SINGAPORE DENTAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR LIM HOCK MENG ARTHUR

6 February 2023

Disciplinary Committee:

Dr Charles Benjamin Long (Chairman)
Ms Sree Gaithiri d/o Kunnasegaran
Dr Asha Karunakaran
A/Prof Audrey Chia Wai Yin
Ms See Tow Soo Ling (Legal Assessor)

Counsel for the SDC:
Ms Lee I-Lin
Ms Grace Lim Rui Si
M/s Drew & Napier LLC

Counsel for the Respondent:
Ms Mar Seow Hwei
Ms Lydia Yeow Ye Xi
M/s Dentons Rodyk & Davidson LLP

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent in this Inquiry is **Dr Lim Hock Meng Arthur** ("Respondent") and the charge brought against him by the Singapore Dental Council ("SDC") was as follows: -

. **Dr Lim Hock Meng Arthur (Respondent)**

"That you, Dr Lim Hock Meng Arthur, a registered dentist under the Dental Registration Act (Cap. 76) are charged that you, on 7 April 2015, whilst practising at West Coast Dental Clinic Pte Ltd located at 154 West Coast Road, #02-14/15 West Coast Plaza, Singapore 127371 (the "**Clinic**"), failed to supervise one XXX ("**XXX**"), who was registered as an Oral Health Therapist under Part II of the Register of Oral Health Therapists and employed by the Clinic: to wit:

PARTICULARS

(a) From early 2012, to on or around 9 September 2016 (the "**Period**"), XXX practised in the Clinic as an Oral Health Therapist under Part II of the Register of Oral Health Therapists;

(b) Pursuant to Section 21A(4) of the Dental Registration Act (Cap. 76), it was a condition of XXX's registration that she may only practise dentistry under the supervision of a fully registered Division I dentist;

(c) During the Period, you were the fully registered Division I dentist appointed to supervise XXX;

(d) By the Singapore Dental Council's circular dated 29 January 2015, amongst others, you were reminded that dentists registered under conditional Registration and OHTs under Part II of the OHT register are required to work under supervision of a fully registered dentist, and the supervisor must work in the same clinic as his/her supervisee.

(e) On the morning of 7 April 2015, you were not present at the Clinic and you failed to supervise XXX when she examined one Ms RC (the "**Patient**") and carried out the following procedures:

i. administered local anaesthesia to the Patient;
ii. extracted a maxillary left second primary molar from the Patient; and
iii. took a radiograph of the Patient after failing to remove the tooth completely, with a broken root remaining in the Patient's jaw; and

(f) The procedures referred to at paragraph (e) above were also not performed under the supervision of another fully registered Division I dentist;

and that, in relation to the facts alleged, you have breached Regulation 16 of the Dental Registration Regulations and your aforesaid conduct amounts to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a dentist, and that you are thereby guilty of professional misconduct under section 40(1)(d) of the Dental Registration Act (Cap. 76, 2009 Rev Ed).

2. The Respondent pleaded guilty as charged. The primary facts relating to the charges are collated in the Agreed Statement of Facts ("ASOF") duly agreed by Counsel for SDC and the Respondent.

3. The Respondent faced a single charge of professional misconduct under Section 40(1)(d) of the Dental Regulations Act (Cap 76). According to the Council's pronouncements as stated in Circular SDC 11:4 Vol 4 dated 4 August 2014 and Circular SDC 8:4 Vol 5 dated 29 January 2015, a supervisor of an Oral Health Therapist must ensure that the Oral Heath Therapist is supervised at work at all times. In addition, Regulation 16 of the Dental Registration Regulations states that "every registered person shall observe the Council's pronouncements on professional matters and professional ethics issued from time to time" (see paragraph 10 of the ASOF).

4. According to paragraph 9 of the ASOF, on 7 April 2015, XXX attended to the Patient, who had made an appointment to be treated at the Clinic, without the Respondent checking or seeing the Patient first and in the absence of supervision of the Respondent or another fully registered Division 1 dentist. XXX examined the Patient and carried out the following procedures:

   (a) Administered local anesthesia to the Patient;
   (b) Extracted a maxillary left second primary molar from the Patient; and
   (c) Took a radiograph of the Patient after failing to remove the tooth completely with a broken root remaining in the Patient's jaw.

5. XXX sought help from another dentist but who was not a fully registered Division 1 Dentist. Unfortunately, this dentist was not able to remove the broken root.

6. According to paragraph 8 of the ASOF, the Respondent did not see the Patient in the morning of 7 April 2016. He had left the Clinic to learn how to use a new CADCAM machine at a dental laboratory. The Respondent felt that he could step out of the Clinic because the procedure of removing a primary tooth was considered routine for an Oral Health Therapist and XXX had done numerous similar procedures without problems. The Respondent only attended to the Patient in the afternoon of 7 April 2016. The Respondent assessed the root of the Patient's maxillary left second primary molar was ankylosed and surgically removed the root with some bone with a piezo surgery unit.

7. The Disciplinary Committee accepts the evidence presented at this Inquiry by Counsel for the SDC and the Respondent.

8. The Respondent breached his duties as XXX's supervisor by allowing XXX to work independently and without supervision in the morning on 7 April 2016 while the Respondent was away from the Clinic.

9. The Respondent's conduct amounts to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a dentist and the Respondent is thereby guilty of professional misconduct under Section 40(1)(d) of the Dental Registration Act (Cap 76).

10. The Disciplinary Committee notes that the Respondent has pleaded guilty to the charge.

11. The Respondent was aware that the Patient had made an appointment to have an extraction of her maxillary primary molar in the morning of 7 April 2016. The Respondent should not have left the Clinic to attend the briefing of the CADCAM machine or for any period of time, knowing that there was no other fully registered Division 1 Dentist at the Clinic during the appointment.

12. The SDC pronouncements are clear as to the roles and responsibilities of supervisors towards Oral Health Therapists and conditionally registered dentists. The Respondent was expected to be within physical proximity of XXX to ensure that the work done by XXX was done appropriately and to the standard required of dental practitioners in Singapore.

13. Sanctions in medical disciplinary proceedings serve two functions (Singapore Medical Council v Kwan Kah Yee [2015] 5 SLR 201:

    (a) First, to ensure that the offender does not repeat the offence and ultimately to ensure that the public is protected from the potentially severe outcomes arising from the actions of errant doctors and

    (b) second, to uphold the standing of the medical profession.

14. The Disciplinary Committee notes that this incident was a one-off incident and there has not been any other similar incidents since. It is fortunate that there was no

actual bodily harm to the Patient but the Disciplinary Committee also has to consider the potential harm that could have resulted from dangerous acts of misconduct and that public confidence in the medical profession has to be maintained.

15. The Disciplinary Committee notes that the Respondent was first informed of the Complaint against him in August 2015 and was issued a warning by the Complaints Committee in 2016. In 2018, the Complainant appealed against the decision of the Complaints Committee to the Ministry of Health. That appeal was allowed in 2020. The Ministry of Health had directed SDC to appoint a Disciplinary Committee to investigate the complaint. The Respondent was served with the Notice of Inquiry (NOI) on 17 March 2022. It has been six and a half years from the time the Respondent was informed of the Complaint against him, to being served the NOI. In determining the sentence, the Disciplinary Committee was of the view that a fine of $20,000 was appropriate as punishment for the misconduct. However, the Disciplinary Committee has considered that the delay in prosecuting the case against the Respondent would have caused some anguish to the Respondent and the Disciplinary Committee is therefore minded to reduce the sentence.

16. Having considered all the facts and circumstances including the length of time that it had taken for this matter to be heard, the respective submissions of the parties, and the sentencing precedents cited, the Disciplinary Committee ordered that:

(1) the Respondent:

a. pay a penalty of $10,000;

b. be censured;

c. submit a written undertaking to the Singapore Dental Council that he will not engage in the conduct complained of and any similar conduct; and

d. pay 50% of the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SDC. This will include the costs incurred by the SDC for engaging the Legal Assessor.

(2) The Disciplinary Committee also orders that the Grounds of Decision be published with the name of the Oral Health Therapist to be redacted. It is important for the Grounds of Decision to be published in order to maintain public confidence in the profession and its self-regulation.

Dated this 17th day of March 2023

Dr Charles Benjamin Long

Chairperson, Disciplinary Committee

Dr Asha Karunakaran

Member, Disciplinary Committee

Ms Sree Gaithiri d/o Kunnasegaran

Member, Disciplinary Committee

A/Prof Audrey Chia Wai Yin

Member, Disciplinary Committee