SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR ZHU XIU CHUN @ MYINT MYINT KYI ON 11 AUGUST 2017 AND 11 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 S Selvaraj
Mr Edward Leong Hoy Loy
(M/s MyintSoe & Selvaraj)

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 Zhu Xiu Chun @ Myint Myint Kyi ("Dr Zhu") on 11 August 2017, she pleaded guilty without qualification to the following amended charge:

"***CHARGE***

*That you **DR ZHU XIU CHUN** @ **MYINT MYINT KYI** 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 managed the Patient jointly with and/or assisted Dr Wong Meng Hang ("Dr Wong") at all times during the Procedure;

(iii) During the Procedure, both of you were accompanied by one Ms F, who was not a registered nurse;

(iv) At the start of the Procedure, an initial starting dose of 30 mL per hour of Propofol was administered to the Patient;

(v) When the Patient exhibited signs of pain stimulation, you increased and/or allowed the dose of Propofol be increased on Dr Wong's instructions;

(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 Wong 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 Procedure room at around 3.45 pm after Dr Wong informed you that you may leave as the Procedure has been completed;

(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 Zhu faces one charge for failing to exercise due care in the management of the Patient, in that she did not adequately monitor the Patient during the Procedure whereby she 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. Dr Zhu however was unable to recognise the signs that the Patient had entered a state of deep sedation. Furthermore, at the end of the Procedure, the Patient was left 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 Zhu 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 Zhu'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. Dr Zhu's anaesthetic training, knowledge, skill and experience are as follows:

a. As a house-officer in Hospital A, she received training in anaesthesia during her rotation at several hospitals. As a Township Medical Officer, she administered anaesthesia.

b. As a medical officer at Hospital B, she assisted and performed general surgical procedures, and assisted in the administration of anaesthesia to patients and its monitoring.

c. As a partner/director in a practice known as Clinic C, she worked as an anaesthetist for about 2 years.

d. She regularly attended the peer review group for liposuction set up under the auspices of the Singapore Aesthetic Medicine Association. She also attended the Vaser Liposuction courses in Singapore and the Vaser Assisted High Definition Liposculpture Course in Bogota, Colombia.

18. 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 her disclosed experience and qualifications, Dr Zhu 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

19. The Patient first consulted Dr Wong at the Clinic on 4 December 2009. Thereafter, arrangements were made for when the Procedure would be carried out. The Patient was scheduled to have the Procedure on 30 December 2009.

*20. 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. Also present during the Procedure was one Ms F ("**Ms F**"). However, Dr Zhu had not seen the Patient before the Procedure.*

21. 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.

22. At the start of the Procedure, Dr Zhu 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.

23. The Procedure started with the lower back area with the Patient lying in a prone position. After the lower back area was completed and the incision points stitched up, the Patient was flipped over to a supine position in order for the Procedure to be carried out on the upper and lower abdomen area and flanks. Finally,

a fat transfer procedure which involved an intramuscular injection of fats into the pectoralis major bilaterally was carried out on the chest area.

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 between Dr Wong, Dr Zhu and Ms Hong 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. Both Ms Hong and Dr Zhu would call out the Patient's parameters for Dr Wong at the relevant timings.

26. For example, when the Patient exhibited signs of pain stimulation, such as moving or displaying discomfort, Dr Zhu would inform Dr Wong. Dr Wong would then inform Dr Zhu to titrate the dose of Propofol according to the Patient's response. The dose of Propofol was therefore increased at Dr Wong's instructions whenever the Patient responded to painful stimulation.

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 Zhu 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. 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 Tan Tock Seng Hospital ("**TTSH**").*

*31. Upon arrival at the Accident & Emergency ("**A&E**") Department at TTSH at about 5.10 pm, 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 does of adrenaline were administered to the Patient intermittently but to no avail. Death was pronounced at 6.02 pm.*

Conclusion

32. In conclusion, Dr Zhu failed to exercise due care in the management of the Patient, in that she did not adequately monitor the Patient during the Procedure whereby she administered or caused to be administered Propofol to him, and as a result the Patient subsequently passed away. She is therefore guilty of professional misconduct under section 53(1)(d) of the MRA in that her aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

33. *Dr Zhu 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 11 August 2017, the DT reserved our decision as we wanted to consider the sentence for the Respondent together the appropriate sentence for Dr Wong Meng Hang ("Dr Wong"). Both cases were fixed before the DT and the hearing for Dr Wong was scheduled for 22 September 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 Respondent's timely plea of guilt and competency in Liposuction (Liposelection) Procedures and Administration of Anaesthetic. It was stressed that the Respondent had monitored the patient to the best of her ability and it was Dr Wong who had chosen to use Propofol. Under the then prevailing guidelines, monitoring could be undertaken by registered nurse or doctor and the Respondent and Dr Wong took turns to monitor for one another as their registered nurse had left the clinic. When the procedure ended, the Respondent was told by Dr Wong that he would take over the monitoring of the patient and she duly left the room to attend to her other patients. The fact that a number of patients who had undergone liposuction procedures by the Respondent were highly satisfied with her work and her commitment to constantly enhance her medical expertise was also stressed in mitigation.

5 On the personal front, it was submitted that as close to eight years had elapsed since the date of the incident, she had already been punished both in relation to

her professional reputation and her financially. 12 testimonials from her employers, colleagues and peers as well as 30 testimonials from her grateful patients were also enclosed in the written mitigation. Documents showing that she was active in community service and generous in her donations to various charitable and religious organisations were also produced in support of her plea in mitigation. On the authority of *Ang Peng Tiam v Singapore Medical Council and another matter [2017] SGHC 143 ("Ang Peng Tiam")*, it was submitted that the inordinate delay of close to three and a half years in serving the Notice of Inquiry after the Complaint had been made should be taken into account in sentencing the Respondent. All in all, the DT was urged to bestow the utmost sympathy on the Respondent to impose a fine and warning with the usual undertaking.

6 In their further submissions dated 13 November 2017, it was highlighted that the Respondent had acted on the instructions of Dr Wong at all times and her culpability ought to be less serious than that of Dr Wong. There was also no motivation or reason for the breach. The lack of any element of dishonesty or even monetary gain was pointed out. The fact that asphyxia, the ultimate cause of death took place after Dr Wong took over the monitoring of the patient was also highlighted. The Respondent regretted that she did not know the patient had been left alone by Dr Wong when he went to the toilet and she had also acted in good faith at all times. The early plea of guilt and non-contestation of the civil action were also highlighted as evidence of remorse. Counsel for the Respondent also sought to rely on the observations of the Court of Three Judges regarding inordinate delay in *Lam Kwok Lai Leslie v Singapore Medical Council* [2017] SGHC 260 *("Leslie Lam")* to support their plea for the utmost leniency.

Submissions on Sentencing

7 In their oral and written submissions, Counsel for the SMC argued that having regard to the degree of severity of the professional misconduct in question and aggravating circumstances, the appropriate sanction was a suspension of at least two years together with the usual censure, undertaking and requirement to pay costs. This was because the relevant precedents on gross negligence were unduly lenient and should no longer be followed as highlighted by the Court of Three Judges in *Singapore Medical Council v Kwan Kah Yee [2015] 5 SLR 201 ("Kwan Kah Yee")*. Counsel for the SMC compiled a table of relevant precedents for the charge and noted that the sentences ranged from a fine of $10,000 up to

a suspension term of six months. Counsel for the SMC further noted that the DT decision of *Dr Teh Tze Chen Kevin ("Kevin Teh No 1")* concluded on 20 November 2015 appeared to be the most relevant given its analogous facts. It was also highlighted on the authority of the Privy Council decision of *Carmichael v General Dental Council [1990] 1 WLR 134 ('Carmichael")* that a practitioner (in that case a dentist) convicted of gross negligence in relation to the improper administration of sedation could be struck off. Reiterating the dire consequences suffered by the patient in our case, Counsel for the SMC submitted that the significant aggravating factors outweighed the mitigating value of the early plea of guilt, warranting a suspension of at least two years.

8 In their further submissions of 27 November 2017, Counsel for the 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 section 53(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 could 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 fine would be manifestly inadequate and risk undermining public confidence in the medical profession.

9 As for the sentencing factors identified by the DT in *Dr Sim Kwang Soon* that was concluded on 18 August 2017*,* 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 a suspension term of at least two years.

The Decision

10 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 ("Ang Peng Thiam") 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."

11 We were also mindful of the need for general and specific deterrence as highlighted at [55-56] of *Kwan Kah Yee*. 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.

12 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. We noted that Particular (viii) of the charge states that at the end of the Procedure, she left the Procedure room at around 3.45pm after Dr Wong informed her that she may leave as the Procedure had been completed. As stated in [28] of the Agreed Statement of Facts reproduced at [2] above, the Procedure ended at about 3.45pm and the infusion of Propofol was turned off. Dr Zhu then left the procedure room at about 3.50pm, after Dr Wong informed her that the Procedure was over. Dr Wong then proceeded to stitch up the Patient's surgical wounds. Based on this, it appeared that Dr Zhu had actually left the room before the Procedure had ended, lending weight to Counsel for the SMC's contention that she had abdicated her patient care responsibilities and taken orders blindly from Dr Wong. Counsel for the Respondent submitted that before Dr Zhu left the procedure room, she had checked the vital signs of the patient and they were noted to be stable. It was further submitted that Dr Zhu's responsibility for monitoring ended when she left the procedure room. In our view, this attempt to "handover care" does not absolve the Respondent. As highlighted by Counsel for the SMC, Guideline 4.1.1.1 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines provides that a doctor is expected to have a sense of

responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination. We would expect the “appropriate clinical examination” to include the post procedure period whenever sedation with Propofol had been employed.

13 Having said that, we were not persuaded by Counsel for the SMC’s submission that she managed the patient jointly with Dr Wong at all times during the Procedure, and thereby shared equal responsibility for the patient with him. In our view, as the designated 'Assistant', she assumed the responsibility of an assistant to Dr Wong. While that did not permit her to abdicate her patient care responsibilities totally, it also did not elevate her status to an equal one and it would be more accurate to say that they both had shared interests in ensuring the best outcomes for the Patient. For the avoidance of doubt, we were also not prepared to fault the Respondent for the purported non-compliance with the American Society of Anesthesiologists’ 2002 “Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists”. In the absence of more compelling evidence, acceptance by one local restructured hospital and similar guidelines in one private hospital would not, in our view, make it a controlling Singapore policy of general application to medical professionals outside those institutions in 2009.

14 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 *Kwan Kah Yee* meriting a suspension of at least two years as pressed by Counsel for the SMC. It is pertinent to note that *Kwan Kah Yee* involved two counts of improperly issuing death certificates for which the doctor was suspended for a total of three years, i.e. 18 months per charge with the suspension to run consecutively. Both charges were under the first limb of *Low Cze Hong* and while they also involved a plea of guilt, the Court of Three Judges considered as aggravating the fact that the doctor was actually a repeat offender who had committed the offences while under investigation for similar offences that were dealt with separately. Even then, the 18 months per charge for deliberate offences involving dishonesty was six months less than the two year suspension that Counsel for the SMC was seeking in our case.

15 Turning to the DT case of *Kevin Teh No 1* which Counsel for the SMC submitted was most similar to our case, it was pertinent to note that the suspension of four months imposed there was a cumulative sanction for two separate charges that Dr Teh was convicted on after trial. One charge concerned failing to refer the patient to a specialist in a timely manner while the other was for failure to ensure that sedation was safely and appropriately administered to the patient. He was acquitted of a third charge of failing to ensure proper and adequate documentation of the sedation given to the patient. As for *Carmichael*, we accept in principle that striking out could be imposed for gross negligence and would only highlight that there was a clear breach of a General Dental Council Notice when the dentist in question acted as both the proceduralist and sedationist. In essence, while we do not doubt as highlighted by the Court of Three Judges in *Singapore Medical Council v Wong Him Choon [2016] 4 SLR 1086 ("Wong Him Choon")* that a recalibration in sentencing benchmarks upwards was necessary, we believed this had been reflected in our sentence below. Moreover, the cases relied upon by Counsel for the SMC were for more serious offences as we have explained above. It is axiomatic that each case must be decided on its own merits in accordance with the law.

16 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. Furthermore, we have noted that Dr Zhu's accreditation by MOH to perform liposuction procedures had been suspended and she was also no longer licensed to administer Propofol sedation in view of the 2014 Guidelines on Safe Sedation Practice by Non–Anaesthesiologist, such that there was unlikely to be a risk of her repeating the offence. 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.

17 We also took into account the fact that she was otherwise of good standing prior to the incident; and considered the testimonials attesting to her qualities as a good doctor, community service and charitable works. 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."*

18 Having regard to all the circumstances of the case, we were of the view that a suspension of six 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 had subsequently been tightened by the authorities to regulate the use of Propofol, thereby minimising the risk of any reoccurrence.

19 In our view, a deterrent sentence did not necessarily mean or invariably require a minimum suspension of two years 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 inadequate.

Orders by this Disciplinary Tribunal

20 Accordingly, the DT determines that the Respondent:-

a) be suspended for **six (6) months**;

b) be censured;

c) give a written undertaking to the SMC that she 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

21 We order that the Grounds of Decision be published.

22 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.

23 The hearing is hereby concluded.

Dated this 11th day of December 2017.