SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR WONG MENG HANG ON 22 SEPTEMBER 2017 AND 13 DECEMBER 2017

Disciplinary Tribunal:
Dr Joseph Sheares - Chairman
Assoc Prof Tan Tong Khee
Mr James Leong - Legal Service Officer

Counsel for the Singapore Medical Council:
Mr Philip Fong
Mr Sui Yi Siong
(M/s Eversheds Harry Elias LLP)

Counsel for the Respondent:
Mr Christopher Chong
Mr Melvin See
(M/s Dentons Rodyk & Davidson LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL

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

Introduction

1 At the Disciplinary Tribunal ("DT") Inquiry for the Respondent Dr Wong Meng Hang ("Dr Wong") on 22 September 2017, he pleaded guilty without qualification to the following amended charge:

"***CHARGE***

*That you **DR WONG MENG HANG** are charged that whilst practising as registered medical practitioner at Reves Clinic situated at 360 Orchard Road, International Building, #04-08 Singapore 238869 (the "Clinic"), you failed to exercise due care in the management of your patient, one **P** (the "Patient"), in that you did not ensure adequate monitoring of the Patient during a medical procedure where you administered or caused to be administered Propofol to him, and as a result the Patient subsequently passed away.*

PARTICULARS

(i) The Patient on 30 December 2009 attended at the Clinic for a VASER-assisted Lipoplasty procedure (the "Procedure"), which lasted from about 12.30 pm to about 3.45 pm;

(ii) You were the proceduralist responsible for performing the Procedure,

(iii) Dr Zhu Xiu Chun @ Myint Myint Kyi, ("Dr Zhu") a registered medical practitioner, was monitoring the Patient throughout the procedure;

(iv) At the start of the Procedure, you administered or caused to be administered Propofol to the Patient at an initial starting dose of 30 mL per hour;

(v) When the Patient exhibited signs of pain stimulation, you increased or instructed that the dose of Propofol be increased according to his response;

(vi) The total dosage of Propofol administered to the Patient during the Procedure was excessive in all the circumstances, causing the Patient to enter a state of deep sedation;

(vii) Throughout the Procedure, neither you nor Dr Zhu were able to recognise the signs that the Patient had entered a state of deep sedation;

(viii) At the end of the Procedure, you left the Patient unattended by any registered medical practitioner or registered nurse for at least 5 minutes;

(ix) The Patient was subsequently found to have collapsed, upon which an ambulance was called; and

(x) At the Coroner's Inquiry No. 10/2010-MO, the Patient was found to have sustained multiple iatrogenic punctures of the intestines due to the liposuction procedure and to have died of the effects of asphyxia due to airway obstruction, secondary to intravenous Propofol administered, and his death was ruled a Medical Misadventure,

and that in relation of the facts alleged, you are guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174) in that your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner."

Agreed Statement of Facts

2 Counsel for the Singapore Medical Council ("SMC") and the Respondent agreed to the following Agreed Statement of Facts:

"*AGREED STATEMENT OF FACTS*

*1. Dr Wong Meng Hang ("**Dr Wong**"), is a registered medical practitioner, who was practising at Reves Clinic situated at 360 Orchard Road, International Building, #04-08 Singapore 238869 (the "**Clinic**") at the material time. Dr Zhu Xiu Chun @ Myint Myint Kyi ("**Dr Zhu**") is a registered medical practitioner, who was likewise practising at the Clinic at the material time (collectively referred to as the "**Respondents**").*

The Complaint

*2. The present inquiry arises from the death of one P (the "**Patient**"), a 44-year old Chinese male who passed away on 30 December 2009 after undergoing a VASER-assisted Lipoplasty procedure (the "**Procedure**") at the Clinic. The Patient had been under the care of the Respondents during the Procedure.*

*3. As the Patient died following the Procedure, a Coroner's Inquiry was duly held. On 4 January 2012, the coroner in Coroner's Inquiry No. 10/2010-M0 ("**CI 10/2010-M0**") recorded the following findings:*

> *a. The deceased person was P, NRIC No.[Redacted], male/44 years old, born on[Redacted].*
>
> *b. On 30 December 2009 at about 6.02 pm, the deceased was pronounced dead at the Tan Tock Seng Hospital following a VASER-assisted Lipoplasty procedure. The liposuction procedure was performed on the same day at Reves Clinic located at 360 Orchard Road, International Building, #04-08, Singapore.*
>
> *c. The deceased sustained multiple iatrogenic punctures of the intestines due to the liposuction procedure and died of the effects of asphyxia due to airway obstruction, secondary to intravenous Propofol administered. [MEDICAL MISADVENTURE]*

*4. On 13 February 2012, the Ministry of Health ("**MOH**") referred the findings in CI 10/2010-M0 by way of letter to the Singapore Medical Council ("**SMC**"). MOH was concerned that the Respondents may have practised beyond their scope of competence, as they had administered Propofol during the Procedure without having undergone adequate training in sedation administration and monitoring, and without the ability to recognise and handle complications relating to sedation. MOH was also concerned that the Respondents failed to ensure adequate monitoring of the Patient under sedation during the Procedure and in the post-operative period.*

The Inquiry

*5. In accordance with the Medical Registration Act (Cap 174) ("**MRA**"), the matter was referred to the Complaints Committee ("**CC**") for further investigation. On 13 November 2013, the CC's Investigation Unit ("**IU**") sent the Respondents a Notice of Complaint to inform them that the SMC had lodged a complaint against them, and invited them to furnish a written explanation pursuant to section 44(2) MRA. On 15 January 2014, both Respondents submitted their written explanations to the IU.*

*6. Subsequently, the CC directed that a formal inquiry be held by a Disciplinary Tribunal ("**DT**"). Both Respondents were notified of the CC"s decision on 11 May 2015. Thereafter, Notices of Inquiry ("**NOI**") dated 9 February 2017 were served on both Respondents.*

*7. At a Pre-Inquiry Conference ("**PIC**") on 30 March 2017, both Respondents through their solicitors communicated their desire to make written representations. The PIC was therefore adjourned for the Respondents to make written representations.*

8. On 13 April 2017, the SMC received written representations from Dr Zhu through her solicitors seeking an amendment of certain particulars of the Charge as stated in the NOI. Dr Zhu subsequently clarified her written representations in a letter dated 27 April 2017. Similarly, Dr Wong through his solicitors submitted written representations by way of letter dated 19 April 2017. Like Dr Zhu, Dr Wong sought an amendment of certain particulars of the Charge as stated in the NOI.

9. By way of letters dated 8 May 2017, the SMC informed both Respondents that their written representations have been acceded to. The amended charges were served on both Respondents in NOIs re-dated 17 May 2017.

The Amended Charge

*10. Dr Wong faces one charge for failing to exercise due care in the management of the Patient, in that he did not ensure adequate monitoring of the Patient during the Procedure whereby he administered or caused to be administered Propofol to him, and as a result the Patient subsequently passed away (the "**Amended Charge**").*

11. Essentially, the total dosage of Propofol administered to the Patient during the Procedure was excessive in all the circumstances, causing the Patient to enter a state of deep sedation. Throughout the Procedure, Dr Wong however, was unable to recognise the signs that the Patient had entered a state of deep sedation. Furthermore, at the end of the Procedure, Dr Wong left the Patient unattended by any registered medical practitioner or registered nurse for at least 5 minutes.

12. As a result, when the Patient developed an airway obstruction and could not maintain his own airway, medical attention was not provided in time to prevent him from dying from asphyxia.

13. Dr Wong is therefore guilty of such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, and is thereby guilty of professional misconduct.

Propofol and Dr Wong's experience and qualifications in anaesthesiology

14. Propofol is a short acting but potent sedative. It can rapidly depress the airway and respiration as well as cause the blood pressure to fall. When given as an infusion, the effect of Propofol will be prolonged the longer the infusion time.

15. According to the instruction sheet provided by the manufacturers of Propofol, it should only be administered by physicians trained in anaesthesia or in the care of patients in intensive care.

*16. Similarly, the American Society of Anesthesiologists' 2002 "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists" ("**ASA Guidelines**") advise that even if moderate sedation is intended, patients receiving Propofol by any route should receive care consistent with that required for deep sedation. Accordingly, practitioners administering Propofol should be qualified to rescue patients from any level of sedation, including general anaesthesia. The ASA Guidelines also advise that when Propofol is used, even for mild or moderate sedation, the monitoring of the patient should be the same as that for general anaesthesia.*

17. In addition, paragraph 7 of the SMC's "Guidelines on Aesthetic Practices for Doctors" dated October 2008 states that "the guiding principle in any medical treatment must be that it is effective and there is due cognizance given to patient safety. In the context of aesthetic practice, it must go beyond the "Do No Harm" principle and be seen to benefit the patient positively".

18. Dr Wong's anaesthetic training, knowledge, skill and experience are as follows:

a. During his housemanship orthopaedic posting, he assisted surgeons in the administration of IV sedation (including Propofol) for procedures in the ward. During his medical officer posting with the emergency department at Hospital A, he administered IV sedation such as IV valium and Propofol.

b. He attended VASER liposuction courses where there were lectures and presentations on the use of IV sedation by non-anaesthetists.

c. He observed the use of IV sedation from working with various foreign surgeons and anaesthetists, such as Dr F1 in Japan and Dr F2 in Korea. He had also worked closely with an anaesthetist who had provided IV sedation (with Propofol) for several of his liposuction cases from 2006 – 2009.

d. He attended several courses such as the 76th Shimmian Rhinoplasty Course conducted at the Clinic B at the Institute C, and the Vaser Assisted High Definition Liposculpture Course in Bogota, Colombia.

19. Titration of Propofol to sedate a patient safely is complex and requires close monitoring of the patient and appropriate response. This expertise can only be provided by a well-trained, experienced and vigilant sedationist. A sedationist should have appropriate knowledge, skill and experience from proper training in the conduct of intravenous sedation. Based on his disclosed experience and qualifications, Dr Wong did not have the necessary training to conduct the complex continuous infusion sedation given to the Patient during the Procedure.

The Facts leading to the Charge

20. The Patient first consulted Dr Wong at the Clinic on 4 December 2009. He had wanted to reduce the extra flab around the tummy and lower back. During the consultation Dr Wong assessed the Patient to be a suitable candidate for liposuction, and informed the Patient that the Procedure was suitable for him. Thereafter, the Procedure was scheduled for 30 December 2009.

21. On 30 December 2009, the Patient attended at the Clinic for the Procedure, which started at about 12.30 pm. Dr Wong was the proceduralist responsible for performing the Procedure, and Dr Zhu monitored the Patient throughout the Procedure.

22. The medical equipment used to monitor the Patient during the Procedure included a blood pressure cuff that was programmed to record the blood pressure at every half an hour interval. A pulse oximeter was also connected via the finger probe to monitor the deceased's pulse rate and blood oxygen level or oxygen saturation. This was recorded down every 15 minutes from 12.30 pm to 3.30 pm. The Patient was also on continuous oxygen supply through a nasal prong.

23. At the start of the Procedure, Dr Wong administered or caused to be administered Propofol to the Patient at an initial starting dose of 30 mL per hour. The infusion was administered via an infusion pump which allowed for the titration of the dose of Propofol.

24. Dr Wong inadvertently caused multiple puncture wounds to the Patient's intestines during the course of the Procedure. However, the Patient's signs remained stable and neither Dr Wong nor Dr Zhu realised that the Patient had suffered multiple iatrogenic perforations of the intestines. This was because the

Patient had ended up in a state of deep sedation, which was caused by the way in which Propofol was administered to the Patient.

25. Throughout the Procedure, the arrangement regarding the administration of Propofol was as follows:

a. Dr Zhu would communicate the Patient's response based on her observations of his responses to Dr Wong;

b. Dr Wong would then decide and order the amount of Propofol to be titrated whilst performing the Procedure at the same time; and

c. The Patient's parameters would be called out to Dr Wong at the relevant timings.

26. For example, when the Patient exhibited signs of pain stimulation, such as moving or displaying discomfort, Dr Wong would inform Dr Zhu to titrate up the dose of Propofol according to the Patient's response reported by Dr Zhu.

27. The total dosage of Propofol that was administered to the Patient during the Procedure was excessive in all the circumstances. It caused the Patient to enter a state of deep sedation to the point of general anaesthesia. However, Dr Wong was unable to recognise the signs that the Patient had entered a state of deep sedation.

28. The Procedure ended at about 3.45 pm and the infusion of Propofol was turned off. Dr Zhu then left the procedure room at about 3.50 pm, after Dr Wong informed her that the Procedure was over. Dr Wong then proceeded to stitch up the Patient's surgical wounds.

29. After stitching up the Patient's wounds, Dr Wong left the Procedure room to use the toilet. As a result, the Patient was left unattended by any registered medical practitioner or registered nurse for at least 5 minutes after the Procedure.

*30. Whilst the Patient was left unattended, he developed an airway obstruction, and was unable to maintain his own airway, and suffered asphyxia leading to cardiac arrest. The Patient was subsequently found to have collapsed at or around 4.15 pm. When he was found to be unarousable, Code Blue was activated. An ambulance call was placed at about 4.30 pm, and it arrived at the clinic at about 4.42 pm. The Patient was then conveyed to the Accident & Emergency ("**A&E**") Department at Tan Tock Seng Hospital ("**TTSH**"), accompanied by Dr Wong.*

Events after the Procedure and Patient's collapse

*31. Upon arrival at the Accident & Emergency ("**A&E**") Department at TTSH at about 5.10 pm, Dr Wong informed the A&E doctors that the Patient was given Pethidine and local anaesthesia for the Procedure but no sedation. This was untrue because Dr Wong knew that Propofol had been administered to the Patient.*

32. Similarly, Dr Wong's medical case notes for the Patient and the Procedure were inaccurate. In his notes, there was no record or any indication that the Patient was to be sedated, and the anaesthetic record showed that the Patient was on local anaesthesia. This was untrue because Propofol was administered to the Patient during the Procedure. In addition, the Patient had previously opted for sedation.

33. At the A&E Department, the Patient was found to have been intubated and was pulseless. There was no spontaneous breathing or heartbeat. Cardiopulmonary resuscitation was continued and during the resuscitation process, emergency medication such as adrenaline and atropine were administered to the Patient. Subsequently, another 6 doses of adrenaline were administered to the Patient intermittently but to no avail. Death was pronounced at about 6.02 pm.

Conclusion

34. Dr Wong did not have the necessary training to conduct the complex continuous infusion sedation given to the Patient during the Procedure. He also did not ensure that the Patient was adequately monitored during the Procedure and in the post-operative period when the Patient was under sedation. The Patient subsequently encountered difficulty in maintaining his own airway and died from the effects of asphyxia due to airway construction, secondary to intravenous Propofol administered. Had the monitoring of the Patient been adequate, medical attention could have been provided in time to prevent him from asphyxiating to death.

35. In the circumstances, Dr Wong failed to exercise due care in the management of the Patient, in that he did not ensure adequate monitoring of the Patient during the Procedure whereby he administered or caused to be administered Propofol to him, and as a result the Patient subsequently passed away. He is therefore guilty of professional misconduct under section 53(1)(d) of the MRA in that his aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

36. *Dr Wong is now pleading guilty to the Amended Charge and admits to the particulars without qualification.*"

3 Following the plea of guilt and submissions on sentencing on 22 September 2017, the DT reserved our decision as we wanted to consider the sentence for the Respondent together the appropriate sentence for Dr Zhu Xiu Chun @ Myint Myint Khi. ("Dr Zhu"). Both cases were fixed before the DT and we had earlier taken the plea of Dr Zhu and heard submissions on 11 August 2017. 17 November 2017 was duly fixed for the delivery of our decision for both cases. Subsequently, the DT decided to request by way of letter dated 30 October 2017 further submissions from parties "*in relation to the decision of the DT in the case of Dr Sim Kwang Soon dated 18 August 2017 and the decision of the Court of Three Judges in the case of Dr Leslie Lam dated 20 October 2017."*

Mitigation

4 In his written and oral mitigation, Counsel for the Respondent highlighted the early guilty plea as evidence of the Respondent's remorse. Counsel also stressed the relative youth of the Respondent at the time of the incident and the fact that

the Respondent was licensed to carry out the procedure and had complied with the prevailing standards. He had also acted in good faith and substantial financial compensation had been awarded to the family of the deceased in civil proceedings that were not contested by the Respondent. The Respondent also had a hitherto unblemished record and was otherwise a doctor in good standing as evidenced by various testimonials on his behalf from medical colleagues and patients exhibited in the written mitigation dated 22 September 2017. It was further submitted that the Respondent had been prejudiced by the inordinate delay in the conduct of the proceedings. It was also suggested that the usual undertaking not to repeat such conduct was not necessary since the Respondent was no longer licensed to carry out liposuction and could no longer use Propofol.

5 In their further submissions on sentencing dated 12 November 2017, Counsel for the Respondent submitted on behalf of Dr Wong, that on the authority of the decision of the Court of Three Judges in *Lam Kwok Tai Leslie v Singapore Medical Council [2017] SGHC 260 ("Leslie Lam")*, *"…no period of suspension should be imposed on him; instead. A heavy fine would be fair, appropriate and proportionate."* Applying the relevant factors articulated by the DT in Dr Sim's case where a suspension was appropriate, it was submitted that a heavy fine would suffice in the circumstances of our case. In the alternative, even if a period of suspension was warranted, the ends of justice would be better served with a heavy fine. This was on account of the inordinate delay and the suffering endured by the Respondent due to the protracted proceedings.

Submissions on Sentencing

6 In their oral and written submissions, Counsel for the SMC pressed for a maximum suspension of three years, arguing that this was the only proportionate sentence as the professional misconduct committed by the Respondent was among the worst of its kind for gross negligence. Equating the conduct of the Respondent to that of the Respondents in the Court of Three Judges cases of *Singapore Medical Council v Kwan Kah Yee [2015] SGC3J 1* ("*Kwan Kah Yee"*) and *Lim Mey Lee Susan v Singapore Medical Council [2013] 3 SLR 900 ("Susan Lim")*, it was submitted that cases in which the misconduct results in a significant erosion of faith in the medical profession, whether through deliberate departure or gross negligence, would warrant the maximum suspension.

7 In their further submissions of 27 November 2017, Counsel for SMC submitted that the relevance of the Court of Three Judges decision in *Leslie Lam* was to highlight Parliament's intention in increasing the maximum fine set out in s53(2)(*e*) of the Medical Registration Act in 2010 " *to bridge the gap between the then maximum financial penalty of $10,000 and the minimum suspension period of three months*". With a maximum fine of up to $100,000 now available, DTs can punish misconduct that would have previously fallen within this "*gap*" by utilising the full spectrum of this aspect of its sentencing jurisdiction. However, the Respondent's misconduct in the present case did not fall within the "*gap"* as a heavy fine or even a low suspension period would be a completely inadequate response.

8 As for the sentencing factors identified by the DT in *Dr Sim Kwang Soon,* Counsel for the SMC noted as a preliminary point that the case was strictly speaking not binding on other DTs, as opposed to a decision of the Court of Three Judges. Nonetheless, the SMC submitted that an application of the *Dr Sim Kwang Soon* factors still led to the conclusion that the appropriate sanction to be imposed was the maximum suspension term of three years.

The Decision

9 In arriving at our decision, we were guided by the decision of the Court of Three Judges in *Ang Peng Tiam v Singapore Medical Council and another matter [2017] SGHC 143 at [89]* that: *" … the overarching consideration in sentencing is that the sentence imposed must be fair and just in the light of all circumstances of the case. It will also be helpful to reiterate the function of sanctions in medical disciplinary proceedings, as this forms the background in our consideration of the appropriate sentence. In Singapore Medical Council v Kwan Kah Yee [2015] 5 SLR 201 ("Kwan Kah Yee"), we observed (at [50]) that sanctions in medical disciplinary proceedings serve two functions: first, to ensure that the offender does not repeat the offence so that the public is protected from the potentially severe outcomes that may arise from the conduct of errant doctor; and second, to uphold the standing of the medical profession. Further, in a case like the present, we consider that the sentence may be informed in particular, by the sentencing objective of general deterrence. The sentence will further be affected by the personal mitigating or aggravating circumstances."*

10 We were also mindful of the need for general and specific deterrence as highlighted at [55-56] of *Kwan Kah Yee* cited above. In this regard, we disagreed with Counsel for the Respondent's submission at [19] of their written mitigation that general deterrence was of no application because the Respondent's serious negligence had no wider consequence to the public. We similarly disagreed with the submission that specific deterrence was also of no application since the Respondent was no longer licensed to undertake such procedures and hence there was no danger of further mischief. In our view, the untimely death of the patient as a consequence of the Respondent's negligence could not by any measure be considered to be of no wider consequence to the public. In our view, both general and specific deterrence was clearly called for to protect the public and remind members of the Medical Profession in general as well as the Respondent specifically of their professional responsibility to practise within their competence and exercise diligence always.

11 Having regard to the serious consequences of the Respondent's actions as highlighted by Counsel for the SMC, the DT was of the view that the threshold for suspension had been clearly crossed. We were unable to agree with Counsel for the Respondent that a heavy fine would suffice in the circumstances of the case, whether in itself or as an alternative to suspension given the delay in the prosecution of the case. Having said that, while we agreed with Counsel for the SMC that a fine was not appropriate and a suspension would be in order, we were not persuaded that this case, involving a single charge under the second limb *of Low Cze Hong v Singapore Medical Council [2008] 3 SLR (R) 612 ("Low Cze Hong")* was in the same category of offending as the cases of *Susan Lim* or *Kwan Kah Yee* meriting the maximum term of suspension of three years. It is pertinent to note that the charges in *Susan Lim* and *Kwan Kah Yee* were both under the first limb of *Low Cze Hong* for intentional misconduct. Dr Susan Lim who received a then maximum fine of $10,000 and a maximum suspension of three years was convicted on 94 counts of overcharging while Dr Kwan Kah Yee was convicted on two counts of improperly certifying the death of his patients for which he was suspended for a total of three years, i.e. 18 months per charge with the suspension to run consecutively. While we agreed with the rationale and the need for the maximum sentences in these two extreme cases of deliberate and dishonest misconduct, we did not think that the actions of the Respondent warranted a similar maximum suspension. For the avoidance of doubt, we agreed in principle with Counsel for the SMC that there was no proposition of law that the maximum suspension was only suitable where there were multiple charges or

that it was intended only for intentional misconduct and not gross negligence. Ultimately, each case must be decided on its own merits in accordance with the law. In this regard, we also did not find the various sentencing precedents highlighted by Counsel for both sides particularly helpful since none of them dealt with facts similar to the case at hand.

12 In arriving at the appropriate sentence, we gave full regard and credit to the Respondent's early plea of guilt which we felt was a very strong sign of remorse. We also gave credit for the fact that civil liability had been resolved enabling the next of kin of the patient to be compensated. In arriving at the appropriate sentence, we also had due regard to the length of time that had elapsed in the conduct of the case. While we agreed with Counsel for the SMC that the length of time per se was not conclusive of inordinate delay and our case might have moved faster than the case against Dr Ang Peng Tiam where inordinate delay was found, proceedings clearly could and should have moved faster. As such, while there was no reason to reduce any suspension by half as was done in *Ang Peng Tiam*, the overall length of the proceedings was nevertheless a factor that we were entitled to take into account in sentencing.

13 We also took into account the Respondent's relative youth; the fact that he was otherwise of good standing prior to the incident; and considered the testimonials attesting to his qualities as a good doctor. These were not particularly strong mitigating factors in the light of the observations in *Ang Peng Tiam* at [101 and 102] rejecting the view that *" … an offender's general good character, or his past contributions to society (such as volunteer work and contributions to charities) can be regarded as a mitigating factor insofar as this rests on the notion that it reflects the moral worth of the offender"* although it was accepted *" … that evidence of an offender's long and unblemished record may be regarded as a mitigating factor of modest weight if, and to the extent, such evidence fairly allows the court to infer that the offender's actions in committing the offence were "out of character" and that therefore, he is unlikely to re-offend".* As stressed at [105] in the context of medical disciplinary proceedings *" … any mitigating value that an offender's good track record might attract must also be balanced against the wider interest of protecting public confidence in and the reputation of the medical profession."*

14 As for the submission based on his relative youth, Counsel for the Respondent had rightly noted that Dr Wong might not have been as young as the doctors in

the cited precedent cases. Moreover, we were of the view that as soon as Dr Wong had professed to have the skills of a sedationist in the use of Propofol and the skills to perform Liposuction procedures, he must be judged according to acceptable Standards of the Duty of Care and Professional Conduct of a skilled sedationist with Propofol and proceduralist in Liposuction treatment. There was no legitimate merit to claim youth as a mitigating factor in the circumstances of the case. In fact, Counsel for the Respondent's conjecture whether a more senior, experienced proceduralist might have been better able to handle the liposuction procedure on the patient, which was more complex due to the number of previous liposuction procedures the patient had undergone previously, actually reinforced the point that the Respondent had negligently practised beyond the scope of his competency and should have referred the patient to a more experienced proceduralist instead.

15 The issue of dishonesty was a point of contention in the submissions of both Counsel for the SMC and the Respondent. As dishonesty was not an element of the charge, we did not propose to determine the question definitively, especially without the benefit of cross examination and further evidence. We were content to rely on [31-32] of the Agreed Statement of Facts reproduced at [2] above and the Findings of the State Coroner. On this basis, we would say that the observation of Counsel for the SMC that the Respondent might have been economical with the truth when he did not give to Tan Tock Seng Hospital the Patient's history of sedation with Propofol was a fair one. In any event, while dishonesty would be an aggravating factor, acting honestly as submitted by Counsel for the Respondent was of little mitigating weight since integrity would be the acceptable standard for all medical practitioners.

16 Having regard to all the circumstances of the case, we were of the view that a suspension of 18 months was called for. In our view, this would serve as adequate specific and general deterrence against any future transgressions by the Respondent and other members of the Medical Profession. It was also sufficient to protect public confidence in the Medical Profession, especially since regulations have subsequently been tightened by the authorities to regulate the use of Propofol, thereby minimising the risk of any reoccurrence.

17 In our view, a deterrent sentence did not necessarily mean or invariably require a maximum sentence of suspension and the orders we made would achieve the ends of justice. On the other hand, we were of the view that a fine as submitted

by Counsel for the Respondent, even for the maximum sum of $100,000 would have been totally inadequate.

Orders by this Disciplinary Tribunal

18 Accordingly, the DT determines that the Respondent:-

a) be suspended for **18 months**;

b) be censured;

c) give a written undertaking to the SMC that he will not engage in the conduct complained of and any similar conduct; and

d) pay the cost and expenses of and incidental to these proceedings, including the costs of Counsel for the SMC.

Publication of Decision

19 We order that the Grounds of Decision be published.

20 We also record our appreciation to Counsel for the SMC and the Respondent for the professional conduct of the hearing and the assistance rendered to the DT.

21 The hearing is hereby concluded.

Dated this 13th day of December 2017.