SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY FOR DR ABS HELD ON 7 & 8 SEPTEMBER 2010 AND 3 DECEMBER 2010

Disciplinary Committee:
Prof Ho Lai Yun (Chairman)
Prof Walter Tan (Member)
Dr Benedict Tan (Member)
Dr Eu Oy Chu (Lay Member)

Legal Assessor:
Mr Joseph Liow (Straits Law Practice LLC)

Prosecution Counsel (M/s Harry Elias Partnership LLP):
Mr Francis Goh
Ms Cassandra Ow

Defence Counsel (M/s Donaldson & Burkinshaw LLP):
Mr Eric Tin
Ms Kang Yixian
Ms Sheryl Loh
Ms Kristie Ho

GROUNDS OF DECISION OF THE DISCIPLINARY COMMITTEE

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

The Charge

1. The Respondent, Dr. ABS, faces one charge which is set out in Tab-1 of the Agreed Bundle, that alleges that on 24 December 2005, whilst practising as a radiology trainee at Hospital A, he had departed from standards observed or approved by members of the medical profession in that he had failed to diagnose serious orbital and facial fractures of the patient, one Mr. P. Particulars of the relevant facts relating to the charge were set out in the charge.

Preliminary Objection by Defence Counsel

2. In paragraph 22 of its Opening Statement, Defence Counsel raised an objection with regards to the charge which his client faces. The gist of the objection was that there is no statement in the charge which asserts that the alleged departure

of standards was "intentional or deliberate". In this regard, Defence Counsel alluded to the case of *Low Cze Hong v Singapore Medical Council [2008] SGHC78*.

3. This being an objection on a point of law, and on the advice of the legal assessor, this Disciplinary Committee had dealt with the objections of the Defence Counsel as a preliminary point as provided for under rule 23(4)(b) of the Medical Registration Regulation, which states:-

Conduct of Inquiry

23(4)(b) the practitioner or his counsel may object to any charge on a point of law, and if any objection is upheld, no further proceedings shall be taken on the charge to which the objections relates;"

4. Prosecution submitted, on the preliminary point of objection, that the definition that Defence Counsel suggested, i.e., that only a 'departure of standards that was "intentional or deliberate" would amount to professional misconduct was unduly restrictive. Counsel for the Prosecution submitted that the two situations stated in *Low Cze Hong* were only two situations in which the conduct of a practitioner may amount to professional misconduct and that the categories of professional misconduct was not closed or limited to only "intentional, deliberate departure" or where there was "serious negligence that it objectively portrayed an abuse of the privileges which accompanied registration". Prosecution submitted that a breach of the ethical codes published by the SMC would also amount to professional misconduct.

5. The Disciplinary Committee ruled that at this preliminary stage, the objection was without merit. The charge was not defective in that it gave the Respondent

sufficient particulars so that he could meet the case which he has to answer. We agreed with Counsel for Prosecution that there could be other instances of professional misconduct which may not be "intentional or deliberate departure from accepted / approved standards" or "serious negligence"; for example, conduct of practitioners in their own private and personal capacity which may bring disrepute to the profession have also been considered professional misconduct that merited sanction.

6. Accordingly, we dismissed the objection and proceeded to hear the evidence of the prosecution. At the close of the Prosecution's case, Counsel for Defence did not make any submissions as to the Prosecution's case at that time and we proceeded to hear evidence tendered on behalf of the Respondent.

Issues to be determined by this Disciplinary Committee

7. It is our view that the following issues required our determination:-

   a) Whether the Prosecution has proved the facts as set out in the charge;

   b) If so, whether the Respondent had departed from standard observed or approved by members of the medical profession; and

   c) If that be the case, whether the departure from the standards observed or approved, amounted to professional misconduct.

8. In determining the issues, we have considered the evidence adduced by and the submissions made on behalf of the prosecution and on behalf of the Respondent. We summarize our understanding of the evidence and submissions herein below.

Prosecution's Case

9. The Prosecution called two witnesses. PW1 was Dr. PE, a Senior Consultant and **[designation and name of department redacted]**, Hospital B. PW2 was the patient, one Mr. P.

10. **Evidence of PW1** – PW1 had prepared a written report dated 14 July 2009 which was exhibited in Tab- 8 of the Agreed Bundle. It was his view in this report that:-

(i) Paragraph 5 – *"The SXR showed a discontinuity of the superior-lateral orbital margin on the right that should have been called a fracture unless proven otherwise."* [Note: PW1 used the annotation "SXR" to refer to 'skull X-ray"]

(ii) Paragraph 6 – *"There was an increased opacity seen below the right inferior orbital margin, which can be due to an inferior blowout fracture. However, Dr. ABS's interpretation that it could be due to mucosal thickening is understandable in light of the clinical history of trauma to the Patient's left cheek but it is also because he had not appreciated the fracture mentioned in the paragraph above."*

(iii) Paragraph 7 – *"The irregularities in the frontal sinuses are usually difficult to interpret on an OM view alone, and a high degree of suspicion is necessary. Nasal septums are often discontinuous or angulated in normal patients and diagnosis of nasal septal fractures on SXR is difficult. These abnormalities would be considered suspicious but not definitive of fractures. In the premises, there is a need for a heightened index of suspicion. Having an additional frontal view, would have helped confirm or clear the suspicion of fracture on the right. In the present context, Dr. ABS did not take any steps to confirm or clear these*

suspicions of fracture."

(iv) Paragraph 10 – *"In conclusion, the key SXR abnormality (fracture on the right superior-lateral margin of the orbit) should have been detected by a radiologist with Dr ABS's level of training. It is unfortunate for both the patient and Dr ABS that the key abnormality was not appreciated on the SXR that day."*

11. During oral testimony, Dr. PE gave evidence that he is involved in training radiologists. In the context of diagnostic imaging, his trainees are trained to look at radiographs and how to interpret them. He gave evidence that whilst some of the extensive fractures were difficult to ascertain (e.g. the frontal sinus), the fracture in the superior orbit was obvious and should be picked up immediately. Dr. PE's evidence was that this fracture was so obvious and unambiguous that if he was testing a trainee and if the trainee was not able to see the fracture, he would have failed him. His view was that if he had used the same radiograph that the Respondent saw that day, it would have been a fair test; he would not have viewed it as a 'discriminatory case'. He was aware that in this particular case, Dr. ABS had received a clinical history contained in the Image Request Form (IRF) that stated "*Laceration & haematoma (L) cheek?#*" and "*Tender at C7/T1?#*" which would normally be understood by practitioners as a request for query for **left** cheek and cervical spine fracture. Dr. PE's evidence was that it is typical that IRFs have very little details; in his mind the clinical question that was asked was whether there was a fracture and when a radiologist reviews an X-ray, he should not just focus on the site identified to interpret an X-ray. The IRF, should not stop a radiologist from detecting something that was obviously there. Dr. PE was of the view that given the Respondent's level of experience at the material time, it would be unusual for the Respondent to miss the fracture at the

superior orbit. Dr. PE was also referred to the report prepared by Dr. DE (at Tab-10 of the Agreed Bundle). Dr. PE disagreed with Dr. DE with regards to Dr. DE's view that "the finding of right orbital discontinuity was not an obvious one, but subtle". In his view, if he was to show the x-ray to his trainees and a number of them would have detected a fracture. An obvious fracture is one where a majority of his trainees would have "picked it up". As to whether it was fair to miss the fracture, PW1's view was that if the fracture was one that his trainee had missed, he would be wondering "if you could miss this, what else you could have missed?" He would not classify this as a fair fracture to miss.

12. PW1's disagreed with Dr. DE's view expressed in paragraph 4.1 of Dr. DE's report where the latter stated that '*(a) reasonable radiologist is guided by the clinical request form*' and that '*the fact that the request form stated "(L) cheek ? fracture" is extremely important*'. PW1 stated that one needs to look at the IRF to aid interpretation but in his view, he did not form the view that the Respondent made any interpretation as he did not detect the fracture. He also noted that the Respondent did not make any suspicious findings. PW1 conceded that the IRF indicating the left cheek as to being the possible site for a fracture could have contributed to the Respondent's error but would not categorize it as an 'overwhelming' factor as Dr. DE had suggested.

13. PW1 was referred to the Respondent's explanation at Tab-4 of the Agreed Bundle. PW1 was unable to accept the Respondent's explanation as to why he missed the fracture. PW1 stated that in his career, he has seen radiologist missing a fracture (meaning fractures were not detected by radiologists) but in such cases, there was always a good reason for missing the fracture. In such cases, these were usually cases where the fracture was subtle, or that there

was something else on the film or due to the angle of rotation. However, with regards to the radiograph in question, he could see no such reason to support why the Respondent missed picking up the fracture.

14. In cross-examination, PW1 stated that if there was a disconcordance between his findings upon a review of the x-ray and the IRF, he should check further. However, in his view, the Respondent did not realize that the reference in the IRF to the left **cheek** was wrong because he did not pick up the abnormality in the right orbital. He was of the view, that one cannot only look at the left cheek but must view the SXR as a whole. His view was that you cannot simply dismiss something just because you cannot explain it. In his view, one must detect the anomaly first and in this case, you will see anomaly in the right orbital margin. Having seen that, one could conclude that this could be for many reasons eg. blow-out fracture, tumour, mucosal thickening etc and relate it to the information available. However, in this case, it appears to PW1 that the Respondent failed to pick up the right fracture completely. PW1's view was that a radiologist would need to carry out a conciliation of all the signs and to call it a blow-out fracture until proven otherwise. One has to come to a unified conclusion.

15. When asked why he formed the view that Dr. ABS had departed from acceptable standards, PW1 stated that it was his view that for a person with that level of training, he should be able to pick up on this fracture. There was no reason for him to miss the fracture and in this regard he considered the act of the Respondent to be below par.

16. During re-examination in chief, PW1 stated that the X-ray in question would be the sort of x-ray which he would use to train his trainees for rapid reporting,

where his trainees are shown a stack of x-rays and to quickly go through them to pick up abnormalities.

17. **Evidence of PW2**- PW2 was P. His evidence was largely on how he met with a road traffic accident, his injuries and extent of this present disability. He had little recollection of the events at the hospital which the Respondent was attached to at the material time although he did not meet the Respondent.

Defence's Case

18. The Respondent gave evidence that he had on 15 February 2008 written to the Singapore Medical Council to provide a written explanation to the complaint made against him. (See Tab-4 of the Agreed Bundle). The Respondent gave oral evidence that at the material time, he was an advance radiology trainee and was rotating through different specialities. He had completed his diagnostic radiology training in May 2006.

19. The Respondent stated that on 24 Dec 2005 that from his recollection, he was on CT Scan duty from 8 a.m. that day and that by the end of the day he had gone through, 9 CT body scans and 2 brain scans and probably between a few hundred to a thousand images. He was the radiologist on-call that day. He stated that Hospital A, which he was attached to at that material time, had no time constraints but he would try to check all his images within the same day. He stated that with X-rays, there was no requirement to check with any consultants except for other modalities. He stated that he did not see the patient (PW2) that day. He informed this Committee that he received the IRF (which is at page 16 of the Agreed Bundle) and he believed the IRF was filled up by the A&E doctor. He was not able to recognize whose handwriting it was. For this

IRF, there was only one (1) view ordered.

20. The Respondent stated that he thought the x-ray view was tilted excessively. In respect of the right orbital, he was unsure if the x-ray was tilted because whilst he could see a line, he was unsure since he was wondering if it was because the x-ray taken was rotated. He said he took about 1- 2 minutes to go through the x-ray. When asked as to how the addendum to his Radiological report came about, the Respondent informed this Committee that sometime after the 24 December 2005, he received a photocopy of the facial x-ray left on his table by Dr W, then the head of **[name of department redacted]**, Hospital A and that he had asked the Respondent to review the x-ray. When the Respondent spoke to Dr W, he was told that he missed something in the x-ray. The Respondent recalled that the x-ray was shown during the morbidity round where the film was shown to senior consultants and trainees and they were all looking for the missed facial fractures. The Respondent did not know what happened but he believes that in morbidity rounds the 'sensitivity' was tuned up with 'specificity' tuned down.

21. The Respondent urged this Committee to take into consideration that he was only a trainee at that time; although he was a Registrar at that time, he was still a diagnostic radiology trainee and was looking for the balance between 'sensitivity' and 'specificity' that an experienced radiologist would have.

22. The Respondent conceded that he made a radiological error and that it has haunted him and devastated him.

23. During cross-examination, the Respondent did not agree that it was good

practice to account for all abnormalities that one could observe in an x-ray. He explained that he could turn any report on an x-ray into a purely descriptive form but that would not be what he wanted to do. His view was that there was a balance which he needed to achieve; he was trying to help a colleague in interpreting an x-ray and although he could describe everything in an x-ray, he would not be helping his colleague if he does not commit himself to a diagnosis.

24. The Respondent disagreed that he would have to report an abnormality stating that it all depended on the clinical context and whether the fracture was subtle or obvious. When asked whether he agreed if he would have called for more x-rays if he had difficulties when viewing the x-ray, he stated that whether or not he called for more x-rays would depend on whether he thought 'it' (referring to what is observable in the x-ray) was suspicious. He said that he cannot dictate to his colleagues whether 3 views were required.

25. The Respondent agreed that if he spotted an abnormality which did not gel with the clinical notes, he should have report this.

Cross-examination of Respondent

Q: If you have difficulties, you should have called for more views?

A: It depends on the clinical context. Where you think it is suspicious. I cannot dictate to them that I must have 3 views.

Q: You agree you can call for 3 views?

A: Yes

Q: Preferable to have 3 views?

A: Yes but depends on clinical context.

Q: If you spotted an abnormality, which did not gel with the clinical notes, you should have reported this?

A: Fairly similar to what I had said earlier. Do I mention other things that we were not asked for ... it must go into context.

Q: (Question repeated). Should you not flag it out for further investigation?

A: Yes.

Q: On 24 December, you could have asked for further investigation?

A: In my mind, the clinical question that I had to answer was whether there was fracture on the left. Looking at the right side, the opacity was not clear to me because it could have been because of the angulation. I could not explain the opacity. I only highlighted mucosal opacity.

26. When it was put to him that it was his duty to interpret the whole x-ray and that it was incorrect for a radiologist to have limited his scope of examination to the findings of the clinical diagnosis, the Respondent disagreed with this suggestion made by Counsel for the Prosecution. The Respondent stated that he did look at the whole radiograph and he was guided by the clinical notes. In his mind, it was only a question of weightage to be given to what he observed. He conceded that he should have increased his 'sensitivity' and that it was a radiological mistake on his part.

27. In answering this Committee, the Respondent indicated that he had viewed a digital image of the x-ray and that using this method, he could manipulate the image to get a clearer view of the x-ray. When asked by this Committee as to whether he called the doctor (from the A&E department) to ask about the 'left-right' discrepancy, the Respondent stated that when the report was made, the Emergency Department was concerned about the left side but because he could not find anything on the left side, he did not discuss this further with anyone else.

28. **Evidence of DW2** – Dr. DE gave evidence in his capacity as an expert evidence on behalf of the Respondent. He had prepared his expert view on this matter in a letter addressed to M/s Donaldson & Burkinshaw dated 2 December 2009 which appears at Tab-10 of the Agreed Bundle. DW2, whilst holding the view that a radiologic error was committed by the Respondent, did not form the view that the error was a 'departure from the standard of the medical profession'.

29. DW2's views were, as follows:-

(a) There is a known rate for diagnostic errors, ranging from 4% to 30% and radiologist should not be held to standards of 'perfection' but to that of a 'reasonable radiologist'.

(b) The finding of right orbital discontinuity was not obvious; it was subtle. Subtle fractures are more difficult to appreciate and may be misinterpreted by a reasonable radiologist.

(c) That there is a danger of hindsight bias, that is to say, the error of perception is always more obvious and more awful with the benefit of hindsight.

(d) A reasonable radiologist is guided by the clinical request form, and interpretation is improved if relevant clinical information is provided; otherwise, accuracy is compromised. In this instance, the fact that the request stated, "(L) cheek ? fracture" is extremely important. A reasonable radiologist would correctly focus on the left cheek and orbit. In the absence of clinical suspicion, Dr. ABS interpreted the right maxilla opacity as incidental 'mucosal thickening', instead of the more sinister possibility of hemoantrum as a result of orbital fracture.

(e) The Left-Right discrepancy overwhelmingly contributed to a suspicious

finding being under-interpreted. Had the right side been noted as the area of suspicion on the request form, the obvious and concordant abnormality, identified by a reasonable radiologist, would have triggered further investigation with CT, and the subtle abnormality (the orbital rim fracture) that was missed would have been irrelevant.

Decision of the Disciplinary Committee

30. The gravamen of the charge against the Respondent was that he had only made a clinical diagnosis of "*mucosal thickening seen in the right maxillary sinus. No definite facial fracture seen in this view*" and failed to diagnose the serious orbital and facial fracture of the patient. It is not in dispute that the patient actually suffered a right blow-out fracture and fracture to the right frontal bone. It is also not in dispute that the Respondent failed to diagnose these fractures.

31. In our view, the critical evidence before us was whether we accepted the evidence of PW1 (Dr. PE) or that of DW2 (Dr. DE). In short, PW1's view was that (i) the facial fracture was an obvious fracture that any trainee should have picked up and (ii) the clinical note was merely a guide but the Respondent should have picked up the fracture because it was obvious. In contrast, DW2's view was that although a radiologic error was committed, it was not a departure from the accepted standards because (i) the fracture was a subtle one and (ii) a reasonable radiologist would rely on the clinical notes on the IRF and the 'left-right' discrepancy had overwhelmingly caused the Respondent to under-interpret what he had observed in the right side of the facial x-ray.

32. We have taken into account the possibility of our hindsight bias. However, in our

view, even taking into account the possibility of hindsight bias, we have concluded that the right superior orbital fracture was indeed an obvious fracture. We come to the conclusion having the benefit of viewing the relevant x-ray during the hearing. Observing that x-ray image available to us, we could see that the right superior orbital fracture was obvious. We hasten to add that even though none of the members of this Disciplinary Committee are radiologists, it was patent to us when we looked at the x-ray that the fracture was obvious. Furthermore, when we took into account the Respondent's own evidence that he had viewed the radiograph digitally (whereby using the digital image he could manipulate the digital image for a clearer and sharper view), the Respondent should have clearly noted the fracture. In our view, there was no under-interpretation but a complete misinterpretation of the x-ray.

33. We do not accept the statement of DW2 that an error rate of 4%- 30% is acceptable. If this was correct, it would imply that all radiologists' errors can be condoned. Where members of a profession adopt a particular practice but if that practice proves to be wrong or negligent, it is no defence to state that the wrongful act was the common practice at that time. We have some doubts as to the reference materials referred to by DW2 and the same may be accounted for in the day and age where radiologist equipment are not the type that we have in Singapore today; where images are often in digital format providing clearer images and where CT scans could be obtained.

34. In our view, even if the Respondent was misled by wrong clinical notes i.e. the left-right dis-concordance, it is our view that the acceptable standard of a radiologist would be for a reasonable radiologist to look at a radiograph systematically rather than just relying on the notes given to him. If what a

radiologist has observed does not gel with the clinical notes, it is our view, that a reasonable radiologist should then call the requesting doctor for further clarification. This the Respondent did not do. In our view, he has failed to do that which any reasonable radiologist would have done. In our view, the proper standard procedure is to do a systematic review first and foremost. A clinical note should only be complimentary to the systematic review. In addition we took into account that since the Respondent noticed the mucosal thickening at the right side of the maxilla side; he should have gone further to look for an associated finding and continued to review the orbital margins. If one saw smoke, one should see where the fire was. It was open to him, if he had any doubts, to call for someone senior for a second opinion but he did not.

35. We did not accept the Respondent's explanation that the abnormality observed could be explained away as a result of a rotational effect. We had the opportunity of observing the relevant x-ray and as stated earlier, the right superior orbital fracture was obvious to us. We had also observed that there was no significant rotation which could have caused the Respondent to miss that fracture. If he had any doubt with regards to the quality of the radiograph, he could have called for a second view or a CT scan to get a better view; which he did not.

36. We were asked by Defence Counsel to give weight to the fact that the Respondent was an advance trainee at the material time and to judge him according to the standard of an advanced trainee and not that of an experienced radiologist. In our view, the Respondent was the only radiologist on-call on that fateful day, and this is a reflection that he was given the full trust of his department to carry out his duty and that his department must have

considered him competent enough for the task that he was entrusted with. In any event, we agree with the view, expressed by PW1, that even a trainee should not make the mistake that the Respondent made. As stated, the Respondent was not merely a trainee; he was an advance trainee that was made the only radiologist on-call that day. Having considered all the facts, we accept the view of PW1 that a mistake such as that made by the Respondent, was one which if was detected earlier, would justify a supervising doctor to review all of the Respondent's x-rays reviewed because his competency would have been in serious doubt.

37. The Respondent also admitted that although he had reviewed quite a significant number of radiographs that day, he was neither under any stress nor in any hurry.

38. Accordingly, we have come to the conclusion that the Prosecution has proved the facts as set out in the charge and has shown, beyond reasonable doubt that, the Respondent had departed from the accepted medical practice. The only question that remained was whether the departure by the Respondent from the accepted medical practice was one that amounted to professional misconduct.

39. We are advised by the legal assessor as to what may constitute professional misconduct and we are guided by the principles enunciated in *Low Cze Hong*. In *Low Cze Hong*, professional misconduct was said not to be limited to that in pages 25 and 26 of the *Ethical Codes and Ethical Guidelines* published by the Singapore Medical Council [see paragraph 21 of the decision]. The High Court affirmed that 'infamous conduct' was one definition of 'professional misconduct'; it also stated, citing In re A Solicitor [1972] 1 WLR 869, that negligence "*may*

amount to professional misconduct if it is inexcusable and is such as to be regarded as deplorable by his fellows in the profession. Professional misconduct requires more than mere negligence; but need not go so far as to require moral turpitude, fraud or dishonesty."

40. In the present case, there is no evidence of infamous conduct, or of moral turpitude, fraud or dishonesty. Clearly the Respondent was negligent. In his own words, he 'had made a mistake'. The question therefore was whether the negligent act was one which amounted to professional misconduct. Being guided by *Low Cze Hong* which approved the above cited paragraph in *In re A Solicitor*, we know that mere negligence is not professional misconduct. The question that we have to address ourselves is what *degree of negligence* would amount to professional misconduct.

41. The decision of *Low Cze Hong* is instructive. In paragraph 20 of Low Cze Hong, the Court cited a paragraph from McKenzie v Medical Practitioners Disciplinary Tribunal [2004] NZAR 47, a decision of the New Zealand High Court, with approval.

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constitution professional misconduct? With proper diffidence.... the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the Tribunal which examines the conduct."*

42. In another decision which was cited, i.e. in Campbell v The Dental Board of Victoria, it was said,

> *"... whether the conduct violates or falls short of, to a substantial degree, the standard of professional conduct observed or approved by members of the profession of good repute and competency."*

43. In Pillai v Messiter (No.2) (1989) 16 NSWLR 197,

> *"... departures from elementary and generally acceptable standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to professional misconduct."*

44. The Singapore High Court in *Low Cze Hong*, stated at paragraph 32 of the judgment, in citing Pillai v Messiter (No.2) emphasized that professional misconduct "*includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner"*. In this paragraph, it appears to us that if the negligence was of the type that suggests that the departure was caused by indifference on the part of the doctor (or in other words, a lack for concern for accepted standards), this would be sufficient to make out a charge for professional misconduct.

45. Having concluded that the Respondent did not (i) do a systematic review, in that he had noted the mucosal thickening on the right side of the maxillary and that he did not go further to review the radiograph and pick up the obvious fracture of the superior right orbital and (ii) that the IRF indicating a possible left cheek

fracture should not have been relied on by the Respondent or excuse him from doing a systematic review, we further conclude that the Respondent had committed a fundamental error in his duty as a radiologist, and that is, to carry out a systematic review of a radiograph. In our view, the error was one that is serious enough and falls far short of standards observed by or approved by practitioners of good repute and competency. It was a mistake, as PW1 puts it, that if his trainee had committed, he would have serious doubts as to their competency and wonder what other mistakes he could have made.

46. We have also concluded that at the very least, the failure to carry out a systematic review by the Respondent portrayed indifference on the part of the Respondent on that fateful day. He could have done a systematic review, he could have (if he had any doubts) ask for the assistance of a senior or sought clarification from the A & E doctor, he could have asked for additional views or for a CT scan, but he chose to do none of those.

Other points made in Defence Submissions

47. It was suggested by the Counsel for the Defence that it was not in the Respondent's purview to second guess his A & E colleagues physical examination of his patients. In our view, if it was obvious to one practitioner that another practitioner had carried out a misdiagnosis, it would not excuse the first practitioner from doing the right thing and perpetuate the mistake. It must be borne in mind that the predominant obligation of any medical practitioner is one that is owed to his patient. Unquestioning deference to one's senior has no place in the medical profession; it may be difficult to point out mistakes of one's senior but that is no excuse for not doing it altogether. Counsel for the Respondent also questions why the A&E doctor was not identified and not

brought to task before a Disciplinary Committee. In this regard, this Committee is only concerned and constituted to hear the complaint against the Respondent. It is not concerned with the perceived misconduct of any other medical practitioner. On the advice of the legal assessor, we are informed that it is no defence to a criminal prosecution that a co-accused was given a lighter charge: *see Thiruselvan Nagaratham v PP [2001] 1 SLR (R) 362 and Sim Min Teck v PP [1987] SLR(R)65*. By an extension of that same logic, it is not defence to a charge of professional misconduct for the Respondent to argue that another doctor involved in this incident was not charged.

48. We have no doubt that the Respondent's mistake was one committed out of indifference and of such a fundamental nature and thus fell grossly short of the standard observed or approved by members of this profession. We accordingly we find him guilty as charged and we accordingly convict him. We will now hear Counsel on the question of sentencing.

Sentence and Verdict

49. The Defence Counsel highlighted that this was an error made in the earlier part of the Respondent's career for which he has expressed remorse for. Defence Counsel argued that the fact that the Respondent's claimed trial to the charge which he faced was merely to place facts before this Disciplinary Committee to decide if his act been wrong. He pointed out that a crushing sanction should not be imposed as the Respondent has no previous record in his otherwise blemish-free career of 12 years. The error was committed 5 years ago and he has since proven himself to be a competent radiologist and has received professional accolades from his colleagues and peers. Defence Counsel argued that it would be unlikely that the Respondent would ever commit such

an error again. Our attention was drawn to his detailed curriculum vitae at Annex A of the written mitigation submitted by his Counsel. At Annex B, we were shown the testimony of the Respondent's colleagues in the profession who spoke well of him.

50. Defence Counsel asserted that the victim was paid compensation by the hospital. He ended his mitigation plea strongly urging this Disciplinary Committee not to impose a sentence of suspension and urged this Disciplinary Committee to find that the imposition of a fine, censure with the usual undertakings and orders as to costs would be sufficient.

51. Prosecution confirmed that there was no adverse matter known against the Respondent. Prosecution also confirmed that the patient did receive compensation from the hospital.

52. The Prosecution submitted that Defence's argument that the Respondent's error was contributed by the incorrect IRF should not be taken into account and that the Respondent's assertion that the Respondent's choice to claim trial should not merit a stiffer sentence should be disregarded. The Prosecution also stated that the fact that the Respondent did not intend harm to the patient should also be disregarded as these are not facts that are mitigatory.

53. Having regard to the representations made by both Counsel, while we agree with the Prosecution's view as stated in paragraph 52 above, we also agree with the Defence Counsel that there are merits in not imposing a crushing sentence on the Respondent in view of the various good that has been said of him by his peers and by those who have worked with him. Although the

Respondent's misconduct was one that was made in the very early stage of his career, whilst inexcusable, we are prepared to give the Respondent the benefit of the doubt that he has learnt his lesson. We see no useful purpose to be served in suspending the Respondent in the circumstances of this case. It is this Committee's decision that the appropriate sentence will be as follows:-

(a) That the Respondent shall be fined a sum of **$3,000.00**;

(b) that the Respondent shall be censured; and

(c) that the Respondent shall pay the costs and expenses of and incidental to these proceedings, including the costs of the Counsel to the SMC and the Legal Assessor.

54. The hearing is hereby concluded.

Dated this 3rd day of December 2010.