SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRIES FOR DR KWAN KAH YEE ON 31 OCTOBER 2014

Disciplinary Tribunal:
Dr Yap Lip Kee - Chairman
Dr Vaswani Chelaram Moti Hassaram
Mr Tan Boon Heng - Legal Service Officer

Counsel for the SMC:
Mr Philip Fong
Mr Lionel Chan
(M/s Harry Elias Partnership LLP)

Respondent:
Dr Kwan Kah Yee (acting in person)

DECISION OF THE DISCIPLINARY TRIBUNAL

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

A. INTRODUCTION

1. This inquiry relates to a physician's professional misconduct for erroneously certifying the cause of death in respect of two deceased persons when that physician had insufficient factual basis to come to any of the conclusions that he had reached.

2. More importantly, this inquiry is unusual in that the subject matter of the present two consolidated charges have dates of the alleged offending acts ***predating*** (i.e. 29 March 2010 and 29 March 2011) the Respondent's earlier conviction and sentence on or after July 2011 on a similar charge. Unlike police investigation and State prosecution, disciplinary proceedings are sometimes dependent on the date in which complaints have been lodged with the relevant authority concerning the alleged offending acts which may even have predated a Respondent's earlier conviction on a similar charge. Such is the case before us.

B. EVENTS LEADING TO THE INQUIRY

3. The Respondent, Dr Kwan Kah Yee ("Dr Kwan") is a registered medical practitioner who was practising at Superbcity Hospice, 111 North Bridge Road, #07-27, Singapore 179098, at the material time. There are two Inquiries which have been consolidated into a single inquiry pursuant to Section 36 of the Medical Registration

Regulations 2010 (“MRR”) as the disciplinary offences form or are a part of a series of disciplinary offences of the same or a similar character. Dr Kwan has no objections to these Inquiries being consolidated.

C. THE AMENDED FIRST CHARGE

4. The First Inquiry arose from a complaint by the Regulatory Compliance Division of the Ministry of Health (“MOH”) dated 18 November 2010 against Dr Kwan (“the MOH Complaint”). According to the MOH Complaint, the MOH had received feedback regarding the medical management of the late Mr Patient A (“Patient A”), who suffered from Autism Spectrum Disorder, and who was admitted at the Institute of Mental Health (“IMH”) from 6 to 27 March 2010 for aggressive behaviour. Patient A subsequently passed away at his home on 29 March 2010.

5. Dr Kwan had certified in the Certificate of Registration of Death that bronchiectasis of approximately three days duration led to Patient A’s demise, with chronic obstructive airway disease as an antecedent cause. Dr Kwan referred to a chest x-ray of the deceased from SATA dated 13 December 2009 which purportedly showed radiological evidence of chronic obstructive airway disease. The MOH had carried out an investigation which revealed as follows:

   (a) according to SATA, there was no record belonging to Patient A in all databases of SATA despite a search by full name, partial name, or NRIC; and

   (b) expert opinion sought by the MOH further concluded that there was no evidence of chronic obstructive airway diseases and/or bronchiectasis.

6. In accordance with Section 39 of the Medical Registration Act (Cap 174) (“MRA”), the MOH referred the matter to the Singapore Medical Council (“SMC”) for further investigation. After due investigation, the SMC decided on 24 April 2012 to refer the MOH Complaint to be heard by a Disciplinary Tribunal. The Notice of Inquiry dated 2 June 2014 relating to the MOH Complaint was served together with an expert report from Dr PE dated 1 August 2013, Senior Consultant Forensic Pathologist.

7. The relevant charge (“the Amended First Charge”) against Dr Kwan reads as follows:-

THE AMENDED FIRST CHARGE

"*You [Dr Kwan] had on or about 29 March 2010, erroneously certified the cause of death in respect of the death of [Patient A] aged 26 years at [home address], in that:*

PARTICULARS

(i) You had certified that the cause of death of the Deceased was (a) Bronchiectasis and (b) Chronic Obstructive Airway Disease when you had insufficient factual basis to come to such a conclusion; and

(ii) You had ostensibly based your certification of the cause of death on an alleged chest x-ray ("the Alleged Chest X-ray") of [Patient A] from SATA Commhealth dated 13 December 2009 which allegedly showed radiological evidences of chronic obstructive airway disease, a document that you were not in possession of, or in fact, did not even exist.

And that in relation to the alleged facts you have been guilty of professional misconduct under Section 53(1)(d) of the MRA."

8. Investigations confirmed that SATA Commhealth had no record whatsoever of Patient A's patient notes. In other words, Patient A was never a patient of SATA CommHealth. Furthermore, SATA Commhealth also highlighted that 13 December 2009 was a Sunday and was outside SATA Medical Centre's operating hours. In Dr Kwan's letter to the SMC dated 4 October 2011, Dr Kwan also did not provide the source of information pertaining to the Alleged Chest X-ray even though he was specifically asked to do so in SMC's letter dated 21 September 2011.

9. In Dr PE's expert report, Dr PE opined that Dr Kwan had "*more than erroneously certified [Patient A's] cause of death*" and that "*[t]here was an attempt to deceive and undermine the whole process of death certification*" because:

(a) there was no record of Patient A's patients records and X-ray films from SATA, contrary to what was alleged by Dr Kwan; and

(b) under the circumstances, Patient A's death should have been reported to the State Coroner and an autopsy conducted to determine the exact cause of death.

10. In the circumstances, Dr Kwan admits that he had erroneously certified the cause of death in respect of the death of Patient A aged 26 at his home address on or about 29 March 2010 in that:

(a) he had certified that the cause of death of the Deceased was (a) Bronchiectasis and (b) Chronic Obstructive Airway Disease when he had insufficient factual basis to come to such a conclusion; and

(b) he had ostensibly based his certification of the cause of death on the Alleged Chest X-ray from SATA Commhealth dated 13 December 2009 which allegedly showed radiological evidences of chronic obstructive airway disease, a document that he was not in possession of, or in fact, did not even exist.

D. THE AMENDED SECOND CHARGE

11. The Second Inquiry arises from a complaint by Ms C ("the complainant") dated 4 July 2011 against Dr Kwan with regard to his certifying the cause of death of her sister, one Ms Patient B ("Patient B") on or about 29 March 2011 (the "Sister's Complaint"). In her complaint, Ms C questioned how Dr Kwan was able to conclude that Patient B's cause of death was Ischaemic Heart Disease. According to Ms C, Dr Kwan had informed Ms C during a telephone conversation that he had based his conclusion ostensibly on an alleged complaint of chest pain made by Patient B to a general practitioner or a doctor at a nearby polyclinic. At the time of death, Patient B was aged 32.

12. In accordance with Section 39 of the MRA, the matter was referred to the SMC for further investigation. After due investigation, the SMC decided on 25 September 2012 to order that a formal inquiry for Dr Kwan be heard by a Disciplinary Tribunal in relation to the Sister's Complaint. A Notice of Inquiry in respect of the Sister's Complaint was served on Dr Kwan on 2 June 2014 together with an expert report from Dr PE dated 1 August 2013. The relevant charge ("the Amended Second Charge") against Dr Kwan reads as follows:

THE AMENDED SECOND CHARGE

"*You [Dr Kwan] had on or about 29 March 2011, erroneously certified the cause of death in respect of the death of [Patient B] aged 32 years at the home of [Patient B], in that:*

PARTICULARS

(i) You had certified that the cause of death of the [Patient B] was Ischaemic Heart Disease when you had insufficient factual basis to come to such a conclusion;

(ii) You had ostensibly based your certification of the cause of death on the following matters, none of which you had sufficient factual evidence of at the time upon which to arrive at such conclusion:

(a) A complaint of chest pain of seven days allegedly made by [Patient B] sometime in May 2007 which was subsequently medically examined and confirmed to be consistent with Angina Pectoris; and

(b) Medical information allegedly from various polyclinics, General Practitioners and/or medical specialists (inclusive of ECGs or laboratory results) of which [Patient B] was a patient that suggested that the patient was being treated for Ischaemic Heart Disease.

And that in relation to the alleged facts you have been guilty of professional misconduct under Section 53(1)(d) of the MRA."

13. In Dr Kwan's exculpatory statement to the SMC dated 11 December 2011, Dr Kwan stated, among others, that:

(a) based on medical information from various polyclinics and General Practitioners beside Dr Kwan himself, Patient B was treated by doctors for Ischaemic Heart Disease for many years;

(b) the approximate interval between onset and death of 3 years and 10 months was based on clinical history, physical examination and investigations including the result of abnormal ECGs and abnormal blood tests on several occasions;

(c) the earliest time when symptoms of Ischaemic Heart Disease occurred was traced back to May 2007 when Patient B complained of chest pain of seven days consistent with Angina Pectoris;

(d) subsequently medical examination and investigation confirmed the diagnosis;

(e) Dr Kwan had conducted examination and certification of the patient on 29 March 2011 and his examination findings were consistent with the diagnosis;

(f) Dr Kwan did not consider this case as a case that needed to be reported to the Coroner because the death was from a known cause i.e. from a disease treated by various doctors including doctors in Polyclinics, various General Practitioners and Medical Specialists. Patient B's medical report also showed that she was admitted to KK Women's and Children's Hospital. Therefore it is not a sudden and unexpected death under suspicious circumstances;

14. Contrary to Dr Kwan's assertions that he had relied on medical information allegedly from various polyclinics to arrive at his conclusion on Patient B's cause of death, investigations revealed that there were in fact no medical records of Patient B's at both the National Healthcare Group Polyclinics and the SingHealth Polyclinics. Investigations also revealed that although Patient B had been a patient of KK Women's and Children's Hospital (as well as Changi General Hospital), there were no medical records indicating that Patient B was suffering from Ischaemic Heart Disease.

15. In a letter from SMC to Dr Kwan dated 27 March 2012, the SMC requested for Dr Kwan to provide copies of all medical reports of Patient B that he may possess, including (but not limited to) the reports from various polyclinics, general practitioners or KK Women's and Children's Hospital. In Dr Kwan's response letter dated 30 March 2012 to the SMC, Dr Kwan replied stating that he did not possess any medical reports of Patient B from polyclinics, General Practitioners or KK Women's and Children's Hospital.

16. In his expert report, Dr PE opined that Dr Kwan had more than erroneously certified Patient B's cause of death. Dr PE opined that there was an attempt to deceive and undermine the whole process of death certification because:

(a) Dr Kwan did not give any documentary evidence that Patient B was a patient of Polyclinics, various GPs and Medical Specialists. As for KK Women's and Children's Hospital, there was a series of admissions for delivery (1998), treatment of pelvic abscess and three (3) subsequent pregnancies (2003, 2004, 2005). However there was no evidence that Patient B suffered from Ischaemic Heart Disease; and

(b) under the circumstances, Patient B's death should have been reported to the State Coroner and an autopsy conducted to determine the exact cause of death.

17. In the circumstances, Dr Kwan admits that he had on or about 29 March 2011, erroneously certified the cause of death in respect of the death of Patient B aged 32 years at her home in that:

(a) he had certified that the cause of death of Patient B was Ischaemic Heart Disease when he had insufficient factual basis to come to such a conclusion; and

(b) he had ostensibly based his certification of the cause of death on:

i. a complaint of chest pain of seven days allegedly made by Patient B sometime in May 2007 which was subsequently medically examined and confirmed to be consistent with Angina Pectoris; and

ii. medical information allegedly from various polyclinics, General Practitioners and/or medical specialists (inclusive of ECGs or laboratory results) of which Patient B was a patient that suggested that the patient was being treated for Ischaemic Heart Disease,

when, in fact, he did not have sufficient factual evidence of the above at the relevant time to arrive at such conclusion.

18. For completeness, it should be set out for the record that in July 2011, the Respondent was found guilty for a charge of wrongful certification of the Certified Cause of Death in that: (a) the Congestive Cardiac Failure was not a cause of the death; and/or (b) there was no factual basis for the Respondent making an entry of 6

days in relation to the onset of ischaemic heart disease. The Respondent was therefore found guilty and convicted of professional misconduct after a full inquiry on 5 to 6 April and 1 and 12 July 2011. The Respondent was sentenced to 3 months' suspension and a penalty of $5,000 among others.

E. AT THE DISCIPLINARY TRIBUNAL (DT) INQUIRY

19. At the DT inquiry, the Respondent elected to plead guilty to the both charges as listed above i.e. professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) (Rev. Ed. 2004).

20. The Respondent admitted to the Agreed Statement of Facts submitted by the Counsel for the SMC, Mr Philip Fong ('Mr Fong'). Accordingly, the DT found the Respondent guilty of both charges and convicted him on both charges.

F. SMC'S SUBMISSION ON SENTENCE

21. SMC's Counsel, Mr Fong, urged the DT to impose a deterrent sentence of at least 12 months' suspension on each charge and to run consecutive i.e. a total of 24 months' suspension. Mr Fong said that this was necessary to issue a strong signal to the medical fraternity that such offences cannot be tolerated. Mr Fong gave the following reasons, among others:

    (a) though the Respondent had received a notice of complaint from SMC on 2 February 2010 against him regarding the erroneous certification of the Cause of Death of a patient who died on 16 October 2009, the Respondent *continued* with such wrongful acts on at least 29 March 2010 and 29 March 2011;

    (b) there are very severe consequences for a wrongful certification of death;

    (c) the Respondent purportedly relied on medical documents which have eventually been shown to have never existed; and

    (d) these were essentially offences of dishonesty and falsification of documents.

G. IN MITIGATION

22. In a combination of written and oral mitigation, the Respondent explained that when he first received the notice of a complaint against him sent to him by SMC on 2 February 2010 ('subject matter of the Disciplinary Committee Hearing in July 2011'), he did not think that he was in breach. Hence, he claimed trial to contest the charge in 2011. The Respondent reasoned that it should not be such a major aggravating factor that he elected to continue the offending acts since he did not know or think that he was in breach. Subsequent to his conviction in July 2011, the Respondent was prepared to accept that he was in breach and he has therefore not breached his undertaking not to re-offend.

23. As a result of the suspension imposed on him in 2011, the Respondent said that he lost his job and could only serve as a locum earning about $500 per month. As at the date of this present inquiry, he was still an undischarged bankrupt.

24. The Respondent has also urged the DT to give due regard to his contributions to the hospice care for the last 21 years since 1993 considering that much of the work rendered was voluntary and performed *gratis*.

H. THE DT'S OPINION

25. We had carefully considered the nature and circumstances of the charges, the aggravating factors and the mitigation tendered. In determining the appropriate penalties, we wish to make following observations:

(a) as conceded by SMC's Counsel, the Respondent is strictly speaking not a repeat offender as the subject matter of the present two charges were committed way before he was sentenced in July 2011 i.e. 29 March 2010 and 29 March 2011;

(b) be that as it may, it is also necessary for us to point out that the Respondent chose to continue with his wrongful actions though he had received notice from the SMC on 2 February 2010 that he was facing a complaint for the erroneous certification of death. While it is clear to us that the Respondent had decided to claim trial to contest the original charge, he took the risk by continuing to repeat the wrongful acts on 29 March 2010 and 29 March 2011 (forming the subject matter of the present set of charges) knowing well that

there may be consequences if he would be found guilty. As these offending acts involved dishonesty and falsification of documents, a suspension is fully warranted;

(c) while the SMC Counsel, Mr Fong, had urged the Tribunal to impose a 12-month suspension on each charge with a consecutive total of 24 months' suspension, it is pertinent to point out that the Respondent claimed trial to the original charge in 2011 and the Disciplinary Committee in July 2011 imposed a 3-month suspension and $5,000 penalty instead for a similar charge as the present charges. In this instance, since he has elected to plead guilty to both charges, we do not see how the sentence should be stiffer than 3 months' suspension with a penalty of $5,000. Considering that the Respondent chose to disregard the possible consequences of the notice of complaint that he received on 2 Feb 2010 from SMC, by continuing to repeat the wrongful acts, we are of the view that a 3- month suspension is nonetheless warranted though he had pleaded guilty to the present charges. Further, taking into consideration that the Respondent has elected to plead guilty to both charges at the earliest instance, we are of the opinion that the monetary penalty is not necessary;

(d) we also note that the subject matter of the Amended First Charge could have been consolidated with the Disciplinary Committee hearing in 2011 if proper steps had been taken. Counsel for the SMC, Mr Fong, briefly explained that the transitional provisions of the new Medical Registration Act had posed difficulties to consolidate the subject matter of the Disciplinary Committee Inquiry in 2011 and the First Amended Charge. From the Respondent's perspective, it is simply unsatisfactory to stand 'trial' twice over especially for similar charges. If SMC had so wished to consolidate, which they ought to have done so, necessary steps could have been effected by the SMC, inconvenient as they may have been. The process must not be unfair to the Respondent. As for the subject matter of the Amended Second Charge, since the SMC only had notice of the complaint towards the end of the DC Inquiry in July 2011, we accept that a consolidation would not have been possible. For these reasons, we are of the view that both the suspension sentences should run concurrently instead of consecutively in all fairness to the Respondent;

(e) since the decision of the Disciplinary Committee in July 2011, we note that the Respondent has to-date complied with the written undertaking to the SMC dated August 2011 that he will not engage in the conduct complained of or any similar conduct. We must give him credit for this; and

(f) in relation to costs, as we were strongly of the view that the Amended First Charge should have been dealt with together with the subject matter disposed by the DC Inquiry in 2011, we were not minded to order the Respondent to pay any costs of the SMC in relation to the Amended First Charge. As it would have been inevitable for the SMC to separately proceed against the Respondent on the Amended Second Charge, a costs order against the Respondent for work done by the SMC Counsel would, however, be justifiable.

I. THE DT'S DECISION

26. In arriving at the appropriate sentence, the Tribunal had regard to all the relevant circumstances of the case. Among others, we had also given full credit to the Respondent for his co-operation with the authorities and his early plea of guilt for these two charges.

27. Bearing in mind the above, in relation to ***both*** charges, this Tribunal determines that the Respondent:

(a) be suspended from practice for a period of **3 months** on each charge *(to run concurrently);*

(b) be censured;

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

(d) to pay only ***half*** the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

J. PUBLICATION OF DECISION

28. We order that the Grounds of Decision be published with the necessary redaction of identities and personal particulars of persons involved.

29. The hearing is hereby concluded.

Dated this 31st day of October 2014.