IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2023] SMCDT 3

Between

Singapore Medical Council

And

Dr Liang Kai Lun Victor

... Respondent

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

TABLE OF CONTENTS

Singapore Medical Council
v
Dr Liang Kai Lun Victor

[2023] SMCDT 3

Disciplinary Tribunal – DT Inquiry No. 3 of 2023
Dr Wong Sin Yew (Chairman), Dr Wong Tzen Yuen Janice, Ms Cornie Ng (Judicial Service Officer)
15 November 2022, 30 March 2023 and 24 August 2023

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

17 October 2023

GROUNDS OF DECISION

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

INTRODUCTION

1. Dr Liang Kai Lun Victor ("**the Respondent**") faced the charges brought by the Singapore Medical Council ("**SMC**") as follows –

1ST CHARGE

That you, Dr LIANG KAI LUN VICTOR are charged that you, on 22 November 2016 at or around 4.30pm to 5pm, whilst practicing as a medical practitioner at the National Healthcare Group Polyclinics, Yishun Polyclinic ("Yishun Polyclinic"), had acted in breach of Guideline 4.2.1 of the 2002 edition of the Singapore Medical Council Ethical Code and Ethical Guidelines ("2002 ECEG") requiring you to treat patients with courtesy, consideration, compassion and respect, as well as to offer patients the right to privacy and dignity, in that you had failed to offer and/or call for a female chaperone to be present when you conducted intimate physical examination of your patient, Ms P ("Patient") which had included the unbuttoning of the first button of her shorts without her prior consent, and you had thereafter accessed the Patient's contact

information without prior authorisation and attempted to contact her after the consultation, to wit:

PARTICULARS

(a) You were aware that the Patient, a female, was a minor;
(b) No one else was present in the room when you physically examined the Patient's abdomen and chest area, and at no point in time did you offer and/or call for a female chaperone to be present;
(c) You instructed the Patient to lie down on the examination couch so as to conduct a physical examination of her abdomen;
(d) Without seeking and/or obtaining the Patient's prior consent, you proceeded to unbutton the first button of the Patient's shorts when she was in a laid down position on the examination couch;
(e) You also conducted a physical examination of the Patient's chest area while the Patient's t-shirt was lifted up and her brassiere loosened; and
(f) On the same day, you accessed the Patient's contact information without prior authorisation, and thereafter sent a text message to the Patient and attempted to call her,

and your aforesaid conduct constitutes an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency, and that you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

ALTERNATIVE 1ST CHARGE

That you, Dr LIANG KAI LUN VICTOR are charged that you, on 22 November 2016 at or around 4.30pm to 5pm, whilst practicing as a medical practitioner at the Yishun Polyclinic, had acted in breach of Guideline 4.2.1 of the 2002 ECEG requiring you to treat patients with courtesy, consideration, compassion and respect, as well as to offer patients the right to privacy and dignity, in that you had failed to offer and/or call for a female chaperone to be present when you conducted intimate physical examination of your patient, one Ms P ("Patient") which included the unbuttoning of the first button of her shorts without her prior consent, and you had thereafter accessed the Patient's contact information without prior authorisation and attempted to contact her after the consultation, to wit:

PARTICULARS

(a) You were aware that the Patient, a female, was a minor;
(b) No one else was present in the room when you physically examined the Patient's abdomen and chest area, and at no point in time did you offer and/or call for a female chaperone to be present;
(c) You instructed the Patient to lie down on the examination couch so as to conduct a physical examination of her abdomen;
(d) Without seeking and/or obtaining the Patient's prior consent, you proceeded to unbutton the first button of the Patient's shorts when she was in a laid down position on the examination couch;
(e) You also conducted a physical examination of the Patient's chest area while the Patient's t-shirt was lifted up and her brassiere loosened; and
(f) On the same day, you accessed the Patient's contact information without prior authorisation, and thereafter sent a text message to the Patient and attempted to call her,

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges of being registered as a medical practitioner, and that you are thereby guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

BACKGROUND

2. The current Disciplinary Tribunal ("**DT**") was appointed on 10 September 2021 and held a total of **six** Pre-inquiry Conferences (20 September 2021, 25 October 2021, 6 January 2022, 24 February 2022, 7 April 2022 and 28 July 2022) for this Inquiry with SMC making three sets of amendments (last amendment made on 29 July 2022) to the Charge and/or Alternative Charge ("**the charges**") and there were two rounds of experts' reports being exchanged.

3. The final position was that the Respondent's Counsel indicated that whilst the Respondent is claiming trial to the charges, he will not be calling any factual witnesses for the Inquiry. Instead, there will be an Agreed Statement of Facts with the SMC and the Respondent will only challenge whether the SMC has proven the charges beyond reasonable doubt based on the experts' reports and testimony.

4. An Agreed Statement of Facts was then tendered on 20 September 2022 and taken as admitted and confirmed by the Respondent. An oral hearing was held on 15 November 2022 where the SMC's expert, Dr PE, and Respondent's expert, Dr DE, took the stand. This was followed by closing submissions from the respective Counsel on 3 March 2023.

5. An oral hearing was convened on 30 March 2023 for clarifications and having fully considered all the facts and circumstances as well as the respective submissions of the parties, this Tribunal found that the SMC had proven beyond reasonable doubt the 1st Charge and the Respondent is guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("**MRA**").

AGREED STATEMENT OF FACTS

6. The undisputed facts[1] are as follows –

(a) The Respondent was aware that the Patient was a female minor at the time of the consultation;

(b) No one else was present in the room when the Respondent physically examined the Patient's abdomen and chest area, and at no point in time did the Respondent offer and/or call for a female chaperone to be present before physically examining the Patient's abdomen and chest area;

(c) The Respondent instructed the Patient to lie down on the examination couch so as to conduct a physical examination of her abdomen where the Respondent proceeded to unbutton the first button of the Patient's shorts without seeking and/or obtaining the Patient's prior consent;

(d) The Respondent conducted a physical examination of the Patient's chest area whilst the Patient's t-shirt was lifted up and her brassiere loosened;

(e) At or around 5.30pm after the consultation, the Respondent accessed the Patient's contact information without prior authorisation and sent a text message to the Patient with his personal handphone:
"Hi (Ms P), Victor here. Was nice to talk to you. Make sure you rest well tonight! Where do you work as a barista?";

(f) There was no response from the Patient, and the Respondent did not follow up with any further text messages; and

(g) Thereafter, at or around 5.31pm, the Respondent attempted to call her from his handphone. The Patient did not pick up the Respondent's call.

[1] See Agreed Statement of Facts dated 20 Sep 2022 at Tab (30) of the Agreed Bundle of Documents ("**ABOD**")

APPLICABLE LEGAL PRINCIPLES FOR ANY FINDING OF GUILT

7. We accept the parties' position that the burden of proof is on the SMC (as the Prosecution) to prove beyond reasonable doubt that the Respondent is guilty of professional misconduct on either the 1st Charge or the Alternative 1st Charge. The Respondent may raise a reasonable doubt (either within the case mounted by SMC or on the totality of the evidence) and the charges against him will be dismissed.

8. In *Low Cze Hong v Singapore Medical Council* ("***Low Cze Hong***"), the Court of Three Judges ("**C3J**") established that professional misconduct could be made out in at least two situations[2]:

   (a) Where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency (the "**LCH first limb**"); and

   (b) Where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner (the "**LCH second limb**").

9. In elaboration, the C3J in *Singapore Medical Council v Lim Lian Arn* ("***Lim Lian Arn***") went on to state that any DT must make the following findings to establish if there is professional misconduct[3]:

   In relation to the LCH first limb:

   (a) First, what is the applicable standard of conduct among members of the medical profession of good repute and competency in relation to the actions that the allegation of misconduct related to ("**First Stage**").

[2] [2008] SGHC 78 at [37] (Tab 4 of the Respondent's Bundle of Authorities dated 3 March 2023)
[3] [2019] SGHC 172 at [29] (Tab 9 of the Respondent's Bundle of Authorities dated 3 March 2023)

(b) Second, the DT should establish whether there has been a departure from the applicable standard ("**Second Stage**").

(c) Third, the DT should determine whether the departure from the applicable standard was an intentional and deliberate departure ("**Third Stage**").

In relation to the LCH second limb:

(d) First, the DT should determine whether there was serious negligence on the part of the doctors; and

(e) Second, the DT should determine whether such negligence objectively constituted an abuse of the privileges of being registered as a medical professional.

10. For purposes of the inquiry, SMC relied on the expert evidence by Dr PE who produced two reports, the first one dated 14 October 2019 with Dr PE2 ("**SMC Experts' First Report**")[4] and the second one on his own dated 23 September 2021 ("**SMC Expert's Supplementary Report**")[5]. The Respondent relied on his expert, Dr DE's views in two expert reports dated 16 February 2021 ("**Respondent Expert's First Report**")[6] and 24 January 2022 ("**Respondent Expert's Supplementary Report**")[7]. Dr PE had the benefit of studying the Respondent Expert's First Report, when he produced his second report. Dr DE had the benefit of studying the SMC Expert's Supplementary Report, when he produced his second report.

11. The Respondent is being charged for breaching Guideline 4.2.1 of the 2002 Ethical Code and Ethical Guidelines ("**2002 ECEG**"), which was in force at the material time on 22 November 2016, requiring the Respondent *"…to treat patients with courtesy, consideration, compassion and respect, as well as to offer patients the right to privacy*

[4] Tab (19) of the ABOD
[5] Tab (26) of the ABOD
[6] Tab (24) of the ABOD
[7] Tab (31) of the ABOD

and dignity". The relevant portion of Guideline 4.2.1 is repeated below for easy reference:–

> Attitude towards patients
> Patients shall be treated with courtesy, consideration, compassion and respect. They shall also be offered the right to privacy and dignity. It is recommended that a female chaperone be present where a male doctor examines a female patient. This will protect both the patient's right to privacy and dignity, as well as the doctor from complaints of molestation.

The rest of Guideline 4.2.1 relates to abuse by patients and/or their relatives and is not relevant for this inquiry.

12. The SMC has focused on the following three acts[8] by the Respondent which are alleged to be in breach of Guideline 4.2.1 of the 2002 ECEG ("**the wrongful acts**"):–

(a) Respondent's physical examination of the Patient without calling / offering to call a chaperone;

(b) Respondent's manner of conducting physical examination of the Patient; and

(c) Respondent's accessing the Patient's contact information without prior authorisation, sending a text message to the Patient and attempting to call her thereafter.

THE DT'S FINDING OF GUILT

13. After the Inquiry, we found that the SMC had proven beyond reasonable doubt that the Respondent is guilty of the 1st Charge, and it is not necessary for us to make a finding on the Alternative 1st Charge. We now state our reasons for our finding of guilt and deal with the three-stage inquiry for each of the wrongful acts in turn below.

[8] See Pages 5, 8 and 9 of SMC's Closing Submissions dated 3 March 2023

REASONS FOR THE FINDING OF GUILT

Physical examination of the Patient without calling / offering to call a chaperone

14. First Stage - What is the Benchmark Standard?

(a) The Respondent's position via Dr DE was that the Respondent has not fallen below the applicable standard for a medical practitioner by not calling for a chaperone *simpliciter*. In this regard, Dr DE highlighted that unlike 2016 ECEG (coming into force from 1 January 2017) which made it mandatory that *"if your patients indicate that they would be more comfortable having a chaperone for clinical examination, or you assess them to be so, you must have a chaperone present."*[9], there is no compulsory requirement (but just a recommendation) to call for a chaperone under Guideline 4.2.1 of 2002 ECEG.

(b) While the SMC accepted that Guideline 4.2.1 of 2002 ECEG and 2016 ECEG are worded differently on the calling of a chaperone (i.e., "recommended" vs "must" respectively), the SMC's position via Dr PE was that the benchmark standard would nevertheless require a male doctor to call a female chaperone to be present for a physical examination of a female patient in certain situations[10]:–

i. If the physical examination is expected to be performed on a part of the body that the patient considers "private" or "sensitive" and/or would result in exposure of a part of the body that is normally covered;
ii. If the physical examination would consist of the female patient lying down on the examining couch and/or being in a vulnerable position; or
iii. If the patient is young and/or a minor and is alone.

("**SMC's applicable benchmark standard for calling of chaperone**")

[9] 2016 ECEG Guideline C4(4)
[10] Dr PE summarised these principles during cross-examination (see lines 20 to 25 of page 144 and lines 1 to 7 of page 145 of the Transcript for the DT Inquiry of 15 November 2022 ("the Transcript"). Also see Paragraph 10 of SMC Experts' First Report at Tab (19) of the ABOD

(c) In support of his position, Dr PE cited various literature covering the period pre- and post- the Patient's consultation with the Respondent (i.e., when the 2002 ECEG was in force and after the 2016 ECEG came into force) to demonstrate the applicable standards or principles on practices relating to the examination of intimate body parts of female patients (including vulnerable patients) and the importance of chaperones above are basic doctoring requirements that have been practiced for years[11].

(d) The Respondent took issue with the applicability of Dr PE's cited literature authored by medical practitioners outside Singapore. We accept SMC's position that there is no evidence to suggest that the applicable medical standards in Singapore are different and should be lower than in those other jurisdictions. We also accept that the principles cited in the various literature appear to be universal in nature and will apply in all developed countries[12], especially in a relatively more conservative country like Singapore[13].

(e) We also note that the Respondent's position via Dr DE on the applicable benchmark under Guideline 4.2.1 of 2002 ECEG for recommended calling of chaperone was when the Doctor feels a *"sense of discomfort"*, and/or where the Doctor feels that the Patient is feeling a *"sense of discomfort"*[14] ("**Respondent's applicable benchmark standard for calling of chaperone**").

(f) The Respondent's position is that the Patient's subjective feelings of discomfort, or lack thereof is crucial, i.e., if the Patient feels no discomfort during the consultation, there is no need to call a chaperone[15]. Following from this, it is the Respondent's position that that during the consultation, the Patient did not display any discomfort with the examination, noting that the Patient had, at no point during the consultation, expressed any concerns to the Respondent[16] nor was there anything in the Respondent's written explanation which suggested

[11] See lines 10 to 14 of page 145 of the Transcript
[12] See lines 7 to 10 of page 145 of the Transcript, and lines 9 to 11 of page 70 of the Transcript
[13] See paragraph 19 of SMC Expert's Supplementary Report, at Tab (26) of the ABOD
[14] See lines 15 and 18 to 20 of page 229 of the Transcript
[15] See paragraph 24 of the Respondent's Closing Submissions dated 3 March 2023
[16] See paragraphs 67 to 71 of the Respondent's First Written Explanation at Tab (14) of the ABOD

that the Patient showed any sign or sense of discomfort and that being the case, the Respondent was not aware that the Patient was uncomfortable and preferred having a chaperone. The Respondent also faulted the SMC for not calling the Patient to testify that she was not comfortable during the consultation.

(g) Against this backdrop, the Respondent had submitted that Dr PE had distorted the rationale behind requiring the presence of a chaperone under Guideline 4.2.1 of 2002 ECEG when he suggested that this is a *"first-line gatekeeping"*[17] against possible subsequent consequences such as sexual harassment, sexual assault, etc. The Respondent's position is that the rationale of having a chaperone present is the *"[protection of] the patient's right to privacy and dignity"* as stated in Guideline 4.2.1 of 2002 ECEG and this is in line with the Respondent's position that the Patient's subjective feelings of discomfort, or lack thereof is crucial.

(h) We make the following observations –

i. We repeat[18] herewith the relevant portion of Guideline 4.2.1 of 2002 ECEG below:-

> Patients shall be treated with courtesy, consideration, compassion and respect. They shall also be offered the right to privacy and dignity. It is recommended that a female chaperone be present where a male doctor examines a female patient. This will protect both the patient's right to privacy and dignity, as well as the doctor from complaints of molestation.

ii. What is to be obeyed is "*Patients shall be treated with courtesy, consideration, compassion and respect. They shall also be offered the right to privacy and dignity"*.

iii. The words following act more like an illustration with a justification – "*It is recommended that a female chaperone be present where a male doctor examines a female patient. This will protect both the patient's*

[17] See lines 21 to 22 of the Transcript
[18] See paragraph 11 above

right to privacy and dignity, as well as the doctor from complaints of molestation."

iv. It appears to us clear that the recommendation in Guideline 4.2.1 of 2002 ECEG is beneficial to both the Patient and any doctor, in that a Patient's right to privacy and dignity will be protected and at the same time, insulate any doctor from complaint(s) of misconduct.

v. With the above in mind, and the statement by the C3J in *Low Cze Hong*[19] that it is imperative for doctors to internalise the ethical responsibilities under the ECEG and to duly perform them not just in letter, but in accordance with its spirit and intent[20], we are inclined to accept the SMC's position that, whilst Guideline 4.2.1 of 2002 ECEG does not make it mandatory to call a chaperone when there is examination of a female patient, SMC's applicable benchmark standard for calling of chaperone is the more preferable and acceptable standard by the profession in Singapore over the Respondent's applicable benchmark standard for calling of chaperone. We also come to this conclusion partly due to our finding that Dr DE's position in paragraph 14(f) above is too general and does not protect "*the patient's right to privacy and dignity, as well as the doctor from complaints of molestation"* as a doctor may be mistaken as to any *"sense of discomfort"*.

vi. In this regard, we also note that Dr DE, who is a Senior Consultant in the Institution A, confirmed at this Inquiry that doctors in Singapore are taught to use a chaperone in the situations described by Dr PE in paragraph 14(b) above[21] and he further confirmed that the applicable principles in pre- or post-2016 *"should not have changed"*[22].

[19] [2008] SGHC 78 (Tab 4 of the Respondent's Bundle of Authorities dated 3 March 2023)
[20] See paragraph 37 of the SMC's Closing Submissions dated 3 March 2023
[21] See line 24 of page 197 and line 1 of page 198 of the Transcript
[22] See line 6 of page 263 the Transcript

vii. Even if we accept the Respondent's applicable benchmark standard for calling of chaperone where the doctor feels a *"sense of discomfort"*, and/or where the doctor feels that the Patient is feeling a *"sense of discomfort"*, we question if the Respondent was in the frame of mind to sense any discomfort at the material time. The Respondent had admitted that he was not observant or poor in observation of any discomfort at the material time[23]. In this regard, we note that Dr F a psychiatrist, who saw the Respondent on 1 December 2016 (one week after the material time) diagnosed the Respondent as suffering from major depressive disorder which would have caused reduced (or poor) judgment and increased (or greater) impulsivity at the time of examination of the Patient although he is of sound mind and culpable for his actions[24].

viii. We also note that the Respondent had explained to Dr F on 1 December 2016 that he had not called for a chaperone as *"he was in a rush and had forgotten to call for a chaperone"* [25] and *"his over-riding goal was to complete the examination and was going through the motions"*. He claims he was preoccupied with stress from his examinations for his Masters in Family Medicine 2.5 weeks prior, getting involved in a motor accident exactly a week before, and being reprimanded by his parents about the said accident on the morning of 22 November 2016[26].

ix. It also appears that on the same day, the Respondent examined two other underaged female patients (14 and 17 years old) and conducted examination with their tops exposed without calling or offering to call for any chaperone and the same explanation of *"completing his examination"* and *"was running through the motions"* was offered[27]. The Respondent's expert indicated that there could have been a *"momentary lapse"* leading to the omission to call a chaperone for the

[23] See paragraph 70 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[24] See Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[25] See paragraph 11 ibid
[26] See paragraphs 16 to 18 ibid
[27] See paragraphs 13 to 14 ibid

Patient[28]. With three patients, we find it difficult to accept any excuse of *"momentary lapse"*, rather, we think that the Respondent deliberately intended not to call a chaperone or acted in a cavalier manner, ignoring and disregarding any discomfort of the patients.

x. As the patient made the police report on the same day after the consultation and complained amongst other things, the non-calling of a chaperone, that goes towards demonstrating that she clearly felt discomfort.

xi. Notwithstanding the Respondent's applicable benchmark standard on the calling of chaperone based on sense of discomfort, the Respondent's own personal position is aligned with SMC's applicable benchmark standard for calling of chaperone as:–

a) the Respondent described the calling of a chaperone when examining a female patient as a *requirement*[29].

b) the Respondent stated unreservedly and repeatedly in his written explanation dated 13 April 2018 –

"I would like to inform the SMC CC that I am fully aware of the importance of having a chaperone present when physically examining a female patient. I know that this is the best practice even since I qualified as a medical practitioner 9 years ago. I would reassure the SMC CC that I would routinely call for a chaperone whenever I have to conduct a physical examination of a female patient[30].

… I would ordinarily call for a chaperone when I have to physically examine a female patient, as in the present case[31]*."*

[28] See Pages 194 and 195 of the Transcript.
[29] See paragraph 49 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[30] See paragraph 7 ibid
[31] See paragraph 27 ibid

c) the Respondent's reason for not adhering to his usual practice of calling a chaperone to the police on 30 November 2016 was that he *"had forgotten to call for a female staff's assistance"*[32] and that is consistent with the explanation he gave to Dr F[33]. At the lowest denomination, for the Respondent to suggest that he forgot will mean that he was aware he needed to call a chaperone or offer a chaperone.

15. Second Stage – Was there a departure from the applicable standard?

As we accept the SMC's applicable benchmark standard for calling of chaperone, i.e., to call a female chaperone to be present for a physical examination of a female patient in certain situations[34]:–

(a) If the physical examination is expected to be performed on a part of the body that the patient considers "private" or "sensitive" and/or would result in exposure of a part of the body that is normally covered;

(b) If the physical examination would consist of the female patient lying down on the examining couch and/or being in a vulnerable position; or

(c) If the patient is young and/or a minor and is alone,

and the examination of the Patient by the Respondent comprised all the factors falling into the three situations above (this is apparent from the Agreed Statement of Fact and not disputed), there was a clear departure by the Respondent from the applicable standard.

[32] See paragraph 6 of the email from SPF to SMC on Police Enquiry on Liang Kai Lun, Victor (IC no. redacted) dated 30 November 2016 at 2.33pm at Tab (9) of the ABOD
[33] See paragraph 11 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[34] Dr PE summarised these principles during cross-examination (see lines 20 to 25 of page 144 and lines 1 to 7 of page 145 of the Transcript for the DT Inquiry of 15 November 2022 ("the Transcript"). Also see Paragraph 10 of SMC Experts' First Report at Tab (19) of the ABOD

16. Third Stage - Was the departure intended and deliberate?

(a) The question to be answered in the third stage is whether the departure in question was *"sufficiently egregious to amount to professional misconduct"* per the test in *Lim Lian Arn*[35].

(b) It appears evident that the Respondent is personally aware of the need to call or offer to call a chaperone when examining a female patient from his positions taken in response to the police investigation on 30 November 2016[36], his visit to Dr F on 1 December 2016[37] and his first written explanation on 13 April 2018[38]. The explanation proffered by him for not carrying out his routine practice to call for a chaperone when he examined the Patient was because he had forgotten as he was *"…on auto-pilot…in a rush…to complete the examination and was going through the motions"* being preoccupied with stress from his examinations for his Masters in Family Medicine two and a half weeks ago, getting involved in a motor accident exactly a week before, and being reprimanded by his parents about the said accident on the morning of 22 November 2016.

(c) Forgetting to call a chaperone whilst acting on *"autopilot"* and *"going through the motions"* (when he examined the Patient) appear to be rather callous and indifferent in light of the Respondent's own characterisation of his routine practice to call a chaperone when examining female patients since he qualified as a medical practitioner (more than seven years at the material time). This is exemplified when the Respondent similarly forgot to call chaperones for **two** other underaged female patients on 22 November 2016 who were alone and had their tops exposed during examination, suggesting that that he has totally turned a blind eye to the need to call a chaperone and making an intentional and deliberate choice to depart from his routine practice to call a chaperone. It will also appear that the Respondent admitted on his visit to Dr F on 1 December

[35] [2019] SGHC 172 at [29] (Tab 9 of the Respondent's Bundle of Authorities dated 3 March 2023)
[36] See paragraph 6 of the email from SPF to SMC on Police Enquiry on Liang Kai Lun, Victor (IC no. redacted) dated 30 November 2016 at 2.33pm at Tab (9) of the ABOD
[37] See paragraph 11 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[38] See paragraph 49 of the Respondent's First Written Explanation at Tab (14) of the ABOD

2016 that for the other **two** underaged patients, he could have completed the examination without exposing their tops and yet he proceeded to do so[39], further illustrating the Respondent's display of a pattern of wilfully turning a blind eye and making an intentional and deliberate choices.

(d) Our observation of the level of the Respondent's disinterest and wilfulness is reinforced by the position taken in the Respondent's first written explanation on 13 April 2018, where he stated matter-of-factly that he *"recall that on 22 Nov 2016, most of the patients I saw were straightforward cases. I do not recall having to specifically call for the chaperone"*[40]. In addition, notwithstanding his statement that he recognised that he was under *"personal stress"* and *"distracted at work"*, and that *"mental fitness is as important as physical fitness when it comes to work"*[41], he did not do or attempt in any way to relieve or remedy the situation. Instead, he chose to act on *"autopilot"* and *"going through the motions"* in examination of the Patient and the other two underaged patients.

(e) While we appreciate that Dr F had diagnosed the Respondent as having Major Depressive Disorder which may have an impact on the Respondent's judgment and impulsivity at the material time[42], Dr F had also categorically stated that the Respondent is of sound mind and culpable for his actions[43]. We also accept SMC's position that Dr F had not corroborated the Respondent's claims that he was on *"auto-pilot"* nor has he suggested that the impact on the judgment and impulsivity control resulted in the Respondent's action on *"auto-pilot"* or *"going through the motions"*.

(f) From the Respondent's first written explanation on 13 April 2018, it appears that the Respondent was very considered on how he should proceed medically to examine the Patient[44], starting with the chest examination using the

[39] See paragraphs 13 to 14 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[40] See paragraph 29 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[41] See paragraph 7 ibid
[42] See paragraphs 27 to 28 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[43] See paragraphs 35 to 36 ibid
[44] See paragraphs 30 to 37 of the Respondent's First Written Explanation at Tab (14) of the ABOD

stethoscope on the chest area, the back area and then deciding that an abdominal examination was necessary. He also made *"mental note to avoid touching the Patient's breast area as she is a female patient"…"percussing over the medial border of the breast and over the lower and lateral chest walls but never over the centre of the breast"*. He also only *"unbuttoned the first button on the Patient's shorts so that it was enough for (him) to palpate her abdomen"*. With the above, it appears that his Major Depressive Disorder which *"depression exerts effects on judgment and impulsivity"* did not affect his well-thought-out process of medical examination and judgment but only resulted in the Respondent's action on *"auto-pilot"* or *"going through the motions"* which is incongruent in our opinion.

(g) With the above, we conclude that the Third Stage will be answered affirmatively. In coming to our conclusion on the Third Stage, we are mindful that *"the conduct complained off must be regarded as falling so far short of expectation as to warrant the imposition of sanctions"* and it will be *"relevant to consider the nature and extent of misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action"*[45].

Manner of conducting physical examination of the Patient

17. First Stage - What is the Benchmark Standard?

(a) From the particulars in the charge preferred, there appears to be two offending acts in conducting physical examination that were in question –

i. The Respondent's conduct of a physical examination of the Patient's chest area while the Patient's shirt was lifted up and her brassiere loosened; and

ii. The Respondent's unbuttoning of the first button of the Patient's shorts without the Patient's prior consent.

[45] *Lim Lian Arn* [2019] SGHC 172 at [38] (Tab 9 of the Respondent's Bundle of Authorities dated 3 March 2023)

(b) SMC chose to only address act ii. above in their Closing Submissions. Act i. above appears to be no longer in issue given that both parties' experts agree that the Respondent's manner of physical examination was appropriate with the Patient's medical history. That being the case, we will only address act ii. here.

(c) Both experts agreed that it was appropriate for an abdominal examination of the Patient to be conducted with the Patient's medical history and it was reasonable for the first button of the Patient's shorts to be unbuttoned to allow for sufficient exposure so that the abdominal examination can be carried out[46].

(d) There is an overlap between the experts on the benchmark standard in the situation, in that, a doctor is to seek a patient's agreement before unbuttoning a patient's shorts. There is also an agreement that as a matter of good practice, a male doctor examining a female patient should refrain from removing a female patient's clothes during the physical examination, unless the patient asks for assistance to do so.[47]

(e) Other than that, the SMC's expert suggested standards on the conduct of such physical examination relying on numerous reference materials in support is as follows[48] -

i. The doctor should refrain from unbuttoning the patient's shorts himself unless assistance was requested by the patient[49];

ii. The doctor should seek the patient's consent before unbuttoning the patient's shorts himself[50]. Ideally, the doctor should ask a chaperone to assist her instead of assisting the patient himself[51];

[46] See paragraph 39 of the SMC's Closing Submissions dated 3 March 2023
[47] See lines 1 to 11 of page 232 of the Transcript
[48] See number 2, 4, 5, 6, 7 in Appendix A of SMC Experts' First Report, Tab (19) of the ABOD and Annexures E and G of SMC Expert's Supplementary Report, Tab (26) of the ABOD
[49] See paragraph 19 of SMC Experts' First Report, Tab (19) of the ABOD
[50] See paragraph 18 ibid
[51] See paragraph 18j of SMC Expert's Supplementary Report, Tab (26) of the ABOD

iii. The doctor should offer the patient the opportunity to undress herself on her own and/or behind a privacy screen[52];

iv. After the patient has become undressed, the doctor should offer the patient a drape to cover up[53]; and

v. Only after the patient was draped for modesty, should the doctor come to the examination couch to start the physical examination[54].

(f) We do not think it necessary for us to deal with all of SMC's proposed applicable benchmark standards although we agree with all the other SMC's proposed applicable benchmark standards as best practices that should be observed when a doctor conducts physical examination of a patient. In this section, we will only focus on the overlapping applicable benchmark standard of obtaining consent or seeking agreement before unbuttoning the Patient's shorts in the circumstances.

18. Second Stage – Was there a departure from the applicable standard?

Based on the agreed facts, the relevant portion as set out below:–

> *Without either seeking or obtaining the Patient's prior consent, the Respondent proceeded to unbutton the first button of the Patient's shorts while she was in a laid down position on the examination couch(.)*

there was a clear departure by the Respondent from the applicable standard obtaining consent or seeking agreement before unbuttoning the Patient's shorts in the circumstances.

19. Third Stage - Was the departure intended and deliberate?

[52] See paragraphs 4c and 4d ibid
[53] See paragraph 4e ibid
[54] See paragraph 18i ibid

(a) The Respondent sought to explain that for the abdominal examination, he had requested the Patient to pull down her shorts. The Patient tugged at her shorts and tried to pull it down but was unable to do so as the shorts were too tight. The Respondent then intuitively assisted the Patient by unbuttoning the first button of the Patient's shorts[55]. The Respondent's submission was that this was a one-off event and there were unusual circumstances leading to the intuitive act of unbuttoning that should be read in the wider context of the circumstances[56]. The Respondent also submitted that owing to the major depressive disorder he was suffering at the material time which *"depression exerts effects on judgment and impulsivity"*, that would have contributed to the Respondent not asking for consent which was an uncharacteristic lapse of judgment on the Respondent's part[57]. That being the case, the Respondent's actions cannot be said to be sufficiently egregious to amount to professional misconduct.

(b) While we note the Respondent's explanation of his intuitive behaviour to assist the Patient to pull down her tight shorts by unbuttoning the first button of her shorts without consent or being asked for assistance and attribution to this being contributed to by his major depressive disorder at the material time, we observe that:–

i. the Respondent examined the Patient's breast or chest area just prior to the abdominal examination with her bra loosened[58] and had asked the Patient if she needed help to hook her bra after the chest examination[59]. This being the case, we are unable to understand how he would not have asked the Patient if she needed assistance to unbutton her shorts shortly thereafter.

[55] See paragraphs 35 and 61 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[56] See paragraphs 30 to 31 of the Respondent's Closing Submission dated 3 March 2023
[57] See paragraph 32 ibid
[58] See paragraph 9 of the Agreed Statement of Facts at Tab (3) of the ABOD and paragraphs 57 – 62 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[59] See paragraphs 4 and 6 of the email from SPF to SMC on Police Enquiry on Liang Kai Lun, Victor (IC no. redacted) dated 30 November 2016 at 2.33pm at Tab (9) of the ABOD

ii. From the Respondent's first written explanation on 13 April 2018, it appears that the Respondent was very considered on how he should proceed medically to examine the Patient[60], starting with the chest examination using the stethoscope on the chest area, the back area and then deciding that an abdominal examination was necessary. He also made *"mental note to avoid touching the Patient's breast area as she is a female patient"…"percussing over the medial border of the breast and over the lower and lateral chest walls but never over the centre of the breast"*. He also only *"unbuttoned the first button on the Patient's shorts so that it was enough for (him) to palpate her abdomen"*. With the above, it appears that his major depressive order which *"depression exerts effects on judgment and impulsivity"* did not affect his well-thought-out process of medical examination and judgment but affected any need to seek consent or his rendering of assistance when there was no request for assistance which is incongruent in our opinion.

iii. Lastly, we will repeat our opinion in paragraphs 16(c) and 16(d) above on the Respondent's display of a pattern of wilfully turning a blind eye and making intentional and deliberate choices as well as the level of the Respondent's disinterest and wilfulness in his conduct at the material time.

(c) We agree with the SMC that that the departure in question was intended and deliberate and sufficiently egregious to amount to professional misconduct, in that the Respondent[61]:-

i. had without the consent / agreement of the Patient unbuttoned her shorts which will expose a sensitive area (pubic area) or cause concern of exposure of a sensitive area;

ii. when no assistance was asked for by the Patient;

[60] See paragraphs 30 to 37 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[61] See paragraph 57 of the SMC's Closing Submissions dated 3 March 2023

iii. this was done while the Patient was lying down on the examination table in a vulnerable position vis-à-vis the Respondent; and

iv. the Patient is a minor and alone with the Respondent without chaperone.

In doing so, the Respondent had clearly disregarded his duty to treat patients with consideration and respect, as well as to offer patients the right to privacy and dignity.

(d) With the above, we conclude that the Third Stage should be answered affirmatively. In coming to our conclusion on the Third Stage, we are mindful that *"the conduct complained off must be regarded as falling so far short of expectation as to warrant the imposition of sanctions"* and it will be *"relevant to consider the nature and extent of misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action"*[62].

Accessing the Patient's contact information without prior authorisation, sending a text message to the Patient and attempting to call her thereafter

20. First Stage - What is the Benchmark Standard?

(a) The SMC's position via their expert Dr PE on the applicable benchmark standard is that –

i. A doctor should not obtain a patient's contact information without prior consent from the patient and/or the patient's guardian (in the situation when the patient is a minor) as well as prior authorisation from NHGP;

ii. A doctor should not send a text message or contact a patient without prior consent from the patient and/or the patient's guardian (in the

[62] *Lim Lian Arn* [2019] SGHC 172 at [38] (Tab 9 of the Respondent's Bundle of Authorities dated 3 March 2023)

situation when the patient is a minor) as well as prior authorisation from NHGP[63]; and

iii. The exception is only when there is a medical emergency requiring the doctor to contact the patient urgently[64].

(b) The Respondent's expert, Dr DE, stated that a doctor has full access to his / her patient's contact information at any time[65] on the concept of presumed consent[66] and went on to state that *"[w]hat [the Respondent] did with the contact information is a separate matter"*[67].

(c) We respectfully disagree with Dr DE on his opinion that a doctor is entitled to full access to any patient's contact information at any time under the presumed consent concept. This flies against all notions of privacy of personal information. We find Dr PE's position more attractive and tenable in that the presumed consent concept will only arise in exceptional circumstances when the consulting doctor is accessing the information due to a clinical or medically relevant reason (such as a medical emergency) or for an administrative reason[68]. We accept SMC's position that a patient does not consent to a doctor obtaining his or her personal contact information simply by virtue of the patient consulting that doctor[69].

(d) We also note that Dr DEhas during cross-examination elaborated that it would be appropriate for a consulting doctor to use a patient's contact information to contact the patient after the consultation in a situation when there is an urgent medical need[70]. He illustrated that urgent medical need will be a situation whereby there was wrong medicine or wrong dosage administered and

[63] See paragraphs 10 to 12 of SMC Expert's Supplementary Report, Tab (26) of the ABOD
[64] See lines 12 to 19 of page 177 of the Transcript
[65] See lines 13 to 16 of page 220 of the Transcript
[66] See paragraph 10 "My Opinion On The Three Questions Asked" at 1.2 (3) on page 7 of Respondent Expert's Supplementary Report at Tab (31) of the ABOD
[67] Ibid
[68] See lines 5 to 11 of page 180 of the Transcript
[69] See paragraph 49 of the SMC's Closing Submissions dated 3 March 2023
[70] See lines 9 to 13 of page 223 of the Transcript

conceded that smoking cessation is not an emergency[71]. He went on to state that if there was nothing life-threatening which required the doctor to contact his patient, it did not make sense for the doctor to try to contact the patient[72]. With this, both experts appear to be aligned in terms of the applicable benchmark standard for a consulting doctor to contact a patient using his or her personal contact information after the consultation when there was an urgent medical need to do so.

21. Second Stage – Was there a departure from the applicable standard?

Based on the agreed facts, the relevant portion as set out below:–

After the consultation on 22 November 2016, at or around 5.30pm on the same day, the Respondent accessed the Patient's contact information without prior authorisation from NHGP and/or the Patient. The Respondent then sent a WhatsApp text message from his personal mobile phone to the Patient's mobile phone, as follows:

"Hi (Ms P), Victor here. Was nice to talk to you. Make sure you rest well tonight! Where do you work as a barista?"
Thereafter, at or around 5.31pm, the Respondent attempted to call her from his handphone. The Patient did not pick up the Respondent's call.

On the face of the message sent, there was a clear departure by the Respondent from the applicable benchmark standard of gaining access to the Patient's contact information without consent or authorisation and proceeding to contact the Patient when there does not appear to be any urgent medical need to do so.

22. Third Stage - Was the departure intended and deliberate?

[71] See lines 17 to 18 of page 221 of the Transcript
[72] See lines 15 to 21 of page 226 of the Transcript

(a) The Respondent's Counsel had sought to explain that the Respondent as attending physician had accessed the medical records some 30 minutes after the consult with the Patient to send one text message to the Patient allegedly as an introductory message before he sent over information on smoking cessation and sleep hygiene[73]. This was purportedly necessary as he did not inform the Patient during the consultation earlier that he would be sending her further information on smoking cessation and sleep hygiene. It was admitted that *"while the tenor of text message of the text message was not professional"* nor *"in itself had no clinical relevance"*, it was done so as not to overwhelm the Patient with the information he was about to send[74]. It was submitted that the text message was not *"extremely personal or offensive to the Patient"*[75] and in this regard, the Respondent's Counsel had pointed out that in the SPF's email to the SMC of 30 November 2016[76], there was no complaint by the Patient regarding the text message sent by Dr Liang and that this was *"suggestive that the Patient was not adversely affected by the text message"*[77]. All these point to the fact that the sending of text message was one-off[78] and not *"so egregious as to amount to professional misconduct"*[79].

(b) The Respondent's Counsel had tried to convince us that this was a one-off incident and after the first call to the Patient was not picked up, the Respondent did not make any attempts to contact the Patient further[80]. The Respondent's Counsel also submitted that the Respondent did not remember making the call and *"(c)onsidering that the phone call was made immediately after the text message was sent, there is a possibility that the phone call was accidental as well"*[81] and the text message plus phone call *"so egregious as to amount to professional misconduct"*[82].

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[73] See paragraphs 50 and 70 of the Respondent's Closing Submissions dated 3 March 2023. Also see paragraph 76 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[74] See paragraph 68 of the Respondent's Closing Submissions dated 3 March 2023
[75] See paragraph 49 of the Respondent's Closing Submissions dated 3 March 2023
[76] See Tab (9) of the ABOD
[77] See paragraph 51 of the Respondent's Closing Submissions dated 3 March 2023
[78] See paragraph 47 ibid
[79] See paragraphs 68 to 70 ibid
[80] See paragraph 47 ibid
[81] See paragraph 48 ibid
[82] See paragraph 69 ibid

(c) We start by observing that whilst the Respondent had explained that the text message was not sent for a social purpose, the text message that was sent as set out below suggested otherwise –

"Hi (Ms P), Victor here. Was nice to talk to you. Make sure you rest well tonight! Where do you work as a barista?"

The Respondent had not described himself as Dr Victor or Dr Liang and was on first name basis with the Patient and the tone of the message was clearly personal and friendly. The text of the message did not make mention of any smoke cessation and sleeping hygiene information to follow. Even if we accept this to be an *"introductory message"* for following up with smoke cessation and sleeping hygiene information, it is not evident to us why the Respondent needed to know where the Patient was working as a barista.

(d) In any case, it is also not clear to us why the *"introductory message"* is necessary given that the Respondent's position is that he had already advised the Patient to *"stop smoking"* and *"avoid smoking areas"*[83] as well as on smoking cessation and adequate rest and hydration[84]. If it is as the Respondent had suggested, would it not be easier or efficient to continue the message to say that he is contacting her on the provision of such information?

(e) In this regard, we agree with the SMC that *"if the Respondent's purpose was to provide medically-relevant information to the Patient, then it should not matter whether or not the Patient had replied his "introductory" message. The Respondent could simply have sent along the necessary information to the Patient regardless, with or without any "introductory" message"*[85].

(f) The Respondent had sought to explain that after he saw the Patient and another few patients, he was anxious but unsuccessful in contacting the workshop and

[83] See paragraphs 36 and 74 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[84] See entries in the Respondent's Doctor Notes for the Patient on 22 November 2016 in Tab (4) of the ABOD
[85] See paragraph 73 of the SMC's Closing Submissions dated 3 March 2023

the insurers about the repair of his parents' car; and he realised that he forgot to give the Patient information on smoke cessation and sleep hygiene, hence his accessing the Patient's information and sending her the text message[86]. Against that backdrop, it is difficult to fathom how the Respondent could have written such a personal and friendly text message to the Patient. If it is as he explained, we imagine that any text message would have been more curt, perfunctory and precise.

(g) We also note that the Respondent provided a different explanation to Dr F on 1 December 2016 (some two weeks after the consultation of the Patient on 22 November 2016) for sending the text message to the Patient. At that interview, the Respondent explained that he sent the text message *"out of concern for the Patient…He said that Patient … shared that she was doing part-time work and found it very stressful and had to work long hours. He said that he wanted to ask her not to work so hard and thought it would be good for her to have some other options (about work)"*[87]. This would explain the personal and friendly nature and tone of the text message.

(h) Given the above, it does not appear to us that the phone call following the text message was accidental as submitted by the Respondent. From the nature and the tone of the text message, it is more likely than not that the Respondent called the Patient when there was no response to his text message.

(i) The Respondent had also admitted in his first written explanation on 13 April 2018 that he is fully aware that he should not have accessed the Patient's information without prior authorisation but did not know why he did so and attributed it to his frame of mind at that time[88]. He also informed Dr F that this was a *"gross error of judgment"*[89]. In this regard, we repeat our opinion in paragraphs 16(c) and 16(d) above on the Respondent's display of a pattern of wilfully turning a blind eye and making intentional and deliberate choices as

[86] See paragraph 74 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[87] See paragraph 11 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[88] See paragraph 77 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[89] See paragraph 12 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD

well as the level of the Respondent's disinterest and wilfulness in his conduct at the material time.

(j) In all, we find that the Respondent had exploited his position to gain access to the Patient's contact information from the patient database after the consultation, made use of the Patient's contact information to send a text message with no clinical relevance (more for social reasons), and to make a telephone call to the Patient who is a minor. We agree with the SMC that *"such conduct erodes the trust that the public places in healthcare institutions when they provide these institutions with their personal information"* breaching a patient's right to privacy and dignity.

(k) We do not accept that the Respondent had acted professionally and note that the C3J had stated in *Ong Kian Peng Julian v Singapore Medical Council and other matters* ("***Ong Kian Peng Julian"***) that *"[p]atients are entitled to expect that their doctors will display a high standard of professional conduct in their dealings and interactions with them. This extends to how their doctors handle their personal information and their details even after the end of their interactions"*[90].

(l) With the above, we conclude that the Third Stage should be answered affirmatively. In coming to our conclusion on the Third Stage, we are mindful that *"the conduct complained off must be regarded as falling so far short of expectation as to warrant the imposition of sanctions"* and it will be *"relevant to consider the nature and extent of misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action"*[91].

23. We will also state for the record that we accept SMC's submission that even if any individual breach or departure does not amount to professional misconduct, the totality of the wrongful acts clearly and objectively portrays the Respondent's indifference in

[90] [2022] SGHC 302 at [69]
[91] *Lim Lian Arn* [2019] SGHC 172 at [38] (Tab 9 of the Respondent's Bundle of Authorities dated 3 March 2023)

the protection of the Patient's right to privacy and dignity. Any reasonable person hearing the Respondent's wrongful acts will conclude that he should not have engaged in them.

24. The Respondent not only failed to call for a chaperone and subjected a female minor to be placed in an inappropriate position of having sensitive or intimate areas of her body examined by a male doctor unaccompanied and unsupervised, he compounded that with the manner he had then unbuttoned the first button of the Patient's shorts to carry out examination of the Patient's abdomen in a supine position without consent or request for assistance. His final wrongful act of accessing and obtaining the Patient's private contact information from NHGP's database and sending an unsolicited text message with no clinical relevance to the Patient after the consultation followed by a phone call sealed the violation of the Patient's right to privacy and dignity.

25. As a clear message must be sent to medical practitioners that any professional breach involving minor and vulnerable patients will not be tolerated, the Respondent's departure from the benchmark standard is especially egregious and warrants disciplinary action.

26. Before we turn to the submissions on sentencing, we pause here to address the Respondent's concerns with the credibility of Dr PE, the SMC's expert in the Respondent's Closing Submissions. Essentially, the Respondent submitted that:–

    (a) Dr PE's conclusions are poorly substantiated in his expert reports and that Dr PE relied on articles with irrelevant subject matter and is unable to justify the use of the same[92]. We have dealt with this in paragraph 14(d) above and will not address this further; and

    (b) Dr PE may potentially have a conflict of interest in the matter as Dr PE is also a Director of Company B, which provides consultancy services to NHGP, and Dr PE also teaches at NHGP NUS and receives payments. This is contrary to Dr PE's signed declaration of no conflict of interests including not having any

[92] See paragraphs 71 to 81 of the Respondent's Closing Submissions dated 3 March 2023

affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this review report. Dr PE appears to be aware of this potential conflict of interest and roped in one Dr PE2 for the SMC Experts' First Report. Upon Dr PE2's death, he carried on as SMC's sole expert and submitted SMC Expert's Supplementary Report. The fact that NHGP did not directly pay Dr PE is irrelevant in the circumstances[93].

27. We fail to see how any conflict of interests will arise in Dr PE acting as SMC's expert for the DT Inquiry. Save that the complaint against the Respondent arose from his work as a doctor in NHGP polyclinic, the SMC Experts' First Report by Dr PE and Dr PE2 does not deal with NHGP at all. Any concern, if at all, will only arise in SMC Expert's Supplementary Report by Dr PE where there was a reference to the Respondent accessing the Patient's contact information in NHGP's database without the Patient's and NHGP's authorisation and texting the Patient without NHGP's oversight and knowledge as well as how the subsequent text message and phone call may alarm NHGP. We note that while there were some issues with reliance on NHGP protocols for this Inquiry at the initial stage, that was resolved consequently with an agreement to not rely and call into evidence the same. With that resolution, we are unable to see how any conflict will arise. Having read and considered all the SMC expert(s)' reports, we are of the opinion that the reports are written impartially, well supported and even-handedly.

SUBMISSIONS ON SENTENCING

General principles

28. Under Section 53(2) of the MRA, we may:–

(a) by order remove the name of the registered medical practitioner from the appropriate register;

[93] See paragraphs 82 to 88 of the Respondent's Closing Submissions dated 3 March 2023

(b) by order suspend the registration of the registered medical practitioner in the appropriate register for a period of not less than three months and not more than three years;

(c) where the registered medical practitioner is a fully registered medical practitioner in Part I of the Register of Medical Practitioners, by order remove his name from Part I of the Register and register him instead as a medical practitioner with conditional registration in Part II of that Register, and section 21(4) and (6) to (9) shall apply accordingly;

(d) where the registered medical practitioner is registered in any register other than Part I of the Register of Medical Practitioners, by order impose appropriate conditions or restrictions on his registration;

(e) by order imposed on the registered medical practitioner a penalty not exceeding $100,000;

(f) by writing censure the registered medical practitioner;

(g) by order require the registered medical practitioner to give such undertaking as the DT thinks fit to abstain in future from the conduct complained of; or

(h) make such other order as the DT thinks fit, including any order that a Complaints Committee may make under section 49(1).

29. In doing so, we note the key sentencing objectives in disciplinary cases involving medical misconduct set out by the C3J in *Wong Meng Hang v Singapore Medical Council* ("***Wong Meng Hang***")[94]:-

(a) To uphold confidence in the medical profession;

(b) To protect the public who are dependent on doctors for medical care;

[94] [2018] SGHC 253 at [75(a)]

(c) To deter the errant doctor and others who might be similarly disposed from committing similar offences; and

(d) To punish the errant doctor for his misconduct.

30. We also note that the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals published on 15 July 2020 ("**Sentencing Guidelines**") reference two further sentencing considerations / principles:

(a) *"**Retribution**: The essence of retribution is that the offender must pay for what he has done. There is a need to punish a doctor who has been guilty of misconduct. 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."*[95]

(b) *"**Rehabilitation:** Rehabilitation seeks to reform the offender by altering his or her values, thus ensuring that the offender does not reoffend… 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."*[96]

31. In *Wong Meng Hang*, the C3J laid down a four-step sentencing framework to sentence a medical practitioner whose misconduct has caused harm to a patient[97]. Subsequently, in *Ong Kian Peng Julian*, the C3J recognised that the *Wong Meng Hang* framework can and should be extended to both clinical and non-clinical offences[98]. The C3J also held that the definition of "harm" in the said framework was broad enough to include other forms of harm, such as non-physical harm (including emotional or psychological distress), potential harm, and harm caused to public confidence in the medical profession, or to public health and safety or to the public healthcare system[99].

[95] See paragraph 10e of the Sentencing Guidelines
[96] See paragraph 10e of the Sentencing Guidelines
[97] [2018] SGHC 253 at [30 - 44]
[98] [2022] SGHC 302 at [62]
[99] [2022] SGHC 302 at [61]

32. The four-step sentencing framework and matrix in *Wong Meng Hang*[100] and adopted in *Julian Ong*[101] is as follows:–

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

(b) Step 2: Identifying the applicable indicative sentencing range using the harm-culpability matrix stated in *Wong Meng Hang*;

(c) Step 3: Identifying the appropriate starting point within the indicative sentencing range; and

(d) Step 4: Adjusting the starting point by taking into account offender-specific aggravating and mitigating factors.

Harm / Culpability	Slight	Moderate	Severe
Low	Fine or other punishment not amounting to suspension	Suspension of up to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months 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

The Respondent's Submissions on Sentencing

33. The Respondent's Counsel submitted that the seriousness of the Respondent's misconduct caused not more than **moderate** harm and was of **low** culpability[102].

[100] [2018] SGHC 253 at [30 - 44]
[101] [2022] SGHC 302 at [63]
[102] See the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023

34. As the SMC and the Respondent are both agreed on the issue of moderate harm and only differed on the issue of culpability, we will only set out the submissions on culpability for both the SMC and the Respondent.

35. The premise for the Respondent's submission on **low** culpability is as below:–

(a) the Respondent's misconduct was a one-off lapse in judgment arising from trying personal circumstances at the material time. The Respondent was suffering from Major Depressive Disorder predating and at the material time of the misconduct; the diagnosis of which was supported by Dr F's psychiatric report. The depression exerted effects on his judgment and impulsivity. The car accident that took place two days prior to the misconduct exacerbated the impairment of the Respondent's judgment and accordingly, at the material time, the Respondent was, *"at worst, negligent in his conduct towards the Patient"* and this state of mind supports the inference of low culpability[103];

(b) the Respondent did not benefit from any financial gain arising from his misconduct[104]; and

(c) the Respondent did not attempt to cover up his misconduct and *"has been forthcoming and cooperative with the authorities"*[105].

36. With the **moderate** harm and **low** culpability attributed to the Respondent's misconduct, the Respondent submitted that the appropriate sentencing range will be suspension of not more than one year based on the matrix. The Respondent submitted for a **light** suspension[106] in face of the following mitigating factors[107] –

(a) The Respondent having a long unblemished track record and good professional standing;

[103] See paragraph 56 ibid
[104] See paragraph 57 ibid
[105] See paragraph 58 ibid
[106] See paragraph 6 ibid
[107] See paragraphs 9 to 36 ibid

(b) An inordinate delay in the prosecution of the Respondent;

(c) The Respondent's remorse and insight; and

(d) The Respondent's difficult personal circumstances at the material time and his state of mind which will offset any countervailing public interest considerations.

37. The SMC submitted that the seriousness of the Respondent's misconduct caused **moderate** harm[108] and was of **medium** culpability[109].

The SMC's Submissions on Sentencing

38. On the issue of **<u>medium</u>** culpability, SMC's submission was that with the Respondent's conviction on the charge that Respondent's misconduct was *"an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency"*, any submission by the Respondent that any harm caused to the Patient was "*purely accidental*"[110] and that the Respondent was "*at worst, negligent in his conduct towards the Patient*"[111] cannot be correct[112].

39. SMC also took issue with the Respondent's submission that he *"has been forthcoming and cooperative with the authorities"*[113], and that he *"has, at no point in time, attempted to cover up his misconduct"*[114] and pointed out that the following Respondent's acts in the course of the Inquiry demonstrated a *"lack of integrity and insight into his misconduct"*[115] –

(a) The Respondent *"tried to suggest that his failure to call for a chaperone was inadvertent"* as he was *"going through the motions"* and on *"auto-pilot"*[116] when he saw the Patient. These excuses were not endorsed by Dr F who had

[108] See paragraph 22 of the SMC's Sentencing Submissions dated 26 May 2023
[109] See paragraph 34 ibid
[110] See paragraph 52 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023
[111] See paragraph 56 ibid
[112] See paragraph 26 of the SMC's Sentencing Submissions dated 26 May 2023
[113] See paragraph 58 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023
[114] Ibid
[115] See paragraph 30 of the SMC's Sentencing Submissions dated 26 May 2023
[116] See paragraph 27 of the Respondent's First Written Explanation at Tab (14) of the ABOD

instead concluded that he was culpable for his actions[117]. This conclusion was reached by Dr F notwithstanding that the Respondent had admitted that on the same day of consultation, the Respondent had consciously and deliberately conducted separate examinations of two other female minors without a chaperone present and with their tops exposed[118] when he could have completed both examinations without exposing their tops. The deliberate nature of the Respondent's misconduct cannot be taken lightly;

(b) The Respondent *"outright lied by stating that he did not recall having to specifically call for the chaperone on 22 November 2016"*[119] in his first written explanation on 13 April 2018; and

(c) The Respondent *"attempted to justify"* accessing the Patient's contact information without prior authorisation, and subsequent text message to the Patient, *"by claiming that it was done with the intention of providing the Patient with medically relevant information on sleep hygiene and smoke cessation"*[120]. When challenged with the fact that the nature of his text message appeared to be social and not contain any medical justification or context to it, the Respondent had then sought to explain that the text message was *"simply meant to be an introductory message such that the Patient would not be immediately overwhelmed by any information which [the Respondent] had hoped to share"*[121].

40. SMC also felt that the Respondent's misconduct cannot be properly considered as a simple *"one-off lapse in judgment"* as he had admitted there were two other inappropriate examinations of female minors on the very same day. In all, SMC submitted that the Respondent had committed multiple breaches of professional standard or guidelines when he had examined the Patient, a minor in a vulnerable position, unbuttoned her clothes without consent and without a chaperone, then

[117] See paragraph 35 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[118] See paragraphs 13 to 14 ibid
[119] See paragraph 29 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[120] See paragraph 74 ibid
[121] See paragraph 68 of the Respondent's Closing Submissions dated 3 March 2023

accessing her contact information without authorisation and contacting her without medical justification (and ostensibly for a social purpose)[122].

41. SMC also submitted that the C3J in *Chia Foong Lin v Singapore Medical Council* ("***Chia Foong Lin***")[123] held that a doctor would be more culpable in failing to uphold the *"most basic and elementary professional standards"*, and the Respondent had done just that when he had examined the Patient, a minor in a vulnerable position, unbuttoned her clothes without consent and without a chaperone, then accessing her contact information without authorisation and contacting her without medical justification (and ostensibly for a social purpose)[124]. All things being considered, SMC's position is that **medium** culpability should be attributed to the Respondent's misconduct.

42. With the **moderate** harm and **medium** culpability attributed to the Respondent's misconduct, the appropriate sentencing range will be a suspension between one to two years. SMC's position was that the appropriate starting point should be near the top end of the applicable range, i.e., a suspension of 18 to 21 months bearing in mind that in *Ong Kian Peng Julian* where the misuse of the patient's information was more aggravating and the C3J stated that the appropriate starting point in that case was a suspension of two years.

43. The SMC also went on to state that[125] –

(a) zero mitigating weight should be attributed to the Respondent's long unblemished track record and good professional standing;

(b) there was no inordinate delay requiring any discount to be considered in sentencing;

(c) the Respondent's lack of remorse was in itself an aggravating factor; and

[122] See paragraph 32 of the SMC's Sentencing Submissions dated 26 May 2023
[123] [2017] 5 SLR 334
[124] See paragraph 31 of the SMC's Sentencing Submissions dated 26 May 2023
[125] See paragraphs 42 to 62 ibid

(d) the public interest considerations in the present case clearly outweigh the Respondent's difficult personal circumstances even if that is to be considered to have any mitigation weight.

44. Bearing in mind the above, the SMC submits that, in addition to a censure of the Respondent and a written undertaking to the SMC from the Respondent that he will not engage in the conduct complained of or any similar conduct, we should exercise our powers pursuant to s53(2) of the MRA to impose a suspension of registration for a period of at least **18** months and costs against the Respondent[126].

THE DT'S DELIBERATION ON SENTENCING

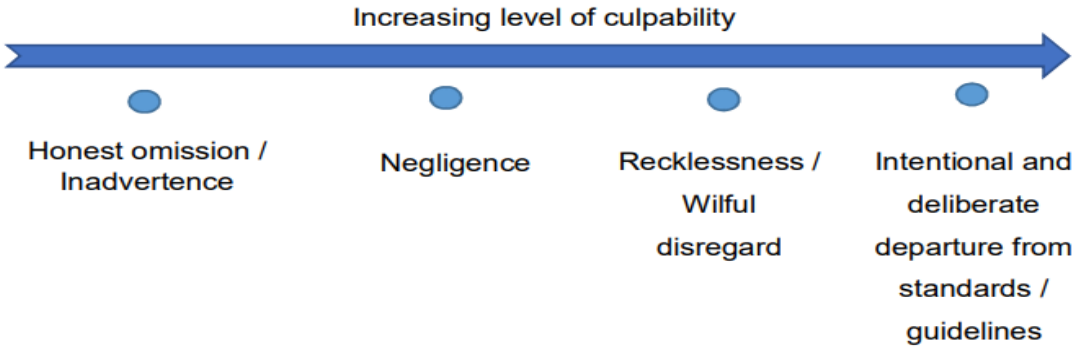
45. All parties are of the position that the Respondent's misconduct caused **moderate** harm and having consideration of the facts and circumstances, we agree and will not elaborate further save to observe that whilst the Respondent's misconduct may not have caused clinical harm to the Patient, it was accepted by all parties there was emotional and psychological distress caused to the Patient[127]. Furthermore, the Respondent's misconduct undermined public confidence to the medical profession and the healthcare system. By putting himself in a position whereby he had examined a female minor in a vulnerable position, unbuttoned her clothes without consent and without a chaperone, then accessing her contact information without authorisation and contacting her without medical justification (and ostensibly for a social purpose), there is cause for concern by any reasonable member of public, particularly any parent, as he has exploited the faith or trust placed on him as a doctor.

46. Parties differed on the culpability to be attributed the Respondent's misconduct, with SMC submitting a case of **medium** culpability and the Respondent, **low** culpability.

47. Culpability is determined with reference to the degree of blameworthiness of the Respondent's misconduct. The Sentencing Guidelines set out a list of non-exhaustive factors that may be considered including the Respondent's state of mind[128]. With this,

[126] See paragraph 64 ibid
[127] See paragraph 46 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023
[128] See paragraph 54 of the Sentencing Guidelines

we set out the level of culpability relative to the doctor's state of mind from the Guidelines which illustrates that an honest omission or inadvertence as the lowest level of culpability and an intentional and deliberate departure from standards or guidelines as the highest level of culpability as follows[129]



48. Other relevant factors to be considered to ascertain culpability are the extent of premeditation and planning involved, including the lengths to which a doctor went to cover up his or her misconduct, extent of departure from the standard of care or conduct reasonably expected of a medical practitioner, urgency of the situation, duration of the offending behaviour, having regard to the circumstances underlying the continuance of the offending conduct, and the extent to which the doctor abused his/her position of trust and confidence[130].

49. We have considered and agree with SMC's position that the Respondent's submission on **low** culpability cannot be supported. Having considered all facts and circumstances, we agree with SMC and find that the Respondent's misconduct is of **medium** culpability.

50. From our Findings of Guilt above, we do not accept that there was anything accidental nor negligent in the Respondent's misconduct. We stand by our findings that the Respondent's misconduct was *"an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency"*. We will also point out that the Respondent's position before us was that his misconduct

[129] See paragraph 54(a) of the Sentencing Guidelines
[130] See paragraphs 54(b), (d), (h), (i) and (j) of the Sentencing Guidelines

could not have been said to be deliberate nor negligent; to now take the position that his misconduct is at best negligent is mischievous and self-serving.

51. We agree with SMC that the Respondent's submission that of his misconduct being a *"one-off lapse in judgment"* or that he was *"going through the motions"* and on *"auto-pilot"* are not endorsed by Dr F in his psychiatric report[131]. We note that Dr F saw him on 1 December 2016, some nine days after the misconduct and diagnosed that the Respondent may be suffering from *"Major Depressive Disorder predating and at the time of incidents"*[132] which *"(R)educe judgment and increased impulsivity are two factors that have contributed to his boundary violations"*[133] but nonetheless found the Respondent culpable for his actions and that *"(N)one of the above actions absolves Dr Liang of his culpability…"*[134].

52. We are also particularly bothered that there were two other incidents of examination of female minors without chaperone and exposing their tops when that was not necessary on the same day before the examination of the Patient, displaying the Respondent's cavalier attitude and total deliberate indifference or disregard which do not go towards supporting the Respondent's submission of low culpability.

53. Whilst the Respondent appeared to have taken the position that he was *"aware that this is the best practice"… "to ensure that a chaperone was present during the Patient's consultation with me on 22 November 2016"* and that he had *"always been practising this ever since [I] qualified as a medical practitioner 9 years ago"*[135], he challenged the need to call a chaperone, necessitating experts to opine in this area. We accept SMC's submission that as the Respondent's misconduct breaches basic profession standards, it is even more culpable under *Chia Foong Lin*[136].

[131] See Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[132] See paragraph 27 ibid
[133] See paragraph 28 ibid
[134] See paragraphs 35 to 36 ibid
[135] See paragraph 79(v) of the Respondent's First Written Explanation at Tab (14) of the ABOD
[136] [2017] 5 SLR 334

54. While we note that the Respondent had admitted on various occasions that his actions were inappropriate[137], made a serious error in judgment[138], apologised for the trouble that he put SMC through for the incident[139] and to the Patient for causing discomfort to her with the incident[140] to demonstrate that he been *"forthcoming and cooperative with the authorities"*[141], and that he *"has, at no point in time, attempted to cover up his misconduct"*[142], we also accept SMC's submissions in paragraph 39 above that the Respondent's excuses and attempts at justifying his misconduct in the course of this Inquiry go to show a *"lack of integrity and insight into his misconduct"*. Such excuses and/or attempts at justifying the Respondent's misconduct fly in the face of lowering culpability.

55. In this regard, we will just highlight or illustrate our point with the Respondent's excuse on or attempt at justifying access to the Patient's contact information, texting the Patient and the subsequent unanswered call to the Patient. On the first visit to Dr F on 1 December 2016 (nine days after the misconduct), the Respondent had explained that he sent the SMS *"out of concern for the Patient"* as he had wanted to *"ask her not to work so hard and thought that it would be good for her to have some other options (about work)"*[143]. This materially changed in the Respondent's first written explanation in 2018 to *"give information on how to quit smoking. I intended to introduce the Patient to the Health Promotion Board smoking cessation website and Quitline ….and information on sleep hygiene"*[144]. Putting aside the fact that none of the above excuses are urgent medical reasons requiring any access to the Patient's contact information, text or call to be made to the Patient, we note that the message sent *"Hi (Ms P), Victor here. Was nice to talk to you. Make sure you rest well tonight! Where do you work as a barista?"* is not congruous with work options nor smoke and sleep hygiene. The Respondent's Counsel then sought to explain this away at the DT inquiry that the text message was *"simply meant to be an introductory message such that the Patient would not be immediately overwhelmed by any information which [the Respondent] had*

[137] See paragraph 6 of the email from SPF to SMC on Police Enquiry on Liang Kai Lun, Victor (IC no. redacted) dated 30 November 2016 at 2.33pm at Tab (9) of the ABOD
[138] See paragraph 22 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[139] See paragraph 5 of the Respondent's First Written Explanation at Tab (14) of the ABOD
[140] See paragraph 6 ibid
[141] See paragraph 58 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023
[142] Ibid
[143] See paragraph 11 of Dr F's medical report on the Respondent dated 2 December 2016 at Tab (7) of the ABOD
[144] See paragraph 74 of the Respondent's First Written Explanation at Tab (14) of the ABOD

hoped to share"[145]. In our minds, the text message is suggestive of an effort to connect on a social level and the call thereafter reinforces the fact that as the Patient did not respond, the Respondent decided to follow up. It was indeed fortunate that Patient did not return text nor call or it may have led to serious consequences. We also bear in mind that patients expect any information that they provide will be used for proper purposes[146].

56. Pursuant to our analysis of **moderate** harm and **medium** culpability above, we are of the position that the appropriate sentencing range will be a suspension between one to two years.

57. We accept that the *"sanctions in medical disciplinary proceedings serve two functions:*

(a) first, to ensure that the offender does not repeat the offence and ultimately to ensure that the public is protected from the potentially severe outcomes arising from the actions of errant doctors; and

(b) *second, to uphold the standing of the medical profession."*[147]

58. In this regard, we also note that the C3J in *Wong Meng Hang* held that *"public interest and the need for general deterrence will often be the central and operative considerations in the sentencing inquiry for disciplinary cases"*[148]; that *"the interest of the public is paramount and will prevail over other considerations such as fairness to the errant doctor"*[149] and that *"personal mitigating circumstances carry less weight in disciplinary proceedings and may be overridden by the public interest… "*[150].

59. In determining the appropriate starting point in the sentencing range of suspension between one to two years, we considered that a clear message or signal should be sent to the medical profession at large that patients should be treated with courtesy, consideration, compassion and respect and offered the right of privacy and dignity

[145] See paragraphs 50 and 70 of the Respondent's Closing Submissions dated 3 March 2023
[146] See *Ong Kian Peng Julian* [2022] SGHC 302 at [1] and [69].
[147] *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201
[148] [2018] SGHC 253 at [44]
[149] [2018] SGHC 253 at [75(a)]
[150] [2018] SGHC 253 at [75(c)]

(especially when the patient is from a vulnerable genre), both during and after a consultation and any intentional and deliberate failure should not be tolerated. In this regard, the requirement for a female chaperone to be present when a male doctor examines a female patient (whether she is a minor or not) and not accessing the contact information and contacting a patient without any urgent medical need are rudimentary principles that must be abided by.

60. We will also state that we agree with SMC that minors like the Patient will usually be *"particularly predisposed to place much trust and confidence"* in a doctor or may be *"less inclined to articulate her discomfort at the point of the consultation"*. We also agree that that a physical examination of a female minor patient without anyone else being present will likely result in any misconduct being ordinarily *"difficult to detect"*. *"The fact that the Respondent's misconduct was discovered can be said to be merely fortuitous"* and a strong signal should be sent that such misconduct should not be tolerated[151].

61. With the above in mind as well as all the facts and circumstances, we are of the opinion that a reasonable starting point would be suspension of about 16 months (somewhere in the middle of the medium range) which will also be in accordance with the principle of proportionality in sentencing.

62. Two previous sentencing precedents were referred to us[152], i.e., *In the Matter of Dr Huang Hsiang Shui Martin*[153] ("***Martin Huang***") & *Ong Kian Peng Julian*[154] and we set out in the table below a summary of the decisions and the sentences in the two cases:

Case Name (Decision Date)	**Offences in question**	**Substantive Sentence**
Martin Huang (2015)	Prior to a medical procedure, on Dr Martin Huang's instructions, a nurse removed the minor patient's underwear without first obtaining her consent.	$10, 000

[151] See paragraph 33 of the SMC's Sentencing Submissions dated 26 May 2023
[152] Our understanding is that there have not been any disciplinary proceedings involving a failure to call for a chaperone to be present during a physical examination.
[153] [2015] SMCDT 8
[154] [2022] SGHC 302

Ong Kian Peng Julian (2022)	Dr Julian Ong ("**Dr Ong**") provided the contact information of his property-agent patient to one Dr Chan Herng Nieng ("**Dr Chan**"), with the said patient's consent on the pretext that Dr Chan was looking to purchase a property, when a series of messages between Dr Ong and Dr Chan revealed that the said patient's contact information was provided for a social purpose.	2 years suspension

63. *Martin Huang* was decided **pre**-publication of the Sentencing Guidelines. That said, with a fine of $10,000 imposed, it will mean that Dr Martin Huang's misconduct caused slight harm and is of low culpability having reference to the sentencing matrix. With the DT's grounds of decision in *Martin Huang* stating that it was a *"serious offence"*[155] and acknowledging that the patient had *"deep emotional trauma and distress"*[156], we do not see how Dr Martin Huang's misconduct can be classified as causing slight harm and is of low culpability. We agree with SMC that the $10, 000 fine imposed in *Martin Huang* is wholly inadequate in light of the sentencing matrix laid down in the subsequent judgment of *Wong Meng Hang* and the Sentencing Guidelines and should be disregarded as any useful reference point.

64. On the other hand, we do accept that the Respondent's misconduct is not on par with that in *Ong Kian Peng Julian* which involved two doctors sharing a patient's personal information in hopes of sexual gratification. In coming to the starting point of 18 months to two years suspension for the Dr Chan and Dr Ong respectively in *Ong Kian Peng Julian*[157], the C3J was of the opinion that *"in light of the "possible negative impact on public confidence in the medical profession"* and general deterrence where it was *"imperative that a clear message be sent to the medical profession that such conduct is utterly unacceptable and that harsh consequences will befall those who might be considering similar acts"*[158] given the *"abuse of the trust of and confidence that a Patient had reposed in him"*. As the Respondent's misconduct is not on par with

[155] [2015] SMCDT 8 at [32]
[156] [2015] SMCDT 8 at [31]
[157] [2022] SGHC 302 at [78]
[158] [2022] SGHC 302 at [81]

that *Ong Kian Peng Julian*, we are of the opinion that the starting point of 16 months is appropriate.

65. The next step will be to consider any mitigating factors that are specific to the Respondent and we had regard to the mitigating factors set out by the Respondent in paragraph 36(a) – (d) above. We are of the opinion that weight should be accorded to some of the four mitigating factors and will address them below in turn.

66. On the long and unblemished track record as well as good professional standing, we note that the Respondent had practiced for about five years before the misconduct, was dismissed by NHGP after the misconduct and continued to practise as a locum doctor at multiple GP clinics, family physician, locum at COVID Isolation Facilities and Vaccination Centres as well as Covid Treatment Facilities and Transitional Care Facilities. He had kept a clean slate since 2016 and had accolades from his former employer for his service as well as done much in community services both in Singapore and overseas[159]. SMC's position is that any mitigating value of the Respondent's clean record should also be displaced in the face of the need for general deterrence and they have pointed us to the C3J's refusal to accord any mitigatory weight to unblemished record in *Ong Kian Peng Julian*[160] for the same reason. We have already pointed out the different factual circumstance in *Ong Kian Peng Julian* that warranted a harsher sentence. While we are of the opinion that a clear message or signal should be sent that such misconduct should not be tolerated, that has already been considered by us in determining level of culpability and the appropriate starting point above. We will therefore accord mitigating weight to the Respondent's unblemished track record and overall good professional standing, considering that the Respondent was relatively junior when the misconduct took place, this is the Respondent's first brush with the law, there appeared to be difficult personal circumstances leading to his misconduct at the material time, the fact that the Respondent had been dismissed and had to take up various locum jobs with no real permanency, as well as the Respondent's rehabilitation and the unlikelihood of the Respondent to re-offend which is also borne out from Dr F's re-assessment on 19 May 2018 that "the risk of a repeat incident is low"[161].

[159] Paragraphs 9 to 16 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023
[160] [2022] SGHC 302 at [81]
[161] Paragraph 37 of Dr F's medical report on the Respondent dated 21 May 2018 Tab (15) of the ABOD

67. We have considered the Respondent's difficult personal circumstances leading to his misconduct at the material time when we accorded mitigating weight to the Respondent's track record and professional standing in paragraph 66 above. While we appreciate and understand that from time to time, all working adults will be affected by personal circumstances and emotions, it is expected that as the lives of patients are dependent on doctors, the Respondent should be able to shut out such personal circumstances when he is carrying out his duties as a doctor. We will wish to attribute part of the Respondent's misconduct to his tender age at the material time and hope that with that episode as well as the treatment that he has received after the episode which has shown a favourable prognosis, that the Respondent will not re-offend.

68. As to the Respondent's remorse and insight, we agree with SMC that any remorse and insight appear to be self-serving and the Respondent had flip-flopped on his positions and tried to justify his actions when he clearly knew they are wrong. As these have all been dealt with in determining the level of culpability, we do not see any need to consider them as aggravating and will instead accord zero mitigating weight to this factor.

69. On the issue of any discount in sentencing for inordinate delay, the Respondent submitted that the sentence should reflect SMC's delay in prosecution leading to anxiety and distress on him as the charges have been hanging over him for some time; SMC denies any inordinate delay.

70. We set out below a chronology of the salient dates or events for these proceedings:–

Date	Event
22 November 2016	The Respondent's misconduct
12 June 2017	SMC's referral of the Respondent's misconduct to the Chairman of the Complaints Panel pursuant to S39(3)(*a*) of the MRA
5 March 2018	Notice of Complaint pursuant to S44(2) of the MRA by the SMC's Investigation Unit to the Respondent
8 November 2018	Conclusion of inquiry by the Complaints Committee
30 September 2019	SMC's Request for Expert Opinion
14 October 2019	SMC Experts' First Report
28 August 2020	Service of the first Notice of Inquiry by Disciplinary Tribunal ("**NOI**") comprising a 1st Charge and an Alternative 1st Charge on the Respondent
10 December 2020	NOI (Amendment No. 1) {comprising an Alternative 1st Charge only} ("**1st amendment to NOI**")
16 February 2021	Respondent Expert's First Report
10 September 2021	Appointment of the current DT
20 September 2021	1st SMC DT Pre-inquiry Conference ("**PIC**")
23 September 2021	SMC Expert's Supplementary Report
25 October 2021	2nd SMC DT PIC
27 October 2021	NOI (Amendment No. 2) - comprising a 1st Charge and an Alternative 1st Charge ("**2nd amendment to NOI**")
6 January 2022	3rd SMC DT Pre-inquiry Conference
24 January 2022	Respondent Expert's Supplementary Report
24 February 2022	4th SMC DT PIC
7 April 2022	5th SMC DT PIC
28 July 2022	6th SMC DT PIC
29 July 2022	NOI (Amendment No. 3) – particulars inserted into 1st Charge and Alternative 1st Charge ("**3rd amendment to NOI**")
20 September 2022	Agreed Statement of Facts tendered
15 November 2022	1st SMC DT hearing
30 March 2023	2nd SMC DT Hearing (Conviction)
24 August 2023	3rd SMC DT Hearing (Sentence)

71. The decision in *Ang Peng Tiam v Singapore Medical Council* ("***Ang Peng Thiam***")[162] sets out four factors that need to be present for any sentence to be discounted –

(a) there were delays which were inordinate;

(b) the offender was in no way responsible for the delay;

(c) the delay had resulted in real injustice or prejudice to the offender: and

[162] [2017] SGHC 143 at [112] to [118]

(d) there must not be countervailing public interest considerations which demand the imposition of a heavier penalty.

The rationale is that in fairness to the offender, if the matter had been pending for some time, it would likely inflict undue suffering on the offender stemming from anxiety, suspense and uncertainty on the offender.

72. We will now run through each of the factors in turn.

73. In all, having considered the circumstances, we find that there was some inordinate delay on the part of SMC in prosecution and we make the following observations –

(a) Even though we appreciate that time is required to run any disciplinary investigation and process, we agree with the Respondent that the case did not involve *"complex question of fact which necessarily engender meticulous and laborious inquiry over an extended period, or whether the case may be disposed of in a relatively uncomplicated manner"*[163].

(b) While the 2.5 years intervening period between the Notice of Complaint to the service of the NOI may not be considered inordinate delay in light of the cases cited by the SMC[164] in their Sentencing Submissions, we do feel that there was some inordinate delay considering the intervening period between the Notice of Complaint to the service of the NOI (Amendment No. 3) which is about 4.5 years.

(c) The charges were amended three times to delete and re-instate the 1st Charge and then to include particulars of the text message that was sent by the Respondent to the Patient. SMC's explanation was that the 1st amendment to NOI was necessary to remove the 1st Charge as SMC was under the impression from the Respondent's representations that the Respondent intended to take a certain course of action in relation to the Alternative 1st Charge. The 1st Charge was then reinstated in the 2nd amendment to NOI after the Respondent indicated

[163] Chan Kum Hong Randy v PP [2008] SGHC 20
[164] See paragraphs 51 to 52 of the SMC's Sentencing Submissions dated 26 May 2023

he intended to contest the Alternative 1st Charge. The 3rd amendment to NOI was necessary to clarify the SMC's case against the Respondent by inserting the particulars of the text message that was sent by the Respondent to the Patient.[165]

(d) We are not privy to the circumstances of the 1st amendment to NOI on or about December 2020 as this DT was only appointed effective 10 September 2021. The NOI (Amendment No. 1), that we received upon our appointment, was marked-up with a deleted 1st Charge and continued to show an Alternative 1st Charge with a corrected spelling error. It may be that this is a typographical error but on the face of it, it is not clear to us why the 1st amendment to NOI to remove the 1st Charge is necessary for the Respondent to take a certain course of action in relation to the Alternative 1st Charge. As stated earlier, the NOI (Amendment No. 1) did not elevate the Alternative 1st Charge to the 1st Charge for purposes of Respondent taking a certain cause of action to it, but continued to show the remaining Alternative 1st Charge for which the Respondent was to take a certain cause of action to. No explanation of any sort in terms of procedure has been proffered by the SMC as to why they could not have withdrawn the 1st Charge when the Respondent took a certain cause of action in respect of the Alternative 1st Charge instead of amending.

(e) The 2nd amendment to NOI in late October 2021 reinstated the 1st Charge and included some typographical changes to move the sequence of the particulars in the reinstated 1st Charge and the Alternative 1st Charge. This effectively brought the proceedings back to ground zero (original NOI in late August 2020), not to mention that the production of supplementary expert report and production of any agreed statement of fact was delayed. According to the SMC, this was made necessary owing to the change in position taken by the Respondent from taking a certain cause of action to NOI (Amendment No. 1) to challenging it.

(f) As for the 3rd amendment to NOI, SMC had submitted that it was necessary to clarify the SMC's case against the Respondent in respect of the Respondent's attempt to contact the Patient so that the Respondent can meet the case against

[165] See paragraph 53 of the SMC's Sentencing Submissions dated 26 May 2023

him directly. We note that the 3rd amendment to NOI sought to insert particulars of the text message sent by the Respondent to the Patient and in this regard, we fail to see why any clarification could not have been done earlier but only in end July 2022 (almost two years after August 2020) when these particulars were clearly available in August 2020.

(g) We also did an exceptional number of PIC to deal with amendments to the NOI, the necessity for supplementary expert report(s) and the agreed statement of facts as well as other issues.

74. We accept that overall, any delay was not caused by the Respondent. While SMC had stated that the Respondent only obtained and disclosed his expert report in February 2021, some 5.5 months after receiving the NOI, our position is that the 1st amendment to NOI was taken in December 2020 and as any Respondent's expert report must be to support a defence in light of the amended charge and accordingly, the time taken to produce any expert report should be taken from December 2020 and not August 2020, i.e., two months after receiving NOI (Amendment No. 1). In this regard, we note that there was an almost 10 months gap taken by SMC to request for expert opinion from the conclusion of the Complaints Committee Inquiry (8 November 2018 to 30 September 2019) and more than 1.5 years between the conclusion of the Complaints Committee Inquiry and the service of the NOI (8 November 2018 to 20 August 2020) which have not been explained.

75. As to delay caused by the Respondent's allegation of bias against the originally constituted DT on certain comments made regarding the filing of sentencing submissions or around 8 February 2021, we are unable to comment as these facts were not put before us. On the face of the submissions made by SMC, it is not clear to us what timely actions were taken by SMC on the recusal of the originally constituted DT, i.e., did SMC raise to the originally constituted DT that having reviewed the audio recordings and transcript of the PIC on 17 December 2020, it transpired that no such comments were made by the original DT, etc.

76. While we note that the Respondent had objected to the 3rd amendment to NOI to clarify the SMC's case against the Respondent by inserting the particulars of the text message that was sent by the Respondent to the Patient, causing a delay of about four months, we will also repeat what we have stated in paragraph 73(f) that no explanation has been given by SMC as to why the 3rd amendment to NOI to insert particulars of the text message sent by the Respondent to the Patient was not done when the charges were first proffered but only in end July 2022 (almost two years after August 2020). If this was taken then, all the subsequent delays could be averted or ameliorated. For completeness, we will add that the Agreed Statement of Facts coming two months after the NOI (Amendment no. 3) appears to be reasonable.

77. On whether the delay had resulted in real injustice or prejudice to the Respondent, we note that SMC had taken objections[166] to the Respondent's submission[167] on the drawing of a natural inference that the protracted proceedings had caused the Respondent significant anxiety and distress without more (i.e., the Respondent has not submitted any objective evidence that he had suffered significant anxiety and distress during this period (such as a psychiatric report or even evidence that he has undergone counselling for these issues during this period). We considered that the Respondent was dismissed almost immediately by NHGP after the misconduct and had to seek practise as a locum doctor at multiple GP clinics, COVID Isolation Facilities and Vaccination Centres as well as Covid Treatment Facilities and Transitional Care Facilities all this time, not knowing when this will be over, his mental state of mind and personal circumstances and are of the opinion that having the matter or charges hanging over him for close to seven years now after the misconduct will have caused any reasonable person to suffer significant anxiety and distress.

78. Lastly, on the question whether there are countervailing public interest considerations countervailing public interest considerations which demand the imposition of a heavier penalty. While we accept that a clear message or signal should be sent to the medical profession at large that patients should be treated with courtesy, consideration, compassion and respect and offered the right of privacy and dignity (especially when

[166] See paragraphs 56 to 58 of the SMC's Sentencing Submissions dated 26 May 2023
[167] Following from *Ang Peng Thiam* – see paragraph 25 of the Respondent's Mitigation Plea and Sentencing Submissions dated 3 May 2023

the patient is from a vulnerable genre), both during and after a consultation and any intentional and deliberate failure should not be tolerated, this has already been considered by us when determining the level of harm, culpability and appropriate starting point in sentencing and we do not feel that this should be rehashed to the Respondent's detriment.

79. All things being considered, we are of the position that a sentencing discount should be accorded for the inordinate delay. In light of the weight to be accorded to all the mitigating factors above, we are of the opinion that a four-month discount will be appropriate in the circumstances.

THE SENTENCE AND PUBLICATION OF GROUNDS OF DECISION

80. Having considered all the facts and circumstances, the respective submissions of both parties, the sentencing precedents cited, and bearing in mind the Sentencing Guidelines, this Tribunal orders that:–

(a) the Respondent's registration in the Register of Medical Practitioners be suspended for a period of **12 months**;

(b) the Respondent be censured in writing;

(c) the Respondent is to provide a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and

(d) the Respondent shall pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

81. We further order that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of the Patient (being underaged at the time of the Respondent's misconduct).

82. The Respondent's Counsel immediately reminded us that he had, earlier on when the amendments to the NOI was allowed, reserved the right to make submissions on the

issue of costs and expenses of and incidental to the amendments vis-à-vis these DT proceedings, including the costs of the solicitors to the SMC ("**SMC costs**"). That being the case, we retracted our order in paragraph 80(d) above and allowed for SMC costs submissions to be made in writing by the parties.

83. We will now deal with the issue of SMC costs considering the following:–

(a) The Respondent's Costs Submissions dated 31 August 2023 with their Bundle of Authorities;

(b) The SMC's Response Submissions dated 7 September 2023 with their Bundle of Authorities; and

(c) The Respondent's Reply Submissions dated 14 September 2023 with their Bundle of Authorities.

SUBMISSIONS ON COSTS

84. The Respondent is seeking to be ordered to pay 35% of the SMC costs. It appears that the 35% figure takes into consideration the following:–

(a) The SMC bearing the costs of the 2nd Amendment to NOI and the Respondent's costs thrown away as a result of the same;

(b) The SMC bearing the costs of the 3rd Amendment to NOI and the Respondent's costs thrown away as a result of the same;

(c) The SMC bearing the costs for the Respondent Expert Supplementary Report; and

(d) The SMC bearing its own costs for the SMC Expert Supplementary Report[168].

85. On the payment of a percentage of the SMC's costs by the Respondent even when they were successful in prosecuting the Respondent, the Respondent relied on two main

[168] Paragraph 17 of the Respondent's Costs Submissions dated 31 August 2023

cases, that of *Ang Pek San Lawrence v Singapore Medical Council*[169] ("***Lawrence Ang***") and *Singapore Medical Council v BXR*[170] ("***BXR***").

86. At the outset, we will state that *Lawrence Ang* involved an acquittal of the respondent from charges brought against him by the SMC and the C3J's decision that the DT could order costs against SMC was in respect of a dismissal of charges brought by the SMC. We also observe that *BXR*[171] similarly dealt with an acquittal and the C3J in dismissing the SMC's appeal against an order of costs against it by the DT in the acquittal made the following observation:–

> "If the medical practitioner is subjected to undue stress, anxiety and uncertainty as a result of having the spectre of disciplinary proceedings hover over him for longer than is necessary, we consider that it would only be fair for him to be compensated by way of costs if he is subsequently acquitted of the charges…It would be akin to double counting if we also took into account the fact that the respondent had to incur legal costs, which he deemed to be unnecessary, because the Charges were not reasonably brought."

87. In that regard, we do not think that the appropriate order is for the Respondent to pay a percentage of the SMC costs. We note from the transcripts of the DT proceedings in *Singapore Medical Council v Ang Peng Thiam*[172] that in ordering that the Respondent pay 60% of SMC costs, the SMC DT took a broad-brush approach in deciding so when SMC succeeded in two charges and lost on two charges in that case. Since SMC is successful in their prosecution in these proceedings, it is somewhat difficult to take a broad-brush approach to attribute a percentage for the two sets of amendments and preparation of the experts' reports, etc, vis-à-vis the entire proceedings.

88. We prefer to consider whether we should make SMC bear each set of costs in paragraph 84 above. With regard to the costs for the two sets of amendments, we considered the Respondent's submissions that the amendments are analogous to an amendment of pleadings that should be compensated by costs[173] ("**costs as compensation for amendment principle**") and that in *Singapore Medical Council v Dr Tan Joong Piang*

[169] [2015] 1 SLR 1179
[170] [2019] SGHC 206
[171] Ibid at [48]
[172] Page 76 Joint Record of Proceedings (Volume III Part J) in C3J/OS 8/2016
[173] Paragraphs 3 and 4 of the Respondent's submissions dated 31 Aug 2023 and citing *Wright Norman and another v Overseas-Chinese Banking Corp Ltd* [1993] 3 SLR(R) 640

("***Tan Joo Piang***") [174], the DT ordered that the SMC costs *"shall exclude the costs occasioned by the amendments to the Charges made by the Prosecution"*.

89. We note that while the Respondent cited *Tan Joong Piang* as a precedent that the DT ordered that the SMC costs *"shall exclude the costs occasioned by the amendments to the Charges made by the Prosecution"*, there is no explanation why this should be the case. We have also reviewed the said Grounds of Decision and there appears to no rationale for why this is so, nor does it appear that the said costs order was disputed. We do note however that paragraph 4 of the said Grounds of Decision stated that "*Prior to the hearing, Counsel for the SMC sought leave from the Disciplinary Tribunal ("**DT**") to reframe the proceeded charges into three separate charges per patient, consistent with the approach taken in recent cases involving inappropriate prescriptions in **SMC v Looi Kok Poh** [2019] SGHC 134, as well as **SMC v Dr Chia Kiat Swan** [2019] SMCDT 1. The alternative charges were removed following this amendment*" and we can only surmise that the DT there was possibly affected by the costs as compensation for amendment principle.

90. Our position on the delay and amendments to the NOI has been aired in paragraph 73 above and we reiterate that. To be clear, our position is that while the 2nd amendment to NOI, which was to reinstate the 1st Charge and included some typographical changes to move the sequence of the particulars in the reinstated 1st Charge and the Alternative 1st Charge, did effectively brought the proceedings back to ground zero, they appear necessary following the change in position taken by the Respondent to NOI (Amendment No. 1), i.e. from taking certain cause of action to challenging it. In that regard, we will not award any costs to the Respondent for the 2nd amendment to NOI.

91. As for the 3rd amendment to NOI, while it may have been necessary for SMC to clarify the charges with the insertion of the particulars of the text message sent by the Respondent to the Patient so that the Respondent can meet SMC's case[175], this could and should have been done in August 2020 when NOI was issued but only done in end July 2022 by way of the 3rd amendment to NOI. Without any reasonable explanation as to the delay, we will order that SMC bear the costs of the 3rd amendment to NOI.

[174] [2019] SMCDT 9 at 43
[175] See paragraphs 13 and 14 of the SMC Response Submissions dated 7 September 2023

However, we will not order SMC to bear the Respondent's costs thrown away as a result of the 3rd amendment to NOI as there is no costs thrown away as such. The Respondent would have had to meet the charges of accessing the Patient's contact information without prior authorisation, and thereafter sending her a text message and attempting to call her, with or without the particulars, in any event and work was not wasted. All experts' reports and supplementary report also preceded the 3rd amendment to NOI.

92. The Respondent's submission that additional work was expended on a revised version of the Agreed Statement of Facts flowing from the 3rd amendment to NOI appears to be flawed. From the DT's records, it was the Respondent's position in that the charges will be contested based on experts' reports and testimony and that parties will submit an agreed statement of facts. Whilst there appeared to be some discourse on the limited point of calling NHGP and the Patient on the issue of seeking consent of NHGP or the Patient before the Respondent accessed the NHGP database to obtain the Patient's contact number, we observed that this did not take long to resolve. In our minds, we do not see how this could be disputed and the same goes for the particulars that were added on amendment since there was clear evidence to that effect. In that regard, we do not see how there could be major or substantive revisions to the Agreed Statement of Fact flowing from the 3rd amendment to NOI.

93. We propose to deal with the Respondent's submission on costs of the experts' Supplementary Reports together.

94. On the Respondent's submission that he should not be made to bear the costs of the SMC Expert's Supplementary Report as this was prepared at SMC's own volition without reasons as to why this is necessary and not covered in the SMC Experts' First Report. We note from our records that the only objection raised by the Respondent in his table of objections to the SMC Expert's Supplementary Report, tendered on 4 February 2022, was prejudice caused to the Respondent owing to the inclusion of material outside of the charges. In any case, we had already discussed the issue of the experts in paragraphs 26 and 27 above and we re-iterate that having read and considered all the SMC expert(s)' reports, we are of the opinion that the reports are written impartially, well supported and even-handedly. The SMC Expert's Supplementary

Report succinctly contained SMC Expert's opinion on the key issues touching each area of the Respondent's misconduct based on the particulars set out in the NOI at the material time in addition to addressing the issue of unauthorised access to the Patient's contact information and sending text messages and attempting telephone calls to the Patient. This was useful to us in trying to understand the differences in opinions of both experts, if any, after the Respondent Expert's Supplementary Report.

95. As to the submission that the Respondent Expert's Supplementary Report was occasioned as a result of the 2nd amendment to NOI so as to address the re-instated 1st Charge, we agree with SMC that the Respondent's change in position from taking a certain cause of action to the Alternative 1st Charge led to the reinstatement of the 1st Charge and the Respondent's need to produce the Respondent Expert's Supplementary Report to address that. In any case, looking closely at the Respondent Expert's Supplementary Report, it was really in rebuttal of the SMC Expert's Supplementary Report.

96. That being the case, we do not order the SMC to bear their own costs of the SMC Expert's Supplementary Report nor do we order that SMC should bear the costs of the Respondent's Expert's Supplementary Report.

97. In summary, on the issue of costs, we order that the Respondent shall pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC, save for the costs occasioned by the 3rd amendment to NOI (which does not include costs thrown away to be specific).

98. In conclusion, the Tribunal's complete order is as below –

(a) the Respondent's registration in the Register of Medical Practitioners be suspended for a period of **12 months**;

(b) the Respondent be censured in writing;

(c) the Respondent is to provide a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and

(d) the Respondent shall pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC, save for the costs occasioned by the 3rd amendment to NOI.

Dr Wong Sin Yew Chairman	Dr Wong Tzen Yuen Janice	Ms Cornie Ng Judicial Service Officer

Ms Sharon Lin and Mr Gideon Phng (M/s Withers KhatterWong LLP)
for Singapore Medical Council; and

Mr Charles Lin and Ms Tracia Lim (M/s Charles Lin LLC)
for Dr Liang Kai Lun Victor