SINGAPORE DENTAL COUNCIL
DISCIPLINARY COMMITTEE INQUIRY AGAINST DR OLIVER HENNEDIGE
ON 14, 16 OCTOBER 2020, 5, 24, 25, 26 NOVEMBER 2020, 1 DECEMBER 2020, 4, 22 FEBRUARY 2021

22 February 2021

Disciplinary Committee:
Dr Kwa Chong Teck (Chairman)
Dr Chang Kok Meng
Dr Ong Kheng Kok
Mr Chua Thian Huat (Observer)

Legal Assessor:
Mr Thio Shen Yi, S.C
(TSMP Law Corporation)

Counsel for the SDC:
Ms Chang Man Phing
Mr Bryce Yeo
(WongPartnership LLP)

Counsel for the Respondent:
Ms Mak Wei Munn
Ms Christine Tee
Ms Simaa Ravichandran
(Allen & Gledhill LLP)

DECISION OF THE DISCIPLINARY COMMITTEE ON SENTENCE

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

INTRODUCTION

1. The Respondent, Dr Oliver Hennedige, is a fully registered dentist under the Dental Registration Act (Cap. 76) ("**DRA**") and has, at all material times, been practising at Oliver Dental Surgery Pte Ltd located at 242 Tanjong Katong Rd, Singapore 437030 ("**Clinic**"), and Oliver Dental Surgery Pte Ltd, located at 1 Orchard Boulevard, Camden Centre, #12-08/09, Singapore 248649 ("**Camden Clinic**").

2. These proceedings arose out of a complaint made on 12 March 2016 by one P ("**Patient**") against the Respondent in relation to a dental procedure performed by the Respondent on the Patient.

3. Pursuant to the said complaint, the Council preferred two charges against the Respondent, as set out in the Notice of Inquiry dated 3 October 2019.

FIRST CHARGE

4. The first charge against the Respondent is as follows:-

"that you, **Dr Oliver Hennedige**, a registered dental practitioner under the Dental Registration Act (Cap. 76), are charged that whilst practicing as a dentist at Oliver Dental Surgery P L and Oliver Dental Surgery Pte Ltd ("**Clinic**") between 2 November 2014 and 5 May 2015, you recommended to and carried out on your patient, one **P** (the "**Patient**"), the treatment with placement of 15 mini-implants to support a 14-unit bridge in the Patient's lower jaw (the "**Treatment**"), which you knew or ought to have known was not an appropriate treatment, in light of the Patient's limited bone width.

PARTICULARS

(a) On 2 November 2014, the Patient attended a consultation with you to seek advice on the suitability of implants for her lower jaw (the "**First Consultation**").

(b) At the First Consultation, you assessed that the Patient's remaining teeth were in poor condition, had caries, and were loose.

(c) On 16 March 2015, the Patient attended a second consultation with you (the "**Second Consultation**"). You assessed that the Patient's remaining four (4) teeth on her lower jaw were mobile and infected, that the remaining bone was very thin and may need augmentation, and that the posterior lower bone was

very narrow and might require bone build-up with Bio-Oss material even for mini-implants.

(d) You were therefore aware that the Patient had limited bone width in her lower jaw. Despite this, you recommended the extraction of all existing teeth in the Patient's lower jaw and the placement of 12 mini-implants or more to support a 14-unit bridge in the Patient's lower jaw.

(e) On 19 March 2015, you extracted the Patient's four (4) remaining teeth on her lower jaw and carried out a surgical procedure where you placed 15 mini-implants to support a 14-unit bridge in the Patient's lower law ("**Procedure**").

(f) Prior to this Procedure, you only carried out two (2) 2-D X-Rays on 2 November 2014 and on 19 March 2015.

(g) During the Procedure, you inserted Bio-Oss material into the bony sockets left by the extracted teeth. After the Procedure, you placed a temporary bridge over the 15 mini-implants.

(h) In light of the Patient's limited bone width, the appropriate practice is:-

i. to carry out a pre-operative 3D X-Ray and/or Cone Bean Computed Tomography (**"CBCT**") for an assessment of bone width and location of nerves prior to the Procedure. This was not done;

ii. to carry out a bone graft to increase alveolar width before inserting the implants. This was not done. The placement of Bio-Oss material in the sockets created by the extracted teeth would not increase the alveolar width of the Patient's jaw;

iii. to raise a flap for bone visibility when performing the implant procedure. This was not done; and

iv. to use conventional regular-sized implants instead of mini-implants

(i) On 5 May 2015, you cemented a 14-unit bridge over the 15 mini-implants in the Patient's lower jaw.

(j) An X-Ray taken on 5 May 2015 revealed substantial bone loss compared to the X-Ray that had been taken on 19 March 2015.

(k) A CBCT taken in or around April 2018 showed that of the fifteen (15) mini-implants inserted, six (6) implants in the #37, #36, #33, #32, #31 and #41 positions were not placed within the confines of the mandibular bone ("**Exposed Implants**"). The Exposed Implants were also placed less than 3mm apart and angled towards each other. The CBCT also showed that implants #37 and #36 perforated the lingual cortex and could have been highly dangerous for the Patient.

and your aforesaid conduct amounts to an intentional or deliberate departure from the standards observed or approved by members of the profession of good repute or competency, and that in relation to the facts alleged you have been guilty of professional misconduct under section 40(1)(d) of the Dental Registration Act (Cap. 76, 2009 Rev Ed)."

AMENDED SECOND CHARGE

5. The Amended Second Charge against the Respondent is as follows:-

"that you, **Dr Oliver Hennedige**, a registered dental practitioner under the Dental Registration Act (Cap. 76), are charged that whilst practicing as a dentist at the Clinic on 5 May 2015, you failed to exercise due care in the design and execution of the treatment of your patient, one **P** (the "**Patient**"), with placement of 15 mini-implants to support a 14-unit bridge in the Patient's lower jaw (the "**Treatment**") to ensure that the treatment was carried out in an appropriate manner."

PARTICULARS

(a) On 19 March 2015, you extracted the Patient's four (4) remaining teeth on her lower jaw and carried out a surgical procedure where you placed 15 mini-implants to support a 14-unit bridge in the Patient's lower jaw ("**Procedure**").

(b) After the Procedure, you placed a temporary bridge over the 15 mini-implants.

(c) Between 19 March 2015 and 5 May 2015, the Patient saw you on several occasions during which she complained to you that she had pain, swelling and slight bleeding in her gums, and that she sometimes experienced bleeding. You prescribed painkillers and told her to wash with ice cold water if she experienced further bleeding.

(d) On 5 May 2015, you permanently cemented a 14-unit bridge over the 15 mini-implants in the Patient's lower jaw (the "**Permanent Bridge**").

(e) The Patient continued to encounter the same problems after the Permanent Bridge was cemented on 5 May 2015. The Patient did not return for dental treatment by the Respondent after the Permanent Bridge was cemented on 5 May 2015.

(f) The design and execution of the Permanent Bridge was not carried out in an appropriate manner including the following deficiencies:-

i. There was a remnant cement intruding on the gingival tissues. The remnant cement would have prevented the Patient from adequately cleaning the gingiva around the Permanent Bridge;

ii. The Permanent Bridge could not easily be cleaned by the Patient;

iii. The implant threads were noted, in March 2017, to be exposed above the gingiva.

(g) On 26 May 2015, the Patient came to see you and complained that she could not clean the Permanent Bridge. You did not take any steps to adequately rectify these deficiencies in the design and execution of the Permanent Bridge.

(h) X-rays taken in or around October 2015 and a CBCT taken in or around April 2018 showed that there had been substantial bone loss. This could be a result of gingival inflammation likely caused by the irritation from the remnant cement and the compromised hygiene maintenance due to the deficiencies in the design and execution of the Treatment.

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a dental practitioner, and that in relation to the facts alleged you have been guilty of professional misconduct under section 40(1)(d) of the Dental Registration Act (Cap. 76, 2009 Rev Ed)."

PROCEDURAL SUMMARY

6. At the commencement of the evidentiary hearing before this Disciplinary Committee, the Respondent chose to plead not guilty.

7. Subsequently, the SDC and the Respondent called the following factual and expert witnesses:-

   (a) By the SDC: PE, P and PW.

   (b) By the Respondent: DE and himself.

8. At the close of the SDC's case, the Respondent chose to call evidence in his defence. Following the testimony of the Respondent, and part of the testimony of DE, his expert witness(s), but prior to the completion of the hearing, parties informed the Disciplinary Committee that the Respondent would be pleading guilty to the charges. Accordingly, after discussion and consensus between SDC and the Respondent's Counsel, the agreed statement of facts was amended and re-issued on 24 December 2020, together with the amended Second Charge.

9. On 8 January 2021, the Prosecution's submissions on sentencing, as well as, the Respondent's plea in mitigation and sentencing submissions were tendered.

10. On 4 February 2021, the Disciplinary Committee heard oral submissions from counsel for the SDC and the Respondent on the issue of sentencing and mitigation.

THE UNDISPUTED AND/OR ADMITTED FACTS

11. On 21 November 2013, the Patient sent an email to the Respondent, asking whether mini dental implants would be suitable for her or whether she had to do conventional implants, and whether a bone graft would need to be done and, on 22 November 2013, sent an email attaching a copy of her full mouth X-Ray to the Respondent.

12. On 24 November 2013, the Respondent replied to the Patient, stating, *inter alia*, that the height of bone appeared sufficient, and that he needed to see her to evaluate the width and determine the quality of her bone. He informed the Patient that she could visit the clinic for a free consultation.

13. On 2 November 2014, the Patient visited the clinic for her first consultation with the Respondent. At this time, the Patient had 6 remaining teeth – 2 on the upper jaw and 4 on the lower jaw (one of which was a tooth stump). The Respondent assessed that the Patient's remaining teeth were in poor condition, had caries and were loose.

14. An orthopantomogram ("**OPG**") 2-D X-Ray was taken during the consultation. The Respondent observed that the Patient's lower jaw bone was thin. At this consultation, the Respondent recommended the placement of 12 mini dental implants in the Patient's lower jaw, with 14 porcelain crowns placed over the mini dental implants ("**Treatment**").

15. The Patient informed the Respondent that she wanted the crowns to look real. The Respondent responded that he understood what she wanted and that they would look like real teeth.

16. The Respondent also informed the Patient that her bone was thin, hence he might add bone material during the procedure. There was no discussion on a bone graft.

17. The Respondent gave the Patient a sheet of paper with cost estimates for "*12 minis*" and "*14 crowns joint*" for the lower jaw. The total estimated cost was $26,800.

18. On 16 March 2015, the Patient saw the Respondent at the Camden Clinic.

19. The Patient informed the Respondent that she wished to proceed with mini dental implants for her lower jaw. An appointment for the mini dental implant placement procedure was fixed for 3 days later on 19 March 2015.

Mini dental implant procedure

20. On 19 March 2015, the Patient visited the Clinic. An OPG 2-D X-Ray was taken. No 3-D X-Ray or Cone Beam Computed Tomography ("**CBCT**") was carried out. The Patient signed a consent form for photo-taking as well as a mini dental implant surgical consent form.

21. The Respondent discussed with the Patient the need for extraction of all her remaining teeth in her lower jaw. The Patient agreed. She was then placed under local anaesthesia and the Respondent performed the mini dental implant placement procedure.

22. During the mini dental implant placement procedure:

    (a) The Respondent extracted the Patient's 4 remaining teeth in her lower jaw;

    (b) The Respondent placed 15 mini dental implants in the Patient's lower jaw. All mini dental implants were of 2.5mm diameter, 8 mini dental implants were of 13mm length, 2 mini dental implants were of 15mm length and 5 mini dental implants were of 18mm length;

    (c) No flap was raised for the placement of the mini dental implants;

(d) The Respondent then placed Bio-Oss material into the bony sockets to fill up the void created by the extractions. No surgical bone build-up or bone graft to increase alveolar width was carried out;

(e) An impression of the Patient's lower jaw was taken; and

(f) The Respondent placed a temporary bridge over the 15 mini dental implants using temporary cement.

23. After the mini dental implant placement procedure, another OPG 2-D X-Ray was taken. The Respondent informed the Patient that he had placed 15 mini dental implants, that he had placed bone building material (Bio-Oss) into the extracted sockets of her lower jaw, and that he had placed a temporary bridge over the mini dental implants.

24. The following medication was prescribed to the Patient:-

(a) Erythromycin (20 tablets), an antibiotic;

(b) Arcoxia (5 tablets), for pain relief; and

(c) Diclofenac (15 tablets), for pain relief.

25. An appointment was fixed for 3 days later on 22 March 2015.

Post mini dental placement procedure and temporary bridge

26. On 24 March 2015, 5 days after the mini dental implant placement procedure, the Patient saw the Respondent at the Clinic.

27. The following medication was prescribed to the Patient to address the Patient's complaints:-

(a) Diclofenac (15 tablets), for pain relief; and

(b) Danzen (10 tablets), for anti-inflammation.

A further appointment was scheduled for 31 March 2015.

28. Between 31 March 2015 and 4 May 2015, the Patient visited the clinic for 6 more consultations with the Respondent on 31 March 2015, 7 April 2015, 9 April 2015, 11 April 2015, 14 April 2015 and 21 April 2015.

29. At the consultation on 31 March 2015, the following medication was prescribed to the Patient:-

(a) Diclofenac, for pain relief; and

(b) Danzen, for anti-inflammation.

30. At the consultation on 7 April 2015, the Respondent documented in his clinic records that the Patient had very slight bleeding. The Respondent told her *inter alia* to wash her mouth with cold water if she experienced further bleeding.

31. The Patient attended a consultation on 9 April 2015.

32. At the consultation on 21 April 2015, the Respondent showed the Patient a metal framework for the Permanent Bridge, and it was understood by the Patient that she would be receiving a Permanent Bridge.

33. A further appointment was scheduled for 28 April 2015. The Patient did not attend this appointment.

Permanent Bridge

34. At the consultation on 5 May 2015, the Patient agreed to proceed with the cementation of the permanent bridge. After the permanent bridge was cemented, the Patient was given a mirror to look at the cemented permanent bridge in situ.

35. The Respondent then proceeded to cement a permanent bridge in the Patient's lower jaw using a resin cement.

36. An OPG 2-D X-Ray was taken.

37. The Permanent Bridge comprised a metal base over which was built porcelain in the shape of teeth.

38. A further appointment was scheduled for 12 May 2015. The Patient did not attend this appointment.

39. On 26 May 2015, the Patient attended at the Clinic. During this visit, the Respondent informed the Patient several times that her mini dental implants were healthy and that there was no problem.

40. The Respondent offered to remove the Patient's mini dental implants and give her a full refund, if she was not satisfied.

41. In June and July 2015, there was various correspondence between the Patient and the Respondent.

42. At the Patient's request, the Respondent also provided the Patient with a dental report dated 16 June 2015.

Final visit to the Clinic

43. On 9 September 2015, the Patient attended at the Clinic. The Respondent agreed to the following:-

    (a) To refund the full amount provided all the mini dental implants were taken out;

    (b) To have the mini dental implants taken out in stages on request by the Patient; and

    (c) To agree should the Patient wish to have the mini dental implants taken out by another dentist.

44. The Patient told the Respondent that she would consider her options.

Visits to other dentists

45. The Patient had consulted other dentists, including:-

    (a) PW at Institution A on *inter alia* 21 May 2015 and 14 October 2015;

    (b) Dr A and Dr B at Institution B between 4 June 2015 and 12 August 2015;

    (c) Dr C at Institution C, in or around June or July 2015;

    (d) Dr D at Clinic D, *inter alia*, between 19 June 2015 and 28 August 2015; and

    (e) Dr E at Clinic E on, *inter alia,* 3 September 2015.

Patient's bone loss

46. The following radiological investigations revealed bone loss compared to the X-Ray taken on 19 March 2015 prior to the insertion of the implants:

    (a) X-Ray taken on 5 March 2015;

    (b) X-Rays taken on 14 October 2015;

    (c) CBCT taken on 17 April 2018; and

    (d) X-Rays taken on 10 March 2020.

47. The bone loss increased over time and ranged from one-third to one-half crestal bone loss in October 2015, and ranged from 35% to 65% crestal bone loss in 2020.

48. Deficiencies in the design and execution of the Treatment compromised the maintenance of dental hygiene. This difficulty in maintaining oral hygiene resulted in gingival inflammation and bone loss.

49. A CBCT taken in April 2018 showed that:

    (a) Six (6) implants in the #37, #36, #33, #32, #31 and #41 positions were not placed entirely within the confines of the mandibular bone.

    (b) The implant at the #37 position had perforated in the lingual cortex and the implant at the #36 position was at the margin of the lingual cortex.

    (c) The implants at positions #43 and #42, #42 and #41, #32 and #33, #33 and #34 were each less than 3 mm apart.

The First Charge

50. At the material time in March 2015, the Respondent was aware that the Patient had limited bone width in her lower jaw.

51. In light of the Patient's limited bone width, the appropriate practice at the material time in March 2015 was:

    (a) To carry out a pre-operative 3D X-Ray and/or a CBCT scan for an assessment of the Patient's bone width and the location of the nerves; and

    (b) To use conventional regular-sized implants instead of mini-implants, and in doing so:

        i. To carry out a bone graft and increase the alveolar width before inserting the implants; and

        ii. To raise a flap for bone visibility when performing the implant procedure.

52. At the material time in March 2015, the Respondent was aware that the treatment set out in paragraph 51 above was the appropriate practice for the Patient's treatment in light of the Patient's limited bone width.

53. At the material time in March 2015, the Respondent knew that the Treatment which he had recommended and carried out on the Patient was not an appropriate treatment in light of the Patient's limited bone width.

54. The Respondent admits that his conduct amounted to an intentional or deliberate departure from standards observed or approved by members of the profession of good repute or competency and that he is thereby guilty of professional misconduct under section 40(1) of the Dental Registration Act (Cap.76).

The Second Charge

55. Between 19 March and 5 May 2015, the Patient saw the Respondent on several occasions during which she complained to the Respondent that she had pain, swelling and slight bleeding.

56. The Respondent cemented the permanent bridge on 5 May 2015 and scheduled a follow-up appointment on 12 May 2015.

57. The Patient continued to encounter the same problems after the permanent bridge was cemented on 5 May 2015. The Patient did not return for dental treatment by the Respondent after the permanent bridge was cemented on 5 May 2015.

58. On 26 May 2015, the Patient attended at the Clinic. The Respondent did not take any steps to rectify the following deficiencies in the design and the execution of the permanent bridge.

    (a) First, the intaglio surface was concave and rough. There was remnant cement on the permanent bridge.

    (b) Second, the above deficiencies presented a maintenance problem for the Patient.

59. The peri-implantitis that resulted from the inadequate hygiene resulted in the many implants with exposed threads noted in March 2017.

60. The Respondent had therefore failed to exercise due care in the design and execution of the Treatment and failed to ensure that the Treatment was carried out in an appropriate manner.

61. The Respondent admits that his conduct amounts to such serious negligence that it objectively portrays an abuse of privileges which accompany registration as a dental

practitioner and is thereby guilty of professional misconduct under section 40(1) of the DRA.

DISCIPLINARY COMMITTEE'S DUTY TO CONSIDER A GUILTY PLEA

62. In accepting the Respondent's guilty plea, the Disciplinary Committee is mindful of its duty, as articulated in *Singapore Medical Council v Lim Lian Arn* [2019] SGHC ("***Lim Lian Arn***"), to closely scrutinise the facts and evidence to satisfy themselves that:-

(a) The conviction was well-founded; and

(b) The sentence to be imposed was appropriate on the facts that are before them.

63. The Disciplinary Committee is aware that the duty articulated in paragraph 63 above applies even where medical practitioners have pleaded guilty and elect not to contest proceedings[1], as was the case in *Lim Lian Arn*.

64. Having received the sentencing submissions, the Disciplinary Committee did consider if it was proper to accept the Respondent's guilty plea on the facts of this case, and came to the conclusion that it was. Given that the Respondent has pleaded guilty, the Disciplinary Committee shall confine itself to making several brief observations.

The First Charge

65. Although the use of mini implants is not universally accepted and its practice was not without some controversy, the Disciplinary Committee is of the view that the use of mini dental implants, in and of itself, is not the issue. The Disciplinary Committee notes that the Ministry of Health issued guidelines in August 2012 which opined at section 6.1 that as a good practice point "due to lack of clinical data regarding implants of less than 2.5mm in diameter (micro-implants), these implants are not recommended for

[1] *Lim Lian Arn* at [5] and [6]

routine treatment of edentulism". However, against this, one cannot say with certainty that the use of such implants is as such a departure from acceptable standards when there is evidence of a body of reputable and competent dental practitioners that engage in such practice, without any apparent detriment.

66. However, the key issue is in the practice of using mini dental implants on a patient when there are clear red flags that potentially preclude it. In the current circumstances, the Patient had :-

(a) A narrow mandibular ridge; and

(b) Poor oral hygiene, having only two teeth left that were in poor condition.

(c) Following from the above at (b), if the intended remedy was to use mini implants as part of the rehabilitation, a removable overdenture should have been used instead of a fixed roundhouse prosthesis.

67. The use of a fixed roundhouse prosthesis of the sort cemented in the patient would cause problems post-procedure such as peri-implantitis and bone loss. Therefore, it would have been important to ensure scrupulous safety in carrying out the mini implant procedure. This would include a CBCT or 3D X-Ray scan to obtain a clear three dimensional view of the bone width, and raising a bone flap for visibility, which the Respondent failed to do

68. Given the Patient's condition, and The Respondent's failure to take proper precautions, the recommendation of mini-dental implants was inappropriate and improper in these circumstances. Accordingly, the Disciplinary Committee finds the Respondent's plea of guilt in respect of the First Charge to be appropriate in the circumstances.

The Second Charge

69. The Disciplinary Committee sees no difficulty in accepting the Respondent's guilty plea in respect of the Second Charge. The design of the Permanent Bridge was doomed to fail from the start for various reasons. It was fabricated with a rough and concave intaglio surface which acted as a food trap. The bridge was poorly fitted with excess cement around it. This would foreseeably cause inflammation of the gingiva and subsequent bone loss around the implants. The limited embrasure space between the implants made it difficult for the Patient to maintain an adequate level of dental hygiene, exacerbating any such inflammation and irritation.

PROSECUTION'S SUBMISSIONS ON SENTENCING

70. In reliance on the sentencing matrix set out in *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526 ("***Wong Meng Hang***"), Counsel for the SDC submitted that the First Charge would have an indicative sentencing range of **1 to 2 years' suspension**, given the:

(a) moderate level of harm caused by the offence; and

(b) medium level of culpability of the Respondent.

71. In respect of the Second Charge, it was submitted that the indicative sentencing range would be **3 months' to 1 year's suspension**, given the:-

(a) slight level of physical harm caused; and

(b) medium level of culpability of the Respondent.

72. Taking into account appropriate sentencing precedents, it was submitted that the circumstances of the present case would warrant a suspension of **19 months** in

respect of the First Charge and **6 months** in respect of the Amended Second Charge, with both charges running consecutively for a total of **25 months**.

73. Subsequently, counsel for the SDC argued that the foregoing should be subject to an uplift of **2 months** due to the following offender-specific aggravating factors:-

(a) The Respondent holding himself out as a senior and eminent member of the profession, resulting in his multiple breaches and professional misconduct having an amplified impact on the public confidence of the dental profession both in Singapore and within the region;

(b) The Respondent's lack of remorse and insight into his wrongdoing, as seen from:-

(i) His inability to justify his failure to carry out a CBCT scan for the Patient when he had the machine at *both* his clinics;

(ii) His persistence in recommending and using mini-implants for a full roundhouse fixed bridge, in spite of the MOH Guidelines recommending otherwise, as well as, his own assessment, at the material time, that the Patient had "very thin" bone, even for mini dental implants;

(iii) His attempt at shifting the blame to the Patient by suggesting that the Patient's peri-implantitis and bone loss was a result of her poor oral hygiene;

(iv) His attempt to amend certain portions of the Agreed Statement of Facts despite evidence to the contrary, as well as, his denial of invoices issued by his own clinic on the grounds that they were administrative errors; and

(v) His failure to mention the medication prescribed to the Patient on 31 March 2015, evidencing a lack of care for his patient's welfare.

74. In this regard, Counsel for the SDC noted that little or no mitigatory weight ought to be accorded to the Respondent's plea of guilt as the aforesaid plea was brought at an advanced stage of the proceedings and at a point where the SDC would have no difficulty in proving its case. Accordingly, minimal time and expenses were saved.

75. It was further submitted that a discount of no more than one-third ought to be applied in light of the delay in the prosecution of the present case due to the need for general deterrence of like-minded persons. Accordingly, Counsel for the SDC arrived at a final sentence of **18 months**.

76. In addition, it was contended that a fine of **SGD 10,000** should be imposed as this was a situation where there was evidence of the Respondent experiencing some element of profit or having an intention to profit on the facts of the case.

RESPONDENT'S SUBMISSIONS ON SENTENCING

77. In reliance on the sentencing matrix set out in *Wong Meng Hang*, Counsel for the Respondent submitted that both Charges had an indicative sentencing range of **2 to 3 years**, given the:-

(a) serious/ severe level of harm caused by the offence; and

(b) moderate level of culpability of the Respondent.

78. Taking into account appropriate sentencing precedents, Counsel for the Respondent argued that the appropriate starting point in the Respondent's case would be a suspension of **not more than 2.5 years**.

79. The Respondent's Counsel then argued that the starting point should be adjusted downwards to a duration of **not more than 15 months suspension**, in light of the following mitigating factors:-

80. **First**, counsel for the Respondent argued that the Respondent's plea of guilt, while late, should still hold mitigating value as:-

(a) The Respondent was genuinely remorseful in pleading guilty;

(b) Time and expenses were saved for all parties as the Prosecution did not need to continue with cross-examination of all the Respondent's remaining witnesses; and

(c) It brought finality to the issue of liability as parties did not need to prepare written submissions, which would likely have been extensive.

81. Further, Counsel for the Respondent argued that the Respondent contesting the Charges should not, in itself, be regarded as an aggravating circumstance. This was something he was entitled to do, given the gravity of the Charges.

82. **Second**, the Respondent had no prior convictions for professional misconduct.

83. **Third**, Counsel for the Respondent argued that the Disciplinary Committee should exercise leniency in view of the Respondent's advanced age and ill health. This was especially since there was little risk of the Respondent re-offending.

84. **Fourth**, it was argued that the inordinate delay in the prosecution of the Respondent's case ought to be taken into account, regardless of the complexity of the case, given that the Respondent was not responsible for the delay. The aforesaid delay was submitted to have caused an extended period of anxiety and distress for the Respondent, as well as, caused his health to deteriorate in the time it took for the matter to be brought before the Disciplinary Committee.

85. Accordingly, Counsel for the Respondent arrived at a sentence of suspension for a period of **not more than 15 months, coupled with an order for payment of costs**.

86. It was further submitted that there was **no need to impose a fine** on top of the suspension order. Counsel for the Respondent argued that the foregoing would only occur where there was evidence that the doctor had profited or intended to profit from his misconduct or where the sentence of suspension would have no direct effect or impact on the doctor because he was not on the register or did not practice in Singapore. However, it was submitted that this was not the case here.

DECISION

87. By way of summary, Counsel for the parties have submitted for the following sentences:-

Counsel for the SDC	Counsel for the Respondent
Suspension period of 18 months, coupled with a fine of SGD 10,000, and the usual undertakings and orders on costs and censure.	Suspension period of not more than 15 months, coupled with the usual undertakings and orders on costs and censure.

Starting point for sentencing

88. In determining the appropriate sentence, the Disciplinary Committee is guided by the 4-step sentencing framework articulated in the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* (the "***Sentencing Guidelines***"), which is a useful and logical framework:-

(a) Step 1: Evaluate the seriousness of the offence with reference to harm and culpability;

(b) Step 2: identify the applicable indicative sentencing range using the Court's matrix for cases involving professional misconduct (as set out in *Wong Meng Hang*);

(c) Step 3: Identify the appropriate starting point within the indicative sentencing range. This would involve the consideration of sentencing precedents;

(d) Step 4: Adjust the starting point by taking into account aggravating and mitigating factors.

89. In respect of Step 1 above, the Disciplinary Committee notes that Counsel for the SDC assessed the level of harm and culpability for the First and Second Charge separately. However, we are of the view that it would be apposite for both charges to be assessed together, as in *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356. While the First Charge relates to the Respondent's decision to carry out the mini implant procedure and the Second Charge relates to the design and execution of the same, the actions under both charges ultimately form part of a singular process. Thus, the harm caused by each charge cannot be segregated disjunctively from said process and should be evaluated as a whole.

90. In so doing, we are in agreement with the Respondent's submission that, when viewed together, the charges would fall into the category of serious/severe harm and moderate culpability. In particular, we are of the view that the harm caused would lie at the lower end of the serious/severe harm spectrum, given the unsustainability of the Patient's current state and the likelihood of some intervention and surgery being necessary in the years to come. Accordingly, we agree with counsel for the Respondent that the

appropriate starting point under Step 3 above would be a suspension period of **2.5 years (30 months).**

Discount due to delay in prosecution

91. In addressing Step 4 above, a **discount of 40% (12 months)** should be applied in light of the delay in prosecution. While due note has been taken of the cases cited by Counsel for the parties in respect of the same, we consider that such cases are not directly applicable to the facts of this case.

92. **First**, the delay in some of the cases cited exceeds the period of delay currently in consideration. For instance, both Counsel cited the case of *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("***Ang Peng Tiam***"). However, *Ang Peng Tiam* involved a time lag of nearly 4.5 years. By contrast, there was a delay of 3 years and 5 months in the current case. Accordingly, it would not be appropriate to halve the Respondent's sentence, as was done in *Ang Peng Tiam.*

93. **Second**, Counsel for the SDC, citing *Yip Man Hing Kevin v Singapore Medical Council and another matter* [2019] 5 SLR 32 ("***Kevin Yip***"), submitted that the discount due to the delay should be no more than one third of the appropriate sentence. However, the countervailing public interest considerations in *Kevin Yip*, which warranted a longer sentence, are not present here.

94. Therefore, in the round, we are of the view that the appropriate discount in sentencing should fall somewhere in between the discounts to sentencing accorded in *Ang Peng Tiam* and *Kevin Yip.* While not a precise computation, we consider that a discount of 40% to the starting position would be fair and appropriate in the current circumstances. This would bring the discounted position on sentence to **18 months**.

Offender-specific aggravating and mitigating factors

95. The Disciplinary Committee agrees with Counsel for the SDC that the Respondent holding himself out as a senior and experienced member of the profession is an aggravating factor. Without more, this would result in an uplift to one's sentence of 2 months. However, in the current circumstances, this uplift is offset by:-

(a) The Respondent's plea of guilt;

(b) The Respondent's lack of prior convictions for professional misconduct; and

(c) The Respondent being an elderly offender (78 years old) suffering from ill health. This pertains to his history of uteric colic, which recently flared, as well as, his severe chronic back pain that has lasted for about 4 years. We are prepared to exercise a degree of sympathy.

96. Further, at the suggestion of the DC Chairman, the Respondent is prepared to do and complete a basic course in dental implantology, conducted by the Centre for Advanced Dental Education, Faculty of Dentistry, NUS[2]. To his credit, the Respondent agreed to it almost immediately when this suggestion was put to him. This would go towards rehabilitation and suggests some level of insight and humility in respect of his error. Accordingly, we are prepared to accord a further discount of **3 months**, which would bring the suspension period down to **15 months**.

Imposition of fine

97. The Disciplinary Committee agrees with Counsel for the SDC that a fine should be imposed as this was a situation where there was evidence that the Respondent had profited or intended to profit from his misconduct. However, a fine of SGD 10,000 is in our view inadequate on the current facts. In this regard, the Respondent's clinic issued

[2] https://www.dentistry.nus.edu.sg/CADE/CADE_main.html

invoices of about SGD 29,000, of which he collected about SGD 20,000. In the absence of restitution, we are of the view that a fine of **SGD 15,000** should be imposed to more fairly represent a disgorgement of the Respondent's profit.

Sentence

98. Having considered all of the submissions tendered by the parties and having taken into account all of the circumstances of the case, the Disciplinary Committee now determines the appropriate sentence to be as follows, and so orders:-

(a) That the registration of the Respondent in the Register of Dentists shall be suspended for a period of 15 months;

(b) That the Respondent shall pay a fine of SGD 15,000;

(c) That the Respondent be censured;

(d) That the Respondent shall give a written undertaking to the Singapore Dental Council that he will not engage in the conduct complained of or similar conduct;

(e) That the Respondent shall also give a written undertaking to the SDC to complete a basic course in dental implantology conducted by the Centre for Advanced Dental Education prior to the end of the suspension period; and

(f) That the Respondent will pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the Singapore Dental Council and of the Legal Assessor.

99. The grounds of our decision may be published for the benefit of the public pursuant to Regulation 25 of the Dental Registration Regulations.

100. The hearing is hereby concluded.

Dated this 22nd day of February 2021.

Dr Kwa Chong Teck

(Chairperson

Dr Chang Kok Meng	**Dr Ong Kheng Kok**	**Mr Chua Thian Huat**
(Member)	**(Member)**	**(Observer)**