SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR YIP MAN HING KEVIN
HELD ON 5, 6, 7, 10, 11 OCTOBER 2016; 10, 12, 18 APRIL 2017; 29 NOVEMBER 2017 AND 29 JANUARY 2018

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GROUNDS OF DECISION OF THE DISCIPLINARY TRIBUNAL

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

INTRODUCTION

1. The Respondent, Dr Yip Man Hing Kevin ("**Dr Yip**"), is an orthopaedic surgeon who practises at his own medical clinic, the Singapore Sports and Orthopaedic Clinic ("**Dr Yip's Clinic**"), located at the Gleneagles Medical Centre at the material time when the subject matter of this complaint ("**Complaint**") arose.

2. On 7 July 2011, Dr Yip examined Mr P ("**the Patient**"), a 47-year old Chinese national employed as a construction worker by Company A ("**Company A**"), who had fallen from a scaffolding platform at a worksite. The Patient fractured his right clavicle and two to four ribs, and suffered a one-cm head laceration, among other injuries. Dr Yip performed an Open Reduction Internal Fixation ("**ORIF**") surgery on the Patient's right clavicle that was completed just past midnight on 8 July 2011, and sutured the laceration. Dr Yip ordered conservative treatment of the Patient's rib fractures, that is, non-surgical treatment, and discharged the Patient on 8 July 2011. Dr Yip issued a medical certificate for 7 to 8 July 2011, and certified the Patient fit for light duties from 9 to 11 July 2011.

3. On 11 July 2011, following his first post-operative follow-up, Dr Yip certified the Patient fit for light duties from 12 to 18 July 2011.

4. On 18 July 2011, following his second post-operative follow-up, Dr Yip certified the Patient fit for light duties from 19 to 25 July 2011.

5. The Patient did not attend the third follow-up on 25 July 2011. On 22 July 2011, the Patient presented himself at the Hospital A ("**Hospital A**") Emergency Department complaining of persistent giddiness and nausea, and right pleuritic chest pain, and was admitted to the Hospital A's Emergency Diagnostic and Therapeutic Centre. On 23 July 2011, the Patient was discharged with hospitalisation leave for seven days, from 22 to 28 July 2011, and was referred

to the Institution B ("**Institution B**") and the Hospital A Orthopaedic Surgery Department for follow-up.

6. The Complaint was filed by Mr C (the "**Complainant**") from the Organisation A ("**Organisation A**") when the Patient had approached Organisation A for assistance with compensation issues.

7. The Agreed Statement of Facts are at **<u>Annex A</u>** of these grounds of decision.

8. By way of summary, Dr Yip faced three charges ("**Charges**") that, given the nature of the Patient's occupation, his condition on each of the three occasions that Dr Yip saw him, and the requisite post-operative management of the Patient, sick leave should have been given to the Patient and it was inappropriate to certify him as fit for light duties. In respect each of these three occasions, Dr Yip was charged that his conduct "*demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency*" (the first limb of the test for professional misconduct per *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*")), pursuant to section 53(1)(*d*) of the Medical Registration Act (Cap 174) ("**MRA**").

9. Dr Yip faced alternative charges ("**Alternative Charges**") in respect of each of the three occasions on the basis that his conduct "*demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner*" (the second limb of *Low Cze Hong*).

10. The Charges and Alternative Charges in full are at **<u>Annex B</u>** of these grounds of decision.

11. Dr Yip pleaded not guilty to the Charges and the Alternative Charges. After due consideration, this Tribunal convicted Dr Yip and ordered that he:

    (a) be suspended for a term of **five (5) months**;

(b) be censured;

(c) give a written undertaking to the Singapore Medical Council ("**SMC**") that he will not engage in the conduct complained of or any similar conduct; and

(d) pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

12. We now set out our reasons below.

OUR DECISION ON CONVICTION

The law

13. This case concerned facts that bore some similarity to those in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("***Wong Him Choon***"), a decision by the Court of Three Judges ("**the Court**") on professional misconduct where a doctor inappropriately certified a patient as fit for light duties. In the present case, the parties did not dispute that the principles set out in *Wong Him Choon* applied, but disputed the extent to which Dr Yip's conduct was distinguishable from that of Dr Wong Him Choon ("**Dr Wong**").

14. Dr Wong was a consultant orthopaedic surgeon who attended to a Chinese national and construction worker who had fallen at a construction site. He first asked to view his patient's work permit, which had two months until expiry. Dr Wong performed surgery involving "K-wire" fixation of the right distal radius on the patient's right hand. After surgery, he certified the patient fit for discharge, issued him a medical certificate ("**MC**") for two days ending on the day of surgery, and certified him fit for light duties for a month thereafter. He scheduled a first post-operative review for the third day of the patient's light duties. At that review, Dr Wong scheduled the patient for his next review after a month of light duties. However, the patient visited Dr Wong earlier than scheduled, and subsequently Changi General Hospital, for discomfort in his hand. At the second post-operative review with Dr Wong, after the patient told Dr Wong that he had not been paid a salary because he had been unable to work and had

not been granted an MC, Dr Wong issued him a backdated MC covering his absence from work. Dr Wong subsequently saw the patient on two more occasions to remove his pins and his sutures before the patient's work permit expired and he returned to China.

15. The Court in *Wong Him Choon* affirmed its earlier decision in *Low Cze Hong* (at [37]) that professional misconduct sanctioned by the MRA can be made out in at least two situations:

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

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

16. The Court noted that the limbs in *Low Cze Hong* set out high thresholds that were more exacting than those in civil liability, "*both in terms of the standard of misconduct that must be shown as well as the standard of proof that must be discharged*" (at [50]).

17. While *Wong Him Choon* proceeded on the first limb (at [18]), the Court observed in *obiter dicta* that the second limb would also have been made out (at [86]-[89]).

18. In respect of the limbs of *Low Cze Hong*, the Court applied the framework set out in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 at [39], and held that the following findings were to be made before the SMC could be found to have proven the charge (*Wong Him Choon* at [49]):

    "(a) In relation to the first limb of Low Cze Hong… :

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

(ii) if the applicable standard of conduct required the said doctor to do something and at what point in time such duty crystallised; and

(iii) whether the said doctor's conduct constituted an intentional and deliberate departure from the applicable standard of conduct.

(b) In relation to the second limb of Low Cze Hong:

(i) whether there was serious negligence on the part of the doctor; and

(ii) whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner."

19. In respect of the applicable standard of conduct for post-surgery discharge of the patient, the Court affirmed the Disciplinary Tribunal's following statements (*Wong Him Choon* at [55]):

*"(a) It was **for the doctor to establish** that there were adequate conditions for rest and rehabilitation if medical leave for two days after the surgery followed by light duty was to be given. A reasonable doctor dealing with a person in the Patient's position should **take proactive steps to make inquiry** from the said patient (see the Disciplinary Tribunal's Decision at [74] and [77]).*

*(b) **It was not the practice among members of the medical profession of good standing and repute to certify a worker fit for light duties instead of two weeks' medical leave immediately after the surgery for a distal radius fracture** (see the Disciplinary Tribunal's Decision at [78]–[79])."* (emphases in original)

20. In respect of (a), "*the doctor's duty to discuss with the patient whether there were adequate conditions for rest and rehabilitation crystallised and was to be discharged before deciding on the type and duration of medical leave*" (*Wong Him Choon* at [62]).

21. The Court also referred to a further finding by the Disciplinary Tribunal on the applicable standard of conduct in respect of post-surgery discharge of the Patient, as follows (*Wong Him Choon* at [23]):

"A doctor had to take into account the following primary factors before deciding on the "type or duration" of medical leave: (i) the nature of the illness, injury or disability; (ii) the method of treatment used; (iii) the amount of recovery time needed post-treatment; (iv) whether the patient needed hospitalisation; (v) the nature of the patient's occupation; and (vi) the patient's medical needs and personal circumstances (see the DT's Decision at [72])."

22. Dr Wong had breached the standard of conduct when he certified the patient fit for light duties without first establishing that those light duties existed, while knowing that it was his duty to do so (*Wong Him Choon* at [84]).

23. Accordingly, four main issues arose for determination in the present case:

    (a) Whether it was the practice among members of the medical profession of good standing and repute to certify a worker with the Patient's injuries fit for light duty on the first post-operative day following clavicle surgery, and when conservative treatment of two to four rib fractures was ordered;

    (b) Whether Dr Yip had intentionally and deliberately departed from the above practice;

    (c) The parties did not dispute that Dr Yip had a duty to establish that there were adequate conditions for rest and rehabilitation. The issues that arose were whether Dr Yip had departed from this applicable standard of conduct, and whether this departure had been intentional and deliberate;

    (d) In respect of the second limb of *Low Cze Hong*, whether there had been serious negligence on Dr Yip's part, and whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

(a) Whether it was the practice among members of the medical profession to prescribe light duties for a worker with the Patient's injuries on the first post-operative day

24. The parties disputed the extent and severity of the Patient's injuries. Dr Yip challenged the SMC's characterisation that the Patient suffered severe injuries that required a period of sick leave. He argued that he had certified the Patient fit for light duties, because surgery had stabilised the Patient's fractured clavicle, and the Patient's rib, scalp and wrist injuries had been minor.

Clavicle fracture

25. In respect of the Patient's clavicle fracture, parties did not dispute the benefits of the ORIF surgery and early mobilisation. Instead, parties disputed whether the Patient should have immediate active mobilisation through unrestricted movement and light duties as a manual labourer, and the duration of sick leave the Patient should have received.

Expert witnesses and medical literature

26. Dr Yip argued that his decision to certify the Patient as fit for light duties from the first post-operative day was supported by his medical experts, Dr DE1 ("**Dr DE1**"), Dr DE2 ("**Dr DE2**") and by medical literature. [1] Dr Yip also tendered:

    (a) Evidence that local orthopaedic surgeons held a similar opinion on early mobilisation, such as in an anonymised email exchange among orthopaedic surgeons in Singapore, including those at restructured hospitals, in which a doctor remarked that he gave two days of light duty and no sick leave to an injured worker with a supportive employer;

[1] Jeray, K.J., *Acute Midshaft Clavicular Fracture*. J Am Acad Orthop Surg, 2007. 15: 239-248; Huh, J., et al., *Performance of Military Tasks After Clavicle Plating Association of Military Surgeons of the U.S.* Military Medicine 2011. 176(8): 950-955; Jubel, A, et al., *Elastic stable intramedullary nailing of midclavicular fractures in athletes*. Br J Sports Med 2003. 37: 480–484 ("**the Jubel study**"); Verborgt, Oliver, et al., *Plate fixation of middle-third fractures of the clavicle in the semi-professional athlete*. Acta Orthop. Belg., 2005. 71(1): 17-21; *Sports-Trauma Clavicle Repair – A compendium of sports-trauma clavicle cases utilizing the SONOMA CRx™ Clavicle Fracture Repair Device*. Sonoma Orthopedic Products, 2012. (Contributed by the operating physicians throughout the United States).

(b) An article by Dr DW1, an orthopaedic surgeon in local private practice, who recounted an experience where, following surgery on a patient who suffered a displaced clavicle fracture from a traffic accident on Friday, the patient was back at work on the Monday thereafter; and

(c) Evidence from his own practice that, after clavicular surgery, he had given office workers sick leave averaging four days (ranging from zero to 35 days), and manual workers sick leave averaging 27 days (ranging from zero to 188 days).

27. Dr DE2's evidence does not fully support Dr Yip's position. Despite advocating early mobilisation, Dr DE2 opined that, on the first post-operative day, there would have been pain over the clavicle, unrestricted motion would not have been possible, and light duties would have been very difficult for a few days.

28. The medical literature cited by Dr Yip was also distinguished by the SMC for relating to highly motivated patient populations such as professional athletes and military personnel. In any event, these reports noted that there continued to be restrictions on overhead lifting and weight-bearing for a period.

29. On the other hand, Dr PE ("**Dr PE**"), the SMC's expert, an orthopaedic surgeon, testified that he would have given six weeks of sick leave, and four to six weeks of light duties depending on the Patient's recovery. During cross-examination, while Dr PE agreed that the Patient could have started light duties at the two-week mark post-injury, he stated that a minimum of two weeks of sick leave should have been given at discharge with reassessment thereafter.

30. Dr PE referred to medical literature that recommended at least six weeks of sick leave for a clavicle fracture. Canadian disability duration guidelines, namely, the WorkSafeNB, "Disability Duration Guidelines", (July 2009), ("**New Brunswick Guidelines**") and the Workers Compensation Board of Prince Edward Island, "Disability Duration Guidelines and Expected Healing Times", (September 2003), ("**Prince Edward Island Guidelines**"), recommend six to 16 weeks, and six to eight weeks of sick leave respectively for patients who had been engaged in heavy work. Conversely, Dr Yip argued that the relevant timeframe in the

Prince Edward Island Guidelines was that for patients doing sedentary work, which was much shorter at zero days to four weeks.

31. During cross-examination, Dr Yip, Dr DE1 and Dr DE2 agreed that they would have given sick leave if there had been no agreement on light duties. Dr DE1 agreed that if there had been no discussion on light duties, or if light duties had not been available, it would have been reasonable to give six weeks of sick leave starting with two weeks at the first instance. Similarly, Dr DE2 opined that he would have given the Patient six to ten weeks of sick leave. Dr Yip conceded that if there had been no agreement on light duties, he would have given medical leave at each session until the next follow-up session, which the SMC submitted would have amounted to 19 days.

Conclusion on clavicle fracture

32. Having considered parties' evidence, the Tribunal was not persuaded that the successful surgical fixation of the Patient's clavicle and the goal of early and active mobilisation justified giving zero days of sick leave.

33. When the SMC challenged Dr Yip to show medical literature that justified zero days of sick leave, Dr Yip pointed to a study where athletes were permitted to return to sporting activity on the first post-operative day.[2] While patients in that study may have had other injuries, it was unclear whether they also suffered the injuries that the Patient had. In addition, the patients were highly motivated athletes, which both parties' experts agreed would have had shorter recovery times than the Patient.

34. In respect of the guidelines cited by the SMC, even if the applicable standard was sedentary work, only the Prince Edward Island Guidelines supported giving zero days of sick leave. In fact, the New Brunswick Guidelines prescribed one to four weeks of sick leave for return to sedentary work. In any event, the Tribunal took the view that, regardless of which guidelines were applied, such

[2] Jubel, A, et al., *Elastic stable intramedullary nailing of midclavicular fractures in athletes*. Br J Sports Med 2003. 37: 480–484.

timelines would need to be adjusted given that the Patient suffered more injuries than just the clavicle fracture.

35. While Dr Yip relied on the fact that he had issued zero days of sick leave to other patients (as opposed to the average days of sick leave from his own practice), the Tribunal found it difficult to understand why some of Dr Yip's patients who suffered a mere clavicle fracture received many more days of sick leave than the Patient given all the Patient's injuries.

36. As for Dr Yip's argument that the SMC had equated bone healing time with the duration of sick leave, Dr Yip and his experts admitted that, absent a discussion and agreement on light duties, they would have given the Patient sick leave.

Two to four rib fractures treated conservatively

37. It appeared from the medical records that the Patient had fractured two to four ribs:

    (a) On 7 July 2011, an X-ray report showed fractures of his seventh to ninth rib;

    (b) On 11 July 2011, a further report showed an additional fracture in the sixth rib;

    (c) On 22 July 2011, a further report showed fractures of the sixth and seventh ribs.

38. Dr DE1 and Dr DE2 opined that the Patient's rib fractures had been minor, because they had been minimally or not displaced, and it had not been a flail chest. However, the SMC submitted that Dr Yip and his experts appeared to diminish the significance of the Patient's rib fractures, such as in Dr Yip's statement that there were no rib fractures in his report to the Patient's employer dated 12 July 2011. During cross-examination, Dr Yip explained that as "*a typing error*", and he acknowledged awareness of the Ministry of Manpower ("**MOM**") requirements for reporting industrial accidents and that his report

would have been used for MOM purposes. It was only during cross-examination that Dr Yip conceded that the Patient's rib fractures had been as significant as his clavicle fracture and that multiple rib fractures would have been more painful than just one. Dr PE and Dr DE2 agreed that there would have been pain laughing and coughing. Dr Yip also noted that the Patient had faced the possible complication of pneumothorax from the rib fractures.

39. Dr PE gave evidence that patients with rib fractures took up to three months off work, and six to ten weeks for fractures to heal. While accepting the literature on healing time, Dr Yip opined that sick leave was not required for that entire duration, and pointed to the SMC's medical literature supporting early mobilisation.[3] In particular, the Prince Edward Island Guidelines stated the return-to-work time for rib fractures as zero to two weeks for sedentary work.

40. Dr Yip and his medical experts criticised the SMC's medical literature for excluding the effect of workmen compensation issues, but tendered no medical literature on the appropriate duration of sick leave for rib fractures. In respect of one study referred to by the SMC, Dr DE2 considered that the Patient's condition had been more similar to those with the more serious injuries in the study and who had a mean time to return to work of 91 +/- 33 days.[4] Even accounting for malingering or work compensation issues, Dr DE1 agreed that such patients would have taken a few weeks off work. In this connection, Dr Yip's own clinic website stated that "*rest is essential for recovery and repair of fractured ribs… Due to the inability to totally rest in this area because of its constant movement during respirations, it takes longer to heal, usually 6-8 weeks*".

Conclusion on rib fractures

41. Having considered the above evidence, the Tribunal took the view that the rib fractures should have been considered as significant as the clavicle fracture.

[3] Rebecca Haylett, "Rib fractures and chest injury: Information for patients" Oxford University Hospitals NHS Trust Publication, April 2014; NHS Choices, "Broken or bruised ribs" (29 April 2015) http://www.nhs.uk/conditions/rib-injuries/Pages/Introduction.aspx; and ReedGroup Medical Disability Guidelines, "Fracture, Rib" http://www.mdguidelines.com/fracture-rib.

[4] Mahlon A. Kerr-Valentic, BS, et al, "Rib Fracture Pain and Disability: Can We Do Better?" J Trauma 2003; 54: 1058-1064.

Dr Yip did not himself present medical literature supporting the giving of zero days of sick leave for rib fractures. The only medical literature that supported immediate return to pre-injury work (in the case of sedentary work) was the SMC's Prince Edward Island Guidelines that stated zero days to two weeks for "Ribs: Single or Multiple". Given that the Patient had suffered more than just the rib fractures, it was not appropriate to use the timeline at the lowest end of the scale.

One-cm scalp laceration

42. The SMC argued that the Patient had possibly suffered retrograde amnesia associated with the scalp laceration. On the other hand, Dr Yip took the view, supported by Dr DE1 and Dr DE2, that the Patient's head injury had been superficial and did not warrant additional leave.

43. About one month after the Patient's fall, Dr PW1 ("**Dr PW1**"), a senior registrar from the NNI, reviewed the Patient and granted him outpatient sick leave for eight days, and gave evidence that the Patient may have risked another fall due to his giddiness. While Dr Yip submitted that this indicated that the injury had not been serious, the SMC submitted that this was not indicative as one month had already elapsed since the injury. Further, Dr PW1 noted that a scalp laceration by its nature was "*not minor*".

44. Dr PE opined that his scalp injury was consistent with having "*some form of concussion or minor head injury*". The Patient displayed symptoms of minor head injury when he complained of a headache to Dr Yip and at Hospital A. The Patient also stated that he had "*lost consciousness*" after the fall in the notes of an interview conducted on 6 October 2011 by Mr PW2, a representative from Organisation A who gave evidence in these proceedings.

45. On the other hand, Dr Yip argued that the Organisation A interview notes contradicted contemporaneous evidence in the Industrial Accident Questionnaire on 7 July 2011, the main contractor's "Incident / Accident Interview Statement of Injured / Witness" by Mr F1, the safety officer of the main contractor, and the evidence by Mr DW2, the safety supervisor of Company A.

Additionally, in the Pre-Anaesthesia Assessment on 7 July 2011, Dr DW3 ("**Dr DW3**") recorded "*0 LOC*", which meant that the Patient had no loss of consciousness). There was a question as to whether Dr DW3's handwriting read as "*Had 0 LOC*" or "*Had LOC*". This was clarified by Dr DW3 who explained that if there had been loss of consciousness, he would have proceeded with a further physical examination and he would not have indicated that the Patient was healthy by circling "1" on the American Society of Anaesthesiology (ASA) classification as he had done.

46. Dr Yip argued that the Patient's claims of nausea and giddiness at Hospital A on 22 July 2011 and other problems complained of at Hospital A, were unrelated to his original injury, and appeared to have been signs of malingering to claim MC wages. When the Patient saw Dr PW1 on 5 August 2011, the Patient had asked Dr PW1 for an MC covering 28 July to 5 August 2011. This suggested that the Patient had not worked during that period despite not being on sick leave.

<u>Conclusion on scalp laceration</u>

47. In the light of the Tribunal's decision on the severity of the Patient's clavicle and rib fractures, the Tribunal took the view that it did not need to make a finding as to whether the Patient had lost consciousness and suffered a concussion, as a matter of fact. There was also no need to determine whether the Patient had been malingering as Dr Yip had argued.

Wrist contusion

48. As the radiologist who had reviewed the Patient's X-ray reported a possible fracture, the SMC argued that Dr Yip should have considered whether the Patient's injuries had been more serious. On the other hand, Dr Yip submitted that the Patient merely had a wrist contusion and did not need sick leave.

49. Dr Yip pointed out that Dr PE did not add sick leave for the wrist injury, which suggested that it had not been severe. Further, the Patient had only complained of a weak grip slightly over two weeks after the accident during admission to

the Hospital A Emergency Diagnostic and Therapeutic Centre on 22 July 2011, but the doctor noted that the Patient had the full range of motion with minimal pain. The Patient had not followed up on his complaint.

Conclusion on wrist contusion

50. While there was no dispute that the Patient did not require sick leave on account of the wrist contusion, the Tribunal noted that this injury should have been considered in the context of all the injuries that the Patient had suffered from the fall.

Other evidence brought by Dr Yip

51. The Tribunal considered the additional evidence tendered by Dr Yip in the form of written opinions by other medical professionals, and a telephone survey of orthopaedic surgeons.

Additional reports from medical professionals not called in proceedings

52. Dr Yip tendered reports from five other foreign doctors, one local doctor, and three physiotherapists ("**Additional Reports**") that were prepared after reviewing various documents relating to the Patient's matter. While the Tribunal was not bound by the Evidence Act (Cap 97, 1997 Rev Ed) in these proceedings, the Tribunal noted the SMC's objection that the Additional Reports were hearsay evidence, because their makers were not called to testify on their views. The Tribunal also noted that without cross-examination, these reports could not satisfy the test for medical opinion, that is, the two-stage test set out in *Bolam v Friern Hospital Management Committee* [1957] 1WLR 582, and as qualified in *Bolitho v City and Hackney Health Authority* [1998] AC 232, and adopted in *Khoo James v Gunapathy d/o Muniandy* [2002] 1 SLR(R) 1024 (at [3], [63]).

53. Be that as it may, for completeness, the Tribunal considered the Additional Reports. While the Additional Reports generally affirmed early mobilisation and

return to work, even those most favourable to Dr Yip were not clear authoritative endorsements of giving no sick leave:

(a) Dr DR1 ("**Dr DR1**"), an orthopaedic surgeon practising in the United States of America ("**USA**"), opined in relation to the clavicle fracture that, "*With regard to workers, they can start sedentary work immediately and this includes even lifting up to 5 to 10 pounds*", and in relation to the rib fractures that, "*there is no reason that rib fractures would stop a patient from doing either sedentary or light duty as long as it did not strain this region*". However, as Dr DR1 concluded that "*it was not unreasonable for Dr Yip to have placed [the Patient] back to light duty two days following surgery*", it appeared unclear to the Tribunal whether Dr DR1 understood that the certification for light duty commenced on the first post-operative day.

(b) Professor DR2 ("**Prof DR2**") consultant orthopaedic surgeon at The London Independent Hospital opined that, *"[i]n the UK, it is suggested that patients should return to work as early as possible, and early mobilisation is recommended to achieve early recovery. Indeed, the best recovery occurs in the patient's own work environment*", but does not state that it should be immediate. Prof DR2 opined that Dr Yip's prescription of light duties was "reasonable".

(c) Dr DR3, an orthopaedic surgeon practising in the USA and a fellow of the American Academy of Orthopaedic Surgeons, opined that after a patient has undergone surgical fixation of his clavicle fracture, there are no restrictions performing office or clerical activities and supervisory (non-labour) activities on the jobsite. Having said that, he noted that his instructions were unclear as to whether the Patient sustained any rib fractures. This was at odds with the undisputed fact that the Patient had suffered rib fractures.

(d) Dr DR4 offered his own anecdotal evidence that after fracturing his left sixth rib, he continued to propel his wheelchair, and he competed in a race six days after. When he fractured his right seventh rib, he "*embarked on light activities immediately without any long term sequelae*".

54. On the other hand, the report by Dr DR5, an orthopaedic surgeon, stated that the active assist range of motion exercises are only carried out for "*30 min to 1 hour daily*", that "*restrictions of not lifting more than the weight of a glass of water for 6 weeks*" applied, and that the "*restriction of not lifting the arm over 90 degrees for the first 3 weeks and not to lift any object over 1 to 2 pounds for the first 6 weeks*".

55. None of these studies expressly supported Dr Yip's claim that a manual labourer with the Patient's injuries could return to light duties from the first post-operative day. Accordingly, even if the Tribunal accepted the Additional Reports, they would not have been of great assistance to Dr Yip.

Dr Yip's survey of 1,513 orthopaedic surgeons

56. Dr Yip commissioned three survey companies to conduct telephone surveys of 1,513 orthopaedic surgeons who treated patients with clavicle fractures. Two of these companies sent representatives to give evidence on their methodology and findings in the proceedings.

57. The main findings were as follows:

(a) Of the 1,513 respondents, 84% agreed that operative treatment allowed early functioning of the injured shoulder which thereby encouraged patients' mobility and early return to light duty work.

(b) Of the 1,513 respondents, 48% would issue two or less days of medical leave followed by a light-duty certificate, following operative fixation of the clavicle and conservative treatment of rib fractures.

(c) Of these 48%, 92% agreed that mobilisation with light duty from the third day onwards was beneficial and reasonable.

58. Dr DE3, ("**Dr DE3**"), an Associate Professor at the Department of Mathematics in the Institution C, conducted data analysis of the survey results and gave evidence on his conclusion that "*the most important and representative of the*

survey outcome" was the finding that 48% of the respondent orthopaedic surgeons would have issued two days or less of sick leave, plus light duties, to patients who had undergone operative fixation of a fractured clavicle and conservative treatment of rib fractures. Dr DE3 opined that since the sample size of 1,513 was fairly large, 48% was regarded as fairly accurate in statistical terms. For this conclusion, the margin of error was +/- 2.5%.

59. Dr DE3 also concluded that the chance that a patient with operative fixation of a fractured clavicle and conservative treatment of rib fractures was given two days or less of sick leave, plus light duties, was "*not small (12.984%)*" and that this practice among orthopaedic surgeons was "*certainly not an uncommon event*", where he used the words "not small" and "not uncommon" in the layman sense. Dr DE3 opined that 12.984% was not small because it was higher than 5%, and stated that this opinion was based on his expertise.

60. While the Tribunal was not bound by the guidelines in *Ferrero SPA v Sarika Connoisseur Café Pte Ltd* [2011] SGHC 176, the Tribunal agreed with the SMC that it was useful to consider the non-exhaustive guidelines set out in that case when considering the weight to be accorded to survey results (at [134]). These guidelines are summarised as follows:

(a) Selection of interviewees represents cross-section of public;
(b) Size of survey was statistically significant;
(c) Survey must be conducted fairly;
(d) All surveys carried out must be disclosed;
(e) Totality of answers must be disclosed;
(f) Questions must not be leading or leading a person to speculate;
(g) Exact answers should be recorded;
(h) Instructions to interviewers should be disclosed; and
(i) Where answers are coded for computer input, coding instructions must be disclosed.

61. Of the flaws and errors in the conduct and design of the survey highlighted by the SMC, the most troubling was that a question had been omitted in the final results where only three of its 93 respondents stated that they would have given

less than one week of sick leave to patients with clavicle and rib fractures ("**Omitted Question**"). Of these three respondents who would have done so, they would have given three to five days of sick leave. These results contradicted Dr DE3's conclusion that 48% of the respondent orthopaedic surgeons would have issued two days or less of sick leave, plus light duties.

62. Initially, Dr Yip had explained that the Omitted Question had been discontinued before he saw the results. On cross-examination, Dr Yip admitted that all three survey companies had completed the survey and given him the results.

63. In addition, respondents had been told to take five to ten minutes to complete the multiple-choice questions, without obligation to check their clinic records, and without room to elaborate or clarify their answers. While respondents were asked to confirm that they had not responded to another survey on the same subject matter, there remained a possibility of duplication since the surveys were conducted in the same geographical regions. It is also pertinent to note that Dr DE3 was not involved in the design of the study and the formulation of the survey questions.

64. In view of the above, the Tribunal formed the view that no weight should be accorded to the survey findings.

Conclusion on whether Patient's injuries required sick leave

65. It was not disputed that the Patient's head injury, wrist injury and soft tissue injury did not merit time off work on their own. Having said that, the Tribunal agreed with the SMC on the basis of its evidence that the Patient's injuries, seen in totality, were more than just the clavicle fracture. Dr Yip himself conceded that the rib fractures were as significant as his clavicle fracture, and that multiple rib fractures would have been more painful than one.

66. Dr Yip sought to distinguish his conduct from Dr Wong's, whose expert witness tendered no medical literature for early mobilisation and was not an expert of the appropriate specialisation. In contrast, Dr Yip argued that the medical literature relied on by Dr DE1 and Dr DE2 supported early mobilisation, and that

he had medical reasons for giving light duty, and that he had considered the Patient's welfare and recovery environment.

67. However, the Tribunal took the view that even though the literature indicated that early mobilisation was beneficial, that did not mean that the Patient should have received zero post-operative sick leave and certification to return to light duties immediately. Medical literature (such as the study by Jubel,[5] the Prince Edward Island Guidelines for clavicle fractures and rib fractures respectively) would have to be viewed in the light of all the Patient's injuries. The Tribunal accepted the evidence of the parties' medical experts, and Dr Yip, that they would have given the Patient sick leave if there had been no agreement on light duties, or if light duties had not been available.

68. Having considered the above matters, the Tribunal took the view that medical evidence showed that it was not the practice among members of the medical profession of good standing and repute to certify a worker with the Patient's injuries as fit for light duties on the first post-operative day following clavicle surgery and given conservative treatment of two to four rib fractures.

(b) Whether Dr Yip intentionally and deliberately departed from the above standard of conduct

69. The Tribunal next considered whether Dr Yip's departure from the above standard of conduct had been intentional and deliberate.

70. During cross-examination, Dr Yip conceded that if there had been no agreement on light duties or if light duties had not been available, he would have given medical leave at each session until the next follow-up session, which the SMC submitted would have amounted to 19 days.

71. Dr Yip sought to justify giving the Patient light duties because he claimed that worker dormitories were unhygienic and not conducive for mobilisation. He also

[5] *Supra* n1.

expressed concern that if the Patient had been unwell in the dormitories, he would have been alone, unlike at the site office.

72. However, Dr Yip's own clinic website emphasised that "*rest was essential for rib fractures"* (paragraph 40 above). The Tribunal accepted Dr PE's evidence that, in the Patient's condition, commuting to and from the dormitory would have been painful. The Tribunal also accepted Dr PE's evidence that light duties could not replace rehabilitation and mobilisation, which were directed at the injured part for recovery.

73. There was no basis to suggest that the Patient needed supervision to carry out mobilisation. If Dr Yip was suggesting that the Patient needed supervised rest, that concept had been rejected by the Court in *Wong Him Choon*.

74. Having considered the above matters, the Tribunal took the view that Dr Yip's conduct in giving the Patient zero post-operative sick leave, was an intentional and deliberate departure from the applicable standard of conduct. The attempt to justify the departure on medical grounds in the interest of the welfare of the Patient was without merit whatsoever.

(c) Whether Dr Yip had intentionally and deliberately departed from the applicable standard of conduct of establishing that there were adequate conditions for rest and rehabilitation before prescribing light duties via a proactive inquiry

75. Dr Yip did not dispute that he had a duty to establish that there were adequate conditions for rest and rehabilitation. Dr Yip argued that he had discharged that duty by discussing the existence and types of light duties with the Patient, in the presence of Mr DW2 and his supervisor, Mr F2, and obtained the Patient's agreement to try light duties.

76. As a preliminary issue on the parties' respective burdens of proof, Dr Yip argued that there was a reasonable doubt on the SMC's case, because the SMC failed to call the Patient to prove that there had been no discussion on light duties. On the other hand, the SMC argued that the main thrust of the Charges was that

Dr Yip had given inadequate sick leave, and not that there had been a discussion of light duties, which Dr Yip raised in his defence to justify not issuing post-operative sick leave.

77. The Tribunal agreed with the SMC that, as Dr Yip raised the fact of the discussion on light duties, Dr Yip bore the burden of proving that fact on a balance of probabilities.

78. The Tribunal next considered Dr Yip's arguments that the SMC had not discharged its burden of proving the Charges beyond a reasonable doubt, and Dr Yip's arguments that he had discussed light duties with the Patient and obtained the Patient's agreement.

Whether the SMC's evidence gave rise to reasonable doubt

79. Dr Yip argued that the SMC had not proved its case beyond reasonable doubt due to deficiencies in its evidence:

(a) First, Dr Yip argued that the Complaint had been prepared second-hand by the Complainant based on notes of a Organisation A's interview that he did not attend. Dr Yip also questioned the reliability of the Organisation A interview notes, because Mr PW2 gave evidence that he had conducted that interview with the Patient, and calculated for the Patient the total number of sick leave days that Hospital A had given him. On this basis, Dr Yip suggested that the Patient's other answers in the Organisation A interview notes might have been recorded with input from Mr PW2.

(b) Second, Dr Yip highlighted concerns that the Complaint was unreliable because the Complainant had complained about Dr Yip's alleged treatment of another patient in 2014, which the SMC dismissed when it was discovered not to have been his patient.

(c) Third, Dr Yip argued that the SMC had made inadequate efforts to call the Patient as a witness in proceedings, which prejudiced Dr Yip.

(d) Fourth, the Patient’s failure to complain to Dr Yip during the three consultations with him, the fact that the Patient had only approached Organisation A for compensation issues, and his apparent disinterest in the present proceedings cast doubt on the SMC’s case.

80. The Tribunal agreed with the SMC that its case did not rest on the Organisation A interview notes or on the Patient’s evidence alone. In any case, the Organisation A interview notes captured the material aspects of the Patient’s account. The Tribunal was not persuaded to draw an adverse inference against the SMC for not calling the Patient as a witness. Neither was the Tribunal prepared to draw any inferences from the earlier complaint that had been dismissed. In the circumstances, the Tribunal did not find that a reasonable doubt had arisen on the SMC’s evidence.

Whether Dr Yip had agreed with the Patient to try light duties

81. Dr Yip gave evidence that, during the second consultation on 7 July 2011, after the X-Ray, he had established with Mr F2, and in the presence of Mr DW2, that light duties had been available at the site office. After a discussion of about 30 minutes, the Patient had chosen light duties. During both consultations on 11 and 18 July 2011, Dr Yip had ensured that the Patient had been doing his mobilisation exercises, and had been comfortable with continuing light duties. On both occasions, Mr F2 had informed Dr Yip that the Patient did not do heavy work.

82. Dr Yip also claimed seeing the Patient on 8 July 2011 before discharge, and discussing light duties then. As evidence, Dr Yip argued that standard procedure did not permit nurses to discharge a patient unless the treating doctor saw that patient. However, this was untested evidence that was not supported on the clinical records.

83. Dr Yip urged the Tribunal to accept Mr DW2’s evidence as the best available evidence of the conversation. The time stamps on photographs taken of the Patient in his clinic and the time the Patient was later admitted into hospital

were about 1.8 hours apart, which supported the fact that there had been a relatively long discussion.

84. However, the SMC cautioned against relying on Mr DW2's evidence because he admitted that he could not understand the conversation between the Patient, Dr Yip and Mr F2 which had partially taken place in Mandarin. During cross-examination, Mr DW2 also admitted that he could not recall the incidents perfectly, because it had been five years since. He also could not recall any other parts of the conversation except the parts on light duties, which the SMC submitted was telling. He also wavered on whether early mobilisation had been mentioned by Dr Yip, or the details of any such mobilisation plan.

85. The SMC alleged that the discussion was an afterthought. The discussion was first raised in Dr Yip's witness statement dated 14 September 2016. It was omitted in his Explanation to the Complaints Committee on 29 June 2012, even though Dr Yip was aware that it was a main issue in the Complaint because he had elaborated on his decision to give certificates for light duties in his Explanation, including as follows:

> *"Medical leave*
>
> *…*
>
> *Mr P did not express any discontent regarding light duties at the end of each consultation and he continued to return to me for follow up. During each consultation, he did not report to me or my clinic assistants that his company had asked him to do any work."*

86. The SMC argued that, during cross-examination, Dr Yip recalled discussing light duties with the Patient as a matter of recollection of his general practice, instead of providing details of the specific discussion with Mr F2 and the Patient.

87. The SMC also argued that the lack of documentation of the discussion in any of Dr Yip's case notes supported its submission that the discussion had not taken place. Dr Yip argued that the lack of documentation did not conclusively prove that no such discussion took place, and only reflected the lack of

guidelines in 2011. In this regard, the Ministry of Health ("**MOH**") and MOM only issued guidelines on light duty certifications on 19 June 2013.

88. Even so, Dr Yip agreed that he should have recorded their discussion pursuant to the standard of recording in the 2002 edition of the SMC Ethical Code and Ethical Guidelines ("**ECEG**"), at paragraph 4.1.2, as follows:

> *"4.1.2 Medical records*
>
> *Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigation results, **discussion of treatment options**, informed consents and treatment by drugs or procedures should be documented."* (emphasis added)

89. Similarly, Dr DE1 opined that he would have recorded a discussion with the Patient and/or his employer on light duties and he would have expected that if there had been an agreement between Dr Yip and the Patient to do certain types of light work, this would have been recorded in the case notes and in instructions passed down from the employer to the staff to ensure this had been carried out. Dr PE similarly agreed that he would have recorded such a discussion with the Patient.

90. The SMC referred the Tribunal to *Eu Kong Weng v Singapore Medical Council* [2011] 2 SLR 1089, where Dr Eu failed to obtain his patient's informed consent. The Disciplinary Committee ("**DC**") considered it "*noteworthy that the above details of the consultation that were material to the Respondent's case on the issue of informed consent were not recorded in his own medical case-notes*" (at [21]).

91. In the circumstances, the Tribunal took the view that the lack of a record of the discussion and the Patient's agreement in Dr Yip's notes, particularly given Dr

Yip's admission that he ought to have recorded that discussion, supported the SMC's case.

92. Further, the Tribunal found it troubling that Dr Yip claimed that he had not been aware that the Patient had not worked since the accident, and that he only found out subsequently from Mr F2. When Dr Yip had asked Mr F2 at each session whether the Patient had been doing heavy work, Mr F2 had answered in the negative, which had been a half-truth. On the other hand, the SMC contended that Dr Yip had been aware at each follow-up session that the Patient did not work at all. Dr Yip's claim that he did not know that the Patient had not worked was belated and contradicted his Explanation, for example, at paragraph 17:

(a) *"According to Company A's project manager, Mr F2, who accompanied Mr P* ***on his follow-up reviews, Mr P has not been working at all since the accident****"* (paragraph 9);

(b) *"Mr P did not express any discontent regarding light duties at the end of each consultation and he continued to return to me for follow up.* ***During each consultation, he did not report to me or my clinic assistants that his company has asked him to do any work. We were also informed by Company A's project manager, Mr F2, who accompanied Mr P on his follow-up reviews, that Mr P had not been working since the injury."*** (paragraph 14); and

(c) *"Although light duties were given to Mr P, he has not worked since the date of the accident"* (paragraph 15). (emphases added)

93. As Dr Yip's treatment plan had been mobilisation through light duties, Dr Yip should have asked questions about that at each session, and it was not enough for Dr Yip to claim that he did not need to investigate into the information provided. Therefore, if Dr Yip had indeed prescribed light duties for the purpose of mobilisation, his plan had been a dismal failure. That the Patient did not work at all since the accident raised the concern that he had physically been unable to do so.

94. The SMC and Dr Yip urged the Tribunal to draw an adverse inference in respect of each party's respective failure in the proceedings to call the Patient and Mr F2. As discussed above, the Tribunal took the view that the SMC did not need to rely on the Patient's evidence to make out its case and was not persuaded to draw an adverse inference against the SMC. The Tribunal was also not persuaded to draw such an inference against Dr Yip for not calling Mr F2 given Dr Yip's explanation that he had returned to China and had refused to attend in Singapore.

Conclusion

95. The Tribunal found that Dr Yip had not proven on the balance of probabilities that he had discussed the existence and types of light duties with the Patient, and obtained the Patient's agreement, because the discussion had not been mentioned in his Explanation, nor had it been documented in all his case notes, and Mr DW2 did not persuasively corroborate Dr Yip's account. If Dr Yip had discussed and agreed with the Patient on light duties and had monitored the Patient's performance of light duties pursuant to his mobilisation plan, it would have been strange that he did not discover that the Patient had not worked at all until after the fact. If light duties had been Dr Yip's mobilisation plan, that plan had failed from the start without Dr Yip's knowledge.

96. In the circumstances, the Tribunal found that, on each of the three occasions that Dr Yip saw the Patient, Dr Yip breached the applicable standards of conduct because he had failed to establish that there were adequate conditions for rest and rehabilitation if light duties were to be given from the first post-operative day. He had also failed to take proactive steps to make inquiry from the Patient and did not even know until subsequently that the Patient had not worked since the accident.

97. Dr Yip accepted that he had been required to ascertain whether and what kinds of light duties had been available before prescribing light duties. Dr Yip conceded that if there had been no agreement on light duties, or if they had not been available, he would have given medical leave at each session until the next follow-up session, which would have amounted to 19 days.

98. Therefore, the Tribunal took the view that Dr Yip's departure from the applicable standards of conduct by failing to establish that there had been adequate conditions for rest and rehabilitation was intentional and deliberate.

Conclusion on the Charges

99. The Charges against Dr Yip stated that he "*did fail to ensure that adequate sick leave was given*", and that "*sick leave should have been given to the Patient upon his discharge*" and at each visit, and "*it was inappropriate of [Dr Yip] to certify the Patient as being fit for light duties*". For the above reasons, the Tribunal took the view that the Charges had been made out against Dr Yip.

(d) Whether there had been serious negligence on Dr Yip's part, and whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner

100. Having found Dr Yip guilty of professional misconduct under the first limb of *Low Cze Hong*, the Tribunal only highlights that it would have found Dr Yip guilty under the second limb as well.

101. In *Wong Him Choon*, the Court explained the elements to be proven in respect of the second limb, as follows (at [86]):

> *"…in relation to the second limb of Low Cze Hong, it has to be shown that (a) there was serious negligence on the part of the doctor; and that (b) such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner."*

102. In respect of (b), the Court found that Dr Wong had shown an indifference to the patient's welfare. The Court noted that the Disciplinary Tribunal had found serious negligence on Dr Wong's part as he "*did not follow the very basic principle of obtaining a detailed history from the Patient, especially in relation to the nature of his work, before issuing a medical certificate for light duty*", and the basics of medical care had been wanting (*Wong Him Choon* at [87]).

103. In the present case, the Tribunal took the view that the evidence showing that Dr Yip had not taken steps to establish the existence and types of light duties available, or to obtain the Patient's agreement, showed that Dr Yip had been seriously negligent on all three occasions. Indeed, the clearest indication had been Dr Yip's ignorance that the Patient had not worked at all since his accident.

104. In the circumstances, the Tribunal took that view that on the Alternative Charges, Dr Yip's conduct in giving the Patient zero days of sick leave and certifying him as fit for light duties from the first post-operative day, and on the two subsequent follow-up sessions constituted serious negligence that had objectively constituted an abuse of the privileges of being registered as a medical practitioner.

SENTENCE

105. We next turn to discuss the parties' submissions on sentence, and the reasons for our decision on sentence.

Dr Yip's mitigation plea

106. Dr Yip argued that a fine would be appropriate without a period of suspension.

107. He argued that general and specific deterrence were not key sentencing objectives here, given that the medical profession was already aware of expected standards of conduct from the joint circular by the MOM and the MOH on 19 June 2013, and that he had a low propensity of reoffending.

108. Dr Yip argued that the aggravating factors present in Dr Wong's case were absent here. Dr Wong was found to have wilfully disregarded his patient's interest when he scheduled one post-operative review after three days, followed by one month of light duty. On the other hand, Dr Yip had scheduled the Patient for three follow-up reviews at short intervals. Dr Yip argued that he had been genuinely concerned about the Patient's welfare if he became unwell in the dormitory, unlike Dr Wong who had assumed his patient would have

abused sick leave. Dr Yip further argued that he had treated the Patient according to his injuries unlike Dr Wong who had been suspicious of his patient's motives with his expiring work permit. Dr Yip's Patient's further complaints were for unrelated problems, unlike Dr Wong's patient who subsequently had related complaints. Dr Yip argued that he had not been dishonest, unlike Dr Wong who had backdated his patient's medical certificate.

109. In mitigation, Dr Yip stated that he had acted in the Patient's best interests, and there had been no evidence of actual harm. Dr Yip urged the Tribunal to consider the lack of relevant guidelines on light duties at the material time, such as the subsequently promulgated 2013 MOM and MOH guidelines, and the 2016 edition of the ECEG.

110. Dr Yip pointed out that fines had been given in more severe cases of misconduct. For example, in *Low Cze Hong*, Dr Low was convicted for recommending glaucoma drainage surgery despite knowing that it was not appropriate and for failing to obtain informed consent, and was fined $7,000 without a suspension.

111. Dr Yip had no antecedents and he submitted multiple testimonials from his past patients. Dr Yip also highlighted his charitable contributions in Hong Kong, in 2012; in Myanmar, in 2016; and to needy students in a Primary School.

SMC's submissions on sentencing

112. The SMC sought a six-month suspension per charge, with a total suspension of 18 months.

113. The SMC argued that general deterrence remained a relevant sentencing objective given that Dr Yip had argued that local doctors would have supported his conduct, such as those in the anonymous email that he had tendered in evidence who did not accept the principles set out in *Wong Him Choon*. Specific deterrence similarly remained relevant, given that Dr Yip believed that his conduct had been justified on medical grounds and in the Patient's best interests.

114. The SMC argued that the aggravating factors present in *Wong Him Choon* were present here as well. Dr Yip had wilfully disregarded the Patient's interests when he excluded the Patient's rib fractures from his report for the Patient's employers, failed to consider available light duties and the 11-hour workdays the Patient would have been returning to, and did not correct his post-operative management despite knowing that the Patient was not doing light duties. Dr Yip had placed the employer's interests above the Patient's when he let the employer decide on the Patient's rest. Dr Yip's defences of allowing unrestricted movement immediately and giving no sick leave were not supported by medical literature or by the experts. Dr Yip's clinical notes were poorly documented and did not indicate that he had taken a proper medical history. Dr Yip raised red-herring defences which showed his lack of remorse, such as by equating early mobilisation with light duties, and if no discussion of light duties had taken place, by fabricating that discussion. Dr Yip also slanted the survey responses in his favour.

Whether there had been inordinate delay

115. It was disputed whether there had been an inordinate delay in instituting and prosecuting proceedings in the present case that merited a sentencing discount.

116. In *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("***Ang Peng Tiam***"), the Court held that fairness to the offender is the underlying rationale that delay in institution or prosecution of proceedings may have mitigating value. The Court held that the delay must be inordinate when assessed, not as an absolute period of time, but in the context of the nature of investigations (at [112], [113]). The delay must also not have been occasioned by the offender (at [114]). The offender bears the burden to prove that he has suffered particular prejudice by reason of the delay. In the context of disciplinary proceedings for professional misconduct, prejudice might be exacerbated if, for instance, the doctor had to run his practice under the cloud of a tarnished name and an impending but delayed prosecution (at [116]). On the other hand, where the offence is particularly heinous, the offender is recalcitrant or has numerous antecedents, the underlying rationale of fairness to the offender which justifies

a sentencing discount may be outweighed by the public interest in imposition of a heavier penalty (at [118]).

117. In *Ang Peng Tiam*, four and a half years elapsed between the SMC's receipt of the Complaint and its issuance of the Notice of Inquiry ("**NOI**"). The Tribunal delivered its verdict more than five and a half years after the Complaint had been lodged. The Court found that the SMC had inordinately delayed proceedings, even if it accepted that the medical issues had been complex and that obtaining experts had been difficult (at [121], [122]). At the same time, the Court did not find that Dr Ang suffered prejudice beyond the anxiety and distress of impending proceedings, such as through lost business opportunities (at [125], [126]). Taking into account the aggravating factors, the Court substituted the fine of $25,000 with a suspension term, and would have imposed suspension for 16 months in respect of two charges. Balancing the prejudice caused to Dr Ang through anxiety against the interests of protecting public confidence and the reputation of the profession, the Court halved that term to eight months (at [128]).

118. In *Jen Shek Wei v Singapore Medical Council* [2017] SGHC 294 ("***Jen Shek Wei***"), the SMC only issued the NOI nearly three years after issuing its Notice of Complaint. It took about six years for the complaint to reach the Court (at [169]). The Court observed that the SMC's delay in issuing the NOI was similar to the three-year delay in *Ang Peng Tiam* between Dr Ang being notified that there would be a formal inquiry and the NOI (at [169]). In *Jen Shek Wei*, the Court stated that it would have imposed an aggregate suspension term of 16 months for two charges. In the light of the delay, the Court halved that term to eight months and did not disturb the Tribunal's remaining fine and other orders (at [173]).

119. In the present case, the Complaint was lodged on 24 October 2011, and Dr Yip was notified of the same on 22 May 2012. Dr Yip issued his Explanation on 29 June 2012 to the Complaints Committee. On 3 November 2015, that is, almost three-and-a-half years after the Explanation, the SMC issued the NOI.

120. The SMC sought to distinguish the present case from *Ang Peng Tiam* and *Jen Shek Wei* by arguing that the material delay in those two cases arose between notifying the doctors that the formal inquiry would proceed and the issuing of the NOI. On the other hand, the SMC argued that the present delay was due to investigations before notification of a formal inquiry, which would have occasioned less anxiety and prejudice. However, the Tribunal was not minded to draw that distinction given that almost three-and-a-half years had elapsed in the present case between the Notice of Complaint and the NOI.

121. Accordingly, the Tribunal took the view that there had been a delay in the present case similar to that in *Ang Peng Tiam* and *Jen Shek Wei*. In *Ang Peng Tiam*, the Court accepted it as a matter of "natural inference" that Dr Ang suffered great anxiety and distress by having the matter hanging over his head. Similarly, the Tribunal accepted Dr Yip's arguments that he had suffered great anxiety and distress in the present matter. The Tribunal also noted that in 2015, the Complainant had published a "Facebook" post naming Dr Yip's Clinic and stating that he was happy to hear that formal inquiries would commence relating to "*shabby treatment of construction workers and colluding with employers*" and that he hoped that the doctors would be "*brought to justice*".

Our decision on sentence

122. The Tribunal was mindful of the observation of the Court in *Wong Him Choon* that sentences relating to professional misconduct concerning doctors would be recalibrated upwards, and that *Wong Him Choon* represented such an instance where the Court made that recalibration (at [117]). Given that the case also concerned similar facts, the Tribunal felt that drawing guidance from *Wong Him Choon* would be most relevant as opposed to making comparisons with other cases where less analogous conduct may have resulted in more serious or less serious sanctions.

123. In *Wong Him Choon*, the Court held that the reason for a doctor's intentional departure from the requisite standard, while not directly relevant to conviction, is relevant to sentencing (at [99]). In that case, when asked why the normal and accepted practice of giving "at least a week" of medical leave was not followed,

Dr Wong disagreed that it was standard practice, and explained that this was the practice of "Government restructured hospital[s]" which could not have two to three days' follow-up appointments. However, when asked why he did not issue medical leave up to the first follow-up appointment, he said that he had wanted his patient to try what he could do at work, and did not want to give him the impression that his condition had been serious. The Court held that this demonstrated Dr Wong's wilful disregard for the patient's need for proper rest and rehabilitation (at [101]). The Court noted that Dr Wong exhibited an indifference to his patient's welfare when he was content with giving him light duties and letting the employer decide the extent to which he should rest (at [105]). The Court also noted that Dr Wong caused harm to his patient because he had complained of pain at subsequent visits (at [109]).

124. The SMC also referred the Tribunal to the case against *Dr Sanjay Srinivasan* (17 to 21 October 2016; 17 February 2017) ("***Dr Sanjay Srinivasan***") that had an element of inappropriate certification. In that case, Dr Sanjay faced two charges for inadequate clinical evaluation when he failed to conduct further examinations in connection with his patient's cataract, and for incompetent and inappropriate care when he assessed the patient fit to continue work as a bus driver (at [42], [43]). Instead of ensuring that his patient had the requisite quality of eye sight, he gave his patient sick leave of one day and asked him to make spectacles. The Disciplinary Tribunal took the view that *Wong Him Choon* concerned a post-operative situation that was clearly more aggravating than Dr Sanjay's case (at [101]). The Disciplinary Tribunal considered that Dr Sanjay's professional misconduct should be sentenced as a whole, and ordered a three-month suspension (at [93], [104]).

125. The present case concerned facts that were more aggravated than those in *Dr Sanjay Srinivasan* while containing similar aggravating factors present in *Wong Him Choon*. We took the view that Dr Yip had disregarded the Patient's welfare and interest when he did not consider the Patient's injuries as significant enough for sick leave. Given the extent and severity of the Patient's injuries, and that the Patient had undergone clavicle surgery and had been ordered conservative treatment for his ribs, the Tribunal took the view that Dr Yip's disregard for the Patient's welfare and interest constituted the most aggravating

factor in this case. The Tribunal also took the view that Dr Yip had disregarded the Patient's welfare and interest when he equated early mobilisation with the Patient's light duties as a construction worker. While Dr Yip's concerns that the worker dormitories had not been conducive for mobilisation and that the Patient would not have had supervision if he had been unwell in the dormitories appeared to have stemmed from some concern for the Patient's welfare, those concerns do not explain Dr Yip's willingness to let the Patient's employer decide on the Patient's rest. If, as Dr Yip argued, light duties had been assigned as the Patient's mobilisation plan, it was troubling that Dr Yip did not discover that the Patient had not worked since his accident. While it was unclear whether the Patient had suffered actual harm from Dr Yip's conduct, the Tribunal was cognisant of the principle that, where physiological harm was not an element of the offence, the absence of harm to a patient would generally be a neutral consideration without mitigating value (*Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66, at [12]).

126. For the reasons set out in these grounds of decision, we consider that a fine would not be suitable, and a term of suspension would be appropriate to maintain the highest professional standards expected of doctors, and to maintain public trust in the medical profession and the reputation of the profession.

127. We noted that the three Charges that Dr Yip faced were of similar nature and arose from three examinations that had taken place over a short period. In the circumstances, the Tribunal took the view that it was appropriate to sanction the professional misconduct of Dr Yip as a whole, instead of separately for each Charge.

128. Bearing in mind the aggravating factors discussed above, the Tribunal considered that an aggregate term of suspension of ten (10) months was appropriate.

129. Having considered the inordinate delay in instituting and prosecuting these proceedings, the need to impose a sanction which was not only sufficiently deterrent but also proportionate in all the circumstances of this case and the

interests of protecting public confidence and the reputation of the profession, we consider that the aggregate sentence of suspension in this case ought to be reduced by half to a period of five (5) months.

130. In the circumstances, the Tribunal ordered that Dr Yip:

(a) be suspended for a term of **five (5) months**;
(b) be censured;
(c) give a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and
(d) pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Whether certification for two counsel allowed

131. Following sentence, the SMC applied for a certification that costs of two counsel be paid, pursuant to section 53(7) of the MRA. Section 53(7) provides that the Tribunal "*in ordering that costs be paid by the registered medical practitioner under this section may certify that costs for more than one solicitor be paid if it is satisfied that the issues involved in the proceedings are of sufficient complexity, and the certification by the Disciplinary Tribunal shall have the same effect as if it were a certification by a Judge in a civil action in the High Court*".

132. As section 53(7) followed the wording of the previous version of Order 59 Rule 19 of the Rules of Court (Cap 322, R 5, 2006 Rev Ed) ("**2006 ROC**") before the 2014 amendments, the SMC submitted that cases decided on the 2006 ROC would be of guidance. The Singapore High Court in *New Civilbuild Pte Ltd v Guobena Sendirian Berhad and Another* [2000] SGHC 47 held that the test "must be whether it was reasonable of the defendants in this case to appoint two instead of one counsel". In that case, the High Court opined that "*a court should award a certificate for two (2) counsel as an exception to the general rule that only one counsel should be awarded costs. Such exceptional circumstances would include cases which involve a high degree of complexity of facts and or law or, where there are many issues of both fact and law and, trial is lengthy*" (at [6]).

133. On that basis, the SMC submitted that there were numerous issues in the fields of medicine and statistics, Dr Yip had called five factual witnesses and three expert witnesses in both fields, Dr Yip had adduced nine additional medical reports without calling their authors, Dr Yip had introduced medical literature and survey documents at a late stage, and Dr Yip had applied to call a statistics expert at the last minute.

134. On the other hand, Dr Yip pointed out that the issues of fact and law were limited in scope. The legal principles regarding the adequacy of medical leave had been set out in *Wong Him Choon* and were not in dispute. The present case was contrasted with having fewer charges and documents than *Singapore Medical Council v Lim Mey Lee Susan* [2015] SGHC 129, where the Court found Dr Lim's case to be complex for involving 94 charges, and 12,531 pages of documents. In *Shorvon Simon v Singapore Medical Council* [2006] 1 SLR(R) 182, which involved inappropriate handling of a research project by the respondent doctor, the Court opined that prosecution required "a thorough understanding of scientific and medical practices, methodologies, ethics as well as a mastery of the copious relevant documents" (at [35]). That case was also novel as the first disciplinary case in Singapore regarding the practices of a research scientist. That the SMC did not consider the surveys to be complex was clear from the fact that they did not see fit to call their own expert, and were able to analyse the reports and cross-examine Dr Yip's experts without introducing any new evidence.

135. Having considered the above submissions, the Tribunal agreed with Dr Yip's submissions and was of the view that the present proceedings had not been of sufficient complexity to warrant a certification for costs of two counsel.

PUBLICATION OF DECISION

136. We order that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of persons involved.

137. The hearing is hereby concluded.

Dated this 28th day of March 2018.

Annex A

1. *The Respondent is Dr Yip Man Hing Kevin ("**Dr Yip**"), a fully registered medical practitioner under the Medical Registration Act (Cap 174). At all material times, Dr Yip was practising as a Specialist Orthopaedic Surgeon at Singapore Sports and Orthopaedic Clinic Pte Ltd located at 6 Napier Road, #02-12 Gleneagles Medical Centre, Singapore 258499 ("**Dr Yip's Clinic**").*

2. *The Complainant is one Mr C (NRIC No. [Redacted]).*

3. *The patient was one Mr P (FIN No. [Redacted]) (the "**Patient**"), a Chinese national working in Singapore on a work permit as at July 2011.*

4. *At the material time, the Patient was 47 years of age and was employed as a construction worker by Company A located at [Address redacted].*

Injury sustained and treatment on 7 July 2011

5. *On 7 July 2011, whilst working at a work site in [address redacted], the Patient fell from a scaffolding platform at his work site.*

6. *The Patient was sent to Hospital D for treatment.*

7. *Upon arrival at Hospital D, the Patient was seen at Dr Yip's Clinic. After being registered, he was examined by Dr Yip, who noted that the Patient had suffered the following injuries:*

   (a) laceration on the scalp on the back of his head;

   (b) multiple abrasions over his lower back;

   (c) reduced range of movement to his right upper limbs due to pain over his right shoulder and his right clavicle bone; and

   (d) abrasions to his right elbow,

after which X-Ray investigations of the Patient's right clavicle and shoulder, right wrist, chest (posterioranterior and oblique views) and lumbar spine (anteroposterior and lateral views) were ordered.

8. *The findings from these X-Rays dated 7 July 2011, among others, were:*

   (a) *displaced fracture of the right clavicle;*

   (b) *fractures involving posterior part of the right 7th, 8th and 9th ribs; and*

   (c) *lucency demonstrated in the pisiform bone of the right wrist.*

9. *Following his review of the Patient, Dr Yip advised the Patient that an open reduction internal fixation ("**ORIF**") procedure was necessary for treatment of the Patient's fracture of the right clavicle. An ORIF procedure is a surgical procedure to fix a bone fracture.*

10. *The following medication was also prescribed to the Patient:*

    (a) *40 tablets (20 days') of Panadine (a painkiller), 500 mg to be taken twice daily;*

    (b) *10 tablets (5 days') of Augmentin (an antibiotic), 625 mg to be taken twice daily; and*

    (c) *20 tablets (20 days') of Diclo-Denk / Voren (a painkiller) to be taken once daily.*

11. *At or about 1637 hours on 7 July 2011, the Patient was admitted to Hospital D in preparation for the ORIF procedure to be conducted on the same day.*

12. *The ORIF procedure was carried out by Dr Yip at about 2255 hours on 7 July 2011 and was completed past midnight at about 0010 hours the next day (8 July 2011). The Patient also received suturing on the laceration on the back of his head.*

Review and discharge on 8 July 2011

13. *On 8 July 2011 at or about 1010 hours, the Patient was discharged from Hospital D.*

14. *Upon the Patient's discharge, Dr Yip issued 2 documents to the Patient:*

*(a) one medical certificate ("**MC**") certifying the Patient unfit for work for 2 days from 7 July 2011 to 8 July 2011; and*

(b) one certificate for light duty certifying the Patient fit for light duty only for 3 days from 9 July 2011 to 11 July 2011.

15. No sick leave was given by Dr Yip for the period from 9 July 2011 to 11 July 2011. The Patient was given a follow-up review appointment with Dr Yip on 11 July 2011.

Follow-up review on 11 July 2011

16. On 11 July 2011, the Patient attended at Dr Yip's clinic for his first post-operative follow-up review with Dr Yip.

17. Dr Yip documented that the Patient had a pain score of 2.5 and a wound score of 2.5 on a scale of 5 (1 being the best). At this review, X-Ray investigations on the Patient's chest and right clavicle were carried out. The reported findings included:

(a) alignment of the plate-screw fixation of the right clavicle was almost anatomical;

(b) a fracture was seen in the right sixth rib posteriorly; and

(c) there was no pneumothorax and the lungs appeared clear. A right pleural opacity blunting the lateral costophrenic angle which may be a right pleural effusion or pleural thickening was noted, subject to clinical correlation.

18. The Patient also had the sutures on the laceration on the back of his head removed.

19. At this review, Dr Yip issued one certificate of light duty certifying the Patient fit for light duty for 7 days from 12 July 2011 to 18 July 2011.

20. No sick leave was given to the Patient.

21. The Patient's next follow-up review was scheduled on 18 July 2011.

Follow-up review on 18 July 2011

22. On 18 July 2011, the Patient attended at Dr Yip's clinic for his second post-operative follow-up review.

23. Dr Yip documented that the Patient had a pain score of 2, wound score of 2 and range of movement score of 2 on a scale of 1 to 5 (1 being the best). No X-Ray scans or other investigations were ordered at this review.

24. At this review, Dr Yip issued one certificate of light duty certifying the Patient fit for light duty for 7 days from 19 July 2011 to 25 July 2011.

25. No sick leave was given to the Patient.

26. The Patient's next follow-up review with Dr Yip was scheduled for 25 July 2011. However, the Patient did not attend the scheduled review.

Reviews at Hospital A ("Hospital A")

27. The Patient presented himself at the Hospital A Emergency Department on 22 July 2011 with complaints of persistent giddiness and nausea, as well as right pleuritic chest pain. The attending doctor admitted the Patient to the Hospital A Emergency Diagnostic and Therapeutic Centre upon his review of the Patient and the investigation findings.

28. The Patient was discharged the following day on 23 July 2011. Upon the Patient's discharge, the Patient was given an MC granting hospitalisation leave for a period of 7 days from 22 July 2011 to 28 July 2011.

*29. The Patient was also referred to the Institution B ("**Institution B**") and the Hospital A Orthopaedic Surgery Department for follow-up.*

30. On 5 August 2011, the Patient attended at the Institution B for the scheduled review and was granted an MC granting outpatient sick leave for a period of 8 days from 5 August 2011 to 12 August 2011.

31. *From 12 August 2011 to 7 January 2012, the Patient continued to receive treatment at the Hospital A Orthopaedic Surgery Department. The relevant doctors issued the following MCs:*

    (a) *at a review on 12 August 2011, the Patient was granted hospitalisation leave for a period of 42 days (i.e. 6 weeks) from 12 August 2011 to 22 September 2011; and*

    (b) *following a review on 21 September 2011, the Patient was granted hospitalisation leave for a period of 42 days (i.e. 6 weeks) from 22 September 2011 to 2 November 2011.*

    Whether or not any further sick leave was issued by Hospital A is disputed.

32. *The Hospital A Orthopaedic Surgery Department referred the Patient for treatment at the Hospital A Physiotherapy Department.*

33. *The Patient did not receive any certificate for light duties from Hospital A.*

Annex B

1st CHARGE

1. *That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 8 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) *At the material time, the Patient was a construction worker.*

(b) *On 7 July 2011, the Patient presented himself at the Clinic with laceration on the back of his head, a fractured right clavicle, fractured right ribs and abrasions to the lower back sustained in a workplace incident.*

(c) *A chest x-ray conducted on the Patient on 7 July 2011 revealed, inter alia, the following findings:*

i) *Displaced fracture of the right clavicle;*

ii) *Possibility of fracture on the right wrist; and*

iii) *Fractures involving the posterior part of the right 7th, 8th and 9th ribs.*

(d) *On 7 July 2011, you performed an open reduction and internal fixation of the Patient's right clavicle under general anaesthesia (the "Surgery") and carried out a suturing on the laceration on the Patient's head at Hospital D (the "Hospital").*

(e) *On 8 July 2011, upon his discharge from the Hospital, you gave the Patient sick leave for 7 and 8 July 2011, and no sick leave for the period after the Patient's discharge.*

(f) *On 8 July 2011, you also gave the Patient light duties starting from the next day, 9 July 2011 to 11 July 2011.*

(g) Given the nature of the Patient's occupation, his condition on 8 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient upon his discharge, and it was inappropriate of you to certify the Patient as being fit for light duties from 9 July 2011 to 11 July 2011.

In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

ALTERNATIVE 1st CHARGE

*That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 8 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) At the material time, the Patient was a construction worker.

(b) On 7 July 2011, the Patient presented himself at the Clinic with laceration on the back of his head, a fractured right clavicle, fractured right ribs and abrasions to the lower back sustained in a workplace incident.

(c) A chest x-ray conducted on the Patient on 7 July 2011 revealed, inter alia, the following findings:

i) Displaced fracture of the right clavicle;

ii) Possibility of fracture on the right wrist; and

iii) Fractures involving the posterior part of the right 7th, 8th and 9th ribs.

(d) *On 7 July 2011, you performed an open reduction and internal fixation of the Patient's right clavicle under general anaesthesia (the "Surgery") and carried out a suturing on the laceration on the Patient's head at Hospital D (the "Hospital").*

(e) *On 8 July 2011, upon his discharge from the Hospital, you gave the Patient sick leave for 7 and 8 July 2011, and no sick leave for the period after the Patient's discharge.*

(f) *On 8 July 2011, you also gave the Patient light duties starting from the next day, 9 July 2011 to 11 July 2011.*

(g) *Given the nature of the Patient's occupation, his condition on 8 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient upon his discharge, and it was inappropriate of you to certify the Patient as being fit for light duties from 9 July 2011 to 11 July 2011.*

In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

2nd CHARGE

2. *That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 11 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) *At the material time, the Patient was a construction worker.*

(b) At the first follow-up review with you on 11 July 2011 after the Surgery, a chest x-ray conducted on the Patient revealed, inter alia, that the Patient had a fracture in the right sixth rib posterior.

(c) On 11 July 2011, you gave the Patient light duties from 12 July 2011 to 18 July 2011. No sick leave was given to the Patient.

(d) Given the nature of the Patient's occupation, his condition on 11 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient during this visit, and it was inappropriate of you to certify the Patient as being fit for light duties from 12 July 2011 to 18 July 2011.

In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

ALTERNATIVE 2nd CHARGE

*That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 11 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) At the material time, the Patient was a construction worker.

(b) At the first follow-up review with you on 11 July 2011 after the Surgery, a chest x-ray conducted on the Patient revealed, inter alia, that the Patient had a fracture in the right sixth rib posterior.

(c) On 11 July 2011, you gave the Patient light duties from 12 July 2011 to 18 July 2011. No sick leave was given to the Patient.

(d) Given the nature of the Patient's occupation, his condition on 11 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient during this visit, and it was inappropriate of you to certify the Patient as being fit for light duties from 12 July 2011 to 18 July 2011.

In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

3rd CHARGE

*3. That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 18 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) At the material time, the Patient was a construction worker.

(b) At the second follow-up review with you on 18 July 2011 after the Surgery, the Patient was given light duties from 19 July 2011 to 25 July 2011.

(c) On 22 July 2011, the Patient attended at Hospital A ("Hospital A"). The Patient's condition warranted an immediate admission to Hospital A and hospitalisation leave from 22 July 2011 to 28 July 2011 was given to the Patient.

(d) Given the nature of the Patient's occupation, his condition on 18 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient, and it was inappropriate of you to certify the Patient fit for light duties from 19 July 2011 to 25 July 2011.

In relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct

demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

ALTERNATIVE 3rd CHARGE

*That you **DR KEVIN YIP MAN HING,** a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Singapore Sports and Orthopaedic Clinic (the "Clinic") on 18 July 2011, did fail to ensure that adequate sick leave was given to your patient, one P (the "Patient"), in light of his condition and the nature of his occupation.*

Particulars

(a) At the material time, the Patient was a construction worker.

(b) At the second follow-up review with you on 18 July 2011 after the Surgery, the Patient was given light duties from 19 July 2011 to 25 July 2011.

(c) On 22 July 2011, the Patient attended at Hospital A ("Hospital A"). The Patient's condition warranted an immediate admission to Hospital A and hospitalisation leave from 22 July 2011 to 28 July 2011 was given to the Patient.

(d) Given the nature of the Patient's occupation, his condition on 18 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient, and it was inappropriate of you to certify the Patient fit for light duties from 19 July 2011 to 25 July 2011.

In relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.