds of insurance claims. From a public health standpoint, it serves a critical function. When an otherwise healthy person dies, it is important that society understands why that has happened so that mistakes may be avoided, lessons may be learnt, and possible sources of disease and infection may be discovered and guarded against. From a personal standpoint, not knowing the true cause of the death of a loved one can cause great anguish and confusion for the bereaved family.

53 The following passage from Serene Ai Kiang Ong and Siang Hui Lai, "Certification of Death in Singapore" (2014) 23(4) Proceedings of Singapore Healthcare 292 at p 292 is instructive:

> The role of death certificates is generally two-fold: legal and statistical. They could be used for medicolegal, insurance, and inheritance matters. At the same time, the information recorded within constitutes essential epidemiological data for national mortality and morbidity statistics, which ultimately affects health-related decisions such as governmental policies and funding. It is thus essential that the information entered

Version No 1: 11 Jan 2022 (19:48 hrs)

> on the certificate must be accurate, yet studies from elsewhere have found error rates as high as 60%.

54 Because of the severity of the potential consequences, we were deeply disturbed by this case. The Respondent issued two death certificates that he later admitted were false. This is not including the matters covered by the Prior Charge. In an attempt to substantiate his lies, he went so far as to claim the existence of extensive medical records and the conduct of treatment and investigations which, upon investigation, proved to be entirely false. For these reasons, we were satisfied that public interest considerations weighed heavily in favour of significantly increasing the sanction to be imposed on the Respondent.

55 Second, we also had regard to the considerations of general and specific deterrence. These were elaborated upon by V K Rajah J (as he then was) in *Tan Kay Beng v Public Prosecutor* [2006] 4 SLR(R) 10 at [31]–[32] and [34]:

> … Deterrence, as a concept, has a multi-faceted dimension and it is inappropriate to invoke it without a proper appreciation of how and when it should be applied. *It is premised upon the upholding of certain statutory or public policy concerns or alternatively, upon judicial concern or disquiet about the prevalence of particular offences and the attendant need to prevent such offences from becoming contagious. Deterrence, as a general sentencing principle, is also intended to create an awareness in the public and more particularly among potential offenders that punishment will be certain and unrelenting for certain offences and offenders.*
>
> 32 Deterrence however also has a more specific application. *Specific deterrence is directed at persuading a particular offender from contemplating further mischief. This assumes that a potential offender can balance and weigh consequences before committing an offence. …*
>
> …
>
> 34 In sentencing a particular offender, both general and specific deterrence must be scrupulously assessed and

Version No 1: 11 Jan 2022 (19:48 hrs)

> measured in the context of that particular factual matrix before deciding exactly how and to what extent each should figure in the equation. …
>
> [emphasis added]

56 In our judgment, the facts of this case amply warranted the application of both these considerations. The Respondent's actions not only led to an erosion of public trust in the medical profession, but also had serious implications and consequences for the family of the deceased persons. In addition, as we have noted above, it would also potentially have an impact on public health, including the work of medical statisticians, and even possibly criminal investigations when homicides might be covered up or investigations hampered. In the light of the wider consequences of his actions, we considered that general deterrence was applicable as a sentencing principle.

57 We were also satisfied that specific deterrence, which is directed at discouraging an offender from contemplating further mischief, was applicable here. The facts showed that when the Respondent committed the acts leading to the Charges, he was being investigated for the acts leading to the Prior Charge. Yet, he went ahead to certify two other deaths without basis or substantiation. His attitude was reckless and callous. Together with his seeming lack of remorse and attempts at justifying his actions, the Respondent did not seem to realise the wrongfulness of his actions. We therefore considered that the principles of general and specific deterrence are applicable in this instance.

58 We turn to the mitigating factors raised by the Respondent at the proceedings below. In this regard, DTs are primarily concerned with the protection of public confidence and the reputation of the profession. For this reason, mitigating circumstances which weigh in favour of an offender in

Version No 1: 11 Jan 2022 (19:48 hrs)

criminal proceedings are viewed in a qualitatively different light where disciplinary proceedings are concerned. *Law Society of Singapore v Tham Yu Xian Rick* [1999] 3 SLR(R) 68 at [22], cited by this court in *Law Society of Singapore v Kurubalan s/o Manickam Rengaraju* [2013] 4 SLR 91 at [48], held:

> … Because orders made by a disciplinary tribunal are not primarily punitive, considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of the disciplinary jurisdiction than on sentences imposed in criminal cases …

59 Here, the Respondent urged the DT to consider that: (a) he is an undischarged bankrupt and no one would employ him after the Charges were brought against him;[63] (b) he did extensive work with a hospice for free;[64] (c) he had not engaged in similar conduct after giving the undertaking on 1 August 2011;[65] and (d) he was active in contributing publicly to the healthcare scene in Singapore.[66] While it does appear from his resume that the Respondent has an extensive record of voluntary work,[67] we were unable to give those factors any weight. In our judgment, the interests of protecting public confidence and the reputation of the medical profession outweighed any mitigating value that the Respondent's voluntary work could give him because:

---

63 ROP vol 3 at Tab 1, pp 37–38, lines 834–838.

64 ROP vol 3 at Tab 1, p 38, lines 842-851.

65 ROP vol 3 at Tab 1, p 38, lines 852–853; ROP vol 4 at Tab 5, p 37.

66 ROP vol 3 at Tab 1, pp 38–39, lines 857–880.

67 ROP vol 4 at Tab 5, pp 42-45.

Version No 1: 11 Jan 2022 (19:48 hrs)

(a) the offences committed by the Respondent were serious ones with potentially damaging consequences;

(b) the Respondent was brazen and his acts of dishonesty were indefensible;

(c) he attempted to cover up his wrongdoing;

(d) he persisted in this conduct despite already facing the Prior Charge; and

(e) he displayed a lack of remorse that was evident in the position he took before us (see [27] above).

Considering his lack of insight into the wrongfulness of his actions, public confidence in and the reputation of the medical profession would not have been adequately protected if the Respondent were given a lighter sentence on the basis of the mitigating circumstances raised, even if we were to accept these as true.

60 *Nwogbo* is instructive in this regard. The doctor had been charged with an offence of assault pertaining to domestic violence in the presence of a child, and had an obligation to inform the General Medical Council without delay of this (at [12]). He failed to do so, and repeatedly sought and obtained employment from various medical establishments without disclosing his charge, and subsequently, his conviction. The FPP found that the doctor displayed dishonest conduct, and erased his name from the medical register, and at the same time suspended him pending the erasure coming into effect (at [5]). The doctor appealed, and the court observed that there was evidence that he had completely failed to accept his offending, face up to his criminal

Version No 1: 11 Jan 2022 (19:48 hrs)

behaviour, or express any regret or remorse for his conduct which involved elements of dishonesty. It was held that those were factors which pointed to the FPP's decision being an appropriate one, and the court declined to vary the FPP's decision (at [83]).

61 In all the circumstances, we considered that a suspension of 18 months for each Charge was appropriate, and that these should run consecutively for an aggregate suspension term of three years.

62 We would also add that the Respondent could well have been struck off the medical register. However, we declined to order that, because there were too many questions left unanswered at the conclusion of the investigation and the DT proceedings. We touch on these below at [70]–[72] in the hope that in any future cases, matters such as these may be fully resolved. Nevertheless, we should say here that even without the additional information and having regard only to the seriousness of the offence and the patent dishonesty on the part of the Respondent, consideration could have been given to striking the Respondent off the medical register. We did not do so in this case as we would have wanted detailed submissions on the question of whether the usual penalty for dishonesty in professional dealings in the medical profession should be similar or different to that in the legal profession. The Respondent was unrepresented and unreliable in the manner he made submissions; it was evident that we would not get much assistance from him. However, we flag this as an open issue that we will take up on an appropriate occasion in the future.

63 The DT also erred in relation to several points of law, and we now turn our attention to address those.

Version No 1: 11 Jan 2022 (19:48 hrs)

Consolidating the charges

64 First, the DT considered that the First Charge should have been consolidated with the Prior Charge. Because this was not done, it ordered the two sentences of suspension to be served concurrently and also to only award the Applicant half of its costs. The DT noted in its grounds that:[68]

> (d) … it is simply unsatisfactory to stand 'trial' twice over especially for similar charges. If SMC had so wished to consolidate, which they ought to have done so, necessary steps could have been effected by the SMC, inconvenient as they may have been. The process must not be unfair to the Respondent. … For these reasons, we are of the view that both the suspension sentences should run concurrently instead of consecutively in all fairness to the Respondent …
>
> …
>
> (f) in relation to costs, as we were strongly of the view that the [First Charge] should have been dealt with together with the subject matter disposed by the DC Inquiry in 2011, we were not minded to order the Respondent to pay any costs of the SMC in relation to the [First Charge]. As it would have been inevitable for the SMC to separately proceed against the Respondent on the [Second Charge], a costs order against the Respondent for work done by the SMC Counsel would, however, be justifiable.

65 In our judgment, the DT erred. It was not possible for the First Charge to be consolidated with the Prior Charge. On 1 December 2010, the MRA 2004 was repealed and the Amendment Act came into effect, which transitioned the MRA 2004 to its current form – the MRA 2010. Section 41(3) of the Amendment Act states that any inquiry, investigations or proceedings commenced before any DC or Complaints Committee ("CC") appointed before 1 December 2010 would be governed by the MRA 2004, but any proceeding commenced after that date would be governed by the MRA 2010.

---

[68] ROP vol 1 at Tab 1, pp 10–11.

Version No 1: 11 Jan 2022 (19:48 hrs)

The upshot of the legislative changes is that r 23B(1) of the Medical Registration Regulations (Cap 174, R 1, 2000 Rev Ed), which was enacted pursuant to the MRA 2004 and gave power to the DC to join similar disciplinary offences, lapsed on 1 December 2010 (see *Public Prosecutor v Tan Teck Hin* [1992] 1 SLR(R) 672 at [27], where it was held that subordinate legislation, unless saved by the repealing enactment, lapses on the repeal of the provisions under which it was made), save for its application to disciplinary proceedings which had been commenced before 1 December 2010.

66 A CC for the Prior Charge was appointed before 1 December 2010,[69] and was therefore bound to apply the MRA 2004. However, the proceedings relating to the First Charge were not commenced until 21 September 2011.[70] The MRA 2010 therefore applied to the proceedings concerning the First Charge while the MRA 2004 applied to those concerning the Prior Charge. There was thus no possibility that the proceedings could have been joined. The DT therefore erred in holding otherwise. Consequently, the basis on which the DT ordered that the Respondent serve the two sentences concurrently and pay only half of the Applicant's costs was wrong and fell aside.

The Prior Charge

67 Second, the DT erred in considering that the Respondent was not a repeat offender on the basis that he had not yet been *sentenced* for the Prior Charge when he committed the two acts of misconduct leading to the Charges. The DT reasoned that the sentence should not be stiffer than that imposed for

---

[69] Appellant's Submissions at para 43.

[70] ROP vol 5 at Tab 1, p 6.

Version No 1: 11 Jan 2022 (19:48 hrs)

the Prior Charge, which was primarily a three-month suspension. In our judgment, the DT was wrong. It is important to note that while the Respondent had not yet been formally charged with the Prior Charge when he falsely certified Patients A and B's death certificates, he *was* on notice that he was under investigation for the prior offence. We considered this to be an aggravating factor and therefore took this into account when imposing the sentences we have set out at [61] above. In any event, it was not evident to us how the Respondent could not be regarded as a repeat offender since the plain facts were that he had repeatedly issued false death certificates. There was simply no ambiguity in this.

The Respondent's guilty pleas

68 Third, the DT erred in placing emphasis on the Respondent's plea of guilt as a mitigating factor. While the court will account for a plea of guilt in mitigation as evidence of remorse, its relevance and weight will depend on the facts (*Wong Kai Chuen Philip v Public Prosecutor* [1990] 2 SLR(R) 361 at [10]–[17]). In particular, Chan Sek Keong J (as he then was) said at [14]:

> 14 In making these comments, I do not dissent from the principle applied by the Senior District Judge that the voluntary surrender by an offender and a plea of guilty by him in court are factors that can be taken into account in mitigation as they may be evidence of remorse and a willingness to accept punishment for his wrongdoing. However, I think that their relevance and the weight to be placed on them must depend on the circumstances of each case. *I do not see any mitigation value in a robber surrendering to the police after he is surrounded and has no means of escape, or much mitigation value in a professional man turning himself in in the face of absolute knowledge that the game is up.* [emphasis added]

69 In our judgment, the facts before us clearly fell within the latter category referred to by Chan J. When the Respondent pleaded guilty, the evidence against him was overwhelming and there was no way in which he

Version No 1: 11 Jan 2022 (19:48 hrs)

could possibly have justified his actions. It was on that basis that the Respondent pleaded guilty, and thus the mitigation value was minimal. Indeed, of greater relevance was the fact that the Respondent had initially maintained the position in relation to the Second Charge that he was entirely justified in issuing the death certificate in that case, and had produced what purported to be a letter from D, and further that before us, he maintained that the medical documents that would have substantiated his claim did in fact exist but were just not before us (see [27] above). This was despite the fact that the Respondent had previously admitted that they had been fabricated. We did not believe these were the actions of a remorseful person. In our judgment, his guilty pleas had no value as a mitigating factor.

Our thoughts on the Applicant's investigations

70 Finally, we make some observations on the investigations that had been carried out by the Applicant. Having looked at the evidence and heard the parties, we found that there were many questions left unanswered and many difficulties unresolved. First, what was the incentive for the Respondent to falsely certify the deaths of both Patients A and B? The Respondent is a doctor with many years of experience and as much as he might claim to be untrained in death certification, there was nothing unclear about why it was wrong to do what he did. He could not possibly have been unaware of the gravity and consequences of his actions. In investigations of this nature, we thought that it would be obvious that one of the most important questions to be answered was *why* the acts had been carried out. The motivations behind such acts would undoubtedly be an important factor in determining the sentence to be meted out against an errant doctor. The consequences might have been quite different depending on whether he had done it to conceal some other illicit act, for profit, or for some other less egregious reasons such as sympathy

Version No 1: 11 Jan 2022 (19:48 hrs)

for a bereaved family. We asked the Applicants' counsel, Mr Philip Fong Yeng Fatt, if this had been looked into, and he told us it had not.

71 Second, we thought that the circumstances surrounding the Respondent's explanation to the Applicant in relation to the Second Charge were highly suspicious. As mentioned at [16] above, the Respondent had attached what purported to be a letter from D dated 10 December 2011[71] together with his explanation to the Applicant regarding the cause of Patient B's death. We found the circumstances surrounding what appeared to be D's letter and its contents extremely odd to say the least. They gave rise to the following unanswered questions:

(a) How did D know that the Respondent was being investigated and what were the circumstances in which he had written the letter?

(b) D was Patient B's husband and unless relations between them were very bad, how could he have been so mistaken as to his wife's medical condition?

(c) Why did D falsely state that C was not the sister of his wife? On the other hand, if C was not the sister of Patient B, why did the Respondent admit to that fact in the Agreed Statement of Facts?[72]

(d) What was D's motivation in requesting that the investigations into the Respondent be stopped?

---

71 ROP vol 5 at Tab 2, p 51.

72 ROP vol 4 at Tab 1, p 5, para 15.

Version No 1: 11 Jan 2022 (19:48 hrs)

(e) The letter was typewritten and printed before D *wrote* his name and signed on it. If D had typed the letter, why would he not type his name on the letter before printing it out and then signing on it?

(f) In all the circumstances, was the letter genuine, and had it in fact been issued by D, Patient B's widower?

72 Our impression formed from reviewing the record of the oral hearing and the papers was that these questions were not asked during investigations. It could be that this was because the Respondent had pleaded guilty to the Charges. In our judgment, the fact that the Respondent had pleaded guilty to the Charges did nothing to quell the concerns that give rise to these questions which ought to have been investigated. Answers to these questions could have given us greater insight into the true culpability of the Respondent and this would have been relevant to sentencing. As we have noted above, had more information been available, we might have found that there were ample grounds for the Respondent to be struck off the medical register even on the basis of the existing sentencing framework without taking into account the point mentioned at [62] above. But as there was no evidence before us as to the matters we have outlined above, we proceeded to sentence him based solely on the facts that we were presented with.

73 However, we remain disturbed by these unresolved issues, and have therefore referred the matter to the Attorney-General to consider what, if any, further steps should be taken to investigate this matter. In our judgment, in future investigations, those leading these inquiries, including those prosecuting these matters, should endeavour to seek answers pertaining to such crucial questions, such as the motivations behind the commission of the offences. Where a plea of guilt is taken, the answers to such questions should be

Version No 1: 11 Jan 2022 (19:48 hrs)

reflected in the agreed statement of facts to the extent they might have a bearing on the appropriate sentence. Apart from ensuring that the sentence is then imposed with the benefit of as complete a picture as possible as to the culpability of the errant doctor, consideration can also be given to any other steps that may need to be taken to ensure that vital interests that are adversely impacted, including those mentioned in the context of this case (see [52] above), the administration of criminal justice and the interests of public health, are attended to.

Conclusion

74 For these reasons, we set aside the sentence of three months suspension for each Charge, and instead imposed a term of suspension of 18 months for each Charge. We ordered that both sentences are to run consecutively, thus giving rise to an aggregate term of suspension of three years. We were informed, though only after the hearing, that the Respondent had already served the sentence of three months suspension that had earlier been imposed by the DT. It is appropriate that this should be taken into account, leaving him to serve the remaining period of suspension of 33 months commencing on 6 July 2015, the date on which we delivered our judgment. We also ordered that the Applicant should have its full costs and expenses of and incidental to the inquiry before the DT, including the costs of its solicitors. Save as

Version No 1: 11 Jan 2022 (19:48 hrs)

aforesaid, we did not disturb the remaining orders made by the DT. Finally, we awarded the Applicant the costs of the appeal which we fixed at $6,000 plus reasonable disbursements.

Sundaresh Menon	Chao Hick Tin	Andrew Phang Boon Leong
Chief Justice	Judge of Appeal	Judge of Appeal

Philip Fong Yeng Fatt and Shazana bte Mohd Anuar (Harry Elias Partnership LLP) for the applicant;
The respondent in person.

Version No 1: 11 Jan 2022 (19:48 hrs)