SINGAPORE DENTAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY FOR DR WANG KIT MAN
ON 3 SEPTEMBER 2019, 17 SEPTEMBER 2019,
10 OCTOBER 2019 & 19 NOVEMBER 2019

Disciplinary Committee:
Dr Kaan Sheung Kin (Chairman)
Dr Seah Tian Ee
Dr Lee Chi Hong Bruce
Dr Rachael Pereira (Layperson)

Legal Assessor:
Mr Edmund Kronenburg (Braddell Brothers LLP)

Counsel for the SDC:
Mr Burton Chen
Ms Junie Loh
Mr Jeremy Sia
(M/s Tan Rajah & Cheah)

Counsel for the Respondent:
Mr S Selvaraj
Mr Edward Leong
(M/s MyintSoe & Selvaraj)

DECISION OF THE DISCIPLINARY COMMITTEE

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

Introduction & Brief Procedural History

1. This Decision should be read in conjunction with the Decision of the Disciplinary Committee In Relation To The Respondent's Plea of Guilt dated 10 October 2019 **("Plea of Guilt Decision")**. The Plea of Guilt Decision summarises the procedural history leading up to it. The present Decision also uses the abbreviations defined in the Plea of Guilt Decision, unless otherwise stated.

2. As stated in the Plea of Guilt Decision :-

(a) the Respondent – Dr Wang Kit Man – is a registered dentist practising at a clinic known as "Q&M Dental Surgery (Simei MRT)" located at 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888 **("Clinic")**;

(b) these proceedings arose out of a Complaint made on 9 January 2017 **("Complaint")** by one Mr P **("Complainant")** in respect of the Respondent's care and management of one Ms T **("Patient")**, who was the wife of the Complainant;

(c) the SDC appointed a Complaints Committee to investigate the Complaint. On 31 August 2017, the Complaints Committee informed the Respondent of its recommendation that the matter be reviewed by a Disciplinary Committee;

(d) the SDC initially brought five charges against the Respondent in respect of his care and management of the Patient. After discussions and correspondence with Respondent's Counsel, the SDC decided to proceed only in relation to the two of the original five charges i.e. the 1st and 3rd Charges, with the 5th Charge being taken into account for purposes of sentencing;

(e) thereafter, the SDC sought to amend, and was granted leave by the

Disciplinary Committee to amend, the 1st, 3rd and 5th Charge (in the form of the Amended 1st Charge, Amended 3rd Charge and Amended 5th Charge, respectively);

(f) the Respondent then sought to plead guilty to the Amended 1st Charge and Amended 3rd Charge; and

(g) the Disciplinary Committee was – for reasons stated in the Plea of Guilt Decision – unable to accept the Respondent's plea of guilt on the Amended 1st Charge.

3. Following the Plea of Guilt Decision, the SDC withdrew the Amended 1st Charge. The only remaining charge against the Respondent is therefore the Amended 3rd Charge, in respect of which the Disciplinary Committee accepted the Respondent's plea of guilt. For ease of reference, the Amended 3rd Charge and Amended 5th Charge (relevant only for purposes of sentencing) are set out below :-

Amended 3rd Charge

*3. That you, **Dr Wang Kit Man,** are charged that on 27 May 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01- 09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient.*

Particulars

(a) You did not maintain sufficient documentation of the history and condition of the Patient's tooth #15, that is, the severity of the mobility of tooth #15 and the nature, duration and severity of the pain at tooth #15.

(b) *You did not maintain sufficient documentation of what investigations you conducted in respect of the Patient's tooth #15.*

(c) *You did not maintain sufficient documentation of your advice to the Patient on alternative treatment options (i.e. details of treatment options other than the extraction of tooth #15 followed by implant surgery) and their risks and benefits.*

(d) *You did not maintain sufficient documentation of your advice to the Patient as to the risks and benefits of an immediate implant fixture placement over that of a delayed implant fixture placement.*

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and ***your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a dentist,*** *accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.*

Amended 5th Charge

5. *That you,* ***Dr Wang Kit Man,*** *are charged that on 11 June 2016 and 22 June 2016, whilst practicing at Q&M Dental Surgery (Simei MRT), 30 Simei Street 3, Simei MRT Station #01-09, Singapore 529888, you failed to keep sufficient records of your care and management of the Patient's post-operative condition.*

Particulars

(a) *On 11 June 2016, you did not record sufficient detail of the nature and severity of the Patient's pain.*

(b) *On 22 June 2016, you did not sufficiently record how the decision to remove the implant fixture was arrived at.*

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECG and ***your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a dentist,***

accordingly you are guilty of professional misconduct within the meaning of Section 40(1)(d) of the Dental Registration Act, which is punishable under Section 40(2) of the said Act.

Agreed Facts

4. The following facts are agreed between the SDC and the Respondent:-

(a) On 27 May 2016, the Patient visited the Clinic for treatment of her pain at an upper pre-molar on the right side. The Respondent attended to the Patient.

(b) The Respondent arrived at a diagnosis of irreversible pulpitis of the Patient's tooth #15 without conducting a comprehensive clinical evaluation of the tooth, in that :-

(i) he failed to take the Patient's history on the nature and duration of the pain experienced by the Patient on exposure of tooth #15 to hot and cold stimuli;

(ii) he failed to conduct hot and cold testing to determine and/or confirm the nature and duration of the pain complained of by the Patient;

(iii) though the Respondent did a radiographic examination of the Patient’s tooth #15, the dental panoramic radiographs did not show significant loss of crestal or apical bone of tooth #15; and

(iv) though the Respondent in his clinical examination noted that tooth #15 was "tender to percussion", this symptom did not justify his diagnosis of "irreversible pulpitis".

(c) The Respondent conducted the procedure of the extraction of tooth #15 and an immediate implant fixture placement for the Patient.

(d) As regards the Respondent's keeping of clinical records of his care and management of the Patient on 27 May 2016, the Respondent failed to keep sufficient records, in that:

(i) he did not maintain sufficient documentation of the history and condition of the Patient's tooth #15, that is, the severity of the mobility of tooth #15 and the nature, duration and severity of the pain at tooth #15;

(ii) he did not maintain sufficient documentation of what investigations he conducted in respect of the Patient's tooth #15;

(iii) he did not maintain sufficient documentation of his advice to the Patient on alternative treatment options (i.e. details of treatment options other than the extraction of tooth #15 followed by implant surgery) and their risks and benefits; and

(iv) he did not maintain sufficient documentation of his advice to the Patient as to the risks and benefits of an immediate implant fixture placement over that of a delayed implant fixture placement.

(e) By reason of the matters set out at (d) above, the Respondent failed to keep sufficient records of his care and management of the Patient in respect of the taking of history and condition of tooth #15, investigations conducted and advice given on alternative treatment options as well as the risks and benefits of the treatment that was carried out, in breach of guideline 4.1.2 of the ECG. This amounted to a serious negligence on the part of the Respondent that objectively portrayed an abuse of the privileges which accompany registration as a dentist.

The Disciplinary Committee's Decision on the Amended 3rd Charge

5. As stated in the [32] to [36] of the Plea of Guilt Decision, the Disciplinary Committee found that based on the Agreed Facts, as well as the evidence placed before it in relation to the Amended 3rd Charge, the Respondent's record keeping fell very far below the standards required by Clause 4.1.2 of the ECG. The Disciplinary Committee also agreed with what the Respondent himself admitted in the Agreed Facts as regards his own conduct and also noted *inter alia* that :-

(a) the Respondent's handwritten records were in many places, wholly

illegible;

(b) the consent-taking process in relation to the Patient was shoddily documented;

(c) on 12 February 2016, upon the Patient's first consultation with the Respondent, the only recorded observation by the Respondent was "tenderness" on tooth #15, after which he then performed adjustments of an "occlusal high spot" on tooth #15; and

(d) on 27 May 2016, when the Patient returned and complained of pain in the upper right quadrant and tooth #15 was "tender to percussion" and "mobile", the Respondent failed adequately to record the severity of this pain and mobility, or other clinical findings regarding tooth #15 sufficient to support his "guarded prognosis".

6. By reason of the matters stated above, and the totality of the evidence before the Disciplinary Committee, the Disciplinary Committee found in the Plea of Guilt Decision that the Respondent's records came nowhere close to being "sufficiently detailed" so that any other dentist reading them would be able to rely on them to take over the management of the Patient's case from the Respondent. The Respondent's conduct fell far short of the mark; it placed the Patient unjustifiably at risk. The Respondent's record keeping was so poor that the Disciplinary Committee concluded that he was either simply indifferent to the Patient's welfare or indifferent to his own professional duties.

7. The Disciplinary Committee accordingly found that the Respondent's aforesaid conduct amounted to *"such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a dental practitioner"*. It therefore accepted the Respondent's plea in relation to the Amended 3rd Charge, and **now finds him guilty in relation to the same**.

Sentencing

8. In relation to sentencing, the SDC and the Respondent have tendered the following documents, which the Disciplinary Committee has duly read and considered :-

Tendered by the SDC

(a) Prosecution's Submissions on Sentencing dated 16 September 2019 **("PSS")**;

(b) Prosecution's Submissions on Respondent's Argument of Inordinate Delay dated 17 September 2019 **("PSD")**;

(c) Prosecution's Supplementary Submissions on Sentencing dated 12 November 2019 **("PSUP")**;

Tendered by the Respondent

(d) Submissions for Mitigation for Dr Wang Kit Man dated 17 September 2019 **("RSM")**; and

(e) Supplementary Submissions for Mitigation for Dr Wang Kit Man dated 12 November 2019 **("RSUP").**

9. Counsel for the SDC and the Respondent also made oral submissions to the Disciplinary Committee at the hearing on 19 November 2019.

10. In summary :

(a) SDC Counsel submits that the appropriate sentence in relation to the Amended 3rd Charge (taking the Amended 5th Charge into account) is as follows :-

(i) the Respondent be fined the sum of S$10,000;

(ii) the Respondent be censured;

(iii) the Respondent is to give a written undertaking to the SDC not to repeat the offences the Respondent has been convicted of; and

(iv) the Respondent is to pay the costs and expenses of and

incidental to this Disciplinary Committee inquiry, including the costs of legal counsel to the SDC and the Legal Assessor

– see PSUP [13].

(b) Respondent's counsel submitted that he should be punished with a "reasonable find with censure and undertaking" – see RSUP [13]. At the hearing on 19 November 2019, Respondent's Counsel clarified that the Respondent's position was that he should be fined not more than S$5,000.

11. As to the appropriate approach to be taken in respect of sentencing, both the SDC and the Respondent were in general agreement at the 19 November 2019 hearing (despite what the SDC had submitted earlier in PSS and PSUP) that the sentencing framework set out in *Wong Meng Hang v Singapore Medical Council* [2018] SGHC 253 ***("Wong Meng Hang")*** ought not to be applied by the Disciplinary Committee in respect of the Amended Third Charge (a charge of failing to keep sufficient records of a patient's care and management), following the approach in *Singapore Medical Council v Dr Tan Kok Jin* [2019] SMCDT 3 ***("Tan Kok Jin")*** at [37] and *Singapore Medical Council v Dr Mohd Syamsul Alam bin Ismail* [2019] SGHC 58 ***("Syamsul")***. We agree.

12. That said, SDC Counsel submitted that the sentence that it had submitted as being appropriate (which included a S$10,000 fine) would be appropriate regardless of whether one were to apply the sentencing framework in *Wong*

Meng Hang or use some other method to determine the appropriate sentence.

13. Both SDC Counsel and Respondent's Counsel urged us to consider past precedents to determine the appropriate sentence. SDC Counsel placed great emphasis on the SDC Case of Dr Sng Wee Hock dated 9 May 2019 ***("Sng")*** which in turn, relied heavily on the Singapore Medical Council **("SMC")** case of Dr Lim Chong Hee dated 4 May 2012 ***("Lim")***. In *Sng,* the SDC imposed *inter alia* an S$8,000 fine on the dental practitioner for his failure to keep clear and adequate dental records of his patient. In *Lim,* the SMC imposed *inter alia* a S$5,000 fine on the medical practitioner for failing to record, in his clinical records, his discussion with his patient in relation to (a) a possible lobectomy and (b) the patient's consent to the lobectomy. Respondent's counsel also urged us to be guided by *Lim* in terms of the appropriate fine to be imposed – see RSUP [10] and [11].

14. Further, SDC Counsel placed reliance on [36] of *Sng*, where the SDC Disciplinary Committee stated (emphasis added) :-

> *"36 The DC agree with the view expressed in [Lim] that the **normal tariff for failure to keep proper records should be about S$10,000.** In the present case however, as some records were kept by the Respondent, the DC was prepared to consider a slight penalty in his favour."*

The SDC's submission was essentially that we should apply the same "tariff" in *Lim* and *Sng.*

15. We are unable to agree with the SDC's proposed approach for various reasons. First, *Sng* appears to have applied the "tariff" in *Lim* without taking into account that in *Lim*, the *maximum fine* was S$10,000 (far lower than the current maximum fine of S$100,000). Second, *Lim* was decided before the 're-calibration' of precedents prompted *inter alia* by *Singapore Medical Council v Wong Him Choon* [2016] SGHC 145 9 ***("Wong Him Choon")***. As such, the worth of *Lim* as a useful precedent is tenuous.

16. In any event, we decline to follow precedent *blindly*. As stated by the Court of Three Judges in *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 (at [45]), although a measure of consistency with sentencing precedents is a consideration, *"fidelity to precedent ought not to lead to ossification of the law"*.

17. For these reasons, we reject the submission that there is a "normal tariff" for failure to keep proper records. If *arguendo*, there is a "normal tariff", we also disagree that the said tariff *today* is S$10,000, especially against the backdrop of a maximum fine of S$100,000 for SMC cases (or S$50,000 for SDC cases).

18. In our view, the better approach (which we adopt) is as follows :-

    (a) The starting point in relation to a failure to maintain sufficient documentation and/or clinical records is as stated in *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66, where the Court of Three Judges held that a failure to keep adequate records **ought not to be seen as a minor or technical breach.** As stated in *Syamsul*

at [12], *"[p]roperly kept medical records form the basis of good management of the patient and of sound communications pertaining* to the care of the patient, and help ensure that the care of patients can be safely taken over by another doctor should the need arise." We agree. In our view, the consequence of a failure to keep adequate records should therefore ordinarily be a substantial fine, or where the case is egregious, a suspension e.g. the 3-month suspension ordered by the Court of Three Judge in Syamsul.

(b) Next, (i) whether a fine or suspension should be ordered, and (ii) the appropriate amount of fine or length of suspension, should be determined by reference to the *severity* of the practitioner's deviation from the standards expected of him i.e. the extent to which his conduct fell below the standard of sufficient documentation as required by Clause 4.1.2 of the ECG, reproduced below, for convenience (emphasis added) :-

> *4.1.2. Dental Records*
>
> *Proper documentation is a hallmark of quality dentistry and a standard of care that patients have come to expect from the profession.* ***All treatment records maintained by dentists shall therefore be clear, accurate, legible and contemporary. All records shall be of sufficient detail so that any other dentist 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 drug or procedures should be documented …***

Much therefore depends on the facts; a more serious deviation from

the above standards will sound in a more serious punishment, a *vice-versa*.

19. With this approach in mind, we now turn to the facts of this case. Having regard to the paucity and often illegible nature of the Respondent's clinical notes (see e.g. ABD pages 4 and 9), and the Respondent's own admission that he failed to maintain sufficient documentation in respect of the Patient's condition, treatment and care (see [4] above), it would *ordinarily* have been appropriate for us to consider a punishment at the high-end of the range of fines, or even a suspension. However, on the facts of this case, we note the following :-

    (a) As the SDC has rightly concerned, no significant harm resulted from the Respondent's poor record-keeping. Indeed, we are of the view (as stated at Plea of Guilt Decision [36]) that based on the evidence before us, the intractable pain that the Patient experienced following the implant placement and its subsequent failure was atypical and was not contributed-to by the Respondent's substandard record-keeping.

    (b) As Respondent's Counsel submitted, and as SDC Counsel rightly conceded, at the hearing on 19 November 2019, the substandard documentation of the Respondent was in no way comparable with the deeply substandard record keeping in *Syamsul*. *Syamsul* was a much more serious case, by far. For that reason also, we declined to regard *Syamsul* as setting a precedent or "tariff" such that a failure to keep proper or sufficient documentation would attract a suspension of three

months (which is what the Court of Three Judges ordered on the specific facts of that case).

(c) Indeed, the facts of this case were quite different from *Syamsul*, where e.g. there was every likelihood that another doctor (i.e. a different doctor from Dr Syamsul) would see the patient on his next visit and would have to rely on the notes previously written by Dr Syamsul. On the facts of this case, although the Respondent was part of a group practice, he was the dental practitioner treating the Patient, and he expected that he would be the dental practitioner seeing her on every visit to the clinic. To that extent, his documentation – although shoddy – may well have served as a sufficient *aide-memoire* to *him*, of the patient's condition and treatment. While this would be insufficient to meet the requirements of Clause 4.1.2 of the ECG, we are prepared to give the Respondent the benefit of the doubt *vis-à-vis* his ability to read and understand his own notes, thereby triggering his personal recollection of the Patient's case, including matters that he did not sufficiently document.

(d) Perhaps most importantly, despite his substandard documentation, the Respondent correctly referred the Patient to an oral surgeon – Dr Yong Loong Tee – and appears to have briefed him sufficiently on the facts and circumstances of the Patient's case, such that Dr Yong was able to take over her treatment and care. This strongly mitigated the prejudice to the Patient resulting from the Respondent's substandard documentation. Putting it another way, although the Respondent's

notes were insufficient to meet the standards required of Clause 4.1.2 ECG, he avoided the potential harm from the substandard conduct by his referral of the Patient to, and briefing of, Dr Yong.

20. The combination of all of the above factors disposes us to ordering a fine (as opposed to a suspension) on the facts of this specific case, and in particular, a fine *significantly lower* than the maximum of S$50,000, but still of sufficient gravity to emphasise that the Respondent's breach of Clause 4.1.2 of the ECG is by no means minor, or merely technical.

21. We also note the following mitigating factors advanced by the Respondent :-

(a) the Respondent's unblemished record of about 15 years' practice;

(b) the co-operation of the Respondent with the SDC, thereby saving time and costs; and

(c) the Respondent's plea of guilt in relation to the Amended Third Charge and his remorse in relation thereto.

22. As such, for the reasons we have set forth above, the Disciplinary Committee now orders as follows :-

(a) the Respondent be fined the sum of S$10,000;

(b) the Respondent be censured in writing;

(c) the Respondent shall give a written undertaking to the SDC not to repeat the offences he has been convicted of; and

(d) the Respondent shall pay the costs and expenses of, and incidental to, this Disciplinary Committee inquiry, including the costs of legal counsel to the SDC and the Legal Assessor.

23. The Disciplinary Committee further orders, pursuant to Regulation 25 of the Dental Registration Regulations that this Decision and the Plea of Guilt Decision be published for the benefit of the public.

24. This hearing is hereby concluded.

Dated this 19th day of November, 2019.

Dr Kaan Sheung Kin
(Chairman)

Dr Seah Tian Ee

Dr Lee Chi Hong Bruce

Dr Rachael Pereira
(Layperson)