SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR DANIEL LEE KIM KWONG ON 11 TO 13 SEPTEMBER, 27 SEPTEMBER 2013 AND 25 OCTOBER 2013

Disciplinary Committee:
Prof John Wong - Chairman
A/Prof Siow Jin Keat
Dr Chang Tou Choong
Ms Elaine Ng (Lay Member)

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DECISION OF THE DISCIPLINARY COMMITTEE

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

Introduction[1]

The Parties

1. The complainant in these proceedings is Ms P. For the purposes of this decision, she will be referred to as "the Patient".

2. The Respondent, Dr Lee Kim Kwong, is a registered medical practitioner under the Medical Registration Act (Chapter 174) (**"MRA"**) with a registered specialty in Obstetrics and Gynaecology[2]. He has been registered with the Singapore Medical Council (**"SMC"**) as a specialist since 1998[3].

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[1] For ease of reference, these footnotes adopt the Bundle References which are abbreviated as follows: Agreed Statement of Facts **("AS1")**, Agreed Bundle of Documents **("AB1-118")**, Prosecution's Bundle of Documents **("PB1-10")**, Respondent's Bundle of Documents **("RB1-51")**, Respondent's Bundle of Expert Reports **("RE"),** Prosecution's Opening Statement **("P1"),** Respondent's Opening Statement **("R1"),** Prosecution's Closing Submissions **("PCS")** and Respondent's Closing Submissions **("RCS")**

[2] AS1 at [1]

[3] R1 at [1]

3. The Respondent is and was at all material times running his own private practice, Lee Women's Clinic & Surgery, located at 304 Orchard Road, #06-33 Lucky Plaza, Singapore 238863[4].

4. After receiving written closing submissions and hearing oral closing submissions on 25 October 2013, this Committee delivered its decision in respect of the charge brought by the Prosecution against the Respondent together with an oral summary of this Committee's reasons. These are the written grounds of the decision of this Committee which sets out in full its reasons for arriving at its decision.

The Charge

5. The Prosecution preferred a single charge (**"the Charge"**) against the Respondent:

> "That you, Dr LEE KIM KWONG, a registered medical practitioner under the Medical Registration Act (Cap. 174), on 17 August 2010 at Mount Alvernia Hospital located at 820 Thomson Rd, Singapore 574623, did perform a lower segment caesarean section ("the Procedure") on your patient, one Miss P ("the Patient"), without ensuring that the anaesthesia had taken full effect, thereby causing pain and distress to the Patient.
>
> Particulars
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> a. The Patient was administered with an epidural injection of local anaesthetic to the epidural space of the Patient by Dr P1 at about 8.10 a.m.
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> b. You commenced the Procedure on the Patient by making an incision before testing if the anesthetic had taken full effect.
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> c. The incision you made on the Patient caused the Patient to scream in pain. Despite this, you proceeded with the Procedure.
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> 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) and in breach of Article 4.1.1.5 of the Singapore Medical Council's Ethical Code and Ethical Guidelines."

Summary of Decision

6. After carefully considering all the material and evidence, this Committee has arrived at the unanimous decision beyond reasonable doubt that the Respondent is guilty of the Charge preferred against him.

Undisputed Factual Background[5]

7. The Patient first saw the Respondent in 2008 for the management of her first pregnancy. The Respondent delivered the Patient's first child via lower segment caesarean section under epidural anaethesia (**"EA"**) on 6 January 2009 due to failure to progress in labour. The Patient's first child was safely delivered.

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[4] AS1 at [2]
[5] Based on AS1

8. The Patient had been scheduled to undergo a lower segment caesarean section (**"the Procedure"**) by the Respondent on 17 August 2010 at 0800 hrs at Mount Alvernia Hospital for her second pregnancy.

9. The Patient arrived at Mount Alvernia Hospital at or around 0525 hrs on 17 August 2010. Upon arrival, the Patient elected to undergo the Procedure under EA.

10. The Patient was wheeled into the operating theatre sometime before 0730 hrs.

11. Dr P1 ("**Dr P1**"), a registered medical practitioner under the MRA with a registered specialty in anaesthesiology, conducted a pre-anaesthetic assessment on the Patient. The EA was administered by Dr P1 after he completed the pre-anaesthetic assessment. It takes at least 15 to 20 minutes for the EA to take effect.

12. After the Respondent entered the operating theatre, the Patient informed him that she still had some feeling in her leg. The Respondent acknowledged this.

13. Subsequently, at or around 0820 hrs, the Respondent made a slit or cut (which the parties dispute) on the Patient's abdomen. The slit or cut caused the Patient to express pain. Dr P1 then administered a gas mixture of oxygen and nitrous oxide for about a minute by face mask to sedate the Patient.

14. The operation ended at or about 0845 hrs. The Patient delivered a baby girl.

Prosecution's Case

15. The Prosecution's case is that the Respondent had made an incision on the Patient before testing if the EA had taken effect and that he had done so before waiting for at least 15-20 minutes after the EA was administered, which is agreed to be the requisite time for EA to take effect[6].

16. The Prosecution's position is that Dr P1 had administered the EA at 0810 hrs[7]. At 0820 hours, the Respondent started the Procedure[8].

17. The Respondent was told by Dr P1 to wait another 10 minutes before starting the Procedure[9].

18. Further, the Patient also told the Respondent that she still had some feeling in her leg[10]. Nevertheless, despite acknowledging this, the Respondent proceeded to start the Procedure at 0820 hours by making a full length incision on the Patient on the first cut, exposing the fat layer and causing bleeding which required Dr P1 to stem the bleeding by placing a gauze over the cut[11].

Respondent's Case

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[6] PCS at [4]
[7] PCS at [9] and [38]
[8] PCS at [10], [21] and [22]
[9] PCS at [8] and [73]
[10] AS1 at [10] and PCS at [8]
[11] PCS at [10] and [86]

19. The Respondent's case is that a scratch test or test cut was performed to test the effect of the EA on the Patient before the Respondent commenced the Procedure[12]. This scratch test was conducted 20 minutes after the EA was administered by Dr P1.

20. The Respondent's position is that Dr P1 had fully completed the EA procedure by 0800 hrs[13]. Upon being informed that the EA had been administered, the Respondent went to the operating theatre to greet the Patient. The Patient informed the Respondent that her legs were not fully numb yet and that she still had some "feeling" in her leg. The Respondent acknowledged this and told her wait. The Respondent then left the operating theatre to scrub up thoroughly before returning five minutes later. The Respondent then cathetherized, cleaned and draped the Patient. A scalpel was handed to the Respondent to commence the Procedure at 0820 hrs[14].

21. The Respondent commenced the Procedure by making a short superficial slit on the incision site to test the effectiveness of the EA[15]. It was during this scratch test that the Patient verbalized her pain in a short loud scream. At this point in time, the Procedure itself had not started yet.

22. As soon as the Patient expressed pain, the Respondent stopped the surgery and allowed Dr P1 to give nitrous oxide to the Patient[16]. Upon being informed by Dr P1 that he could proceed, he then went ahead to deliver the baby by the Procedure at 0823 hrs.

The Law

Professional Misconduct

23. In considering an appeal against the decision of the SMC in relation to two charges of professional misconduct against a consultant ophthalmologist, the Singapore High Court in *Low Cze Hong v Singapore Medical Council*[17] ("***Low Cze Hong***") had the opportunity to consider the scope of the phrase "professional misconduct" under the MRA.

24. The following observations by the Court in *Low Cze Hong*, are apposite:-

> "[32] Counsel for the SMC relied on *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 ("*Pillai*") where the New South Wales Court of Appeal considered the statutory test of "misconduct in a professional respect" under the Medical Practitioners Act 1938 (NSW). Kirby P said (at 200):
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> > **"Misconduct" means more than mere negligence:**
> >
> > The words used in the statutory test ("misconduct in a professional respect") plainly go beyond that negligence which would found a claim against a medical practitioner for damages: *Re Anderson* [*& the Medical Practitioners Act 1938-1964* (1967) 85 WN (Pt 1) (NSW) 558], (at 575). On the other hand gross negligence might amount to relevant

[12] RCS at [25] and [164]
[13] RCS at [12] and [89]-[91]
[14] RCS at [24]
[15] RCS at [25]
[16] RCS at [26]
[17] [2008] 3 SLR(R) 612

> misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient: cf *Re Anderson* at (575). Departures from elementary and generally accepted standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to such professional misconduct: ibid. But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. *It 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*: cf *Allinson* (at 760-761). These are the approaches which have been taken in our courts. They have been taken in the courts of England where such misconduct is alleged. And they have similarly been taken in the courts of the United States. The entry in *Corpus Juris Secundum*, vol 58, (1948) at 818, reads:
>
> > "Both in law and in ordinary speech the term 'misconduct' usually implies an act done willfully with a wrong intention, and conveys the idea of the intentional wrongdoing. The term implies fault beyond the error of judgment; a wrongful intention, and not a mere error of judgment; but it does not necessarily imply corruption or criminal intention, and, in the legal idea of misconduct, an evil intention is not a necessary ingredient. The word is sufficiently comprehensive to include misfeasance as well as malfeasance, and as applied to professional people it includes unprofessional acts even though such acts are not inherently wrongful. Whether a particular course of conduct will be regarded as misconduct is to be determined from the nature of the conduct and not from its consequences."

[36]… The importance of maintaining the highest level of professionalism and ethical conduct has been duly acknowledged by the SMC in the Introduction section of the SMC Ethical Code (at p 1):

> The medical profession has always been held in the highest esteem by the public, who look to their doctors for the relief of suffering and ailments. In modern medical practice, patients and society at large expect doctors to be responsible both to individual patients' needs as well as to the needs of the larger community. Much trust is therefore endowed upon doctors to do their best by both. *This trust is contingent on the profession maintaining the highest standards of professional practice and conduct*.
>
> ...
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> ... The SMC has the role of promulgating the Ethical Code and Ethical Guidelines on acceptable professional practice and behaviour and has the responsibility to exercise its duty to discipline members of the profession who fail to uphold the high standards demanded by society.
>
> This Ethical Code represents the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore. The Ethical Guidelines elaborate on the application of the Code and are intended as a guide to all practitioners as to what SMC regards as the *minimum* standards required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore. It is the view of the SMC that *serious disregard or persistent failure to meet these standards* can potentially lead to harm to patients or bring disrepute to the profession and consequently may lead to disciplinary proceedings.

> [37]…In summary, we accept Kirby P's suggestion in *Pillai* ([32] *supra*) that that professional misconduct can be made out in at least two situations: first, where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; and second, where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner …"

25. In the course of its judgment, the Court stressed that the SMC Ethical Code and Ethical Guidelines "serves a crucial role in providing an ethical "compass" to guide doctors on what the acceptable standards are from which a departure may constitute professional misconduct" (at [37]). Further, the Court stated:-

> "[86]… the SMC Ethical Code is an embodiment of the ethical values the SMC strives to inculcate in each member of the medical profession, and, in so doing, raise the overall standards of professional practice and conduct. In this connection, it is imperative for doctors to internalise the ethical responsibilities under the SMC Ethical Code and to duly perform them not just in letter, but in accordance with its spirit and intent."

26. The principles in *Low Cze Hong* were referred to in *Low Chai Ling v Singapore Medical Council*[18] ***("Low Chai Ling")***. The Court stated:-

> "[52] Although this court's decision in *Low Cze Hong* was not meant to be an exhaustive determination of what professional misconduct consists of, the passage above at least shows that professional misconduct ordinarily does carry with it the *severity* of sanctioning either an intentionally errant doctor who chooses to go against established conventional standards or a grossly negligent medical practitioner."

Medical Negligence

27. In *Bolam v Friern Hospital Management Committee*[19], the English Court set forth the test relating to the standard of care in medical negligence at p587:-

> "**[A doctor] is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art** … Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion." (**emphasis added**)

28. However, the Bolam test was deemed to confer undue deference to the medical profession due to the reluctance of the Court to define the term "a responsible body of medical opinion". Thus, the House of Lords in *Bolitho v City and Hackney Health Authority*[20] established that a medical opinion must have a logical basis in order to constitute a responsible body of opinion at 241:-

> "… the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice …

[18] [2013] 1 SLR 83
[19] [1957] 1 WLR 582
[20] [1998] 1 AC 232

> The use of these adjectives - responsible, reasonable and respectable - all show that **the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis**. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter." (**emphasis added**)

29. The Singapore Court of Appeal in *Khoo James and another v Gunapathy d/o Muniandy and another appeal*[21] confirmed that the *Bolam* test, as supplemented by the *Bolitho* ruling, is applicable in Singapore.

30. This Committee has considered the evidence based on the above legal principles.

The Witnesses

31. The Prosecution called 4 witnesses of fact and 1 expert witness:-

    (a) The Patient;

    (b) Nurse P2 (**Nurse P2"**);

    (c) Anaesthetic Assistant P3;

    (d) Dr P1 (**"Dr P1"**); and

    (e) Dr PE.

32. The Respondent called 3 witnesses of fact and 2 expert witnesses:-

    (a) The Respondent;

    (b) Nurse D1;

    (c) Ms D2 (**"Ms D2"**);

    (d) Dr D3 (**"Dr D3"**); and

    (e) A/Prof DE (**"A/Prof DE"**).

The Preliminary Matters

33. Before we deal with the main issues that need to be decided on for the purposes of the Charge, this Committee would like to comment on some preliminary matters brought up by the Respondent in his closing submissions:-

[21] [2002] 1 SLR(R) 1024

The surrounding circumstances which contributed to the Patient's unhappiness with the Respondent and the Patient's disposition

34. Based on events which had taken place on the day in question prior to the Procedure, the Respondent characterizes the Patient as one who was unhappy or otherwise displeased with the Respondent and his staff – even when it may have been the case that anaesthetist, Dr P1 was partially responsible for the incident. This coupled with the Patient's disposition towards pain and her tendency to exaggerate, would necessarily point to her lack of credibility as a witness of truth[22].

35. This Committee has carefully considered the evidence of the Patient especially her demeanor when she was on the witness stand. While there may have been instances where her evidence may not have been completely coherent or consistent, these related to matters which were not relevant to the Charge.

36. This Committee has also not placed any emphasis on the conduct of the Respondent after the Procedure. It may well have been a situation where the Patient's anger and the Respondent's less than effective communication skills contributed to a strained relationship between them after the Procedure. Nevertheless, this Committee is well aware that the Charge relates to an allegation of professional misconduct in relation to the Procedure and that the matters that occurred before and after the Procedure are not relevant for the purposes of our determination. In any event, we do not believe that the Patient's evidence was clouded or in any way motivated by any factors which pointed to her lack of credibility as a witness or that she was untruthful.

37. As for the Respondent's submission that the Patient failed to consider that Dr P1 was partially responsible, all that the Committee needs to say is that it is the Respondent and not Dr P1 who is being charged. It is not for this Committee to make findings on the conduct of a doctor who is not the subject matter of this inquiry. This Committee has no such jurisdiction.

The issue of the reconstruction of the facts by an expert

38. The Respondent has submitted that based on the reconstruction of facts as conducted by their expert, Dr D3, the EA was administered at 0800 hrs thereby casting doubt on the contemporaneous medical case-notes as well as the evidence of the Prosecution's witnesses.

39. This Committee notes that Dr D3, in casting doubts on the veracity of the 0800 hrs timing for the administration of the EA, states that:-

> "This timing seems to have been borne out by the OT Intra-operative Nursing Record, which documented that the Patient was supine and ready for surgery at 0800Hrs. There is also a note made by Ms D2 signed and dated as 13/10/11 that the epidural injection had been given and the Patient was in the supine position at 0800Hrs."[23]

40. This Committee does not accept this aspect of Dr D3's opinion which is based on the said OT Intra-Operative Nursing Record. It is beyond doubt that this record (in so far as it contained the handwritten note by Ms D2) was not

[22] RCS at [52]-[53]
[23] RE at Tab 2, p 5, para 27

contemporaneous and in fact "engineered". The OT Manager, Ms D2 had actually admitted to the fact that she was not present at the time of the Procedure, she did not verify the facts with the nurses who were present at the material time, and that it was the Respondent who had asked her to insert the words "[p]atient is in supine position after Epidural Anaesthesia at 0800 hrs." Ms D2 had further admitted that what she had written **was incorrect**.

41. This Committee is dismayed and appalled by the Respondent's conduct in relation to what had transpired with regards to the OT Intra-Operative Nursing Record. Firstly, there is absolutely no basis to cause a hospital employee to supplement contemporaneous medical case notes. This would contradict the very reason why these case notes are considered contemporaneous – and the Respondent would have known this. Secondly, it is completely unacceptable for the Respondent to cause a senior staff member of a hospital who was not even present during the Procedure to simply insert notes at his request. It also does not escape this Committee that, as admitted by the Respondent, the request to Ms D2 to insert the comment was made after disciplinary proceedings had commenced.

42. For the reasons which will be explained later in this decision, the issue of the exact timing of the administration of the EA, and for that matter, the issue of whether an expert is entitled to reconstruct the facts, is not relevant for the purposes of finding whether the Charge has been made out.

The deficiencies in the Charge

43. The Respondent submits that the Charge is deficient for the following reasons:-

    a. The Charge does not particularize the duration or period of time whereby the Patient allegedly suffered from pain and distress[24];

    b. The Charge does not particularize the length or depth of the incision[25]; and

    c. The Charge states that Dr P1 administered "local anaesthetic" instead of "epidural anaesthesia" at or around 0810 hrs[26].

44. It bears emphasis that the Charge clearly states that the Procedure was commenced when the Respondent made the incision which thereby caused pain to the Patient. It is clear that that the pain was caused at the time of incision. That is the gravamen of the Charge. The Committee is of the view that quite apart from the fact that the duration of the pain suffered is irrelevant, the failure to state this in the Charge does not render the Charge deficient.

45. As for the objection relating to the omission of the "length or depth" of the incision, this Committee accepts the submissions of the Prosecution in this regard[27]. The Charge states clearly that an incision (as opposed to a scratch) was made. No more needs to be said in the Charge. The rest is a matter of evidence.

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[24] RCS at [243]
[25] RCS at [245]
[26] RCS at [244]
[27] PCS at [125]

46. This Committee also finds the objection to the use of the words "local anaesthetic" in the Charge unmeritorious. The Charge clearly refers to the administration "with an epidural injection of local anaesthetic to the epidural space". This Committee is of the view that the description is accurate.

Our Findings on the Charge

Issue 1 - Time of administration of the EA

47. It is the Prosecution's case that the EA was administered at around 0810 hrs while the Respondent asserts that it was administered at 0800 hrs.

48. This Committee also notes that the Respondent went to great lengths to try and establish the timing of the administering of the EA. This was apparent in the manner the Respondent's witnesses were examined and the Prosecution's witnesses were cross-examined.

49. It was the Respondent's case that if the EA was administered at 0800 hrs and that it was generally agreed that the EA would take 15-20 minutes to take effect, when the Procedure was commenced at 0820 hrs, the Patient would have been under the effects of the EA and therefore it would have been acceptable for the Respondent to have started the Procedure[28].

50. This Committee does not view the exact timing of the administration of the EA as being relevant for the purpose of making out the Charge. Regardless of when the EA was administered, the Respondent had an obligation to test if the EA had taken full effect before commencing the Procedure. This is so regardless of the time that had elapsed from the administration of the EA. To frame the issue as whether "it would have been acceptable to have started the Procedure" is incorrect and misses the point. It is important to note that the Charge states that the Respondent commenced the Procedure by making an incision before testing if the EA had taken full effect.

51. While this has not been expressly raised by the Respondent, for good order, this Committee has also considered the issue of whether an incorrect timing (if at all it was incorrect) in the Charge renders the Charge fatal. In this regard, this Committee is guided by the dicta of the High Court in *Low Chai Ling*:-

> "[33] ... **While it is usually not fatal to a charge that the time of the offence is wrongly or imprecisely stated as long as the accused has a fairly reasonable idea of the case facing him**, here, the difference between the time period specified in the charges against the applicant (i.e. the period prior and up to 20 Sep) and the time period following the MOH's letters (i.e. the period after 20 Sep) is not just a matter of timing per se, but an altogether fundamental difference in the nature and substance of the charges against the applicant." (**emphasis added**)

52. This Committee is of the view that the exact timing of the administering of the EA does not affect whether the Charge has been made out. This is because the gravamen of the Charge relates to the conduct of the Respondent after the administering of the EA – which will be discussed below. In any event, even if the timing is of ultimate importance, this Committee is of the view since the Charge refers to the administering of the EA "at about 0810 hrs" – the evidence adduced would support this aspect of the Charge.

[28] RCS at [195]

Issue 2 – Whether the Respondent tested if the EA had taken effect before commencing the Procedure and if so, the manner in which the test was conducted

53. It is the Prosecution's case that no such test was conducted and that the Respondent started the Procedure by making an incision on the abdomen of the Patient.

54. It is the Respondent's case that the Respondent did in fact conduct a test before commencing the Procedure by making "a very short superficial slit"[29].

55. At the outset, this Committee notes that the Respondent acknowledges that the Patient did tell him that she had feeling in her legs. However, the Respondent also admits that he did not ask her again about the feeling in her legs before commencing.

56. After hearing evidence of the witnesses, this Committee finds the evidence of Nurse P2 compelling. Nurse P2 was the scrub nurse for the Procedure and was employed by Mt Alvernia Hospital. She was an independent witness. She looked to the Patient after she heard the Patient scream. She saw that the Respondent had done an "incision" and that it was a "normal c-section incision". She stated that she saw the "fat layer" exposed. She also confirmed that when the Respondent continued with the Procedure, he did not have to lengthen the incision. In other words, it was the c-section incision that was done first.

57. In his expert evidence, Dr PE confirmed that if the fat layer was exposed, it would be an incision as opposed to a superficial scratch.

58. This Committee has also taken into account that the Respondent's evidence in this respect (i.e. whether it was a test scratch, slit or incision) evolved throughout the proceedings.

59. In his letter to the Patient dated 14 September 2010[30], the Respondent states that he made a "gentle superficial cut".

60. In his reply to the Complaints Committee[31], the Respondent states that he made a "short superficial slit"[32] on the incision site and that he had stopped the Procedure "[w]hen the patient said she felt the pain". Later in that same reply, the Respondent states "[w]hen the patient complained of pain, I stopped the short and gentle superficial slit on the skin immediately"[33].

61. Under cross-examination, the Respondent seemed to accept that it was more than a case of the patient simply stating that she felt pain. The Respondent appeared to concede that it was a "yell". In fact, his own nurse, Nurse D1 testified that the reason why she remembered this incident was because of the "scream" and that she had never heard such a scream during a lower segment caesarean section.

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[29] AB24 [6c]
[30] AB20
[31] AB22
[32] AB24 [6d]
[33] AB29 [16]

62. Upon further questioning by this Committee, the Respondent accepted that the test scratch may have in fact penetrated the dermis causing bleeding. When questioned further, the Respondent accepted that "little bit of fat" may have been seen[34].

63. This Committee has also considered the evidence of A/Prof DE who opined that it may be possible for some fat to be exposed if when doing a scratch, more strength is used[35]. We have noted the opinion of A/Prof DE and we feel that strength exerted by the Respondent on the abdomen was a key fact.

64. It cannot be disputed that the Patient did in fact scream and was certainly in a lot of pain as evidenced in the sudden increase in her vital parameters at that particular time. It also cannot be disputed that the cut made by the Respondent penetrated the epidermis and the dermis (which contained the nerves, thus the pain, and which contained the blood vessels, thus the bleeding) and so exposing the subcutaneous fat. We can find no reason to doubt the veracity of the Patient's evidence as to the pain and anguish she suffered at the time of the incision. This Committee also finds the evidence of Nurse P2 as truthful. The above facts and evidence point to the inescapable conclusion that the Respondent neither did a scratch or a superficial slit. It was a c-section incision which did not need to be lengthened.

65. Accordingly, this Committee finds beyond reasonable doubt that the Respondent had made an incision on the skin of the abdomen of the Patient as opposed to a test scratch or slit.

66. As to whether such an incision could amount to the requisite testing that was required to be done to check whether the EA had taken effect, this Committee reviewed the expert evidence of A/Prof DE, Dr D3 and Dr PE and has concluded that such an incision could not amount to an appropriate test.

67. In fact, this Committee would go further to state that it would defy all tenets of acceptable medical practice for a surgeon to conduct a test in this manner. The fact of the matter is that the Respondent did not conduct any such test and it is beyond reasonable doubt that the Respondent simply proceeded with the Procedure by making the incision. In this regard, the elements of the Charge that the Procedure was commenced by making an incision before testing if the EA had taken full effect, has been made out.

68. We have noted the Respondent's submission that the EA must have been administered by 0800 hrs to have taken effect by 0820 hrs as that would explain why the baby could have been delivered within 3 minutes. This Committee is of the view that the timing of when the EA was administered is not relevant to any finding of guilt on the Charge. The Charge does not state that the Respondent failed to ensure that EA had taken effect for the duration of the Procedure. While there may be plausible explanations as to how and why the Respondent was able to deliver the baby within 3 minutes, we are only concerned with the commencement of the Procedure and whether the incision was made before the EA had taken effect. We have made a finding of fact that this has been proved beyond reasonable doubt.

Issue 3 – Was it the Respondent's obligation to test if the EA had taken full effect?

[34] RCS at [174]
[35] RCS at [175]

69. Since this Committee has found that the Respondent did not test to check if the EA had taken effect, the question to be considered is whether it is the responsibility and obligation of the anaesthesist or the surgeon to ensure that the EA had taken effect.

70. We are of the view that while the anaesthesist has a responsibility to check whether the EA had taken effect, it is the surgeon who has the ultimate responsibility and primary obligation to ensure that the EA was effective before commencing the surgery. This is not disputed by the experts and even by the Respondent[36]. This Committee also accepts that sometimes even with the most careful administering of anaesthetic drugs, taking into account the different physiologies of patients and the difference in response of individuals to drugs, the anaesthesia may fail completely or not work to its optimal effect.

71. In this regard, and as stated above, we do not believe that the issue of whether the EA was administered at 0800 hrs or 0810 hrs is all that relevant. Regardless of when it was administered and regardless of whether the anaesthesist gave the go-ahead, it is the surgeon who had to ultimately test that the EA was effective before commencing the Procedure.

Issue 4 – Did the Respondent continue with the Procedure after the incision and was it acceptable to do so?

72. This Committee notes that particular (c) of the Charge states that "[t]he incision you made on the Patient caused the Patient to scream in pain. Despite this, you proceeded with the Procedure."

73. This Committee notes that after the Patient screamed, nitrous oxide gas was administered to the Patient. It is the Respondent's position that he had stopped and had only continued with the Procedure after the patient was sedated.

74. This Committee also notes the evidence of Dr P1 when he stated that after the Patient screamed, the Respondent did not stop the Procedure and proceeded to operate and deliver the baby[37]. Upon seeing that the Respondent was continuing with the Procedure, Dr P1 had to administer the nitrous oxide gas to the Patient in an attempt to alleviate the Patient's pain. Nurse P2 also testified that there was hardly any stoppage and at most only "more than a few seconds to less than a minute"[38].

75. The Respondent testified that he only stopped for half a minute while the nitrous oxide gas was administered, yet it is undeniable that the baby was delivered at 0823 hrs – a mere 3 minutes after the incision.

76. The fact remains that while it was possible to have delivered the baby within 3 minutes (or less, considering that 30 seconds were spent on the administering of the nitrous oxide gas), this was a rapid delivery. It is difficult to accept that if the Respondent did in fact stop after hearing the scream of the Patient, that he would have been able to deliver the baby in less than 3 minutes, especially since this was the Patient's second c-section which would have made surgery much more difficult given the inherent fibrosis and scarring that would have

[36] PCS at [3]
[37] PCS at [111]
[38] PCS at [112]

been present from her previous c-section. After considering the evidence, the Committee finds beyond reasonable doubt that the Respondent did not actually stop but simply proceeded with the Procedure after the incision.

77. As to whether it was acceptable for the Respondent to have proceeded with the Procedure, it is important to consider the relevant context. The Respondent had not tested if the EA had taken effect. He made a full c-section incision which caused the Patient to scream – a scream which stayed in the minds of several of the medical professionals in that operating theatre – even to this day. This was an extraordinary occurrence in an operating theatre. Acceptable medical practice and standards would dictate that the Respondent immediately stop the Procedure and carefully consider all circumstances, i.e. the Patient's physical and mental well-being; and whether the anaesthetist recommended continuing under General Anaesthesia.

78. This was not an emergency procedure. Neither the life of the Patient nor that of her baby was at risk. The Respondent did not give any consideration to these factors and simply proceeded with the Procedure in such a rapid manner as to deliver the baby within 3 minutes from the time the Patient screamed.

79. The Respondent would also have known that nitrous oxide gas merely sedates the Patient as opposed to anaesthetising the Patient. The Patient may still experience pain although she may not be in a position to open her eyes and to vocalize her pain. While nitrous oxide gas has been used in such surgeries as confirmed by A/Prof DE[39], in the present case, it was wrong for the Respondent to have continued with the Procedure in such a rapid manner. While not relevant to the Charge, this Committee notes that the Respondent did not even conduct another test before proceeding.

80. Accordingly, this Committee finds that it was completely unacceptable for the Respondent to have proceeded with the Procedure in these circumstances.

Conclusion on Misconduct

81. Having considered all the evidence and for the reasons set out above, this Committee finds beyond reasonable doubt that the Respondent is guilty of the Charge.

82. We are also of the view that the actions of the Respondent amounted to professional misconduct in that it was an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency. While this would be sufficient to amount to professional misconduct based on the High Court's decision in *Low Cze Hong,* we would go further to state that even the 2nd limb as set out by the High Court has been satisfied, i.e. the Respondent has committed such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

83. This Committee's decision is unanimous.

[39] RCS at pg 92

Penalty & Mitigation

84. On 25 October 2013, this Committee delivered a summary of its decision.

85. After delivering its decision, we asked the counsels for the Prosecution and the Respondent to make submissions on the appropriate penalty and mitigation. This Committee has heard the submissions and taken into account the aggravating and mitigating factors, including the following factors:-

Aggravating Factors

(a) The misconduct in this case is serious. The pain inflicted on the Patient was significant. When a practitioner, particularly one of the Respondent's experience and seniority, breaches so egregiously his duty of care to his patient, it inevitably had a deeply corrosive effect on the relationship of trust and confidence that subsists between the medical profession and the public.

(b) The Patient's conduct of his defence to the Charge displayed a lack of probity. In particular, his actions in procuring the Nurse Manager Ms D2 to endorse the OT Record (some 14 months after the Procedure) when she was not even in the OT that day – for which she now concedes that the endorsement was incorrect, cannot be ignored.

(c) The penalty has to reflect the serious nature of the misconduct and to send a signal to the public that the medical profession will not allow such misconduct to go unpunished, no matter how experienced the medical professional is, and at the same time reinforce the standards that are required of all medical professionals in such situations.

Mitigating Factors

(d) We have noted the Respondent's service to the community as well as the letters of support from his patients and fellow medical professionals.

86. We are of the view that a penalty of a censure or a financial penalty alone is insufficient.

87. This Committee accordingly orders and imposes the following penalties under section 45(2) of the Medical Registration Act (Cap 174, 2004 Ed):-

(a) That the Respondent be suspended from practice for a period of **9 months** pursuant to section 45(2)(b) of the Act;

(b) That the Respondent be ordered to pay a financial penalty of **S$10,000**, the maximum permissible under section 45(2)(d) of the Act;

(c) That the Respondent be required to provide a written undertaking that he will abstain from repeating such similar conduct in the future;

(d) That the Respondent pay to the Singapore Medical Council the costs and expenses of and incidental to these disciplinary proceedings, such costs to include the fees, disbursements and other expenses of counsel for the Singapore Medical Council and the fees disbursements and other expenses of the legal assessor appointed to this Committee, pursuant to section 45(4) read with section 45(7) of the Act.

Further Applications and Orders by this DC

88. After delivering its decision on 25 October 2013, the parties made the following applications:-

(a) The Prosecution applied for an order certifying that the costs of 2 solicitors be paid, pursuant to Section 45(6) of the MRA; and

(b) The Respondent applied for the commencement of his suspension to be deferred to 15 January 2014.

89. This Committee directed the parties to file written submissions. In relation to the application for a deferment, this Committee also directed parties to address the issue of whether this Committee had the jurisdiction to grant a deferment in light of Sections 46(9) and 46(10) of the MRA.

90. This Committee has considered the written submissions of the parties and sets out its decision:-

Certification of Costs of 2 Solicitors

91. This Committee notes the submissions made on the amendments to the Rules of Court and the fact that Section 45(6) of the MRA has not been amended. Be that as it may, this Committee is bound by the powers and duties imposed on it by the MRA and cannot comment on whether Section 45(6) should have been amended or whether there were specific reasons why it was not amended.

92. This Committee can only certify that the costs of more than one solicitor be paid if it is satisfied that the issues involved in the proceedings "are of sufficient complexity".

93. This Committee finds that the issues were not of sufficient complexity that the costs of more than 1 solicitor be paid. Accordingly, this Committee disallows the Prosecution's application.

Request for Deferment

94. This Committee notes that the 9-month suspension under Section 46(9) of the MRA would take effect on or about 25 November 2013.

95. The Respondent has justified his application on the fact that he is a sole practitioner and that he would need time (considering that it is near to the festive year end period) to find alternative obstetricians and gynaecologists to manage his existing patients. This Committee is mindful of the fact that the health and safety of patients are paramount and should not in any way be affected or compromised as a result of the findings of the inquiry. As both the Prosecution and Respondent have submitted that we have the jurisdiction under the MRA to grant a deferment and in light of the Prosecution not objecting to the Respondent's request, this Committee hereby grants the deferment.

96. Accordingly, the 9-month suspension is to take effect from 15 January 2014.

Publication of Decision

97. We hereby order that the Grounds of Decision be published.

98. The hearing is hereby concluded.

Dated this 25th day of October 2013.