SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR CHEAH WAY MUN ON 11 AND 12 NOVEMBER 2013 AND 19 MARCH 2014

Disciplinary Committee:
Prof John Wong - Chairman
A/Prof Siow Jin Keat
A/Prof Lim Thiam Chye
Ms Serene Wee - Lay Member

Legal Assessor:
Mr Chia Chor Leong
(M/s CitiLegal LLC)

Counsel for the SMC:
Mr Edmund Kronenburg
Mr Kevin Ho
Ms Lynette Zheng
(M/s Braddell Brothers LLP)

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

GROUNDS OF DECISION OF THE DISCIPLINARY COMMITTEE

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

INTRODUCTION

1. The Respondent, Dr Cheah Way Mun, was an Ophthalmologist in private practice at The Eye Centre in Mount Elizabeth Medical Centre, Singapore.

2. These proceedings arose out of a complaint made on 29 April 2009 by one Mdm PW ("**the Complainant**") against the Respondent, in relation to, *inter alia*, the medical care and/or treatment provided by the Respondent to the Complainant in respect of the latter's cataracts.

3. Pursuant to the said complaint, the Singapore Medical Council ("**SMC**") preferred two charges against the Respondent, as set out in a Notice of Inquiry dated 28 August 2012. The second of these charges was later amended by SMC at the hearing of the Inquiry on 12 November 2013.

THE CHARGES

4. Pursuant to the amendment of one of the original charges as aforesaid, the two charges faced by the Respondent are as follows ("**the Charges**"):

1ST CHARGE

"*That you DR CHEAH WAY MUN are charged that on 18 February 2009, you employed inadequate and/or improper and/or erroneous biometric measurement techniques in the diagnosis and/or treatment of your patient namely one Mdm PW, and that in relation to the facts alleged you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.).*"

2ND CHARGE

"*That you DR CHEAH WAY MUN are charged that, between 26 February 2009 and 27 March 2009, in respect of your patient, one Mdm PW, you failed to promptly ascertain and/or inform and/or provide adequate advice to the said patient that the intraocular lens implant that you had inserted into the said patient's left eye on 26 February 2009 was excessively powered, and that in relation to the facts alleged you have been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.).*"

THE GUILTY PLEA

5. At the hearing of the Inquiry on 12 November 2013 before this Disciplinary Committee ("**DC**"), the Respondent pleaded guilty to both of the Charges ("**the Guilty Plea**").

6. The facts relating to the Charges and which are admitted by the Respondent ("**Admitted Facts**") are set out in an Agreed Statement of Facts dated 12 November 2013 ("**ASOF**").

7. Pursuant to the Guilty Plea and the Respondent's admission of the Admitted Facts, the Respondent was duly convicted of both of the Charges.

THE ADMITTED FACTS

8. The Admitted Facts in relation to the Charges as set out in the ASOF are as follows:

   (a) The Complainant was a patient of the Respondent since 1989 with very high myopia, in excess of -10 Diopters;

   (b) In or around 2000, the Respondent informed the Complainant that she had cataracts in both her eyes but, as the condition of her cataracts was still at an early stage, he would prescribe eye drops to slow their development;

   (c) The Complainant continued to visit the Respondent's clinic for regular check-ups for a period of approximately 9 years;

   (d) On or around 18 February 2009, the Complainant visited the Respondent's clinic as she was experiencing blurred vision in her left eye. During the consultation, the Respondent told the Complainant that the cataract in her eyes had matured and could now be removed through an operation. The Respondent also informed the Complainant that he would operate on the Complainant's left eye;

   (e) During the said consultation, the Respondent erroneously measured the axial length of the Complainant's left eye to be approximately 25.21mm. In taking the aforesaid measurement, the Respondent *inter alia*:

      (i) did not consider the earlier recording of the axial length of the Complainant's left eye of about 28.99mm, which the Respondent himself had measured in or around May 1996; and/or

(ii) recorded the said axial length of the Complainant's left eye by manually writing the same into the Complainant's case notes instead of using and/or relying on the electronic print-out from the Sonomed-A-Scan machine he had used to measure the axial length of the Complainant's left eye;

(f) Based on his erroneous measurement of the axial length of the Complainant's left eye, the Respondent chose an Intra-Ocular Lens ("**IOL**") with a power of +16 Diopters which was incorrect / inappropriate for the Complainant;

(g) On or around 26 February 2009, the Respondent performed an operation on the Complainant *inter alia* to remove the cataract. In the course of the operation, the Respondent also implanted the aforesaid incorrect / inappropriate IOL into the Complainant's left eye ("**1st Operation**");

(h) After the 1st Operation, in the period between February 2009 and March 2009, the Complainant visited the Respondent at his clinic a total of 5 times on or around the following dates for post-operation consultations:

(i) 27 February 2009;

(ii) 5 March 2009;

(iii) 10 March 2009;

(iv) 17 March 2009; and

(v) 25 March 2009;

(i) In the course of the 5 post-operation consultations as well as in various telephone calls made by the Complainant's husband ("**the Husband**") to the Respondent on the Complainant's behalf, the Complainant and/or the Husband repeatedly informed the Respondent of the Complainant's

concerns regarding her medical condition and the lack of improvement in her vision after the 1st Operation;

(j) On or about 10 March 2009, during one of the consultations the Complainant had with the Respondent, the Complainant informed the Respondent that her vision remained poor. Readings were taken from her eye and her vision was tested with various lenses. Her vision with refraction for the left eye was: -7.0DS/-11.0DCX 13 6/9;

(k) Despite the above being sufficient for the Respondent to be alerted to the fact or possibility that an incorrect / inappropriate IOL had been implanted during the 1st Operation, the Respondent failed to ascertain and/or inform the Complainant of the same;

(l) On or about 17 March 2009, a further reading was taken and her vision with refraction for the left eye was: -9.50DS/-6.0DCX 170 6/12;

(m) On or about 25 March 2009, approximately a month after the 1st Operation, during the Complainant's 5th consultation, the Respondent finally informed the Complainant that he had implanted an incorrect / inappropriate IOL into her eye and told her that she had to undergo a further operation to correct the mistake he had made;

(n) At the said consultation, the Respondent apologized for the outcome of the 1st Operation and he offered to perform a second operation free of charge;

(o) On or about 27 March 2009, the Complainant underwent a second operation to replace the incorrect / inappropriate IOL ("**2nd Operation**");

(p) In summary:

(i) The Respondent had failed to provide the Complainant with adequate and/or appropriate medical care / treatment, in that:

(1) he had employed inadequate and/or improper and/or erroneous biometric measurement techniques in the diagnosis and/or treatment of the Complainant and as a result, the wrong IOL was used for the purposes of the Complainant's cataract operation; and

(2) he failed to promptly ascertain and/or inform and/or provide adequate advice to the Complainant that the IOL he had inserted into the Complainant's left eye during the 1st Operation was excessively powered;

(ii) The Respondent acted *inter alia* in breach of his obligations under the Singapore Medical Council's Ethical Code and Ethical Guidelines ("**ECEG**"), in particular Guidelines 4.1.1.1, 4.1.1.5 and 4.1.2 thereof;

(q) The Respondent knew and/or understood that under the aforesaid Guidelines, he was obliged and/or required to:

(i) provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination (Guideline 4.1.1.1);

(ii) arrange appropriate and timely investigations and ensure that results of tests are communicated to the patient and the most appropriate management is expeditiously provided (Guideline 4.1.1.5); and

(iii) maintain clear, accurate and legible medical records of his patients with sufficient details documented (Guideline 4.1.2).

SUBMISSIONS ON MITIGATION AND SENTENCE

9. The Respondent tendered a Mitigation Plea as well as submissions on sentencing.

10. On its part, the SMC tendered sentencing precedents and submissions on sentencing.

11. The DC has duly considered the Respondent's Mitigation Plea and the submissions made by the respective parties on sentencing, including the sentencing precedents cited by them.

DC'S DECISION ON SENTENCE

12. Members of the medical profession have the responsibility to uphold the highest and noblest standards of medical competence and ethical conduct.

13. In the present instance, the Respondent had failed to discharge that responsibility. By failing to employ adequate and proper biometric measurement techniques in the diagnosis and treatment of the Complainant, which resulted in the Respondent choosing the wrong IOL for the Complainant's cataract operation, the Respondent had caused harm to his patient, who had to undergo the pain, risk and anxiety of a second operation to correct the Respondent's mistake. The Respondent had therefore breached one of the most fundamental and sacrosanct tenets of the medical profession, which is to do no harm.

14. The 1st Operation was an elective operation. There was no immediate or imminent danger to the Complainant's medical condition, and there was no immediate urgency for the operation to be performed. In other words, there was no medical emergency and no rush to perform the operation. The pre-operation assessment and management of the Complainant should therefore have been thorough, adequate and correct.

15. This, of course, is *not* to say that the pre-operation assessment and management of a patient in the case of a non-elective operation need not be thorough, adequate or correct. It is just that where the procedure is an elective one and is done outside the context of a medical emergency, there is simply no excuse for such assessment and management to be so inadequate and

incorrect as to amount to professional misconduct. The Respondent's misconduct committed in relation to an elective procedure is even more serious, and attracts a greater degree of reprobation, than if it had been committed in relation to a non-elective or emergency procedure.

16. Doctors are held to the highest standards of professional competence and ethical conduct. It is the expectation, and indeed presumption, that doctors will relentlessly and uncompromisingly defend, uphold and adhere to these standards that form the foundation of the public's trust and confidence in, and indeed respect of, the medical profession.

17. As important as it is for a doctor to not make any mistake in the first place in the management and treatment of a patient, it is equally if not more important that if the doctor unfortunately does make a mistake, the doctor will quickly find out and *promptly* tell the patient about it, with adequate and proper advice on how to rectify the mistake. This is an integral part of a doctor's professional duties. The public's trust and confidence in the medical profession lies also in the further expectation and presumption that if a doctor makes a mistake, he will honestly and *promptly* own up to it and correct it, thereby placing the patient's interests above his own.

18. In the present case, therefore, the Respondent *compounded* his misconduct in relation to the wrong choice of the IOL for the 1st Operation, by then failing to promptly ascertain that he had made the mistake and to promptly inform the Complainant of the mistake and advise her on how to deal with it. Of course, the Respondent did find out that he had made a mistake, and he did inform the Complainant of the mistake, and he did advise her on what to do about it. His misconduct lies in the fact that he had failed to *promptly* do these things.

19. Such misconduct damages public confidence and trust in the medical profession, and a clear and unequivocal message must be sent that such misconduct cannot be condoned.

20. However, the DC takes into account the fact that, fortunately, the Complainant was well after the second operation, and no permanent injury was caused to her.

21. The DC also takes into account the fact that the Respondent has had a long and unblemished record. He has been in medical practice for more than 32 years, and this is the first time he has ever been involved in professional disciplinary proceedings.

22. Indeed, not only has the Respondent had a long and unblemished record, that record has been a distinguished one. Amongst other things, the highlights of the Respondent's long and illustrious career included his contributions to Tan Tock Seng Hospital, KK Women's & Children's Hospital, the Singapore National Eye Centre, and the National University of Singapore, the Children Aid Society of Singapore, and the Singapore Association of the Visually Handicapped.

23. The DC also takes into account the fact that the Respondent has pleaded guilty, although this mitigating factor is somewhat diluted by the fact that the Respondent pleaded guilty at a very late stage of the Inquiry against him.

24. Nevertheless, the Respondent has expressed remorse, and the DC has no reason to doubt his sincerity.

25. Having considered all of the submissions tendered by the parties and having taken into account all of the circumstances of the case, the DC now determines the appropriate sentence to be as follows, and so orders:

    (a) That the Respondent shall pay the maximum fine (under the relevant edition of the Medical Registration Act) of S$10,000.00;

    (b) That the Respondent be censured;

(c) That the Respondent shall give a written undertaking to the Singapore Medical Council 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 solicitor to the Singapore Medical Council and of the Legal Assessor.

CONCLUSION

26. We hereby order the Grounds of Decision herein to be published.

27. The Inquiry is hereby concluded.

Dated this 19th day of March 2014