
SENTENCING GUIDELINES

For Singapore Medical Disciplinary Tribunals

SINGAPORE MEDICAL COUNCIL

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I. INTRODUCTION

1. The Sentencing Guidelines Committee (the “**Committee**”) was appointed by the Singapore Medical Council (“**SMC**”) on 1 January 2019. The Committee was given a mandate to develop a framework to guide SMC Disciplinary Tribunals (“**DTs**”) on the appropriate sanctions to be meted out to doctors who are charged and found guilty before the DTs.¹

A. The Role of Disciplinary Tribunals in Medical Disciplinary Proceedings

2. The medical profession in Singapore is an esteemed one that is granted the privilege of self-regulation. It is crucial that self-regulation is effective. When a doctor departs from acceptable standards of conduct, a process is set in motion to establish whether the departure is egregious enough to warrant disciplinary action. As noted by the Court of Three Judges (the “**Court**”) in *Singapore Medical Council v Lim Lian Arn*,² “*the law seeks to strike a balance between, on the one hand, providing for the imposition of appropriate sanctions in those cases where there has been a grave failure on the part of the medical practitioner with possibly severe consequences for the patient, and, on the other hand, providing a rich range of options for the counselling, education and rapid rehabilitation of those practitioners who have departed from the expected standards but not in a persistent or sufficiently serious way.*”
3. The DTs sit at the apex of the medical profession’s self-regulatory disciplinary process. When a complaint is lodged against a doctor, the SMC refers the complaint to the Chairman of the Complaints Panel, who will appoint a Complaints Committee (“**CC**”).³ The CC will refer the case to a DT if it determines that a formal inquiry is necessary.⁴ In this regard, members of the medical profession should be able to trust DTs to reach fair and consistent outcomes, not only in determining guilt, but also in sentencing after guilt is determined. DTs should in all cases determine the issue(s) on guilt first, and may in certain cases (especially the more complex cases) find it useful to have a separate hearing to consider the appropriate sentence.

¹ The composition of the Committee and its Terms of Reference are at **ANNEX A** and **ANNEX B** respectively.

² [2019] SGHC 172 at [1] (“*Lim Lian Arn (SGHC)*”).

³ Medical Registration Act (Cap. 174, Rev. Ed. 2014) (“**MRA**”) s. 39(2), s. 40

⁴ MRA s. 49(2)

B. The Objective of the Sentencing Guidelines

4. When a doctor is found guilty of the charge(s) brought against him, the DT has a wide range of sentencing options at its disposal, ranging from counselling, censure and fines, to suspensions or striking off the doctor's name from the medical register.⁵
5. Without established sentencing guidelines, DTs have often had to rely on submissions from the SMC (i.e. the prosecutor) or the doctor (i.e. the offender), or even conduct their own research to distil principles or factors from precedent cases or other jurisdictions before determining the sentence. This can result in patchy, inconsistent results.
6. In November 2018, the Court in *Wong Meng Hang v Singapore Medical Council*⁶ ("**Wong Meng Hang**") laid down a four-step sentencing framework and a "harm-culpability matrix" containing an indicative sentencing range to assist DTs or the Court to systematically weigh all the relevant considerations when making a sentencing decision.
7. These Sentencing Guidelines therefore serve to explain, elucidate and elaborate on the *Wong Meng Hang* sentencing framework. They are intended to provide guidance to DTs on their sentencing decisions, as well as inform practising doctors on the possible consequences of their transgressions. It is hoped that these Sentencing Guidelines will promote fairness, consistency and transparency in the sentencing of errant doctors in the Singapore medical disciplinary process.
8. These guidelines are not a substitute for legislation. They may be revised and updated as and when the need arises. The illustrations and guidance contained in these guidelines are not exhaustive or binding, and DTs should consider the facts and circumstances of each case when applying these guidelines.

⁵ MRA ss. 53(2) and 49(1)

⁶ [2019] 3 SLR 526

II. SENTENCING OBJECTIVES IN MEDICAL DISCIPLINARY PROCEEDINGS

9. Medical disciplinary proceedings enforce professional standards which keep the public safe, uphold the standing and reputation of the profession, and prevent an erosion of public confidence in the trustworthiness and competence of its members. Unlike criminal proceedings (where the general objective is to punish the criminal conduct) or civil proceedings (where the general objective is to compensate the patient for medical negligence), broader public interest considerations are paramount in medical disciplinary proceedings.⁷ At the same time, the DTs should also bear in mind other sentencing objectives such as deterrence, retribution and rehabilitation.
10. By way of elaboration, the sentencing objectives in medical disciplinary cases are as follows:

Public interest considerations

- a. **Upholding the reputation of and confidence in the medical profession** – The medical profession is founded upon a bedrock of unequivocal trust and a presumption of unremitting professional competence, and is a historically venerated profession. Commensurate with the high level of trust and esteem which society reposes in the medical profession, the SMC expects its members to uncompromisingly maintain the highest standards of professionalism and ethical behaviour.⁸ Disciplinary sanctions signal the medical profession’s disapproval of an errant member’s conduct, thereby enabling the medical profession to maintain its revered and respected position in society.
- b. **Protection of the health, safety and well-being of the public** – When a doctor fails to discharge his or her duties to the expected standards, disciplinary sanctions ensure that the doctor does not repeat the offence, and that the public is protected from potentially severe outcomes.⁹ This ensures that only doctors who are competent and fit to practise medicine are allowed that privilege.

⁷ *Wong Meng Hang* at [23] – [24].

⁸ *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [87] – [88]; *Wong Meng Hang* at [23].

⁹ *Singapore Medical Council v Kwan Kah Yee* [2015] SGHC 227 (“*Kwan Kah Yee*”) at [50] – [51]; *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 (“*Ang Peng Thiam*”) at [89].

Other sentencing considerations

- c. **General deterrence** – One objective in sentencing is to, by making an example out of a particular doctor, educate the public and other like-minded doctors that punishment will be certain and unrelenting,¹⁰ thereby deterring similar conduct. Together with public interest considerations, general deterrence is a central and operative sentencing objective in most, if not all disciplinary cases.¹¹
- d. **Specific deterrence** – Specific deterrence is directed at discouraging *the particular doctor* from committing future offences.¹² The idea is that if a sufficient degree of unpleasantness and distress is placed on the doctor through the imposed sanction, that doctor will take steps to desist from that conduct in the future to avoid the distress and ignominy of further punishment.¹³ More weight may be accorded to this sentencing objective in cases involving recalcitrant doctors, as opposed to those with long, unblemished track records that are suggestive of a lack of propensity to reoffend.¹⁴
- e. **Retribution** – The essence of retribution is that the offender must pay for what he has done.¹⁵ There is a need to punish a doctor who has been guilty of misconduct.¹⁶ The corollary is that the sanction meted out should reflect the severity of the misconduct. Unlike the other sentencing objectives, retribution justifies punishment by looking at past conduct rather than its prospective usefulness in preventing the errant conduct.¹⁷
- f. **Rehabilitation** – Rehabilitation seeks to reform the offender by altering his or her values, thus ensuring that the offender does not reoffend.¹⁸ In Singapore medical disciplinary proceedings, the CC is empowered to make several rehabilitative orders, such as ordering the doctor to complete specified further education or training,¹⁹ or seek and take advice in relation to the management of the doctor's

¹⁰ *Kwan Kah Yee* at [55]–[57], citing *Tan Kay Beng v PP* [2006] 4 SLR(R) 10 at [31].

¹¹ *Wong Meng Hang* at [25] and [44].

¹² *Wong Meng Hang* at [25].

¹³ *PP v Loqmanul Hakim bin Buang* [2007] 4 SLR(R) 753 at [25].

¹⁴ *Wong Meng Hang* at [25], citing *Kwan Kah Yee* at [57] and *Ang Peng Tiam* at [105]–[107].

¹⁵ Kow Keng Siong, *Sentencing Principles in Singapore* (Academy Publishing (2009) (“**Sentencing Principles in Singapore**”) at [06.015].

¹⁶ *Wong Meng Hang* at [25].

¹⁷ *Sentencing Principles in Singapore* at [06.019].

¹⁸ *Public Prosecutor v Mohammad Al-Ansari bin Basri* (2008) 1 SLR 449 at [29] – [30].

¹⁹ MRA s. 49(1)(d)

medical practice.²⁰ While rehabilitation features less prominently in cases reaching the DTs, the DTs are nonetheless empowered to impose orders that a CC can impose, including rehabilitative orders.²¹ Rehabilitative orders may be considered in appropriate cases, whether as an alternative or in addition to the other sanctions. They may be appropriate in less serious cases where the other sentencing objectives do not feature as prominently, and/or where the doctor shows that he or she is amenable to reform.

11. When particular interests pull the DT in different directions in a given case, it is the interest of the public that is paramount and must therefore prevail.²² A particular sentence that may appear excessive when assessed solely from the perspective of the doctor's offence may nonetheless be warranted from a public interest perspective.²³

²⁰ MRA s. 49(1)(f)

²¹ MRA s. 53(2)(h)

²² *Law Society of Singapore v Ravi s/o Madasamy* [2016] 5 SLR 1141 at [32].

²³ *Law Society of Singapore v Chia Choon Yang* [2018] 5 SLR 1068 at [17], citing *Law Society of Singapore v Ravi s/o Madasamy* [2016] 5 SLR 1141.

III. COMMON TYPES OF DISCIPLINARY OFFENCES

12. Under MRA s. 53(1), a DT may impose disciplinary sanctions on a doctor only if one or more of the five limbs is made out: -
 - a. The doctor has been convicted in Singapore or elsewhere of any offence involving fraud or dishonesty (MRA s. 53(1)(a));
 - b. The doctor has been convicted in Singapore or elsewhere of any offence implying a defect in character which makes him unfit for his profession (MRA s. 53(1)(b));
 - c. The doctor is guilty of such improper act or conduct which brings disrepute to his profession (MRA s. 53(1)(c));
 - d. The doctor is guilty of professional misconduct (MRA s. 53(1)(d)); or
 - e. The doctor failed to provide professional services of the quality which is reasonable to expect of him (MRA s. 53(1)(e)).
13. The DTs see a wide range of offences, which can broadly be categorised into clinical and non-clinical care offences.
14. Clinical care offences generally involve the medical management of patients where the treatment and care of the patient is the doctor's primary concern, and harm is actually or may have potentially been caused to an individual patient. Clinical care offences can include: (a) failure to provide adequate clinical evaluation; (b) misdiagnosis / failure to diagnose; (c) failure to practice within a doctor's area of competence; (d) failure to refer a patient when necessary, and in a timely manner; (e) delay in treatment; (f) unnecessary / inappropriate treatment; (g) mismanagement in treatment or care of a patient; (h) excessive / inappropriate prescription of drugs; (i) non-evidence based practices / practices not generally accepted by the profession; (j) failure to obtain informed consent (including where inadequate and inappropriate consent was obtained); and (k) failure to provide professional services of a quality that may be reasonably expected.
15. Non-clinical care offences concern all other matters not directly related to patient care, including (a) breach of advertising guidelines; (b) false / inappropriate certification; (c) failure to keep proper medical records or documentation; (d) providing false / misleading

information or false declaration; (e) breach of medical confidentiality; (f) inappropriate relationship with a patient; (g) failure to protect a patient's right to privacy and dignity; (h) overcharging / improper charging; (i) inappropriate association with persons not qualified to provide medical or medical support services; and (j) convictions in court for offences involving fraud or dishonesty or offences implying defect in character making the doctor unfit for his profession.

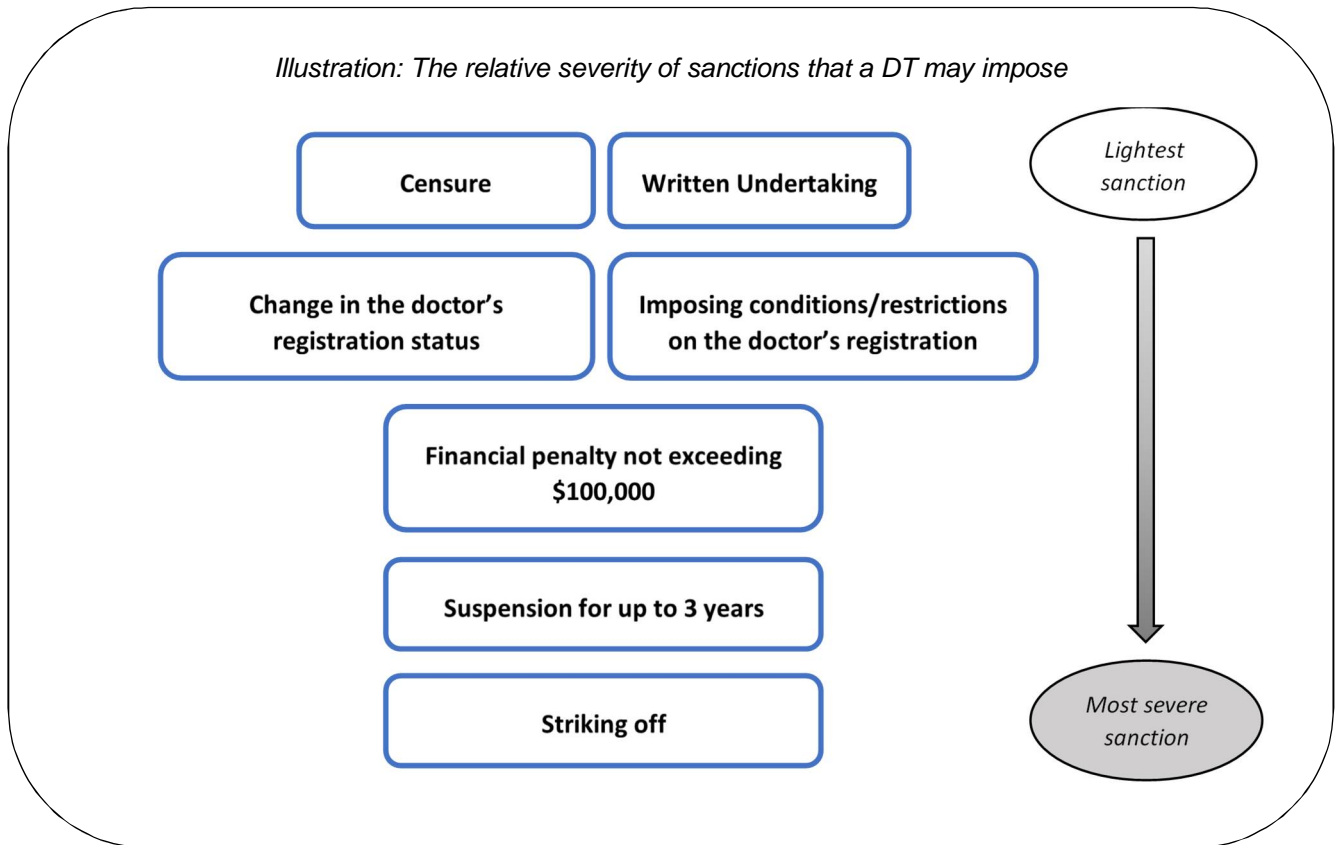
16. Unlike clinical care offences, the harm caused to individual patients in non-clinical care offences may not be as apparent or direct. However, with such offences, there is still harm to public confidence in the profession, and the health and safety of the public.
17. As discussed at paragraphs 43 - 45 below, the *Wong Meng Hang* sentencing framework can be applied to analyse both clinical and non-clinical care offences. It is highlighted that a doctor's misconduct may transverse both clinical and non-clinical care matters, and it is not necessary to maintain a rigid dichotomy between clinical and non-clinical care offences.

IV. SENTENCING OPTIONS

A. Overview

18. A DT may make one or more of the following orders against a respondent doctor:²⁴
- a. Removal of the doctor's name from the register of doctors;
 - b. Suspension of the doctor for up to 3 years;
 - c. Change in the doctor's registration status, i.e. from a fully registered doctor to a conditionally registered doctor;
 - d. Impose conditions or restrictions on the doctor's registration;
 - e. Financial penalty not exceeding \$100,000;
 - f. Censure in writing;
 - g. A written undertaking be given by the doctor to abstain in future from the conduct complained of; and/or
 - h. Such other order as the DT thinks fit, including those that a CC can make.

²⁴ See MRA s. 53(2).



B. Types of Sentences

(1) Censure and Written Undertaking (*MRA s. 53(2)(f) – (g)*)

19. A censure is a formal disapproval of a doctor's conduct and is regarded as a lighter form of sentence as compared to a financial penalty or a suspension.²⁵ A censure on its own does not impose any restriction or affect the doctor's practice, and as such, is commonly paired with an order for the doctor to provide an undertaking to abstain in future from the conduct complained of. This pair of orders, together with payment of costs, is commonly sought by the SMC and granted by DTs, and is sometimes collectively referred to as the

²⁵ See *Kwan Kah Yee* at [49] where the Court commented that a mere censure was "overly lenient" where the doctor had improperly issued a false death certificate based on non-existent medical grounds, which constituted a "very serious breach" of the SMC Ethical Code and Ethical Guidelines. In *Singapore Medical Council v Dr Yeo Eng Hui Damian* [2019] SMC DT 6 ("**Yeo Eng Hui Damian**"), the DT also considered that a censure would be inadequate as a sanction as it was necessary to make it clear to the medical profession and the public that the doctor's misconduct of illicit drug consumption will not be condoned, and to assure the public that measures have been put in place to ensure that the doctor does not relapse or abuse drugs while on duty: at [31]. See also *Wong Meng Hang* at [34].

“usual orders”.²⁶ It is however, common for DTs to impose other sanctions, such as a fine and/or a term of suspension in addition to the usual orders.²⁷

(2) Financial Penalty (*MRA s. 53(2)(e)*)

20. Financial penalties or fines are generally considered to be a less severe sanction than a suspension or an order to remove the doctor’s name from the register, and may be suitable for cases where the harm caused by the doctor is slight and the culpability of the doctor is low (see paragraph 55 below).
21. Fines may also be appropriate as an additional sentence, e.g. on top of a suspension order, in the following scenarios:
- a. Where there is evidence that the doctor has profited or had intended to profit from the misconduct.²⁸

Illustrations

- (i) A doctor forged medical certificates to absent himself from work at the hospital where he was employed, in order to work as a locum at a private clinic and earn more money.
(e.g. *Singapore Medical Council v Dr Joel Arun Sursas* [2018] SMCDT 8)
- (ii) A doctor is found to have excessively prescribed cough syrup or hypnotics, and had profited or intended to profit from the sale of such medicines.

- b. Where a sentence of suspension may have no direct effect or impact on the doctor because he is not on the register, or does not practise in Singapore.²⁹ In such cases, the additional measure of a fine may be relied upon to achieve the appropriate punitive effect. The fine also sends a signal to errant doctors who are able to practise overseas that they cannot simply avoid the punishment for their

²⁶ *In the Matter of Dr Chew Yew Meng Victor* [2017] SMCDT 3 at [31]; *In the Matter of Dr Sim Kwang Soon* [2017] SMCDT 4; *In the Matter of Dr Siew Hin Chin* [2017] SMCDT 5 at [36(c)].

²⁷ See for instance *Singapore Medical Council v Leo Kah Woon* [2018] SMCDT 12 at [24] and [82]; and *In the Matter of Dr Goh Yong Chiang Kelvin* [2018] SMCDT 2 at [72]. See also *Wong Meng Hang* at [34].

²⁸ *Singapore Medical Council v Dr Joel Arun Sursas* [2018] SMCDT 8 (“**Dr Joel Arun Sursas**”) at [32]-[33] and [61].

²⁹ *Dr Joel Arun Sursas* at [60]-[61]; *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] SGHC 58 (“**Mohd Syamsul Alam bin Ismail**”) at [21]-[22].

misconduct by practising elsewhere and/or waiting out the period of suspension. In such a situation, a fine may be imposed as an additional sentence and not to *replace* the intended sentence. It should not substitute a suspension, as a suspension carries implications on a doctor's registration, and may affect the doctor's ability to practise elsewhere.

Illustration

Where the doctor is no longer on the register by the time the DT makes a decision on sentence, or where the doctor has ceased practice in Singapore and is instead practising overseas, an additional sentencing measure of a fine would be appropriate because the punitive effect of a suspension may be curtailed or diluted insofar as his practice in Singapore is concerned.

(e.g. *Singapore Medical Council v Mohd Syamsul Alam Bin Ismail* [2019] SGHC 58)

22. The maximum fine that may be imposed by a DT is \$100,000. The MRA does not prescribe the precise quantum for fines for specific types of breaches, but the quantum of fines imposed should still be carefully calibrated according to the specific facts of each case, and should be proportionate to the seriousness of the offence.³⁰

(3) Change in Registration Status or Imposition of Conditions or Restrictions on Registration (MRA s. 53(2)(c) – (d))

23. A DT may:
- a. Order the removal of the name of a fully registered doctor from Part I of the Register of Medical Practitioners and register him instead under Part II of that Register as a medical practitioner with conditional registration, with the orders under MRA ss. 21(4) and (6) to (9)³¹ to apply accordingly: MRA s. 53(2)(c); or

³⁰ In the case of *Lim Lian Arn* (SGHC), the DT had imposed the maximum fine of \$100,000, a sentence proposed by the doctor himself. While the doctor was later acquitted by the Court of Three Judges, the Court remarked in *dicta* that the quantum of the fine imposed by the DT would have been “wholly unwarranted” even if the misconduct had been made out, as the doctor’s degree of culpability and the harm that ensued were not high: at [63]. The Court of Three Judges in *Lam Kwok Tai Leslie v. Singapore Medical Council* [2017] 5 SLR 1168 at [89] also mentioned that fines at the higher end of the range set out in the MRA s. 53(2)(e) should be imposed where the offences are not so serious as to deserve the statutory minimum of three months’ suspension, but too serious to be punished merely by the sanctions set out in ss. 53(2)(f) and 53(2)(g).

³¹ These sections set out a supervision framework involving the supervision of the doctor by an SMC approved doctor, as well as the review and management of the performance of the doctor under supervision.

- b. Where the registered medical practitioner is registered under any register other than Part I of the Register of Medical Practitioners, order the imposition of conditions or restrictions on his registration: MRA s. 53(2)(d).
24. These sanctions seek to restrict and/or impose conditions on a doctor's practice. It may entail requiring the doctor to work under supervision, be subjected to treatment and/or rehabilitation sessions, provide progress reports etc. These sanctions may be suitable in cases where the doctor has sufficient insight into the seriousness and consequences of his or her conduct, is likely to be able to comply with the conditions and restrictions imposed, and has the potential to positively respond to remediation, retraining, supervision and/or rehabilitation.³²
25. A doctor is likely to have insight into the seriousness and consequences of his or her misconduct if he or she:
- a. Accepts that he or she should have behaved differently (e.g. by showing empathy and understanding);
 - b. Takes timely steps to remediate (e.g. takes steps to address concerns about his knowledge, skills, conduct or behaviour, for example, voluntarily attending courses and/or taking active steps to improve his or her clinical care and medical practice, such that the lapse would not be repeated³³);
 - c. Expresses remorse at an early stage; and
 - d. Demonstrates the timely development of insight during the investigation and hearing.

³² See *Dr Yeo Eng Hui Damian* at [31]-[32].

³³ See *Singapore Medical Council v Dr Ganesh Ramalingam* [2018] SMCDT for an example of timely remediation. In that case, the doctor failed to (i) obtain informed consent; (ii) keep proper medical records; and (iii) undertake an adequate clinical assessment and evaluation of the patient before offering a gastroscopy and colonoscopy. The doctor acknowledged his shortcomings, and voluntarily took active steps to improve his clinical care and medical practice, including (i) using pamphlets and visual aids when obtaining informed consent; (ii) ensuring there is a sufficient elapse of time before the advice is given and a patient signs a consent form, and even after signing the consent form, the patient would be informed that they have the liberty to cancel the procedure if they decide not to proceed; (iii) typing contemporaneous case notes, and double checking at the end of the day that the patients' records are properly and accurately captured; and (iv) instituting a 24-hour hotline on which patients can contact him personally if they have any queries or doubts regarding their procedure or medical condition.

26. On the other hand, a doctor is likely to lack such insight if he or she: -
- a. Refuses to apologise or accept his or her mistakes;
 - b. Promises to remediate, but fails to take appropriate steps, or only to do so when prompted immediately before or during the hearing; and
 - c. Does not demonstrate the timely development of insight.
27. Any conditions or restrictions imposed should be clear, workable, achievable, straightforward to carry out, with a clear end date to aim towards.³⁴ As these sanctions are generally less severe than a fine and/or suspension, it may not be suitable for a doctor guilty of serious personal misconduct such as dishonesty or sexual offences, or serious professional misconduct.³⁵
28. Some situations where the imposition of conditions or restrictions may be appropriate include:
- a. Where there are identifiable and discrete aspects of the doctor's practice that are problematic, and which may be addressed by the imposition of appropriate conditions or restrictions;
 - b. Where the deficiencies are not so significant such that patients will be put at risk directly or indirectly as a result of the doctor continuing to be registered and allowed to practise; or
 - c. Where the doctor has shown timely evidence of insight into the seriousness and consequences of his or her misconduct, and willingness to respond positively to conditions or restrictions.

³⁴ *Yeo Eng Hui Damian* at [38].

³⁵ *Yeo Eng Hui Damian* at [48].

Illustration

A doctor had been arrested and investigated for drug related offences. The DT noted that the doctor had been compliant with the informal conditions and restrictions imposed on him by his employer, with no reports of any incidents since then. His colleagues and supervisors also appeared to provide him a good level of support. The DT agreed that what he needed was addictions counselling. The order for the doctor's placement on conditional registration was to reintegrate the doctor into his professional work, to build the confidence of, and to show good faith to, his colleagues and the public.

(e.g. *Singapore Medical Council v Dr Yeo Eng Hui Damian* [2019] SMCDT 6)

(4) Suspension (*MRA s. 53(2)(b)*)

29. A DT may order the suspension of the registration of a doctor from the appropriate register for a period of not more than 3 years.³⁶
30. A suspension order would be appropriate in cases apart from those involving slight harm and a low level of culpability (see paragraph 55 below). A suspension is considered when the misconduct is serious and unbecoming of a doctor, but does not cross the threshold of being fundamentally incompatible with the profession to warrant a removal from the register. It is a serious sanction meant to signal the profession's disapprobation of the misconduct and carries with it the view that the doctor should not be able to practise for a period of time. As such, a suspension of a nominal period is typically unsuitable.

³⁶ MRA s. 53(2)(b)

Illustration

Where there is serious harm to patients and a negligent failure on the part of the medical practitioner to do something that he ought to have done which would have avoided that harm or at least reduced the likelihood of that occurrence, a suspension is likely to be warranted. For example, the doctor had performed a procedure on his patient which failed, with a known complication of the failed procedure being perforation of the duodenum. Despite having an ‘inkling’ that something might be wrong after the patient complained of abdominal pain after the procedure, the doctor went home for the day instead of personally examining the patient that day. He was found guilty on a charge of wilful neglect of his duties and gross mismanagement of the post-operative treatment of his patient, and was suspended from practice.

(Lee Kim Kwong v Singapore Medical Council [2014] 4 SLR 113 at [34], [37]- [40], referring to the case of Gan Keng Seng Eric v Singapore Medical Council [2011] 1 SLR 745)

(5) Removal of Doctor’s Name from Register (s 53(2)(a) of MRA)

31. Also known as “striking off”, an order to remove the name of the doctor from the register is regarded as the “strongest signal of professional sanction and disavowal”, and is reserved for the most serious cases of misconduct.³⁷ The guiding principle to assessing whether striking off would be appropriate would be whether the misconduct was so serious or so fundamentally at odds with the values of the medical profession that it renders the doctor unfit to remain as a member of the medical profession.³⁸
32. Several factors which would give rise to a consideration for striking off include:³⁹
- a. When the misconduct in question involves a flagrant abuse of the privileges accompanying registration as a medical practitioner;
 - b. Where the doctor’s misconduct has caused grave harm, either to his or her patients or to society as a whole, or creates a real risk of enormous potential harm to his or her patients;

³⁷ *Wong Meng Hang* at [45].

³⁸ *Wong Meng Hang* at [66].

³⁹ *Wong Meng Hang* at [67].

- c. Where the culpability of the doctor is high, and where the doctor has acted in callous disregard of his or her professional duty as well as the health of his or her patients or the general public;⁴⁰
- d. Where the departure from the relevant professional standards is particularly egregious;
- e. Where a continuing risk of harm to patients or other persons is identified;
- f. Where a doctor's misconduct evinces a serious defect of character;
- g. Where the facts disclose an element of dishonesty, particularly where it is persistent or covered up (see paragraph 33 below);⁴¹
- h. Where there is an abuse of a position or trust or violation of rights of patients, or if it involves vulnerable persons;
- i. Where there are convictions or findings involving sexual offences; and
- j. Where any of the above factors are present, the facts also reveal the further and additional factor that the doctor has shown a persistent lack of insight into the seriousness and consequences of his or her misconduct.⁴²

Illustration

A doctor was convicted by the Singapore courts on criminal charges of outrage of modesty of his patient under sedation, and administering stupefying drugs with the intent of committing molest. In such cases where the doctor's actions imply a defect of character that renders him fundamentally unsuited to continue as a registered medical practitioner, the interest of the public can only be protected by a removal of the doctor's name from the register.

(e.g. *Singapore Medical Council v Tan Kok Leong* [2019] SMCDT 4)

⁴⁰ *Singapore Medical Council v Tan Kok Leong* [2019] SMCDT 4 at [46], citing *Wong Meng Hang* at [67(c)]: "...e.g. when a doctor acts in callous disregard of professional duties or the health of patients or the general public, or abdicates the basic duties of a doctor by falsifying patient's charts due to sloth."

⁴¹ See *Wong Meng Hang* at [72]-[74].

⁴² *Wong Meng Hang* at [67(f)]: "...this will generally be a further or additional factor, in that there must be sufficiently serious misconduct before a doctor's lack of insight may contribute to a finding that striking off would be appropriate."

Dishonesty

33. The integrity of doctors is crucial given the high regard accorded to the medical profession, and the fact that patients entrust their health to and place their lives in the hands of doctors. Dishonesty, particularly when associated with professional practice, is highly damaging to a doctor's fitness to practice and to public confidence in the profession. Examples of dishonesty in professional practice include, but are not limited to:
- a. Defrauding an employer or contracting body;
 - b. Falsifying and/or improperly amending patient records;
 - c. Submitting or providing false references;
 - d. Providing misleading information on a CV; and
 - e. Misconduct in relation to research, for example, presenting misleading information in publications or dishonesty in relation to clinical trials.
34. Dishonesty is serious even if the offence was committed outside of a doctor's professional practice, and did not involve direct harm to patients.
35. Offences involving dishonesty will be visited with severe sanctions, including an order for striking off, in cases where:
- a. The dishonesty is integral in the commission of a criminal offence of which the doctor has been convicted; or
 - b. The dishonesty violates the relationship of trust and confidence between doctor and patient.⁴³
36. In other cases involving dishonesty, but which do not fall into the categories in paragraph 35 above, the following non-exhaustive factors should be considered:⁴⁴
- a. The real nature of the wrong and the interest that has been implicated;

⁴³ *Wong Meng Hang* at [72].

⁴⁴ *Wong Meng Hang* at [73].

- b. The extent and nature of the deception;
- c. The motivations and reasons behind the dishonesty and whether it indicates a fundamental lack of integrity on the one hand or a case of mis-judgment on the other;
- d. Whether the doctor benefited from the dishonesty; and
- e. Whether the dishonesty caused actual harm or had the potential to cause harm to the patient that the doctor ought to have or in fact recognised.

(6) Any Other Orders (MRA s. 53(2)(h))

- 37. Apart from the specifically defined orders listed under MRA s. 53(1), a DT is also empowered to make “such other order as [it] thinks fit”, including any order a CC may make under MRA s. 49(1).
- 38. This means that a DT may, where appropriate and in addition to any of the above orders, issue a letter of advice or warning to the doctor; order the doctor to seek and undergo medical or psychiatric treatment or counselling; or order the doctor to undergo further training.⁴⁵ For example, an additional order may be made for a doctor to obtain an additional number of Continuing Medical Education points as a condition for renewal of his or her practising certificate.⁴⁶

⁴⁵ See MRA s. 49(1).

⁴⁶ *In the Matter of Dr Ng Hor Liang* [2015] SMCDT 4.

V. MAKING THE APPROPRIATE SENTENCING ORDER

39. When a complaint is referred to the DT, the DT should establish that the departure in question (e.g. from the standards provided in the SMC Ethical Code and Ethical Guidelines, or from the standards observed by reasonable practitioners in the profession) is so egregious that it warrants disciplinary action.⁴⁷ The DTs should then determine whether the doctor is guilty of the charge(s). Only then, should the DTs proceed to consider the appropriate sentence to be imposed.
40. Having considered what sentencing seeks to achieve (see Part II above), the types of disciplinary offences (see Part III above), and the range of sentencing options available to a DT (see Part IV above), we now turn to how a DT should make an appropriate sentencing order.

A. General Sentencing Principles

41. In general, sentences imposed must be fair and just in the light of all the circumstances of the case.⁴⁸ Other than applying the sentencing framework laid down in *Wong Meng Hang*, a DT can take guidance from sentencing principles developed by the Singapore criminal courts, while always bearing in mind the unique, broader public interest considerations, as well as sentencing objectives such as deterrence, retribution, and rehabilitation in medical disciplinary cases.⁴⁹ These general sentencing principles also include proportionality and consistency in sentencing, as well as the one-transaction rule and the totality principle in cases of multiple offences. These principles are elaborated on at paragraphs 60 - 61, 62 - 65, 79 - 80, and 82 - 85 below.

B. Application of Sentencing Principles in Medical Disciplinary Cases

(1) The Sentencing Framework

42. In *Wong Meng Hang*, the Court laid down a four-step sentencing framework to systematically weigh all relevant considerations in medical disciplinary cases. This sentencing framework takes into account offence-specific factors of “harm” and “culpability”, as well as offender-specific aggravating and mitigating factors. The Court

⁴⁷ *Lim Lian Arn (SGHC)* at [1] & [30].

⁴⁸ *Ang Peng Tiam* at [89].

⁴⁹ See paragraph 10 above.

also laid down an indicative sentencing range. In these guidelines, the four-step analysis shall be referred to as the “Sentencing Framework”.

The Sentencing Framework can apply to both clinical and non-clinical offences

43. The facts of *Wong Meng Hang* pertained to clinical care offences. In analysing that case, the Court was of the view that the sentencing framework it expounded was only applicable “*where deficiencies in a doctor’s clinical care cause harm to a patient*”⁵⁰ (i.e. clinical care offences), and not to non-clinical care offences, because the latter involved “*considerations that are specific to the type of misconduct in question and which would not arise in cases relating to clinical care*”, and “*the types of harm caused by those forms of misconduct may be markedly different in nature to that which is caused by the misconduct in the form of deficient clinical care*”.⁵¹ The Court’s reservation appeared to be that because non-clinical care offences, unlike clinical care offences, did not necessarily result in physical harm to the patient, a different yardstick should be used.
44. Nonetheless, the definition of “harm” in *Wong Meng Hang* is broad enough to include other forms of harm, such as non-physical harm (e.g. emotional or psychological distress), potential harm, as well as harm caused to public confidence in the medical profession, or to public health and safety or the public healthcare system.⁵² For this reason, the Sentencing Framework may be extended to non-clinical care offences.
45. For the avoidance of doubt, the Sentencing Framework can apply not only to professional misconduct (MRA s. 53(1)(d)), but also to all five limbs under MRA s. 53(1).
46. Paragraphs 47 - 72 below elaborate on the general individual steps to be applied in the Sentencing Framework, while paragraphs 73 - 85 provide guidance on how to apply it when a doctor is found guilty of multiple offences.

⁵⁰ *Wong Meng Hang* at [36].

⁵¹ *Wong Meng Hang* at [36].

⁵² The Court explained that harm referred to “*the type and gravity of the harm or injury that was caused to the patient and indeed to society by the commission of the offence*”: *Wong Meng Hang* at [30(a)].

(1.1) Step 1 - Evaluate the seriousness of the offence with reference to harm and culpability

(a) “Harm”

47. Harm is the type and gravity of the harm or injury that was caused to the patient and society by the commission of the offence.
48. Harm to the patient can take various forms, including bodily injury, emotional or psychological distress, serious economic harm, increased pre-disposition to certain illnesses, dependence or tolerance to addictive drugs, loss of chance of recuperation or survival, and at the most severe end of the spectrum, even death.⁵³
49. Harm to society includes harm to public confidence in the medical profession, as well as harm to public health and safety,⁵⁴ and the public healthcare system.⁵⁵
50. DTs should consider not only the actual harm caused, but also the *potential* harm that could have resulted from the breach, even if such harm did not actually materialise on the given facts. For example, while using unregistered health products may not have resulted in actual harm in a particular case, the *potential* to cause harm should be considered so as to meet the sentencing objectives of general and specific deterrence.⁵⁶ When assessing potential harm, DTs should consider both (i) the seriousness of the harm risked, and (ii) the likelihood of the harm arising.⁵⁷ Potential harm should be taken into account only if there was a *sufficient likelihood* of the harm arising; it would not be appropriate to consider every remote possibility of harm for the purposes of sentencing.⁵⁸

⁵³ *Wong Meng Hang* at [30(a)].

⁵⁴ E.g. Excessive prescription of cough mixture can cause dependence to codeine, an addictive drug. Other than actual and potential harm caused to individual victims, codeine also carries the potential for abuse, e.g. drug addicts may consume them in between their supply of illicit drugs to get “high”, etc. Excessive prescription, particularly when the doctor knows that the drugs can be resold at a substantial profit in the black market, raises wider public health and safety concerns, and can cause harm to society by facilitating the black market trade and abuse of these addictive controlled substances by numerous unidentified victims other than just the individual concerned. See *Wong Meng Hang* at [49] and [67(b)].

⁵⁵ E.g. Issuing false death certificates, creating fraudulent medical records, and leaking patient’s private data harm the integrity of the public healthcare system.

⁵⁶ *Neo Ah Luan v Public Prosecutor* [2018] 5 SLR 1153 at [65] – [67].

⁵⁷ *PP v GS Engineering & Construction Corp* [2017] 3 SLR 682 at [77(c)], cited by the prosecution in *Neo Ah Luan* at [58].

⁵⁸ *Wong Meng Hang* at [30(a)].

51. DTs may wish to consider the following non-exhaustive factors when assessing the level of harm. These factors are fact-specific and should not be applied mechanistically. Much would depend on the circumstances of the case:-

Harm to the Patient

- a. **The seriousness of the eventual harm suffered by the patient.**
- b. **Permanence / reversibility of harm.**
- c. **The extent to which the eventual harm was connected to the doctor's misconduct.**⁵⁹ The eventual harm caused to the patient may not always be a direct result of the doctor's misconduct. For example, a doctor may have misdiagnosed a patient, who eventually died. However, the direct harm which the doctor caused to the patient may merely have been the loss of chance to receive appropriate and timely treatment, or loss of chance to recuperate. It may be that the patient would have died in any event. In considering the connection between the eventual harm and the doctor's misconduct, DTs may wish to consider:
 - (i) What was the direct harm caused to the patient as a result of the misconduct?
 - (ii) Were there extraneous factors that contributed to the eventual harm?
 - (iii) To what extent did the misconduct cause the eventual harm?
 - (iv) For informed consent cases, the extent to which the patient's autonomy was undermined, e.g. would the patient have chosen to undergo the procedure even if he had been informed of the risks and possible complications that could arise?

⁵⁹ *Wong Meng Hang* at [30(a)] and [82] – [84].

Illustration

The eventual harm suffered by the patient was death in all of the following three cases. However, as explained in *Wong Meng Hang* at [83] – [84] and [90], the levels of harm for the first two cases were lower than that in the last case.

- (i) In *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356, the patient was already suffering from life-threatening cancer. The oncologist misrepresented the chance that her disease would respond to his prescribed treatment of chemotherapy without testing for a particular mutation, and failed to offer the patient the alternative of surgery. The direct harm caused by the doctor was the patient's loss of chance of survival and right to make her decision on the type of treatment she should undergo. The doctor did not directly *cause* the death. The risk of death was inherent in the patient's medical condition.
- (ii) In *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745, the surgeon failed to personally attend to a patient post-operation, and hence failed to discover a known complication of surgery, which the patient eventually succumbed to. While the doctor was negligent, the direct harm caused by the doctor was the delay in the patient receiving medical attention to address the complication. The doctor did not directly *cause* the death. The risk of death was inherent in the medical procedure.
- (iii) In contrast, in *Wong Meng Hang*, the doctors administered anesthesia for an elective aesthetic procedure even though they were not trained to do so. They then failed to recognize that the administered dose was excessive causing the patient to enter a state of deep sedation. They also inflicted multiple puncture wounds to the patient's intestines in the course of the procedure, failed to monitor the patient closely after administering anesthesia, and left the patient unattended after the procedure even though monitoring was essential. The patient developed an airway obstruction and asphyxiated to death. In this case, the doctors' actions and omissions were the sole and direct cause of the patient's death.

- d. **The potential harm that could have been caused by the misconduct.** Potential harm should be taken into account only if there was a *sufficient likelihood* of the harm arising.⁶⁰

⁶⁰ *Wong Meng Hang* at [30(a)]; see paragraph 50 above.

Harm to Public Confidence in the Medical Profession

- e. **The number of breaches and extent of the doctor's breach.**
- f. **Severity of the consequences.** The greater the actual or potential harm caused to the patient, and the greater the number of patients harmed, the greater the harm would be to public confidence in the medical profession.
- g. **The nature of the offence.** With respect to offences not related to patient care (e.g. criminal offences in relation to fraud, dishonesty, other criminal offences implying a defect in the doctor's character, or improper acts or conduct which bring disrepute to the profession (MRA ss. 53(1)(a) – (c)), DTs can take into consideration: (i) the seriousness of the offence; (ii) the sentence imposed for the offence; and (iii) the extent to which the doctor's conduct has fallen short of qualities expected of doctors, such as integrity, honesty, compassion, sensitivity etc.
- h. **The circumstances in which the offence was committed.** Generally, offences committed in the doctor's professional capacity would cause greater harm to public confidence in the medical profession than offences committed in the doctor's personal capacity. Greater harm to public confidence is caused when the doctor abuses his or her relationship of trust and confidence with the patient.

Harm to Public Health and Safety or the Public Healthcare System

- i. **The number of breaches and extent of the doctor's breach.**

- j. **Severity of the consequences.** In determining the severity of the consequences, DTs may wish to consider: (i) the rationale behind the guideline or rule; (ii) the extent to which the doctor's misconduct undermined or could undermine that rationale; (iii) the consequences on public health and safety or the integrity of the public healthcare system because of the doctor's misconduct; and (iv) the number of people affected, or who could potentially be affected.

Illustrations

- (i) Greater harm is caused in improperly certifying death certificates than medical certificates. The harm caused by improperly issuing medical certificates is typically economic loss or lower productivity (on the part of the employer). On the other hand, improperly certified death certificates can potentially cover up homicides and evidence for civil lawsuits in malpractice or insurance cases, undermining society's ability to learn from the patients' deaths and diseases to formulate remedial or preventive measures in the future, and may cause great anguish and confusion for the bereaved family.

(Singapore Medical Council v Kwan Kah Yee [2015] SGHC 227 at [32] and [52] – [53])

- (ii) It is important for doctors to properly keep medical records, so that the care of patients can be safely taken over by another doctor should the need arise. Greater potential harm of inadequate medical records arises when the doctor practises in a group practice or where there is team-based care, with several other doctors any of whom might be called upon to take over any given case. (The other rationale for properly keeping medical records is to allow for the effective review of cases where problems have ensued and for the development of remedial or preventive measures.)

(Yong Thiam Look Peter v Singapore Medical Council [2017] 4 SLR 66 at [10])

52. As a broad guideline⁶¹: -

Level	Description
Slight Harm	<ul style="list-style-type: none"> • Where no actual personal injury was caused and there was low potential for personal injury; • Where the offence did not cause actual psychological or emotional harm to the patient; • Where the offence did not undermine public confidence in the medical profession and the healthcare system; and/or • Where the offence did not actually undermine public health and safety or the public healthcare system, and had low potential for doing so.
Moderate Harm	<ul style="list-style-type: none"> • Where there was some actual personal injury or substantial potential for serious personal injury; • Where the offence caused psychological or emotional harm to the victim; • Where the offence undermined public confidence in the medical profession and the healthcare system; and/or • Where the offence actually undermined public health and safety or the public healthcare system, or had substantial potential for seriously doing so.
Serious Harm	<ul style="list-style-type: none"> • Where the offence caused serious personal injury, including injuries which are permanent in nature and which necessitate surgical attention; • Where the offence caused serious mental injury, in the sense of a recognisable psychiatric illness; • Where the offence seriously undermined public confidence in the medical profession and the healthcare system; and/or • Where the offence seriously undermined public health and safety or the public healthcare system.

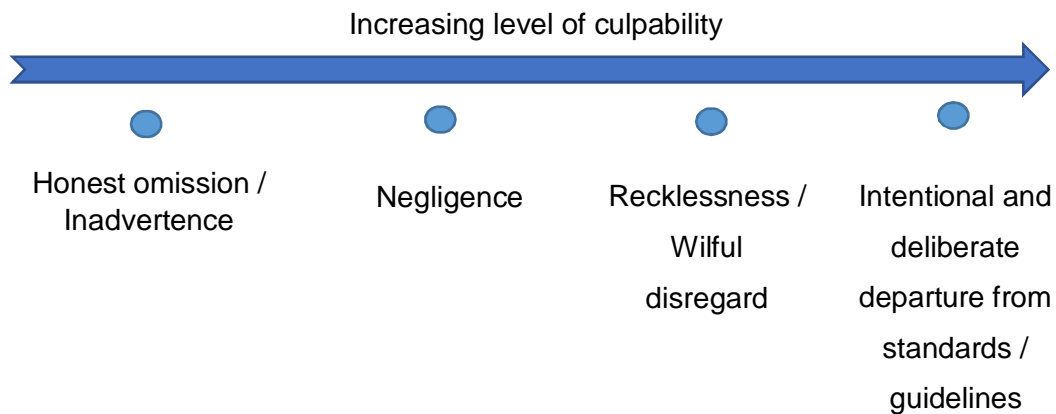
⁶¹ This guideline, with some minor adaptations, was laid down by the High Court in the criminal case of *Neo Ah Luan* at [74(a)(i)]. In that case, the offender was found guilty of two counts of practicing as a medical practitioner as an unauthorised person in contravention with MRA s. 13, which is an offence punishable under MRA s. 17(1)(e).

(b) “Culpability”

53. Culpability measures the doctor’s degree of blameworthiness.

54. DTs may wish to consider the following non-exhaustive factors when assessing the level of culpability. These factors are fact-specific and should not be applied mechanistically. Much would depend on the circumstances of the case:-

- a. **The doctor’s state of mind.** As a general guide from least culpable to the most culpable state of mind⁶²:



However, DTs should carefully consider the circumstances of the case before them. For example, a doctor’s intentional departure from medically-approved standards that was motivated by a genuine but mistaken concern for the patient’s interests may be less culpable than a doctor who acted negligently but in blatant disregard of the patient’s well-being.⁶³

- b. **The extent of premeditation and planning involved, including the lengths to which the doctor went to cover up his or her misconduct.** An offence committed with planning evinces premeditation towards flouting the rules, and attracts greater culpability than one committed opportunistically or on impulse.

⁶² In general, a less culpable state of mind would be one where ill intention on the part of the doctor is lacking. For example, an honest omission would be one where the doctor’s omission was not deliberate and not in bad faith. On the other hand, a more culpable state of mind would be one where an intention/awareness that a particular action was inappropriate was present. For example, a case of recklessness would involve awareness of the inappropriateness of a decision on the doctor’s part, but where the doctor decides to take on the risk anyway.

⁶³ *Wong Meng Hang* at [28], [37], [94(c)].

Attempts to cover up the misconduct attract greater culpability because such conduct prevents the harm from being rectified quickly, and evidences a preference for the doctor's own interest over the welfare of his or her patient and the integrity of the healthcare system, and dishonesty.⁶⁴

- c. **Whether the doctor was motivated by financial gain, and the extent of profits gained by that doctor from his or her breach.** A doctor who was motivated by financial gain when committing the offence prefers his or her own interests over the welfare of his or her patient and the integrity of the healthcare system, and is generally more culpable.
- d. **Extent of departure from the standard of care or conduct reasonably expected of a medical practitioner.** A doctor would be more culpable if what he or she failed to uphold was the "*most basic and elementary professional standards*".⁶⁵
- e. **Extent and manner of the doctor's involvement in causing the harm.** All things being equal, the lead proceduralist / senior doctors would generally be more culpable than his or her assistant / junior doctor.⁶⁶
- f. **Whether the treatment was an appropriate management option, and within the doctor's area of competence.** There is greater culpability if the prescribed treatment was not an appropriate management option for the disease / injury, or if the doctor lacked the requisite qualifications, training and/or experience to carry out the procedure, or if the doctor practised outside his or her area of competence.
- g. **Extent to which the doctor failed to take prompt action when patient safety or dignity was compromised.**
- h. **Urgency of the situation.** A doctor who committed the offence in an emergency situation may be less culpable than one who did not.
- i. **The duration of the offending behavior, having regard to the circumstances underlying the continuance of the offending conduct.** An offence being perpetrated over a sustained period of time (i.e. a pattern of misconduct) would be more culpable than a one-off offence, if it shows how "determined" that doctor was,

⁶⁴ *Wong Meng Hang* at [91].

⁶⁵ *Chia Foong Lin v Singapore Medical Council* [2017] 5 SLR 334 at [67]; *Dr Amaldass s/o Narayana* at [17].

⁶⁶ *Wong Meng Hang* at [108(a)].

or that the doctor is more likely to be a habitual offender. The weight to be given to this factor depends on the facts, including the state of mind of the doctor. For example, this factor may be given more weight if the doctor engaged in intentional and deliberate misconduct, but may carry less weight if the doctor negligently or unwittingly engaged in the misconduct over an extended period of time.⁶⁷

- j. **The extent to which the doctor abused his or her position of trust and confidence.** Patients are particularly vulnerable because of their dependence on doctors to treat their health issues, and the information asymmetry between them and their doctors.⁶⁸ A doctor who abuses a patient's trust and confidence for his or her own personal gain would be more culpable.

(1.2) Step 2 – Identify the applicable indicative sentencing range using the Court's matrix

55. The Court has laid down the following indicative sentencing ranges:-⁶⁹

Harm	Slight	Moderate	Severe
Culpability Low	Fine or other punishment not amounting to suspension.	Suspension of up to 1 year.	Suspension of 1 to 2 years.
Medium	Suspension of up to 1 year.	Suspension of 1 to 2 years.	Suspension of 2 to 3 years.
High	Suspension of 1 to 2 years.	Suspension of 2 to 3 years.	Suspension of 3 years or striking off.

56. The indicative range is a “*guide only*” and it “*does not displace the duty upon each sentencing tribunal to consciously seek, determine and impose the sentence which is appropriate in all the circumstances, and therefore to depart from [the] matrix where it is appropriate to do so*”⁷⁰. If a DT decides to depart from the indicative sentencing range, it should state its reasons for doing so in its written decision. In addition, as discussed at paragraphs 19 to 38 above on the types of sentences, a DT may in appropriate cases consider other orders in addition to the indicative sentencing range set out above, e.g.

⁶⁷ *Neo Ah Luan v Public Prosecutor* at [73].

⁶⁸ *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 at [44].

⁶⁹ *Wong Meng Hang* at [33].

⁷⁰ *Wong Meng Hang* at [33].

a fine in addition to an order of a suspension etc. DTs should also be aware that there are other sentencing options available, apart from what has been set out in the sentencing matrix above, such as changes in doctor's registration status or the imposition of conditions or restrictions on a doctor's registration.

57. The following illustrations show how the sentencing matrix may apply to a clinical care case and a non-clinical care case. They show how different facts and circumstances may attract different levels of harm and culpability. They are for illustrative purposes, and should not be applied mechanistically in cases before DTs. Much would depend on the unique facts and circumstances of the case.

Illustration: Clinical Care Misconduct

Core Facts

A patient in his late eighties complained of a persistent headache lasting about one week. He was referred to a neurosurgeon who ordered a cerebral angiogram. Upon reviewing the results, he noted that there was an unruptured aneurysm. The patient's aneurysm was located at the mid-basilar artery.

The treatment options for the aneurysm are either surgical clipping ("**Clipping**") or endovascular coiling ("**Coiling**"). Surgical clipping is an open surgery, performed by a neurosurgeon, where the skull is cut and the aneurysm is clipped with a device to seal off the aneurysm. Endovascular coiling is a less invasive technique, performed by an interventional radiologist, where a catheter is used to reach the aneurysm in the brain. Platinum coils are then released to induce clotting of the aneurysm and prevent blood from getting into it.

Coiling is a more recent treatment that has been found to be useful for older patients due to the less invasive nature and lower morbidity rates. On the other hand, one advantage of Clipping is long term durability. However, Clipping would not be appropriate if the aneurysm is located in a part of the brain where surgical access would be difficult, i.e. at the mid-basilar artery.

In the present illustration, the doctor, a neurosurgeon, decided to perform a Clipping procedure on the patient. However, given the patient's age, and the location of the aneurysm (i.e. at the mid-basilar artery) which made it almost inoperable, the less invasive procedure (i.e. Coiling) would have been less risky and therefore more appropriate. The DT accepted that given the circumstances of the patient and his condition, a Coiling procedure was the appropriate procedure as the Clipping procedure carried with it a high morbidity rate, was riskier and should not have been performed.

Non-exhaustive factors affecting the level of harm include:

1. The actual or potential harm suffered by the patient;
2. The permanence / reversibility of the harm;
3. The extent to which the eventual harm was connected to the doctor's misconduct (i.e. in this case, the doctor's decision to perform a Clipping procedure was not appropriate based on the circumstances of the patient, as it carried a high morbidity rate; the Coiling procedure would have carried less risk); and
4. The seriousness of the eventual harm suffered by the patient.

Non-exhaustive factors affecting culpability include:

1. The doctor's state of mind;
2. The extent to which the doctor departed from the applicable standard of care;
3. The doctor's motivation (e.g. malice, financial gain, etc.); and
4. Whether there was pre-meditation and attempts to conceal the misconduct.

■ = Harm Factors ■ = Culpability Factors

Illustration: Clinical Care Misconduct (cont.)

Harm Culpability	Slight	Moderate	Severe
Low	<p>Illustration (1)</p> <p>The doctor believed that it was in the best interests of the patient to perform the Clipping procedure and represented to the patient that the Clipping procedure was the more appropriate procedure for him. While the doctor had explained the risks of both the Clipping and Coiling procedure, he omitted to explain that the Clipping procedure carried a higher risk in his case due to the location of the aneurysm. The patient would have opted for the Coiling procedure rather than the Clipping procedure had he known of the higher risk.</p> <p>The patient suffered from an infection at the site of the head incision, which is a known complication. He recovered within a week, with no long term side effects.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Slight Harm: Patient suffered some pain and discomfort, but it was temporal in nature. • Low Culpability: (i) The doctor's representation and material omission affected the patient's decision; (ii) While the doctor had erred in making the decision to perform the Clipping procedure, he did so with patient's best interests at heart. <p>Indicative Sentence: Fine or other punishment not amounting to suspension.</p>	<p>Illustration (2)</p> <p>The doctor believed that it was in the best interests of the patient to perform the Clipping procedure and represented to the patient that the Clipping procedure was the more appropriate procedure for him. While the doctor had explained the risks of both the Clipping and Coiling procedure, he omitted to explain that the Clipping procedure carried a higher risk in his case due to the location of the aneurysm. The patient would have opted for the Coiling procedure rather than the Clipping procedure had he known of the higher risk.</p> <p>The patient suffered known complications during the surgery, which led to permanent memory loss, necessitating long term care.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Moderate Harm: The patient suffered permanent memory loss as a result of the Clipping procedure, which arose due to the doctor's inappropriate treatment. • Low Culpability: (i) The doctor's representation and material omission affected the patient's decision; (ii) While the doctor had erred in making the decision to perform the Clipping procedure, he did so with patient's best interests at heart. <p>Indicative Sentence: Suspension of up to 1 year.</p>	<p>Illustration (3)</p> <p>The doctor believed that it was in the best interests of the patient to perform the Clipping procedure and represented to the patient that the Clipping procedure was the more appropriate procedure for him. While the doctor had explained the risks of both the Clipping and Coiling procedure, he omitted to explain that the Clipping procedure carried a higher risk in his case due to the location of the aneurysm. The patient would have opted for the Coiling procedure rather than the Clipping procedure had he known of the higher risk.</p> <p>The patient died as a result of complications arising from the surgery.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Severe Harm: Death. The patient's death directly resulted from the doctor's misconduct of performing the Clipping procedure when it was not the appropriate treatment. • Low Culpability: (i) The doctor's representation and material omission affected the patient's decision; (ii) While the doctor had erred in making the decision to perform the Clipping procedure, he did so with patient's best interests at heart. <p>Indicative Sentence: Suspension of 1 to 2 years.</p>

■ = Harm Factors ■ = Culpability Factors

Illustration: Clinical Care Misconduct (cont.)

Harm Culpability	Slight	Moderate	Severe
Medium	<p>Illustration (4)</p> <p>As the doctor failed to keep up to date with medical developments, he was <u>not aware that the Coiling treatment existed</u>. He therefore <u>failed to offer the patient the option of Coiling</u>. Moreover, he <u>failed to explain the risks of the Clipping procedure</u>. The patient trusted the doctor and agreed to the surgery.</p> <p>The patient suffered from an <u>infection</u> at the site of the head incision. He <u>recovered within a week with no long term side effects</u>.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Slight Harm: Patient suffered some pain and discomfort, but it was temporal in nature. • Medium Culpability: The doctor had a duty to keep up to date and to offer the patient the various treatment options available. The failure of the doctor to do so led to the patient undergoing a risky surgery when a lower risk procedure was available. The doctor should also explain the risks of surgery. <p>Indicative Sentence: Suspension of up to 1 year.</p>	<p>Illustration (5)</p> <p>As the doctor failed to keep up to date with medical developments, he was <u>not aware that the Coiling treatment existed</u>. He therefore <u>failed to offer the patient the option of Coiling</u>. Moreover, he <u>failed to explain the risks of the Clipping procedure</u>. The patient trusted the doctor and agreed to the surgery.</p> <p>The patient suffered <u>complications during the surgery, which led to permanent memory loss</u>, necessitating <u>long term care</u>.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Moderate Harm: The patient suffered permanent memory loss as a result of the Clipping procedure, which arose due to the doctor's inappropriate treatment. • Medium Culpability: The doctor had a duty to keep up to date and to offer the patient the various treatment options available. The failure of the doctor to do so led to the patient undergoing a risky surgery when a lower risk procedure was available. The doctor should also explain the risks of surgery. <p>Indicative Sentence: Suspension of 1 to 2 years.</p>	<p>Illustration (6)</p> <p>As the doctor failed to keep up to date with medical developments, he was <u>not aware that the Coiling treatment existed</u>. He therefore <u>failed to offer the patient the option of Coiling</u>. Moreover, he <u>failed to explain the risks of the Clipping procedure</u>. The patient trusted the doctor and agreed to the surgery.</p> <p>The patient <u>died as a result of complications arising from the surgery</u>.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Severe Harm: Death. The patient's death directly resulted from the doctor's misconduct of performing the Clipping procedure when it was not the appropriate treatment. • Medium Culpability: The doctor had a duty to keep up to date and to offer the patient the various treatment options available. The failure of the doctor to do so led to the patient undergoing a risky surgery when a lower risk procedure was available. The doctor should also explain the risks of surgery. <p>Indicative Sentence: Suspension of 2 to 3 years.</p>

■ = Harm Factors ■ = Culpability Factors

Illustration: Clinical Care Misconduct (cont.)

Harm Culpability	Slight	Moderate	Severe
<p>High</p>	<p>Illustration (7)</p> <p>The doctor was <u>aware that due to the location of the aneurysm and the patient's age</u>, the patient <u>was not a suitable candidate</u> for the Clipping procedure.</p> <p>However, the doctor decided to <u>mislead</u> the patient that the Clipping procedure was the only treatment option available. The doctor did so because he wanted to <u>profit from the Clipping procedure and referring the patient to a radiologist to perform the Coiling procedure would mean a reduction in his fees</u>. The doctor <u>also failed to explain the risks of the Clipping procedure</u>.</p> <p>The doctor further <u>tampered with the clinical notes</u> to state that the patient was advised on alternative treatment options, when that was untrue.</p> <p>The patient suffered from an <u>infection</u> at the site of the head incision. He <u>recovered within a week, with no long term side effects</u>.</p> <p>Analysis Slight Harm: Patient suffered some pain and discomfort, but it was temporal in nature. High Culpability: The doctor (i) had misled the patient, (ii) was motivated by profit at the expense of patient's interests; and (iii) also attempted to cover up his misconduct</p> <p>Indicative Sentence: Suspension of 1 to 2 years.</p>	<p>Illustration (8)</p> <p>The doctor was <u>aware that due to the location of the aneurysm and the patient's age</u>, the patient <u>was not a suitable candidate</u> for the Clipping procedure.</p> <p>However, the doctor decided to <u>mislead</u> the patient that the Clipping procedure was the only treatment option available. The doctor did so because he wanted to <u>profit from the Clipping procedure and referring the patient to a radiologist to perform the Coiling procedure would mean a reduction in his fees</u>. The doctor <u>also failed to explain the risks of the Clipping procedure</u>.</p> <p>The doctor further <u>tampered with the clinical notes</u> to state that the patient was advised on alternative treatment options, when that was untrue.</p> <p>The patient suffered <u>complications during the surgery, which led to permanent memory loss</u>, necessitating <u>long term care</u>.</p> <p>Analysis Moderate Harm: The patient suffered permanent memory loss as a result of the Clipping procedure, which arose due to the doctor's inappropriate treatment. High Culpability: The doctor (i) had misled the patient, (ii) was motivated by profit at the expense of patient's interests; and (iii) also attempted to cover up his misconduct.</p> <p>Indicative Sentence: Suspension of 2 to 3 years.</p>	<p>Illustration (9)</p> <p>The doctor was <u>aware that due to the location of the aneurysm and the patient's age</u>, the patient <u>was not a suitable candidate</u> for the Clipping procedure.</p> <p>However, the doctor decided to <u>mislead</u> the patient that the Clipping procedure was the only treatment option available. The doctor did so because he wanted to <u>profit from the Clipping procedure and referring the patient to a radiologist to perform the Coiling procedure would mean a reduction in his fees</u>. The doctor <u>also failed to explain the risks of the Clipping procedure</u>.</p> <p>The doctor further <u>tampered with the clinical notes</u> to state that the patient was advised on alternative treatment options, when that was untrue.</p> <p>During the surgery, the doctor <u>placed the clip on the normal artery, which was far from the site of the aneurysm</u>. He also completely failed to clip the aneurysm. The patient <u>died as a result of complications arising from the failed surgery</u>.</p> <p>Analysis Severe Harm: Death. The patient's death directly resulted from the doctor's misconduct of performing the Clipping procedure when it was not the appropriate treatment High Culpability: The doctor (i) had misled the patient, (ii) was motivated by profit at the expense of patient's interests; and (iii) also attempted to cover up his misconduct.</p> <p>Indicative Sentence: Suspension of 3 years or striking off.</p>

*Illustration: Non-Clinical Care Misconduct***Core Facts**

A doctor working in a public hospital in Singapore accesses the records of patient(s) who are not under her care.

Non-exhaustive factors affecting the level of harm include:

1. Sensitivity of information, including type of information and profile of the patient(s);
2. Number of patients affected;
3. The actual or potential harm suffered by the affected patients;
4. Whether the information was released to third parties or the public sphere;
5. The harm to public confidence that doctors would respect and uphold the confidentiality of patient records; and
6. The harm to public confidence as to the security of the public healthcare system's electronic database.

Non-exhaustive factors affecting culpability include:

1. Number of breaches;
2. The doctor's state of mind;
3. The doctor's motivation (e.g. malice, financial gain, etc.); and
4. Whether there was pre-meditation and attempts to conceal the misconduct.

■ = Harm Factors ■ = Culpability Factors

Illustration: Non-Clinical Care Misconduct (cont.)

Harm Culpability	Slight	Moderate	Severe
Low	<p>Illustration (1)</p> <p>The doctor suspected that her elderly father had been seeking treatment at the hospital, but had been concealing it from her. Concerned, the doctor accessed her father's records on a single occasion to check on her father's recent and upcoming hospital appointments, and the name of the doctor in charge. She did not look at the diagnosis or other medical records. Her father's records were the only records that the doctor accessed. The doctor privately confronted her father about it. The father admitted that he had a chronic ailment, and eventually disclosed it to the rest of the family.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Slight Harm: (i) Only information about hospital appointments and doctor in charge was accessed. These are relatively less sensitive compared to other medical information. (ii) Only one patient affected. • Low Culpability: (i) Isolated breach. (ii) While the misconduct was deliberate, doctor was motivated by genuine good intentions and concern for her father. <p>Indicative Sentence: Fine or other punishment not amounting to suspension.</p>	<p>Illustration (2)</p> <p>The doctor's colleague, a nurse, had been on medical leave for a month. That nurse was vague when the doctor asked about the former's medical condition. Concerned, the doctor checked the nurse's records on a single occasion. The nurse's records were the only records that the doctor accessed. The doctor discovered that the nurse had been diagnosed with cancer. The doctor alerted the nurse's supervisors to this, with instructions to reduce the nurse's workload to help her manage. The doctor also privately spoke to the nurse and recommended an oncologist. While grateful for the concern, the nurse was distressed that colleagues had discovered her medical condition, as she feared being discriminated in the workplace.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Moderate Harm: (i) Sensitive information was accessed. (ii) Only one patient affected. (iii) Patient suffered from distress. (iv) Harm to public confidence that doctors would respect the confidentiality of patient records. • Low Culpability: (i) Isolated breach. (ii) While the misconduct was deliberate, the doctor was motivated by genuine good intentions and concern for her colleague. <p>Indicative Sentence: Suspension of up to 1 year.</p>	<p>Illustration (3)</p> <p>The doctor's colleague, a nurse, had been on medical leave for a month. That nurse was vague when the doctor asked about the former's medical condition. Concerned, the doctor checked the nurse's records on a single occasion. The nurse's records were the only records that the doctor accessed. The doctor discovered that the nurse had been diagnosed with cancer. The doctor alerted the nurse's supervisors to this, with instructions to reduce the nurse's workload to help her manage. The doctor also privately spoke to the nurse and recommended an oncologist. While grateful for the concern, the nurse was distressed that colleagues had discovered her medical condition. The nurse sank into depression, and became suicidal.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Severe Harm: (i) Sensitive information was accessed. (ii) Although only one patient was affected, she suffered from serious harm, namely distress, depression and becoming suicidal. (iii) Harm to public confidence that doctors would respect the confidentiality of patient records. • Low Culpability: (i) Isolated breach. (ii) While the misconduct was deliberate, the doctor was motivated by genuine good intentions and concern for her colleague. <p>Indicative Sentence: Suspension of 1 to 2 years.</p>

■ = Harm Factors ■ = Culpability Factors

Illustration: Non-Clinical Care Misconduct (cont.)

Harm Culpability	Slight	Moderate	Severe
Medium	<p>Illustration (4)</p> <p>The doctor's spouse had threatened and physically assaulted the doctor, resulting in their relationship breaking down and their separation. For self-protection, over the course of 6 months, the doctor deliberately accessed her spouse's records to find out when her spouse had hospital appointments, so that she could physically avoid him. The doctor did not access any other information. Her spouse's hospital appointments were the only records that the doctor accessed.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Slight Harm: (i) Only information about hospital appointment was accessed, which is relatively less sensitive compared to other information. (ii) Only one patient affected. • Medium Culpability: (i) Repeated breaches over 6 months. (ii) The doctor deliberately accessed the records, despite knowing it was unauthorised. (iii) However, the doctor was not motivated by malice or financial gain, but self-protection. <p>Indicative Sentence: Suspension of up to 1 year.</p>	<p>Illustration (5)</p> <p>Over the course of 2 years, the doctor repeatedly accessed records of a significant number of people out of idle curiosity. She accessed both their personal and medical records. She did not release any information to third parties or the public. Nonetheless, the affected patients were anxious and distressed when they learnt about the breach.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Moderate Harm: (i) Sensitive information was accessed. (ii) A significant number of patients were affected. (iii) Affected patients were anxious and distressed when they learnt about the breach. (iv) Harm to public confidence that doctors would respect the confidentiality of patient records. • Medium Culpability: (i) Repeated breaches over 2 years. (ii) The doctor acted recklessly and/or in wilful disregard of patient confidentiality. (iii) However, the doctor was not motivated by malice or financial gain. <p>Indicative Sentence: Suspension of 1 to 2 years.</p>	<p>Illustration (6)</p> <p>The doctor discovered a vulnerability in the hospital's electronic database that allowed her to download patients' records to her personal computer. Instead of reporting the vulnerability, over the course of 2 years, the doctor repeatedly accessed and downloaded the records of a very large number of patients out of idle curiosity. She accessed and downloaded both their personal and medical records. The affected patients were anxious and distressed when they learnt about the breach. This incident raised a public outcry, with many members of the public writing in to express concern.</p> <p>Analysis</p> <ul style="list-style-type: none"> • Severe Harm: (i) Sensitive information was accessed. (ii) A very large number of patients were affected. (iii) Affected patients were anxious and distressed when they learnt about the breach. (iv) Harm to public confidence that doctors would respect the confidentiality of patient records, and uphold the security of the electronic database. (v) Harm to public confidence as to the security of the public healthcare system's electronic database. • Medium Culpability: (i) Repeated breaches over 2 years. (ii) The doctor acted recklessly and/or in wilful disregard of patient confidentiality. (iii) However, the doctor was not motivated by malice or financial gain. <p>Indicative Sentence: Suspension of 2 to 3 years.</p>

■ = Harm Factors ■ = Culpability Factors

Illustration: Non-Clinical Care Misconduct (cont.)

Harm \ Culpability	Slight	Moderate	Severe
High	<p>Illustration (7)</p> <p>The doctor's friend, X, is an insurance agent. X asked the doctor for the contact information of some patients for his business. Over the course of 1 week, the doctor deliberately accessed the records of a small number of random patients. She only accessed the personal information and not the medical records. The doctor provided the surnames and phone number of those patients to X, and tried to conceal her involvement by expressly instructing X not to reveal that she was the source of information. X would thereafter approach the patients, and collect further information from the patients who wished to purchase insurance. The doctor would obtain a fee for each person who signed up for the insurance.</p> <p>Analysis</p> <p>Slight Harm: (i) Only the surnames and phone numbers were released to X. These are relatively less sensitive compared to other medical information. (ii) Only a small number of patients was affected.</p> <p>High Culpability: (i) Repeated breaches over 1 week. (ii) The doctor's conduct was deliberate, and (iii) motivated by financial gain. (iv) The doctor's instructions to X to not reveal that she was the source of information evidenced pre-meditation and attempts to conceal her misconduct.</p> <p>Indicative Sentence: Suspension of 1 to 2 years.</p>	<p>Illustration (8)</p> <p>Over the course of 6 months, the doctor repeatedly and deliberately accessed the records of a significant number of male Chinese patients who had undergone a particular procedure. The doctor provided the surnames and phone numbers of those patients to Company Y, a company conducting a survey on the efficacy of this procedure. The doctor tried to conceal her involvement by expressly instructing Company Y not to reveal that she was the source of information. Company Y would thereafter approach the patients, and collect further information from the patients who wished to participate in the survey. The doctor would obtain a fee for each patient who participated in the survey.</p> <p>Analysis</p> <p>Moderate Harm: (i) While the doctor only released the surnames and phone numbers of the patients to Company Y, Company Y effectively also knew the patients' gender, race, that the patients had gone through a certain procedure, and the likely disease that the patients had. (ii) A significant number of patients were affected. (iii) Harm to public confidence that doctors would respect the confidentiality of patient records.</p> <p>High Culpability: (i) Repeated breaches over 6 months. (ii) The doctor's conduct was deliberate, and (iii) motivated by financial gain. (iv) The doctor's instructions to Company Y to not reveal that she was the source of information evidenced pre-meditation and attempts to conceal her misconduct.</p> <p>Indicative Sentence: Suspension of 2 to 3 years.</p>	<p>Illustration (9)</p> <p>The doctor discovered a vulnerability in the hospital's electronic database that allowed her to download patients' records to her personal computer. Instead of reporting the vulnerability, over the course of 2 years, a doctor repeatedly and deliberately accessed and downloaded the personal and medical records of a very large number of patients using her colleague's account instead of her own account. At the same time, although the doctor did not have the authority to access the hospital's database of HIV patients, the doctor used her colleague's account to deliberately access and download the records in the HIV database. The doctor sold the information to anyone who would buy it, including medical insurance companies, pharmaceutical companies, research organisations etc. The doctor created a fake identity to sell the information. Investigations took a long time because of the steps taken by the doctor to conceal her identity. The doctor was eventually convicted in the Singapore criminal courts. The affected patients were anxious and distressed when they learnt about the breach and leak. The incident raised a public outcry, with many members of the public writing in to express concern.</p> <p>Analysis</p> <p>Severe Harm: (i) Sensitive information was accessed, including the particularly sensitive HIV records. (ii) A very large number of patients were affected. (iii) Affected patients were anxious and distressed when they learnt about the breach. (iv) Harm to public confidence that doctors would respect the confidentiality of patient records, and uphold the security of the electronic database. (v) Harm to public confidence as to the security of the public healthcare system's electronic database.</p> <p>High Culpability: (i) Repeated breaches over 2 years. (ii) The doctor intentionally and deliberately acted in disregard of patient confidentiality and (iii) was motivated by financial gain. (iv) Steps taken to conceal her identity (e.g. using her colleague's account, creating a fake identity to sell information) evidenced pre-meditation and attempts to conceal her misconduct. (v) There is an element of dishonesty.</p> <p>Indicative Sentence: Suspension of 3 years or striking off.</p>

(1.3) Step 3 – Identify the appropriate starting point *within* the indicative sentencing range

58. After identifying the indicative sentencing range, DTs should identify precisely where *within* that range the present offence falls to derive the starting point. This is to be done with regard to: (i) the level of harm caused by the offence; and (ii) the level of the doctor's culpability. While this involves engaging the same factors in Step 1, it is not an instance of double-counting but rather granulating the case in order to arrive at a sense of what the starting point should be.⁷¹
59. It would be helpful for DTs to bear in mind the general sentencing principles of proportionality and consistency in sentencing at this stage.
60. **The proportionality principle** operates essentially as a restraint against excessive, arbitrary and capricious punishment. Although there are good reasons to adopt a strong deterrent sentencing philosophy especially in light of public interest considerations in medical disciplinary cases, it must nonetheless be tempered with proportionality. The sentence to be imposed should be reasonably proportionate to (i) the maximum prescribed penalty, and (ii) the gravity of the offence committed.⁷²
61. As can be observed, the proportionality principle is inherent in the indicative sentencing range in Step 2 (at paragraph 55 above) and should be applied in Step 3 as well.
62. **Consistency in sentencing** means that where there are no differentiating factors, public interest demands that there should be some consistency in the imposition of sentences on offenders committing the same or similar offences.⁷³ The DTs should hence, at Step 3, consider sentencing precedents. Consistency in sentencing is important to protect public confidence in the administration of justice.⁷⁴
63. However, the Courts have cautioned that reference to sentencing precedents should be made on the basis that the facts and circumstances as a whole are truly comparable,

⁷¹ *Logachev Vladislav v Public Prosecutor* [2018] 4 SLR 609 at [79], cited in *Wong Meng Hang* at [42].

⁷² Sentencing Principles in Singapore at [06.074]; *Angliss Singapore Pte Ltd v PP* [2006] 4 SLR(R) 653 at [84] – [87].

⁷³ *Liow Eng Giap v Public Prosecutor* [1968 – 1970] SLR(R) 681.

⁷⁴ *Public Prosecutor v UI* [2008] 4 SLR(R) 500 at [19].

and that comparisons that fail to consider adequately the totality of the relevant facts and circumstances would not be helpful.⁷⁵

64. It should also be noted that the Courts have commented in past medical disciplinary cases that the sentences imposed by the DTs in the past were lax and unduly lenient, and that comparisons with past sentences can only afford, at best, a starting point in the analysis.⁷⁶ Therefore, caution should be exercised especially when looking at the more dated sentencing precedents.
65. The Courts have since recalibrated sentencing benchmarks for medical disciplinary cases as the cases come before them, to allow them to be commensurate with the gravity of the matter.⁷⁷ In this regard, DTs should focus on the sentencing objectives and sentencing ranges as laid out in these Sentencing Guidelines, and provide robust reasoning in their written decisions. It is hoped that a corpus of sentencing precedents would eventually be built up, for the benefit of future DTs.

(1.4) Step 4 – Adjust the starting point by taking into account offender-specific aggravating and mitigating factors

66. The first three steps of the sentencing framework consider offence-specific factors and assist a DT in determining the appropriate starting point. The fourth step of this framework requires a DT to take into account offender-specific aggravating and mitigating factors which do not relate directly to commission of the particular offence, but may nonetheless warrant an adjustment in the sentence. These factors calibrate the sentence.
67. A DT should also consider the weight to be attributed to aggravating and mitigating factors. Given the broader public interest objectives of protecting the public and upholding the reputation and confidence in the medical profession, mitigating factors and principles of fairness to the offender ought not to carry as much weight in medical

⁷⁵ *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 (“**Yong Thiam Look Peter**”) at [17].

⁷⁶ *Wong Meng Hang* at [38]; *Yong Thiam Look Peter* at [17]; *Wong Him Choon* at [117]; *Kwan Kah Yee* at [34]; *Lee Kim Kwong* at [45] - [46].

⁷⁷ *Wong Meng Hang* at [38]; *Yong Thiam Look Peter* at [17]; *Wong Him Choon* at [117]; *Kwan Kah Yee* at [34]; *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 (“**Lee Kim Kwong**”) at [45] - [46].

disciplinary cases as they typically would in criminal cases. For example, in cases where the offence is particularly egregious, the existence of prejudicial prosecutorial delay (which would normally justify a sentencing discount out of fairness to the offender), may be accorded no weight at all to ensure that the interests of the public are sufficiently met.⁷⁸

68. If the aggravating or mitigating factors have been taken into account in the harm/culpability analysis, DTs should be mindful not to double-count them at this fourth step.
69. Potential aggravating factors include: -
- a. **Prior instances of professional misconduct**, especially where such antecedents bear similarities to the conduct underlying the charge at hand. This may demonstrate the offender's recalcitrance and unwillingness to adhere to the values and the ethos of the profession, or a troubling lack of insight into the errors of his or her ways.⁷⁹
 - b. **The seniority and/or eminence of the offender**. Unlike criminal sentencing where the seniority and/or eminence of the offender is sometimes regarded as a mitigating factor, it is an aggravating factor in medical disciplinary cases. This is because the seniority and/or eminence of a doctor attracts a heightened sense of trust and confidence in the practitioner and the profession, and the negative impact on public confidence in the integrity of the medical profession is amplified when such an offender is convicted of professional misconduct.⁸⁰ Unlike criminal proceedings, there is an overarching need in medical disciplinary cases to uphold the standing of the medical profession, and prevent an erosion of public confidence in the trustworthiness and competence of its members.⁸¹
 - c. **Lack of remorse or insight**, for example, where the offender attempts to pin blame on the patient or others for his or her own improper conduct,⁸² or continues

⁷⁸ *Wong Meng Hang* at [24] and [26]; *Ang Peng Tiam* at [103] and [118].

⁷⁹ *Wong Meng Hang* at [43]; *Yong Thiam Look Peter* at [13] – [15].

⁸⁰ *Ang Peng Tiam* at [93].

⁸¹ *Wong Meng Hang* at [23].

⁸² *Wong Him Choon* at [108].

to justify his or her improper conduct despite overwhelming evidence against him or her,⁸³ or refuses to participate in the disciplinary proceedings.⁸⁴

- d. **Multiple charges/breaches (including charges taken into consideration)**, in relation to the same patient, or a number of different patients. For example, in a case involving the over-prescription of Benzodiazepines and hypnotics to patients, the fact that there are multiple charges involving multiple patients may be an aggravating factor.⁸⁵

70. Potential mitigating factors include: -

- a. **A timely plea of guilt and co-operation with investigations** in circumstances that indicate genuine remorse, contriteness and/or a desire to facilitate the administration of justice.⁸⁶ However, the mitigating weight would be less where there is overwhelming evidence against the offender such that the prosecutor would not have any difficulties in proving its case against him.⁸⁷ It should also be highlighted that the mere fact of claiming trial is *not* an aggravating factor.⁸⁸
- b. **Having a long unblemished track record and good professional standing** may show that the doctor's actions in committing the offence were out of character and therefore, he is unlikely to re-offend. In those circumstances, this may be regarded as a mitigating factor of modest weight.⁸⁹ However, a doctor's general good character and past contributions to society (e.g. volunteer work and contributions to charities) in and of itself will not be regarded as a mitigating factor because it is not the DT's place to judge the moral worth of the doctor. It has no relevance to the doctor's culpability or the harm he has caused by the commission of the offence, and may be perceived as unfairly favouring more privileged offenders who have more opportunities to make such societal contributions as compared to less privileged offenders.⁹⁰

⁸³ *Kwan Kah Yee* at [37].

⁸⁴ *Mohd Syamsul Alam bin Ismail* at [19].

⁸⁵ *In the Matter of Dr Heng Boon Wah Joseph* [2016] SMCDT 8 at [11].

⁸⁶ *Angliss Singapore* at [77].

⁸⁷ *Chia Kah Boon v Public Prosecutor* [1999] 4 SLR 72 at [12].

⁸⁸ *Kuek Ah Lek v Public Prosecutor* [1995] 3 SLR 252 at [65].

⁸⁹ *Ang Peng Tiam* at [102] – [103].

⁹⁰ *Ang Peng Tiam* at [101].

- c. **An inordinate delay in the prosecution** of the proceedings not occasioned by the offender that caused prejudice to the offender (including the anxiety and distress suffered by the offender in having the charge hang over the offender's head).⁹¹
- d. **Remorse and insight** such as an apology to the patient,⁹² voluntarily ceasing medical practice,⁹³ taking steps to improve medical practice and to prevent the recurrence of the offence⁹⁴ show the remorse of the offender and desire of the offender to remediate. These factors may be considered as mitigating factors.
71. In some cases, it may appear contradictory that the seniority and/or eminence of the doctor is an aggravating factor (paragraph 69(b) above), while the doctor having a long unblemished track record and good professional standing is a mitigating factor (paragraph 70(b) above). These two factors target different sentencing objectives, with the former targeting upholding the reputation and confidence of the medical profession, and the latter targeting specific deterrence.
72. Depending on the circumstances, it may be appropriate to place more weight on one factor rather than the other. For example, if the offence is one of slight harm and low culpability, public interest considerations may not be so high and it may be fair to treat the doctor's long unblemished track record and hence his or her lack of propensity to re-offend as a mitigating factor. However, in most situations, public interest considerations would be paramount, and the seniority and/or eminence of the doctor would be treated as an aggravating factor.

⁹¹ *Ang Peng Tiam* at [109] – [118].

⁹² In *In the Matter of Dr Garuna Mathee Kavitha* [2015] SMCDT 1 at [15]. the respondent doctor had, on her own accord, apologised, to the family of the patient. The DT deemed this a mitigating factor in determining sentence.

⁹³ In *SMC v Ling Ngan Ngieng* [2011] SMCDC 7, the DT held that voluntarily abstaining from practice for a period of some 8 months was a clear show of remorse by the respondent doctor and was a mitigating factor.

⁹⁴ In *In the Matter of Dr ABH* [2010] SMCDC 5 at [42(iii)], the DT held that the fact that the respondent doctor had attended various courses and seminars reflected his desire to improve his practice in that particular area of medicine. This was deemed to be a mitigating factor.

(2) Additional Steps in the Sentencing Framework when a Doctor is Guilty of Multiple Offences

(2.1) The Two-Step Approach May Be Adopted

73. In cases where an offender is convicted of multiple offences, the Singapore criminal courts apply two analytically distinct, sequential steps. First, the court must determine the appropriate individual sentence for each charge. Second, the court must determine the overall sentence which should be imposed.⁹⁵
74. When considering the second step (viz. the overall sentence), the criminal courts are guided by the one-transaction rule and the totality principle.⁹⁶ Both principles are manifestations of the proportionality principle.⁹⁷ These principles will be dealt with in more detail at paragraphs 79 to 85 below.
75. In past medical disciplinary cases however, DTs have generally not applied the two sequential steps, resulting in them imposing a “global” sentence without individualising the sentence for each charge. This practice of imposing a “global” sentence for multiple charges creates a lack of transparency and makes it difficult for a doctor considering an appeal, as well as for the Court when reviewing whether a DT’s sentence was fair and appropriate.
76. For example, it is not possible to determine what a DT deemed was an appropriate sanction for each charge (where the charges may carry different levels of harm and culpability), and/or whether the DT decided to run the sentences consecutively or concurrently. While the Court in *Yip Man Hing Kevin v Singapore Medical Council* suggested in *dicta* that stating the individual sentence for each individual charge “*may not always be necessary*”, it nonetheless held that on the facts of that case, individual sentences for each individual charge ought to have been provided.⁹⁸
77. In that case, the doctor faced three charges for failing to ensure that the same patient was given adequate sick leave in light of his condition and occupation as a construction worker, and had inappropriately certified that the patient was fit for light duties on the three occasions that he saw the patient (i.e. 8, 11 and 18 July 2011). The Court found

⁹⁵ *Gan Chai Bee Anne v Public Prosecutor* [2019] 4 SLR 838 (“**Gan Chai Bee Anne**”) at [19] - [22].

⁹⁶ As elucidated in *Mohamed Shouffee bin Adam v Public Prosecutor* [2014] 2 SLR 998 (“**Shouffee**”).

⁹⁷ *Shouffee* at [47] and *Chan Chun Hong v Public Prosecutor* [2016] 3 SLR 465 at [144].

⁹⁸ *Yip Man Hing Kevin v Singapore Medical Council* [2019] SGHC 102 (“**Yip Man Hing Kevin**”) at [90].

that while all three charges pertained to the same type of failure by the doctor towards the same patient, the doctor had a fresh and distinct duty on each occasion to assess the patient based on circumstances prevailing at that particular point in time, including the patient's changing medical condition. The doctor's failure to issue an appropriate duration of sick leave on each of the three occasions was a separate and distinct default. As a result, the Court ordered the sentences to run consecutively rather than concurrently.⁹⁹

78. To achieve transparency, consistency and fairness in sentencing, the two sequential steps as laid down by the criminal courts may be applied to medical disciplinary cases. Hence, the following sentencing framework may be adopted for cases involving multiple offences: -
- a. First, apply Steps 1 – 4 of the Sentencing Framework (as elaborated in paragraphs 42 - 72 above) to determine the appropriate individual sentence for each charge, and
 - b. Second, to ensure proportionality, calibrate the overall sentence by applying the one-transaction rule (paragraphs 79 – 81 below) and the totality principle (paragraphs 82 – 85 below).

(2.2) The One-Transaction Rule in Medical Disciplinary Cases

79. The one-transaction rule provides that sentences for two or more offences which form part of the same transaction should generally not be ordered to run consecutively, but should be ordered to run concurrently instead. This is because even if there are several offences, if there is only a "*single invasion of the same legally protected interest*", concurrent sentences would ordinarily suffice to reflect the seriousness of the offences. This rule assists the DT to determine "*whether an offender should be doubly punished for offences that have been committed simultaneously or close together in time*".¹⁰⁰
80. When determining whether the offences form part of the same transaction, the DT may consider whether, in the commission of the offences, there was proximity in time, proximity in location, proximity in type of offence, whether the same interest was being invaded, whether there was continuity of action, and/or continuity of purpose etc.

⁹⁹ *Yip Man Hing Kevin* at [91] – [92].

¹⁰⁰ *Shouffee* at [27], [30] – [32]; *Public Prosecutor v Raveen Balakrishnan* [2018] 5 SLR 799 at [39]

However, none of these factors are determinative, and the determination is ultimately one of common sense.¹⁰¹ That said, in appropriate cases, even if the offences form part of the same transaction, consecutive sentences may be ordered if it is necessary to give sufficient weight to the interest of deterrence, or if the imposition of consecutive sentences would be in keeping with the gravity of the offences. If the DT decides that it is appropriate to do so on the facts of a particular case, it should state the reasons and considerations that led to the decision.¹⁰²

¹⁰¹ *Shouffee* at [27] – [40]

¹⁰² *Shouffee* at [45] – [46]

Illustrations

One-transaction rule applies, sentences to run concurrently:

- (i) A doctor misdiagnosed a patient and carried out a simple procedure based on that misdiagnosis. He faced three charges: (1) misdiagnosis; (2) failure to offer alternative treatment due to the misdiagnosis; and (3) carrying out inappropriate treatment, also as a result of the misdiagnosis. Given the causal connection between the offences, this may be considered to form one transaction, with the sentences to run concurrently.

One-transaction rule does not apply, sentences to run consecutively:

- (ii) As a result of a single consultation and procedure with a patient, the doctor faced three charges: (1) failure to obtain informed consent on procedures to be performed on the patient; (2) failure to provide adequate clinical evaluation and competent care before offering the procedures to the patient; and (3) failure to keep proper records in respect of the treatment and care of the patient. Although all three charges arose out of a single interaction with the same patient (proximity in time and place), those three charges pertain to different types of offences which are not causally connected to one another and implicate separate interests (e.g. respect for patient autonomy, standards of care, and public health considerations). The one-transaction rule should not apply.

(Adapted from In the Matter of Dr Ganesh Ramalingam [2018] SMCDT 6.)

One-transaction rule applies to certain charges and not to other charges:

- (iii) A doctor who was driving under disqualification was involved in a hit-and-run accident, and killed a pedestrian. The doctor was found guilty on 7 criminal charges: (1) driving under disqualification; (2) using a vehicle without third-party insurance in force; (3) failing to stop after an accident; (4) failing to render assistance after an accident; (5) moving of vehicle after an accident without authority of a police officer; (6) failing to make a police report within 24h of the accident; and (7) causing death by a rash act. Seven disciplinary charges were brought against the doctor mirroring the criminal charges. Although all the offences arose in a short span of time, there were three factually and conceptually distinct group of offences namely (a) driving under disqualification (Charges 1 and 2), (b) failing to stop and render assistance after the accident (Charges 3 - 6), and (c) causing death (Charge 7). Each group of offences were serious and did not necessarily or inevitably flow from one another. Sentences within each group can be ordered to run concurrently, while sentences vis-à-vis each group can be ordered to run consecutively.

(Adapted from Public Prosecutor v Lee Cheow Loong Charles [2008] 4 SLR(R) 961, and In the Matter of Dr Teo Tiong Kiat [2014] SMDCT 1)

81. DTs should also be alive to the possibility that multiple charges were brought only because of the way in which the charges were framed. For example, multiple charges framed based on each interaction with the patient may conceivably have been framed as a single charge of clinical mismanagement, with each interaction forming part of the particulars instead. In those cases, it is open to the DTs to query the prosecution's reasons for framing multiple charges, consider whether the aggregate sentence would be disproportionate in the circumstances, and order that the sentences run concurrently rather than consecutively in the appropriate case. The DT should expressly provide its reasons when it does so.¹⁰³

(2.3) The Totality Principle in Medical Disciplinary Cases

82. The totality principle is applied at the end of the sentencing process to ensure that the overall aggregate sentence, i.e. the total sentence, is neither excessive nor manifestly inadequate. It has been described as a broad-brush “last look” at all the facts and circumstances to ensure the overall proportionality of the aggregate sentence.¹⁰⁴

83. To ensure that the overall sentence is not excessive, the DT should consider two limbs, namely: -

- a. Whether the aggregate sentence is substantially above the normal level of sentences for the most serious of the individual offences committed; and
- b. Whether the effect of the sentence on the offender is crushing and not in keeping with his or her past record and future prospects.

84. If so, consideration ought to be given as to whether the aggregate sentence may be reduced by re-assessing which of the appropriate sentences ought to run consecutively, and/or by re-calibrating the individual sentences so as to arrive at a more appropriate and proportionate sentence.¹⁰⁵

85. The totality principle is equally capable of having a boosting effect on individual sentences when the aggregate sentence is manifestly inadequate. Consideration should

¹⁰³ *Lim Seng Soon v Public Prosecutor* [2015] 1 SLR 1195 at [33] and [43].

¹⁰⁴ *Shouffee* at [47] and [58]; *Haliffie bin Mamat v Public Prosecutor* [2016] 5 SLR 636 at [79].

¹⁰⁵ *Shouffee* at [54] – [59].

be given as to whether there are any extraordinary cumulative aggravating factors or particular public interests which justify calibrating the individual sentences upwards and/or running those calibrated sentences consecutively.¹⁰⁶

Illustrations

A doctor was found guilty of 12 charges for inappropriate prescription of benzodiazepines to 12 different patients. None of the patients suffered actual harm. The harm was assessed to be “slight” and the culpability “medium”. After considering the harm-culpability matrix, and the aggravating and mitigating factors, the DT decided that 3 months’ suspension per charge was appropriate. However, the aggregate sentence of 3 months’ per charge x 12 charges = 36 months’ suspension (i.e. the maximum suspension allowed under law) would have been substantially above the normal level of sentence for any one offence, and crushing for the doctor. The DT may use the totality principle to reduce each individual charge (e.g. 1 month per charge x 12 charges = 12 months aggregate sentence), or have some of the sentences run concurrently rather than consecutively, to arrive at a more proportionate sentence.

VI. CONCLUSION

86. It is hoped that applying these Sentencing Guidelines would aid DTs in arriving at fair and consistent sentencing decisions and ultimately achieve the overall objective of upholding the standards of medical practice, and the confidence and trust of both the public and the medical profession in the medical disciplinary process.

¹⁰⁶ *Gan Chai Bee Anne* at [19] and [22].

Chairman and members of the SMC's Sentencing Guidelines Committee

S/n	Name	Status	Designation and/or Institution
<u>Chairman / Justices / Lawyers</u>			
1	Judge of Appeal Judith Prakash	Chairman (Lawyer)	Judge of Appeal Supreme Court of Singapore
2	Justice Belinda Ang Saw Ean	Member (Lawyer)	Justice Supreme Court of Singapore
3	JC Dedar Singh Gill	Member (Lawyer)	Judicial Commissioner Supreme Court of Singapore
4	Ms Kuah Boon Theng SC	Member (Lawyer)	Managing Director Legal Clinic LLC
<u>Council members and Representatives from the Professional Bodies</u>			
5	A/Prof Chen Fun Gee	Member (Doctor)	Council member Singapore Medical Council
6	A/Prof Ng Suah Bwee Agnes	Member (Doctor)	Council member Singapore Medical Council
7	Dr Leong Choon Kit	Member (Doctor)	Council member Singapore Medical Council
8	Prof Abu Rauff	Member (Doctor)	Representative Academy of Medicine Singapore
9	Dr Loke Chi Wei Peter	Member (Doctor)	Representative College of Family Physicians Singapore
10	Dr Wong Chiang Yin	Member (Doctor)	Representative Singapore Medical Association
<u>Ministry Representatives and Representatives from Panel of Disciplinary Tribunal Chairmen</u>			
11	Dr Benjamin Koh	Member (Ministry Representative) [w.e.f. 22 March 2019]	Deputy Secretary (Development) Ministry of Health
12	Mr Calvin Phua	Member (Ministry Representative) [w.e.f. 16 September 2019]	Deputy Secretary Ministry of Law

S/n	Name	Status	Designation and/or Institution
13	Dr Joseph Sheares	Member (Doctor)	Panel of DT Chairmen Singapore Medical Council
14	A/Prof Roy Joseph	Member (Doctor)	Panel of DT Chairmen Singapore Medical Council
<u>Ex-Officio</u>			
15	Prof Chee Yam Cheng	Member (Ex-officio) [w.e.f. 20 August 2019]	President Singapore Medical Council
16	A/Prof Kenneth Mak	Member (Ex-officio) [w.e.f.1 February 2020]	Registrar Singapore Medical Council
<u>Former Members</u>			
17	Prof Tan Ser Kiat	Member (Ex-officio)	Former President Singapore Medical Council
18	A/Prof Benjamin Ong	Member (Ex-officio)	Former Registrar Singapore Medical Council
19	Ms Ngiam Siew Ying	Member (Ministry Representative)	Deputy Secretary (Policy) Ministry of Health
20	Mr Han Kok Juan	Member (Ministry Representative)	Former Deputy Secretary Ministry of Law

Terms of Reference for the SMC's Sentencing Guidelines Committee

The Terms of Reference are as follows:

- 1) To provide guidance to the Singapore Medical Council's Disciplinary Tribunals (DTs) on the appropriate sanctions to be meted out taking into account sentencing principles.
- 2) To identify and categorise a list of offences based on past DT cases as well as existing complaints.
- 3) To conduct a comparative study of the type and severity of sanctions imposed by the disciplinary arm of overseas Medical Councils (such as the UK General Medical Council) so as to ensure that the sanctions to be imposed by the SMC DTs are broadly in line with international practices.
- 4) To identify and set out the mitigating and aggravating factors (e.g. stage of doctor's medical career, antecedents, testimonials) which a DT can take into account when deciding on the appropriate sanction.