SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR LIM CHONG HEE HELD ON 4 MAY 2012

Disciplinary Committee:
Dr Lim Cheok Peng (Chairman)
A/Prof Pang Weng Sun
A/Prof Tsang Bih Shiou Charles
Ms Mabel Ong (Layperson)

Legal Assessor:
Mr Andy Chiok
(M/s Michael Khoo & Partners)

Counsel for the SMC:
Ms Melanie Ho
Ms Yuwen Teo-Mcdonnell
(M/s WongPartnership LLP)

Counsel for the Respondent:
Mr Charles Lin
(M/s MyintSoe & Selvaraj)

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. This inquiry arose from a complaint dated 25 February 2009 against the Respondent Dr Lim Chong Hee, a Cardiothoracic surgeon.

2. The complaint dated 25 February 2009 was made in connection with treatment that the Complainant received from the Respondent from 29 May 2007 to 17 June 2007. On 14 May 2009 the Respondent provided a written explanation to the Complaints Committee, which then issued a letter of advice to the Respondent. Upon the appeal by the Complainant to the Minister for Health, it was directed that the complaint be referred to the Disciplinary Committee for formal inquiry.

3. The essence of the sole Charge against the Respondent for professional misconduct is his failure to record his discussion with the Complainant of (a) a possible lobectomy and (b) the Complainant's consent to the lobectomy in his medical records.

4. The Respondent pleaded guilty to the Charge, and we then called for his counsel to address us by way of mitigation.

5. In mitigation, Counsel for the Respondent tendered a written mitigation plea and also submitted orally to this Committee on various mitigating factors. It was urged on his behalf that the appropriate punishment is that of the administration of a censure and the provision of an undertaking by the Respondent not to repeat the offending conduct.

6. Counsel for the SMC drew our attention to a precedent in 2005 where on a charge involving a failure to keep proper medical records, a censure was ordered together with a fine of $10,000. It was also drawn to our attention the potential difficulty that another doctor will have in the management of the patient if medical records are not properly maintained.

7. We are of the view that the maintenance of proper medical records is an important aspect of medical treatment. Paragraph 4.1.2 of the SMC Ethical Guidelines states:

> "Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented."

8. Apart from being an important part of the treatment of patients, proper medical record keeping is also crucial in avoiding disputes between a doctor and his patient, and the present complaint could have been avoided with proper record keeping. To this end, medical records are important and for the benefit of a patient as well as a doctor, and serious punishment can be meted out if the circumstances so warrant.

9. Reverting to the present case, we accept that the following are mitigating factors:

   (a) the Respondent's long unblemished record of 22 years' medical practice,

   (b) the co-operation of the Respondent with the SMC with the saving in costs and time, and

   (c) the impressive testimonials offered in favour of the Respondent testifying to his valuable contributions to the medical service.

10. To the above, we would add that the following are relevant factors that have an impact on the appropriate sentence to be imposed:

   (a) the Respondent is a senior medical practitioner, of which a higher standard is expected by the public and the medical profession. Further to that, we note that he held important appointments, notably, he was the Director of the Heart and Lung Transplant Programme, and a member of the National Heart Centre Credentialing Committee and of the NHCS Quality Management Committee. A senior medical practitioner with the Respondent's seniority and qualifications is in the position where he sets standards and is a role model for the junior practitioners.

(b) while the present case involves an oversight in the recording, we must also distinguish between cases where there was no informed consent obtained and one where consent was obtained but was not recorded. It appears from the Agreed Statement of Facts that it is undisputed that this is a case where consent was obtained but was unfortunately not recorded.

(c) we also do not ignore the fact that the Complaint and this inquiry had hung over the Respondent over the last few years.

11. Taking into the above mitigating circumstances and the circumstances of the case, we are of the view that the appropriate punishment is:

(a) that the Respondent be fined the sum of $5,000;

(b) that the Respondent shall be censured;

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

(d) 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.

12. We also order that the grounds of decision and outcome of this inquiry be published.

13. The hearing is hereby concluded.

Dated this 4th day of May 2012.