SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR CHAN HEANG KNG CALVIN ON 22 NOVEMBER 2017

Disciplinary Tribunal:
Prof Sonny Wang Yee Tang – Chairman
Dr Tow Lee Choon Sharon
Mr Tan Boon Heng – Legal Service Officer

Counsel for the Singapore Medical Council:
Mr Burton Chen
Ms Loh Yu Wei Junie
(M/s Tan Rajah & Cheah)

Counsel for the Respondent:
Mr Eric Tin
Ms Sarah Nair
Ms Cheryl Tsai
(M/s Donaldson & Burkinshaw LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL

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

A. INTRODUCTION

1. The issue of whether the custody threshold has been crossed is a perennial and difficult decision in sentencing. In the same vein, it is by no means an easy decision to make when determining whether an errant physician should be penalised with a term of suspension (instead of a fine *per se*) when found guilty under section 53(1) of the Medical Registration Act (Cap 174) ["the Act"]. This difficulty is exacerbated by the fact that the maximum fine under the Act was increased from $10,000 to $100,000 since the 2010 amendments to the Act. This amendment was to bridge the "*significant gap in the range of penalties*" between the then maximum fine of $10,000 and the minimum suspension term of three months under the Act.

2. In this decision of the Disciplinary Tribunal ("DT"), the physician pleaded guilty to a combination of charges under section 53(1)(*d*) for professional misconduct including failure to: (a) obtain informed consent; (b) use generally accepted methods; (c) maintain sufficient documentation; and (d) provide competent and appropriate care.

3. Having taken into consideration all the circumstances of the case, the DT imposed, among others, a six-month suspension term on the Respondent. We now set out the reasons for the decision.

B. THE CHARGES

4. The respondent, Dr Chan Heang Kng Calvin (the "Respondent") is a registered medical practitioner. In the Notice of Inquiry ("NOI") dated 21 April 2016 and 22 November 2017, the Singapore Medical Council ("SMC") preferred a total of eight charges (in which there was an agreement that the 6th and 7th Charges would be Amalgamated) against the Respondent for professional misconduct within the meaning of Section 53(1)(*d*) of the Act which is punishable under Section 53(2) of the said Act:

> ***1st CHARGE*** (Proceeded)
>
> *That you,* ***Dr Chan Heang Kng Calvin****, are charged that between 4 August 2008 to 5 August 2008, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to obtain informed consent from your patient, namely one Ms P ("****the Patient"****), in that you did not adequately inform the Patient that there were no acceptable published clinical studies or data on the safety of the Aqualift Dermal Filler procedure ("****ADF procedure****") and/or the Aqualift Hydrophilic Gel filler material ("****AHG****"), before performing the ADF procedure on the Patient by injecting 150 cc of AHG into each of her breasts on 5 August 2008,*
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> *and that in relation to the facts alleged, you have breached Clause 4.2.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines ("****ECEG****") and accordingly, you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a medical practitioner.*
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> ***2nd CHARGE***
> (Taken Into Consideration For Sentencing)
>
> *That you,* ***Dr Chan Heang Kng Calvin****, are charged that on 30 July 2009, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to obtain informed consent from the Patient in that you did not adequately inform the Patient that there were no acceptable published clinical studies or data on the safety of the ADF procedure and/or the AHG before performing the ADF procedure on the Patient by injecting 100 cc of AHG into each of her breasts on 30 July 2009,*
>
> *and that in relation to the facts alleged, you have breached Clause 4.2.2 of the ECEG and accordingly, you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a medical practitioner.*
>
> ***3rd CHARGE*** (Proceeded)

That you, ***Dr Chan Heang Kng Calvin****, are charged that on 5 August 2008 and on 30 July 2009, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to treat the Patient according to generally accepted methods in that you performed the ADF procedure of injecting AHG for breast augmentation on the Patient when AHG was not a generally accepted material for breast augmentation and when the aforesaid ADF procedure was not performed in the context of a formal and approved clinical trial.*

PARTICULARS

a. *As at 5 August 2008 and 30 July 2009, there were no acceptable published clinical studies or data based on randomised control trials on the use of AHG in humans.*

b. *The injection of synthetic material such as the AHG into a human entails an obvious potential risk to the safety of the person.*

c. *You were not conducting a formal and approved clinical trial when you performed the ADF procedure of injecting AHG on the Patient on 5 August 2008 and on 30 July 2009.*

And that in relation to the facts alleged, you have breached Clause 4.1.4 of the ECEG and accordingly you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good standing and repute.

4th CHARGE (Withdrawn)

That you, ***Dr Chan Heang Kng Calvin****, are charged that on 30 July 2009, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to practise within the limits of your own competence in that you performed the ADF procedure of injecting AHG for breast augmentation on the Patient, which was an invasive "Breast Enhancement" procedure under the Guidelines on Aesthetic Practices for Doctors ("****the Guidelines****") and should only be performed by a plastic surgeon.*

PARTICULARS

a. *The Guidelines were published on 24 July 2008, updated on 28 October 2008, and came into force on 1 November 2008.*

b. *The ADF procedure which you performed on the Patient on 30 July 2009, which involved the injection of 100cc of AHG into each of the Patient's breasts, was a breast enhancement procedure;*

c. *Under Table 1 List A of the Guidelines, "breast enhancement or reduction" is categorised as an "invasive" procedure, and it is stated that the minimum level of competence required to carry out "breast enhancement or reduction" is that of a "Plastic surgeon".*

d. *You are a general practitioner, not a plastic surgeon.*

And that in relation to the facts alleged, you have breached Clause 4.1.1.6 of the ECEG and accordingly you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good standing and repute.

5th CHARGE (Proceeded)

That you, ***Dr Chan Heang Kng Calvin****, are charged that on 5 August 2008 and 30 July 2009, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to keep sufficient medical records of the ADF procedures performed on the Patient.*

PARTICULARS

a. *You did not maintain sufficient documentation of your discussions with the Patient about the ADF procedure or about breast augmentation during the Patient's outpatient consultations with you before the procedures were performed.*

b. *Your medical records on the Patient did not include sufficient documentation of the Patient's consent to the ADF procedures using AHG and the risk involved in there being no acceptable published clinical studies or data on the safety thereof.*

c. *Your medical records on the Patient did not include any information on the position(s) where AHG was injected.*

And that in relation to the facts alleged, you have breached Clause 4.1.2 of the ECEG and accordingly, you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a medical practitioner.

AMALGAMATED 6TH & 7TH CHARGE (Proceeded)

That you, ***Dr Chan Heang Kng Calvin****, are charged that on 28 April 2010 to 19 June 2010, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to exercise due care and competence in the management of the Patient's right breast mastitis in that you inappropriately prescribed to the Patient several classes of antibiotics without obtaining information as to the infectious organism(s) by taking a swab for bacterial culture testing, and did not perform the incision and drainage procedures appropriately and/or thoroughly in the management of the Patient's right breast mastitis.*

PARTICULARS

a. *From 28 April 2010 to 19 June 2010, you performed treatments and procedures on the Patient relating to her right breast mastitis.*

b. *You inappropriately prescribed to the Patient several classes of antibiotics on the following dates, before you performed a swab for bacteria culture on her on 19 June 2010 and sent it for testing.*

   (i) *On each of 28 April 2010, 3 May 2010 and 4 May 2010, 1g of intravenous Ceftriaxone, by normal saline infusion;*

   (ii) *On 8 May 2010, 100mg of oral Doxycycline for 5 days;*

   (iii) *On 14 May 2010, 1g of intravenous Ceftriaxone by normal saline infusion;*

   (iv) *On 15 May 2010, 250mg of oral Zithromax for 6 days; and*

   (v) *On 20 May 2010, 500mg of oral Ciprofloxacin for 5 days.*

c. *You performed a total of 4 incision and drainage procedures of the Patient's right breast abscess, on 15 May 2010, 20 May 2010, 24 May 2010 and 31 May 2010 respectively, after which the Patient's right breast mastitis persisted.*

And that in relation to the facts alleged, you have breached Clause 4.1.1.5 and/or Clause 4.1.3 of the ECEG and accordingly you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated such serious negligence that it objectively amounts to an abuse of the privileges which accompany registration as a medical practitioner.

8th CHARGE (Withdrawn)

*That you, **Dr Chan Heang Kng Calvin**, are charged that in the period from 28 April 2010 to 23 June 2010, whilst practising as a general practitioner at Calvin Chan Aesthetic and Laser Clinic, 501 Orchard Road, #05-11 Wheelock Place, Singapore 238880, you failed to refer the Patient in a timely manner to a medical specialist with the necessary expertise (namely a surgeon treating breast diseases) for the management of the Patient's right breast mastitis with discharge ("**the Breast Complications**"), which was beyond your competence to manage.*

PARTICULARS

a. On or around 28 April 2010, the Patient consulted you regarding the Breast Complications.

b. You performed treatments and procedures on the Patient relating to the Breast Complications from 28 April 2010 to 19 June 2010.

c. The Breast Complications persisted for almost 2 months under your management of the Patient's condition.

d. You only referred the Patient to one Dr FW1, a breast surgeon, for additional management of the Patient's condition on or around 23 June 2010.

And that in relation to the facts alleged, you have breached Clause 4.1.1.6 of the ECEG and accordingly you are guilty of professional misconduct within the meaning of Section 53(1)(d) of the Medical Registration Act (Cap. 174) which is punishable under Section 53(2) of the said Act in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good standing and repute.

C. AT THE DT INQUIRY

5. As the Respondent intimated that he would take a certain course, the SMC agreed to proceed only with the 1st, 3rd, 5th Charges and the Amalgamated 6th and 7th Charges. SMC informed the DT that it had withdrawn the 4th and 8th Charges. In addition, the SMC applied for the 2nd Charge to be taken into consideration for sentencing should the Respondent admit to the charges.

Plea of Guilt

6. At the DT inquiry, the Respondent elected to plead guilty to the 1st, 3rd, 5th and Amalgamated 6th and 7th Charges of the NOI. In addition, the Respondent also consented to the 2nd Charge to be taken into consideration for sentencing.

7. Counsel for the SMC then proceeded to submit the Agreed Statement of Facts to the DT.

The Agreed Statement of Facts

8. The Respondent (Medical Council Registration No. M08694J) is a registered medical practitioner who, at all material times, was practising as a General Practitioner at a clinic known as "Calvin Chan Aesthetic & Laser Clinic".

9. This Agreed Statement of Facts relates to the 1st, 3rd, 5th and the Amalgamated 6th and 7th Charges in the Notice of Inquiry dated 21 April 2016 ("the NOI").

10. On 5 August 2008, the Respondent performed breast augmentation by an Aqualift Dermal Filler procedure ("ADF Procedure") on Ms P ("the Patient") by injecting 150cc of Aqualift Hydrophilic Gel filler material ("AHG") into each of the Patient's breasts. On 30 July 2009, the Respondent performed another ADF Procedure on the Patient by injecting 100cc of AHG into each of her breasts.

11. At all material times, there were no acceptable published clinical studies or data on the safety of the ADF Procedure and/or AHG, even though the AHG bore a CE mark.

12. Further, an application made in 2007 by the product owner to the Health Sciences Authority ("HSA") to register the AHG was not approved. In 2009, another application was made by the product owner to register the AHG, and this application was also not approved due to inadequate clinical data to support the long term safety and effectiveness of the product for its indicated uses.

13. AHG was not a generally accepted material and the ADF procedure was not a generally accepted method for breast augmentation. The ADF Procedure and/or AHG should only have been performed/used (as the case may be) in the context of a formal and approved clinical trial. Hence, in performing the ADF Procedure on the Patient on 5 August 2008 and 30 July 2009, the Respondent was in breach of Guideline 4.1.4 of the 2002 edition of the Singapore Medical Council's Ethical Code and Ethical Guidelines ("2002 ECEG").

14. At no time during the period of consultations prior to performing the ADF Procedures on the Patient on 5 August 2008 and 30 July 2009 did the Respondent inform the Patient that there were no acceptable clinical studies or data on the safety of the ADF Procedure and/or the AHG. The Respondent therefore failed to obtain the informed consent of the Patient for the ADF Procedures carried out on her and the Respondent was thus in breach of Guideline 4.2.2 of the 2002 ECEG.

15. Further, on each of 5 August 2008 and 30 July 2009, the Respondent failed to keep sufficient documentation of the following matters:

    (a) The Respondent's discussions with the Patient about the ADF Procedure or about breast augmentation during the Patient's outpatient consultations with the Respondent before the procedures were performed;

    (b) The Patient's consent to the ADF Procedures using AHG and the risk involved in there being no acceptable published clinical studies or data on the safety thereof; and

    (c) Information on the position(s) where AHG was injected into the Patient by the Respondent.

    By reason of the failure to keep sufficient documentation, the Respondent had breached Guideline 4.1.2 of the 2002 ECEG.

16. The Patient developed right breast mastitis in or around 28 April 2010 after the Patient started lactating. In the period 28 April 2010 to 19 June 2010, in treating the Patient's right breast mastitis, the Respondent failed to provide competent and/or appropriate care, in that:

    (a) The Respondent inappropriately prescribed to the Patient several classes of antibiotics on the following dates:

        (i) On each of 28 April 2010, 3 May 2010 and 4 May 2010, 1g of intravenous Ceftriaxone, by normal saline infusion;

        (ii) On 8 May 2010, 100mg of oral Doxycycline for 5 days;

(iii) On 14 May 2010, 1g of intravenous Ceftriaxone by normal saline infusion;

(iv) On 15 May 2010, 250mg of oral Zithromax for 6 days; and

(v) On 20 May 2010, 500mg of oral Ciprofloxacin for 5 days.

(b) The Respondent did not perform a swab for bacteria culture on the Patient for testing until 19 June 2010.

(c) The Respondent did not appropriately or thoroughly perform the 4 incision and drainage procedures of the Patient's right breast abscess, on 15 May 2010, 20 May 2010, 24 May 2010 and 31 May 2010 respectively. The Patient's right breast mastitis persisted after the 4 incision and drainage procedures.

17. The Patient did, however, send an email dated 19 May 2010 to the Respondent attaching the report of the bacteria culture swab performed by one Dr FW2 on or around 13 May 2010.

18. By virtue of the facts set out above, the Respondent had failed to exercise due care and competence in the management of the Patient's right breast mastitis, and was in breach of Guideline(s) 4.1.1.5 and/or 4.1.3 of the 2002 ECEG.

19. In the circumstances, Counsel for the SMC submitted that:

(a) The Respondent was guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174) as set out in the 1st, 3rd, 5th and Amalgamated 6th and 7th Charges of the NOI; and

(b) The Respondent was hence liable to be punished under Section 53(2) of the said Act in respect of these Charges, with the 2nd Charge to be taken into consideration for sentencing.

In Mitigation

20. The Respondent confirmed the correctness of the Agreed Statement of Facts and pleaded guilty to all the proceeded charges. In mitigation, his counsel submitted an extensive mitigation plea which we shall now highlight the salient points for the record:

(a) The Respondent's plea of guilt which had helped to save considerable time and resources of the DT and SMC;

(b) That the instances of misconduct happened many years ago with some dating back to 2008 and 2009;

(c) That the Respondent was relatively new to aesthetic medical practice in 2008/2009 which just saw regulation in 2008;

(d) That the Respondent being new to aesthetic medical practice, which was then an evolving area of practice in Singapore, had naturally relied heavily on mentors and trainers of aesthetic practices to learn what constituted acceptable standard of care. It was an honest mistake on the Respondent's part to have assumed that being CE-marked, AHG was safe and "generally accepted", when he saw that other doctors were also using AHG at the material time;

(e) In relation to the 1st Charge, at the material time, the Respondent would not have had any reason to suspect that the AHG and ADF procedure had safety concerns. He also did not induce the Patient to undergo the treatment by deliberately choosing not to discuss whether there were published clinical studies or data on the safety of the product and the procedure;

(f) In relation to the 3rd Charge, while the Respondent accepted, with the benefit of hindsight after perusing the report of SMC's expert, Associate Professor PE ("A/Prof PE"), that the ADF procedure using AHG material was not considered generally accepted and therefore should be performed under a formal and approved clinical trial, the Respondent stressed that he had followed what he thought was the prevailing accepted clinical practice in 2008 and 2009 based on his training under Dr FW3 and what he perceived other medical practitioners were doing. He also received the requisite training and done a directly supervised procedure under Dr FW3's guidance, before he treated the Patient in 2008 and 2009. This should be distinguished from cases where a medical

practitioner, without any training under direct supervision, simply embarked on a procedure that was not considered generally accepted by the medical profession. To the best of the Respondent's knowledge, since AHG became legally available in Singapore sometime in 2007 until its voluntary recall on 7 December 2010, there were no known or reported cases of long-term complications relating to breastfeeding after patients underwent the ADF procedure of injecting AHG material;

(g) In relation to the 5th Charge, the Respondent readily accepted that his medical record documentation in this case was lacking, apologised for and offered no excuse whatsoever for this shortcoming. As elaborated below, he had since taken stock of the situation mainly by introducing comprehensive and detailed informed consent forms for various procedures offered in his clinic;

(h) In relation to the Amalgamated 6th and 7th Charges, among others, it was submitted in mitigation that the Respondent's decision to administer the respective antibiotics medications was not without basis, and borne out of a genuine desire to treat the Patient's condition in a manner which he had considered to be in the Patient's best interests at the time. Further, it was submitted that it was not conclusive that the Patient's breast complications were related to the AHG or ADF procedure performed by the Respondent in 2008 and 2009. The experts had opined that they had not encountered or heard of any case of breast abscess and deformity related to breastfeeding arising from Aqualift breast enhancement procedures;

(i) Since receiving the Complaint, the Respondent had put in concrete efforts and remedial steps to improve his consent taking and documentation of patient medical records. This was an indication that he had insight of his shortcomings and was willing to change in order to improve patient care. He had developed standard consent forms that detail the procedure, benefits, risks, complications and alternatives/options to the procedure;

(j) The Respondent's practice today focuses on non-invasive medical aesthetic procedures that are evidence-based and FDA and HSA-approved. Since

receiving this Complaint, he had taken pains to ensure that his practice is fully compliant with the prevailing Aesthetic Guidelines as well as the 2002 ECEG.

(k) In the present case, the Complaint is dated 28 August 2012. The Notice of Complaint is dated 19 December 2012. The Respondent's written explanation is dated 30 January 2013, and he submitted a supplemental explanation dated 7 February 2013. The SMC wrote to their expert A/Prof PE around August to September 2014. A/Prof PE's expert report was dated 25 February 2015 ("the 1st Report"). The Prosecution then sought A/Prof PE's clarifications in their letter dated 29 July 2015. A/Prof PE's supplemental report was dated 29 February 2016. The Respondent was served the Notice of Inquiry on 21 April 2016. From the above chronology, nearly three and a half years elapsed between 19 December 2012 when SMC notified the Respondent of the Complaint against him and 21 April 2016 when he was served with the Notice of Inquiry. Since receiving the Complaint till now, the Respondent had spent the last five years in anxiety and distress. It was submitted that the delayed disciplinary process itself had served as extracurial punishment to the Respondent when determining the appropriate sanction;

(l) This would be the Respondent's first SMC conviction in a medical career spanning 16 years. The present conviction would be a permanent blot on his otherwise blemish-free record, a stigma that he would have to carry for the rest of his medical career;

(m) The present conviction would be a severe blow to the Respondent, as he had enjoyed fairly good standing in the medical profession. His peers held him in high esteem at the professional and personal levels. Four of them had given written testimonials in which are mentioned, amongst other things, his professional competence and conscientiousness and care towards his patients;

(n) In the eyes of his patients, the Respondent had been professional and had truly cared for his patients. One of them, Ms DW, had seen him as a patient for about 10 years;

(o) The Respondent could enjoy such good standing amongst his peers and with his patients because of his constant strive for excellence. He often went to great lengths to participate in medical aesthetic conferences and training workshops both at home and abroad to continuously learn and improve his medical skill sets for his area of special interest; and

(p) The Respondent had a charitable spirit. He believed in giving back to society. Over the years, he had within his means and ability, given to various charitable organisations and causes.

D. SUMMARY OF SMC'S SUBMISSION ON SENTENCE

21. Counsel for the SMC submitted that where the medical practitioner was facing a combination of disciplinary charges involving the failure to obtain informed consent, performing a method of treatment that was not generally accepted, failure to keep proper medical records and/or a failure to exercise due care and competence in the management of a patient, the medical practitioner was typically sentenced to, among others, a period of suspension.

22. As this case involved an aesthetic procedure, Counsel for the SMC drew the attention of the DT to paragraph 7 of the Guidelines on Aesthetic Practices for Doctors dated October 2008 (see Tab 28 of the PBA) which stated:

> "*The guiding principles in any medical treatment must be that it is effective and there is due cognizance given to patient safety.* ***In the context of aesthetic practice, it must go beyond the "Do No Harm" principle and be seen to benefit the patient positively*** (emphasis original)".

23. In view of the severity of the Respondent's professional misconduct, the legal principles and sentencing precedents referred to earlier, the Counsel for the SMC urged the DT to exercise its powers under section 53(2) of the Act to make the following orders, among others:

(a) The Respondent's registration as a medical practitioner be suspended for nine months and he be fined the sum of $10,000 in respect of the 1st, 3rd and 5th Charges (with the 2nd Charge taken into consideration); and

(b) The Respondent's registration as a medical practitioner be suspended for three months in respect of the Amalgamated 6th and 7th Charges, which was to run consecutively from the 9 months' suspension for the 1st, 3rd and 5th Charges thereby giving a total suspension of 12 months.

E. SUMMARY OF THE RESPONDENT'S SUBMISSION ON SENTENCE

24. In coming to an appropriate sanction, Counsel for the Respondent submitted that the DT ought to consider what type and quantum of sanction would be proportionately deterrent having regard to all the circumstances of this case, including: (a) the Respondent's degree of culpability given his level of experience at the material time; (b) the practice context in 2008 to 2010; (c) the vintage of and material change of circumstances since the disciplinary offences; and (d) the prejudice caused to Dr Chan due to the substantial length of time taken for these formal proceedings to be brought in April 2016 through no fault of his own.

25. Counsel for the Respondent contended that there was no or little need for specific deterrence in this case since AHG was no longer in the Singapore market and breast filler procedures like the ADF procedure had been prohibited since 1 August 2016. There was no way the Respondent could ever treat patients using breast filler procedures and/or AHG for as long as he was practising in Singapore.

26. As for general deterrence, Counsel for the Respondent reasoned that with the unavailability of AHG and prohibition of breast fillers procedures following the 2016 Guidelines, the medical profession does not need to be generally deterred in the use of such procedure and product. General deterrence must also be tempered with proportionality, in that the sanction cannot be out of proportion with the Respondent's degree of culpability. In this case, Counsel for the Respondent argued that the Respondent only performed the ADF procedure using AHG on one patient. Whatever general deterrence intended through a sanction meted out to the Respondent should not disregard this essential fact upon which his plea of guilt was made.

27. Counsel for the Respondent reiterated that a suspension term would not be the only effective general deterrent to deter such appreciable harm. General deterrence could also be served by an appropriate financial punishment. Under section 53(2)(*e*) of the MRA, a DT may by order impose on the registered medical practitioner a penalty not exceeding $100,000. This maximum fine was increased when the MRA was amended

in 2010, from what used to be $10,000, in order to bridge the "significant gap in the range of penalties" in the MRA.

28. For the reasons given above, Counsel for the Respondent submitted that a high fine of between $30,000 and $40,000 should suffice on the facts of this case (even if it was up to a maximum fine of $100,000) rather than a term of suspension. He reasoned that a high fine would be adequate to reflect the severity of the Respondent's breaches and also achieve the aim of proportionate deterrence. Counsel for the Respondent added that that a nine-month or 12-month suspension would be manifestly excessive in all the circumstances of this case.

F. THE DT'S OBSERVATIONS

29. At the heart of this proceeding was whether the *combination* of acts of professional misconduct of the Respondent should attract a term of suspension, and if so, the appropriate length of the suspension.

30. We noted from the inquiry documents tendered to the DT that there were aggravating factors in this matter which we now set out.

A combination of serious acts of professional misconduct

31. The DT was mindful that the Respondent had committed *several* acts (rather than an isolated breach) of professional misconduct under section 53(1)(*d*) of the Act including:

(a) **Failure to obtain informed consent.** The Respondent failed to obtain informed consent from the Patient for the first ADF Procedure, which was performed on 5 August 2008, in that the Respondent did not inform the Patient that there were no acceptable clinical studies or data on the safety of the ADF Procedure and/or the AHG (1st Charge);

(b) **Failure to use a generally accepted method.** As at 5 August 2008 and 30 July 2009, AHG was not a generally accepted material for breast augmentation. Guideline 4.1.4 of the 2002 ECEG stated that *"A doctor shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial."* In breach of Guideline 4.1.4, the Respondent performed the ADF Procedures on

the Patient outside the context of a formal and approved clinical trial (3rd Charge);

(c) **Failure to maintain sufficient documentation**. In relation to the ADF Procedures performed on the Patient on each of 5 August 2008 and 30 July 2009, the Respondent had failed to keep sufficient documentation (5th Charge); and

(d) **Failure to provide competent/appropriate care**. In relation to the ADF Procedures performed on the Patient on each of 5 August 2008 and 30 July 2009, the Respondent had failed to provide competent / appropriate care (Amalgamated 6th and 7th Charges). Firstly, the Respondent inappropriately prescribed to the Patient several classes of antibiotics on seven occasions. As pointed out by A/Prof PE in the 1st Report, the Respondent's prescription of antibiotics to the Patient was inappropriate as: (i) there was no consistency to the antibiotic therapy; (ii) several classes of antibiotics were given to the patient without any information as to the infective organisms; and (iii) frequent switching of antibiotics also encourages the emergence of multi-resistant strains of bacteria in the Patient. Secondly, the Respondent did not perform a swab for bacteria culture on the Patient for testing until 19 June 2010. Thirdly, the Respondent did not appropriately or thoroughly perform the four incision and drainage procedures of the Patient's right breast abscess, on 15, 20, 24 and 31 May 2010. The Patient's right breast mastitis persisted after the four incision and drainage procedures.

The Respondent did not act in the Patient's welfare and interests

32. From the inquiries that the Respondent made, he would have realised that there was a lack of acceptable safety clinical studies and/or data on the ADF Procedure and/or AHG. Notwithstanding that, the Respondent still proceeded to perform inappropriate breast augmentation on the Patient by way of the ADF Procedures, plainly relying on the assurances by the AHG product manufacturer and distributor, and on Dr FW3, who claimed to be a trainer for the ADF Procedure for breast augmentation[1], and Dr FW3's

[1] Paragraphs 21 and 22 of the Written Explanation at pages 37 and 38 of the Agreed Bundle of Documents (ABOD).

letter dated 10 January 2013[2]. In Dr FW3's letter dated 10 January 2013 to the Respondent, it was apparent that Dr FW3 was also relying on the manufacturer's assurances made in the product brochure.

33. In addition, the Respondent represented to the Patient that there were no known risks associated with the use of AHG, so much so that he did not think there was a need for a consent form to be signed by the Patient[3]. This was perhaps even *more* culpable in the context of performing an aesthetic procedure given paragraph 7 of the 2008 edition of the ***Guidelines on Aesthetic Practices for Doctors***, which states:

> "The guiding principles in any medical treatment must be that it is effective and there is due cognizance given to patient safety. In the context of aesthetic practice, it must go beyond the "Do No Harm" principle and be seen to benefit the patient positively (emphasis original)".

34. Given that aesthetic procedures must go beyond the ***"Do No Harm"*** principle, we agreed with the Counsel for the SMC that the Respondent was required to uphold the highest standards of professional practice and conduct that any medical practitioner intending to perform an aesthetic procedure should observe: (a) assure himself of the safety of the procedure before performing it on a patient; (b) ensure that the patient is fully equipped to give informed consent; and (c) properly document the process so as to facilitate the review of the patient's condition or the treatment of any complications that may arise. The Respondent breached all of the above.

35. For the reasons given above, it was an aggravating factor that the Respondent failed to act in the Patient's welfare and interests.

The Patient suffered prolonged pain and inconvenience under the Respondent's medical management

36. The nature and extent of the harm suffered by the Patient as a result of the errant physician's breach was always a relevant factor for sentencing. In the present case, while we know that the Patient developed breast mastitis after lactation, it was less clear what had caused the inflammation. There was no evidence as to whether it was as a result of the AHG filler and/or other intervening causes. That said, it was clear that when the Patient developed breast mastitis, as a result of the Respondent's failure to

[2] See page 66 of the ABOD.

[3] Paragraph 36 on page 40 of the ABOD.

exercise due care and competence in the management of the Patient's right breast, the Patient suffered prolonged pain and inconvenience from 28 April 2010 to 19 June 2010 i.e. the substance of the Amalgamated 6th and 7th Charges.

37. The Respondent's haphazard approach to the management of the Patient's right breast mastitis exposed the Patient to the possible emergence of multi-resistant strains of bacteria, caused her unnecessary pain (given that she underwent multiple incision and drainage procedures) and prolonged the Patient's suffering, resulting in an erosion of trust in the medical profession. By a Statutory Declaration, the Patient made a complaint dated 28 August 2012 ("**the Complaint**") to the SMC. In the Complaint, the Patient expressed, among others:

    (a) her anguish and suffering of "*physical inconvenience, pain and emotional and mental anguish as a result of [her] injury*"[4];

    (b) her disappointment as a mother for not being able to breast feed her son for as long as he needed to be breast fed, and as a wife for the loss of romance and intimacy in her relationship with her husband as a result of her condition[5]; and

    (c) her loss of trust in the Respondent as her doctor as she had "*looked to him* [the Respondent] *as my doctor to provide me with full information regarding AHG and the breast enlargement procedure. However, I was not able to give my informed consent to the procedures. Dr Chan did not look out for my best interests*"[6].

Whether a term of suspension is warranted

38. In determining whether a term of suspension would be warranted on the facts of this case, the DT was cognisant that the maximum fine under the Act had been increased from $10,000 to $100,000 in the 2010 amendment. This amendment helped to bridge the significant gap between the then maximum fine of $10,000 and the minimum 3-month imprisonment under the Act. Notwithstanding the substantially higher maximum fine that may be imposed against the errant physician, the issue before the DT remains whether a term of suspension would be necessary on the facts of our present case.

[4] Paragraph 33 on page 27 of ABOD.
[5] Paragraph 34 on page 27 of the ABOD.
[6] Paragraph 35 on page 28 of the ABOD.

39. In view of the aggravating factors enumerated above, it was patently obvious to the DT that the appropriate penalty for the Respondent's professional misconduct for the combination of breaches should be a term of suspension rather than a fine, even if it were a high fine of up to $100,000. Taken as a whole, the Respondent's acts were simply unacceptable and inconsistent with upholding high standards of the medical profession. He had made far too many assumptions about the safety of the AHG product, was overly hasty and ignored guidelines in carrying out the ADF procedure and was sloppy and haphazard in his medical management of the Patient. The DT was of the unanimous view that the fact that the Respondent was relatively new to aesthetic medical practice at the material time (when he committed the breaches) was no excuse. On the contrary, being inexperienced, he ought to have exercised even more caution. In addition, given that aesthetic procedures must go beyond the ***"Do No Harm"*** principle, it was incumbent on the Respondent to seek advice from seniors in the field especially when it may be potentially controversial.

40. That said, the DT was mindful that the Respondent by not claiming trial on the charges not only displayed a degree of remorse but also helped to save time and cost. In addition, we noted that he had since taken pains to ensure that his practice is fully compliant with the prevailing Aesthetic Guidelines as well as the SMC Ethical Code and Ethical Guidelines. While these points of mitigation are valid, in our minds, they were nonetheless not sufficient to tip the scales in favour of a fine *per se* without a suspension.

The appropriate length of the suspension

41. Having decided that it would be necessary to impose a term of suspension on the Respondent for the combination of breaches, the next task was to determine the appropriate length of the suspension.

42. Both Counsel for the SMC and Respondent referred to numerous cases. We did not think that there was any particular precedent that was especially helpful for the matter before us. In this regard, we are guided by the High Court's guidance in *Jen Shek Wei v SMC* [2017] SGHC 294 *("Jen Shek Wei"*) at [155] that any comparison with sentencing precedents must be on the basis that the facts and circumstances as a whole are truly comparable. This echoes what was said in *Yong Thiam Look Peter v SMC* [2017] 4 SLR 66 *("Yong Thiam Look Peter")* at [17] that, *"Mechanistic or discrete*

comparisons that fail to consider adequately the totality of the relevant facts and circumstances would not be fruitful". With the above guidance from the High Court in mind, we cannot overemphasise that the following selection of precedents would only afford, at best, a starting point in the analysis and certainly not the basis for the penalties that the DT eventually decided on.

43. In *SMC v Dr Teoh Kheng Hoe Gerrard* [2012] ("Dr Teoh"), Dr Teoh pleaded guilty to the following: (a) one charge of recommending and administering Velcade-based targeted therapy as a first-line treatment to treat the patient's lymphoma when it was not a generally accepted method of treatment; and (b) one charge of inappropriately recommending the Velcade-based targeted therapy as a first-line treatment to treat the patient's lymphoma. The Disciplinary Committee ("DC") ordered that Dr Teoh be suspended for a period of six months for each charge, with the periods of suspension to run concurrently as they arose from the same treatment of the patient, and be fined $10,000. Counsel for the SMC drew the DT's attention to paragraph 9(c) of the decision in *Dr Teoh* that the DC therein commented, *"We are of the view that a breach of the ethical guidelines involving inappropriate treatment will attract substantial punishment involving a period of suspension for the medical practitioner concerned."* Returning to our present case, the 3rd Charge relating to a failure to treat the Patient according to generally accepted methods was a facet of providing inappropriate treatment which would attract a substantial punishment. Though Counsel for the Respondent pointed out that there were aggravating factors in *Dr Teoh's* case not found in our present case, we were not particularly troubled by that. Each case would have its own aggravating factors in the same way that there were aggravating factors in the matter before us which may or may not be found in another. When we compared the breaches of Dr Teoh and the Respondent in totality, we were of the view that the Respondent ought to receive a higher punishment than Dr Teoh i.e. more than a six-month suspension.

44. In *Yong Thiam Look Peter* ("Dr Yong"), the physician performed a trigger finger release procedure on the Patient at the consultation table in his clinic. Arising out of this complaint by his patient, three charges were proceeded against him before the DT. Two of the charges were professional misconduct charges involving his failure to obtain the required informed consent for the procedure he performed and to keep proper medical records in respect of the treatment on the Patient. The third charge related to him performing the procedure on the Patient at his consultation table instead of a procedure room or operating theatre. He pleaded guilty to all three charges and the DT had ordered that Dr Yong: (a) be suspended for a period of six months; and (b) to be

fined $10,000. We have also noted that Dr Yong had antecedents. Dr Yong appealed to the High Court. His appeal was dismissed. The High Court further added that they had in a number of decisions already said that they were of the view that the sentencing regime for cases of medical discipline in the past had tended to be somewhat lax, and that the High Court would recalibrate this as cases come before them. Be that as it may, even if we take into consideration that Dr Yong had antecedents, we were satisfied that the charges faced by Dr Yong were not as serious as the Respondent's i.e. having regard to the number of proceeded charges as well as the nature of the breaches.

45. Based on the sentences imposed against Dr Teoh and Dr Yong, we felt that an appropriate penalty for the Respondent should be higher than a six-month suspension since the Respondent not only pleaded guilty to *more* charges but they were also *more* serious in nature. It bears repeating that, like our Respondent, Dr Teoh and Dr Yong did not claim trial and pleaded guilty to the charges. Though we had formed the view that the Respondent's *combination* of breaches ought to attract a suspension of higher than six months, the next question was how much higher. We therefore now turn to consider the sentencing precedents wherein the breaches were arguably more serious which attracted longer suspensions. Again, we must stress that we are not making an observation that these precedents are directly relevant to our present case. In fact, they can be easily distinguishable for one reason or another. We do so simply to provide a comparison with our present case for the purpose of determining an appropriate length of the suspension term to be imposed.

46. In *SMC v Wong Yoke Meng* [2011] ("Dr Wong"), Dr Wong faced several charges in relation to his treatment of four patients. Most pertinent to the present case were the three charges relating to Mr W which were for: (a) the carrying out of intra-muscle and intra-thecal stem cell injections, which was not medically proven as a treatment for amyotrophic lateral sclerosis, outside the context of a formal and approved clinical trial; (b) failing to obtain the patient's proper informed consent prior to carrying out the stem cell injections, in that Dr Wong did not explain to Mr W that the procedure was experimental or the risks involved; and (c) carrying out a procedure (the intra-thecal stem cell injections) outside his registered speciality of obstetrics and gynaecology. In respect of these three charges, Dr Wong was sentenced to 12 months' suspension. At least two out of three of the charges against Dr Wong were fairly similar to our present case i.e. failing to obtain informed consent and not using generally accepted methods of treatment. In the case of Dr Wong, we noted that the 3rd Charge for carrying out a

procedure outside his registered speciality was a serious charge which was not proceeded with in relation to our Respondent. Be that as it may, considering that our Respondent had injected a total of 500cc of AHG into the Patient's breasts (250cc per breast), which was equivalent to a standard size (i.e. 500ml) bottle of water, we agreed with the Counsel for the SMC that the injection of such a significant volume of foreign matter into a human body cannot be lightly regarded especially since AHG was not a generally accepted material for breast augmentation. All things considered, we did not think it was unreasonable to place the culpability of Dr Wong and our Respondent more or less on the same plane i.e. a 12-month suspension.

47. Pressing on with our comparison to determine the appropriate length of suspension for the Respondent, we finally come to the case of *Jen Shek Wei* ("Dr Jen"). Dr Jen was convicted after trial on both charges under section 53(1)(d) of the Act. The 1st Charge was to the effect that the Respondent had advised the Patient to undergo surgery to remove a pelvic mass discovered during a Magnetic Resonance Imaging scan without conducting further evaluation and investigation of her condition, when such further assessment was warranted. The 2nd Charge was to the effect that the Respondent had performed a surgical procedure to remove an ovary on the Patient without having obtained her informed consent. The DT ordered, among others, that the Respondent: (a) be suspended for a period of eight months; and (b) pay a fine of $10,000. The Respondent appealed. The High Court dismissed the appeal but articulated that the suspension term ought to have been 16 months but in view of the inordinate delay in the prosecution, the suspension term was halved to eight months. While *Jen Shek Wei's* case was not directly relevant and could be distinguished from the present case, it was however helpful to the extent that the suspension for the case before us ought not to be higher than the 16-month suspension in *Jen Shek Wei* since he was convicted after trial and the Patient had lost her ovary ***against*** her will. In our case, the Patient's prolonged suffering from breast mastitis including the inability to breastfeed and loss of intimacy was certainly not as serious as the unwanted removal of the Patient's ovary (and without her knowledge). In our present case, the Respondent's decision to plead guilty was another strong reason why the length of suspension ought to be lower than that in *Jen Shek Wei* since Dr Jen was convicted only after trial.

48. While the sentence of a 16-month suspension in *Jen Shek Wei* would be too stiff for the Respondent, the DT felt that the 12-month suspension in *Wong Yoke Meng* could seem fairly comparable to our present case taking into consideration the nature and number of charges. In the DT's deliberation on sentence, we also addressed our minds

to another two specific points. Firstly, we did not think it would be necessary to impose separate penalties for the proceeded charges as submitted by Counsel for the SMC i.e. 1st, 3rd and 5th Charges (first set), and the Amalgamated 6th and 7th Charges (second set). We were of the view that a single set of penalties for all the proceeded charges will better reflect the *cumulative* gravity of the Respondent's breaches. Secondly, on the facts of this case, given that we were of the view that a global 12-month suspension would be appropriate, we also did not think it would serve any additional purpose to add on a fine to the Respondent.

Inordinate Delay

49. The issue of inordinate delay and the impact on sentencing for such matters had been addressed by the Court of Three Judges in *Jen Shek Wei*, *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] SGHC 260 ("Dr Lam") and *Ang Peng Tiam v Singapore Medical Council* [2017] SGHC 143 ("Dr Ang").

50. When determining whether there was any inordinate delay in the prosecuting of such matters, the High Court had consistently adopted the following milestones i.e. the length of time elapsed between the date of service of the **Notice of Complaint** and the date of service of the **Notice of Inquiry**. As the High Court remarked in *Jen Shek Wei, "Each case must obviously depend on its precise facts and circumstances".*

51. In Dr Jen's case, the High Court consciously halved the term of suspension from 16 to eight months taking into consideration the inordinate delay of three years from the date of the Notice of Complaint to the date of Notice of Inquiry:

> [171] … **We understand that it may take time to find and brief an expert witness given that the available pool of potential experts may be small and not every potential witness may be willing to testify. *Still, we are of the view that a delay of three years is overly lengthy by any reasonable measure*.** To place that length of time in context, three years is the maximum period of suspension that could be imposed on any doctor pursuant to s 53(2)(c) of the Act. For the avoidance of doubt, we are not stating that a length of delay of fewer than three years is necessarily tolerable. ***The point is that the delay in this case was clearly unacceptable even if one factored in the time it might reasonably take to prepare the case.*** Each case must obviously depend on its precise facts and circumstances.
>
> [172] Second, although the DT was asked to take delay into account (see [153(c)] above), it is ***not apparent from its GD that the DT***

> ***considered the inordinate delay in arriving at the term of suspension it imposed.***
>
> [173] Further, based on the presence of the peculiar aggravating considerations we have mentioned, we consider that it would have been justified to impose a term of suspension of eight months for each charge, with both to run consecutively, making an aggregate of 16 months' suspension. ***On the other hand, we think the inordinate delay in this case would have warranted halving that term of suspension, with the result that the term of suspension to be imposed on Dr Jen would remain at eight months.***
>
> ***[emphasis added]***

52. Returning to the present case, the Complaint was dated 28 August 2012. **The Notice of Complaint was dated 19 December 2012.** The Respondent's written explanation was dated 30 January 2013, and he submitted a supplemental explanation dated 7 February 2013. The SMC wrote to their expert, A/Prof PE, a Senior Consultant at Hospital A, around August to September 2014. A/Prof PE's expert report was dated 25 February 2015. The SMC then sought A/Prof PE's clarifications in their letter dated 29 July 2015. A/Prof PE's supplemental report was dated 29 February 2016. **The Respondent was served the Notice of Inquiry on 21 April 2016.** From the above chronology, about **three years and four months had elapsed** between 19 December 2012 when SMC notified the Respondent of the Complaint against him and 21 April 2016 when he was served with the Notice of Inquiry. Counsel for the Respondent submitted that since receiving the Complaint, the Respondent had spent the last five years in anxiety and distress and urged the DT to accord weight to this significant factor – that the delayed disciplinary process itself had served as extracurial punishment to the Respondent – when determining the appropriate sanction.

53. Counsel for the SMC did not agree that the approximate three years four months was an *inordinate* delay between the Notice of Complaint and Notice of Inquiry. He stressed that it took time to identify experts, for the experts to consider assisting and also time for the experts to prepare the reports. The length of the elapsed time merely revealed how challenging it was to engage experts to assist the SMC on the matter. On the other hand, Counsel for the Respondent urged the court to take guidance from the High Court in finding that there was an inordinate delay in the present case. The reasons for the delay were no different from the case of *Ang Peng Tiam* and *Jen Shek Wei* i.e. difficulties in procuring experts and for the experts to prepare the reports. In *Dr Ang's* case, the suspension on the doctor was halved from 16 months to eight months on account of a delay of more than three years nine months between the Notice of

Complaint (27 June 2011) and the Notice of Inquiry (22 April 2015) had been sent to the doctor (see *Ang Peng Tiam v SMC* [2017] SGHC 143 at [10]). As for the delay in *Dr Jen's* case, it was about three years and the High Court had observed that this was overly lengthy by any reasonable measure. Returning to the case before us, the delay was about three years and four months. Looking at the chronology of events between the Notice of Complaint and Notice of Inquiry, there were no good and sufficient reasons for the intervening lapses that would distinguish it from the inordinate delay in prosecuting the cases of Dr Ang and Dr Jen. Though the delay in our present case of about three years four months was shorter than Dr Ang's delay of about three years and nine months, it was longer than the delay in Dr Jen's case of about three years. Therefore, following the reasoning and approach in *Dr Ang* and *Dr Jen's* decisions, we see no basis not to half the term of suspension from 12 to six months for the inordinate delay in the matter before us.

G. THE DT'S DECISION

54. In light of all the circumstances of the case and for the reasons provided above, this DT determines that the Respondent:

(a) be suspended from practice for a period of **six 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.

H. PUBLICATION OF DECISION

55. We order that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of parties including but not limited to the Patient.

56. The hearing is hereby concluded.

Dated this 28th day of November 2017.