SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR TEH TZE CHEN KEVIN FROM 18 TO 22 MAY 2015 AND ON 20 NOVEMBER 2015

Disciplinary Tribunal:
Dr Yap Lip Kee - Chairman
Prof Sonny Wang Yee Tang
Mr James Leong - Legal Service Officer

Counsel for SMC:
Ms Chang Man Phing
Ms Jocelyn Ngiam
(M/s WongPartnership LLP)

Counsel for the Respondent:
Mr Christopher Chong
Mr Melvin See
Ms Maggi Goh
(M/s Rodyk & Davidson LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL

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

Introduction

1. These proceedings emanate from a complaint made against Dr Teh Tze Chen Kevin ("the Respondent") for professional misconduct. The Respondent was referred to this Disciplinary Tribunal ("the Tribunal") by the Complaints Committee of the Singapore Medical Council ("SMC") and the Notice of Inquiry ("NOI") dated 11 December 2014 was duly served on him to attend a Pre-Inquiry Conference ("PIC") on 28 January 2015. The Respondent informed the Tribunal through his Counsel from the outset that he was contesting the charges in the NOI and dates were duly fixed for the hearing. The three charges against the Respondent read as follows:

CHARGES

> *1. That you, DR TEH TZE CHEN KEVIN, a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising in Singapore Lipo, Body & Face Centre ("the Clinic"), between 14 October 2010 to 21 October 2010, you were in willful neglect of your duties to your patient, one Ms P ("the Patient"), in that you had failed to refer her to a specialist for*

proper evaluation and treatment of her condition, in a timeous manner, despite the seriousness of her condition.

Particulars

(a) *On 14 October 2010, the Patient underwent a Vaser liposelection procedure of both thighs ("the Procedure") performed by you.*

(b) *On 15 October 2010, whilst reviewing the Patient, you observed fluid-filled blisters and some swelling and bruising over the posterior aspect of both thighs, and managed her condition conservatively. You assured the Patient that the blisters would heal with proper care and dressing.*

(c) *Between 16 October 2010 to 20 October 2010, you reviewed the Patient daily. The Patient continued to have fluid-filled blisters over the posterior aspect of both thighs, which you pricked and drained. The swelling and bruising in her thighs did not subside. You changed her dressings daily and continued to manage her condition conservatively.*

(d) *On 16 and 17 October 2010, you informed the Patient that the blisters were burns which could have been caused by, amongst others, the chemical solutions used or the bed warmer, and they were superficial and would heal with proper care and dressing.*

(e) *On 21 October 2010 at about 2000 hours, the Patient had a temperature of 39.1 degree Celsius and the surrounding skin on her posterior thighs had areas of purple blotchiness.*

(f) *The Patient was immediately admitted to the Singapore General Hospital Burns Centre, where she was diagnosed to have full thickness burns on both posterior thighs.*

(g) *In light of the seriousness of the Patient's condition, you should have referred her to a specialist for proper evaluation and treatment of her condition once you observed the fluid-filled blisters on 15 October 2010, or at any time between 16 to 20 October 2010, when her condition did not improve.*

and that in relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.).

2. *That you, DR TEH TZE CHEN KEVIN, a registered medical practitioner under the Medical Registration Act (Cap 174), are charged that whilst practising in Singapore Lipo, Body & Face Centre ("the Clinic"), on 14 October 2010, you had failed to ensure that the sedation was safely and appropriately carried out on your patient, one Ms P ("the Patient"), who was undergoing a Vaser*

liposelection procedure of both thighs ("the Procedure") performed by you.

Particulars

(a) On 14 October 2010, the Patient underwent the Procedure from around 1019 hours to around 1318 hours.
(b) The Patient was to undergo the Procedure under Tumescent local anaesthesia and twilight sedation.
(c) You had administered propofol at a higher than recommended infusion rate to the Patient during the Procedure.
(d) You had also administered fentanyl and dormicum which would have an additive effect to the propofol.
(e) The propofol in combination with fentanyl and dormicum, would have rendered the Patient to be at least moderately sedated.
(f) You had failed to give supplemental oxygen to the Patient to reduce the risk of hypoxemia developing during sedation.
(g) You did not have the necessary training in anesthesia or intensive care to rescue the Patient from her state of sedation.
(h) You had failed to ensure that the Patient was adequately monitored after the Procedure ended at about 1318 hours.

and that in relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.).

3. That you, DR TEH TZE CHEN KEVIN, a registered medical practitioner under the Medical Registration Act (Cap. 174) are charged that whilst practising in Singapore Lipo, Body & Face Centre ("the Clinic"), on 14 October 2010, you had failed to ensure proper and adequate documentation of the sedation given to your patient, one Ms P ("the Patient") who was undergoing a Vaser liposelection procedure of both thighs ("the Procedure") performed by you.

Particulars

(a) You had failed to ensure that the dosage of dormicum given to the Patient during the Procedure was recorded.
(b) You had failed to ensure that the Patient's parameters such as blood pressure, pulse rate and pulse oximetry for oxygen saturation were recorded at frequent intervals of less than 15 minutes.
(c) You had failed to ensure that the conscious level of the Patient intraoperatively was recorded.

and that in relation the facts alleged, you have been guilty of professionally misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) (2004 Ed.).

2. The hearing was conducted over 5 days from 18 to 22 May 2015. Evidence was adduced from the following witnesses:

Prosecution's Witnesses
(a) The Patient
(b) Mr PW1 (the Patient's boyfriend)
(c) Ms PW2 (the Patient's sister)
(d) Dr PW3
(e) A/Prof PE1 – Expert
(f) A/Prof PE2 – Expert
(g) Dr PE3 – Expert

Respondent's Witnesses
(a) The Respondent
(b) Ms DW1 (the Respondent's nurse)
(c) Ms DW2 (the Respondent's nurse)
(d) Dr DE1 – Expert
(e) Dr DE2 – Expert

3. At the conclusion of the hearing, a time table was set for the exchange of written submissions and the parties duly filed the following:

(a) Respondent's Closing Submissions dated 12 June 2015;
(b) Prosecution's Closing Submissions dated 3 July 2015;
(c) Respondent's Rebuttal Submissions dated 15 July 2015; and
(d) Prosecution's Reply Submissions dated 23 July 2015.

Undisputed Facts

4. The following which was gleaned from the Agreed Statement of Facts were generally not in dispute. At all material times, the Respondent was not an anaesthesiologist or intensivist. The Patient first consulted the Respondent on 11 September 2010, and subsequently underwent a Vaser Liposelection treatment performed by the Respondent on 14 October 2010. The Procedure took place on 14 October 2010 from 1019 hours to around 1318 hours.

5. Prior to the Procedure, the Patient was asked to sign a consent form, which stated *inter alia*, that "*tumescent local anaesthesia and twilight sedation will be used. There will be a numbing solution introduced to the subcutaneous issues*

to reduce pain and bleeding, and intravenous medication to make the patient sleepy. No intubation is required and the patient will be able to breathe comfortably on his/her own." Both the Procedure and the administration of the sedation were carried out by the Respondent. The Respondent carried out the Procedure on the bilateral anterior, posterior, medial and lateral thighs and medial knees of the Patient.

6. According to the Patient's Anaesthesia Record, the following drugs were administered to the Patient intravenously during the Procedure:

	INDUCTION			INTRA-OPERATIVE		
S/No.	Drug	Dose	Time	Drug	Dose	Time
1	Fentanyl	1 ml	1010	Propofol	1 ml	1015
2	Dormicum	1 ml	1010	Propofol	↑ @ 25 ml/hr	1019
3	Propofol	20 ml/hr	1010	Fentanyl	0.25 ml	1025
				Dormicum	0.5 ml	1028
				Propofol	1 ml	1040
				Propofol	↑ 30 ml/hr	1040
				Propofol	1 ml	1153
				Fentanyl	0.5 ml	1200
				Propofol	1 ml	1203
				Propofol	1 ml	1226
				Dormicum	0.5 ml	1226

7. After the Procedure, the Patient was transferred to the recovery room. When she woke up, she was lying on a bed warmer. The Patient informed the nurse that she felt discomfort. The nature and extent of the discomfort were however not agreed upon. The Respondent attended to the Patient and reassured her that it was normal to feel some discomfort after the Procedure. Both the Patient's thighs were bandaged with crepe bandage with underlying gamgee and gauze dressing on the outer thighs.

8. The Patient was discharged later that day (14 October 2010) and left the Clinic in the evening that day. She was told to return the next day (15 October 2010) for a follow-up appointment.

9. After the Patient returned home, the pain did not subside. As such, the Patient called the Clinic at about 1900 hours to ask if the Respondent could check on the Patient's condition at her home.

10. When the Respondent attended to the Patient at the Patient's home at about 2045 hours, the Respondent examined the Patient and gave her an injection of 30 mg of IM Pethidine to relieve the pain.

11. On the morning of 15 October 2010, the Patient returned to the Clinic for her follow-up appointment with the Respondent. During the consultation, the

Respondent noted that the Patient had fluid-filled blisters on the back of both thighs that were not present the day before and there was some swelling and bruising on the Patient's thighs. There was moderate redness and tenderness around the blisters. The Patient's wounds were treated with chlorhexidine wash, bactroban antibiotic cream, bactigras dressings, gamgee and gauze. The Respondent asked the Patient to return to the Clinic daily for review of her blisters and liposelection results. She was instructed to continue with the medication she was given, which included an antibiotic.

12. On the morning of 16 October 2010, the Patient returned to the Clinic. The Patient's temperature was taken and she was afebrile. The Patient reported pain in the thighs. The Respondent observed that the Patient's condition remained largely the same with fluid-filled blisters. The Patient's wounds were cleansed with saline and chlorhexidine wash and dressed with bactigras. Loose crepe bandages were also applied. The Respondent asked the Patient to return to the Clinic daily for checks and change of dressing.

13. On the morning of 17 October 2010, the Patient returned to the Clinic. The Patient's temperature was taken and she was afebrile. The Patient's condition was reviewed. The Patient's wounds were cleansed with saline and chlorhexidine wash, dressed with bactigras, gauze and gamgee. During the consultation, the Respondent informed the Patient that the blisters were superficial burns and surmised that it could be related to the bed warmer. The Respondent instructed the Patient to wear the compression garment and advised her on the correct technique and application. The Patient put on the compression garment and left the Clinic. Later in the evening, the Patient informed the Respondent that her feet were swollen and numb after wearing the compression garment. The Respondent advised her to remove the compression garment for the time being.

14. On the night of 18 October 2010, the Respondent and his nurses went to the Patient's home. The Patient's condition was reviewed and her wounds were cleansed and dressed.

15. On the night of 19 October 2010, a house visit was conducted. The Patient's temperature was taken and she was afebrile. The Patient's condition was reviewed and her wounds were cleaned and dressed.

16. On the night of 20 October 2010, the Respondent and his nurses went to the Patient's house. The Patient's temperature was taken and she was afebrile. The Patient's condition was reviewed and her wounds were cleaned and dressed.

17. On the night of 21 October 2010, the Respondent and his nurses went to the Patient's house. The Patient reported feeling chills that evening. Upon taking the Patient's temperature at about 2000 hours, it was noted that the Patient

developed a fever of 39.1°C. The Respondent also observed, among other things, swelling and bruising on the bilateral thighs with more erythema and areas of purple blotchiness extending 1 – 2 cm from the blister edges.

18. The Patient arrived at the Accident & Emergency ("A&E") Department of the Singapore General Hospital ("SGH") at about 2200 hours accompanied by the Respondent, his nurses and the Patient's family. At about midnight, the Patient was seen by the on-call Registrar for the Department of the Plastic, Reconstructive & Aesthetic Surgery, Dr A. Upon a review of the Patient's condition, Dr A admitted the Patient to the Burns Unit and scheduled the Patient to undergo skin graft surgery the next morning. The Patient was admitted in SGH from 22 October 2010 to 8 November 2010.

First Charge

19. Insofar as the 1st charge was concerned, relying on the expert opinions of A/Prof PE1 and A/Prof PE2, it was the Prosecution's case as set out at [33] of their Opening Statement that the "*Respondent ought to have referred the Patient to a specialist for proper evaluation and treatment of her burns as early as the 1st post-operative day, 15 October 2010, once he observed the fluid-filled blisters covering a large portion of her posterior thighs, as her condition was clearly serious. Indeed, over the next few days, when her condition did not improve, he had ample opportunity to refer her to a specialist to treat her burns, and should have done so. Instead, he waited until she developed a high fever and chills, clear signs of infection, on the night of 21 October 2010, the 7th post-operative day, before he agreed that the Patient should be sent to hospital.*" It was the Prosecution's submission that this failure to refer amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner within the second limb of the test laid down in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR (R) 612.

20. The Respondent's defence in brief to this charge as set out in [7] of their Closing Submissions "*is that the Complainant (Patient) appeared to be stable and improving with conservative management and the Complainant was referred appropriately to the National Burns Centre on 21 October 2010 when there were signs of infection and deterioration.*" The Respondent further submitted at [78] of their Closing Submissions that "*it is not necessary for the Tribunal to come to any definitive view of the cause of the burns, given that there is no charge against the Respondent for causing the burns. In any event, the evidence of the experts is not easily reconciled.*" and at [80] that "*Instead, the Tribunal should consider whether in deciding to manage the Complainant himself, the Respondent should have referred the Complainant to a specialist.*"

21. In analysing the evidence and deciding the charge, the Tribunal agreed with the Respondent that it was not necessary for us to come to any definitive view as to the cause of the burns. We also agreed that the issue for determination was whether the Respondent should have referred the Patient to a specialist earlier. In this regard, we found ourselves in broad agreement with the Prosecution's Closing Submissions that there was no evidence in support of the Respondent's contention that the Patient was stable and improving. We also agreed that in consequence of the Respondent's failure, for whatever reason, to consider the Vaser as a differential diagnosis, he embarked on a course of management that was inappropriate and resulted in the Patient failing to receive timeous specialist treatment.

22. Insofar as the timing of the referral was concerned, we were satisfied that based on the clear medical evidence of the experts for both sides, a referral should have been made much earlier in this case, rather than only after high fever and infection had set in on the 7th post-operative day. In this regard, we noted that notwithstanding the fact that they were both plastic surgeons, A/Prof PE1 and A/Prof PE2 would both have referred the patient to a specialist Burns Centre by the 2nd post-operative day. Even the expert for the Respondent, Dr DE1 agreed that burns can evolve over time and there was a need for close observation even for specialists like himself.

23. We also agreed with the submissions of the Prosecution that even if the Respondent did not refer the Patient on the 1st or 2nd post-operative date, there was unanimous expert medical opinion that a referral ought to have been made soon after in light of the clear progression of the burns and no improvement in the Patient's condition. As noted by the Prosecution in their Closing Submissions, there was no real basis beyond the Respondent's clinical impression that the Patient was indeed stable and improving. Any improvement was also not documented in the case notes and contradicted by the evidence of Ms DW1 (the Respondent's Nurse) that the wounds were not improving.

24. Having regard to all of the above, we were satisfied that the Prosecution had proven the first charge against the Respondent within the second limb of the test in *Low Cze Hong v Singapore Medical Council* at [19] above.

<u>Second Charge</u>

25. Relying on the expert opinion of Dr PE3, the Prosecution's case in respect of the second charge was as set out in [42] of their Opening Statement. In essence, it was alleged that the Respondent had failed to ensure that the sedation was safely and appropriately carried out on the Patient in the following four aspects:

(a) The Respondent had given the Patient higher than recommended amounts of sedative drugs, namely, Propofol, in combination with Fentanyl (an opioid) and Dormicum (a benzodiazepine), which would have rendered the Patient to be at least moderately sedated. This was despite the fact that the Procedure was to be carried out under tumescent local anaesthesia and twilight sedation.

(b) The Respondent had failed to give supplemental oxygen to the Patient to reduce the risk of hypoxemia developing during sedation.

(c) The Respondent did not have the necessary training in anaesthesia or intensive care to rescue the Patient from her state of sedation.

(d) The Respondent had failed to ensure that the Patient was adequately monitored after the Procedure ended at about 1318 hours.

26. In brief, the Respondent's defense to this charge as set out at [9] of their Closing Submissions was that:

(a) The infusion rate of Propofol administered to the Patient during the procedure was appropriate;

(b) It was appropriate for the Patient to be moderately sedated for the procedure;

(c) It was appropriate not to give supplemental oxygen to the Patient during the sedation;

(d) The Respondent met the requirements at the relevant time in 2010 to administer the sedation he gave to the Patient and to rescue her from it; and

(e) The monitoring of the Patient after the procedure ended was adequate.

27. In analysing the evidence and deciding the charge, the Tribunal found itself in broad agreement with the submissions of the Prosecution that having decided to carry out both the Vaser and sedation himself in the context of a solo practice, it was imperative on the part of the Respondent to ensure safe and appropriate sedation. That said, we were conscious not to impose any additional burden or higher standard on the Respondent purely on this account. We were also conscious of the fact that the Procedure was undertaken in 2010 and we should not scrutinise it with the benefit of hindsight, which always seems clearer and almost perfect

28. It was not in dispute that the Respondent was not aware of the "Guidelines for Safe Sedation Practice for Investigation and Intervention Procedures" issued by the Academy of Medicine in December 2002 ("2002 Guidelines"). It was also clear that the amount of Propofol administered by the Respondent exceeded the manufacturer's recommended dosage. The Tribunal found these two aspects of the Respondent's behaviour particularly troubling since it would be incumbent on any doctor who intends to conduct his own sedation to ensure

that he is familiar with the prevailing guidelines as well as something as basic as a recommended dosage. The Respondent's attempts to explain them away by saying that the guidelines were not well known and the dosage he administered was normally used by other General Practitioners were totally unacceptable and demonstrated a cavalier attitude towards patient safety and his duty as a medical practitioner.

29. Contrary to the 2002 Guidelines and against the expert evidence of both Dr PE3 and Dr DE2, the Respondent did not give supplemental oxygen although it was available for use if needed as the Respondent felt it may not be safer to give supplemental oxygen. In our view, there was no basis for the Respondent to depart from established guidelines and recommended dosages on his own accord, especially since he was neither a trained anaesthetist nor intensivist. In our view, the manufacturer's guidelines as set out in the product insert that Propofol is to be administered only by anaesthetists or intensivists underlines the potency of this drug and the need for greater care, which the Respondent totally disregarded. We also agreed with the Prosecution that neither the "Advanced Cardiac Life Support Certification" nor his Navy and other experiences constituted sufficient necessary specialised training for the administration of sedation.

30. This disregard was reinforced by the failure of the Respondent to have in place a system to monitor the Patient after the Vaser ended. As noted by the Prosecution in their Closing Submissions, there was a dearth of medical records in this regard as to the actual monitoring undertaken by the nurses under the charge of the Respondent.

31. In summary, we were satisfied on the preponderance of the evidence before this Tribunal that the Respondent's failure to ensure that the sedation was safely and appropriately carried out amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner within the second limb of the test laid down in *Low Cze Hong v Singapore Medical Council* at [19] above. In coming to our conclusion on this, we noted the invitation of the Prosecution to find that the Respondent had deliberately downplayed the level of sedation and the severity of the burns in his explanation to the SMC to cover up and/or mitigate his wrongdoing. While the Respondent could certainly have been more forthcoming and precise in his explanation, we did not think that any adverse inference was warranted in this case since the explanation to SMC was essentially a form of written representation where a party would naturally be keen to put his best case forward.

Third Charge

32. The case for the Prosecution in respect of this charge as noted at [57] of their Opening Statement was that "*the Respondent failed to keep proper and adequate documentation of the sedation given to the Patient during the Procedure.*" The three main planks of the Prosecution's case for this charge related to the Respondent's alleged failures to firstly ensure that the dosage of Dormicum was recorded; secondly, to record the Patient's parameters such as blood pressure, pulse rate and pulse oximetry for oxygen at frequent levels of less than 15 minutes; and thirdly, for not recording the Patient's conscious level intra-operatively.

33. It was not in dispute that the Respondent only recorded the quantity of Dormicum and not the dosage. Ms DW1 (the Respondent's Nurse) testified that this was a mistake on her part. She also corroborated the Respondent's evidence that while Dormicum came in two concentrations, his clinic only had stock of the higher concentration. It was thus argued that since everyone in the clinic was aware of this, the dosage could be calculated. While we agreed with Dr DE2 that this was not ideal, we did not think it was sufficient to constitute professional misconduct, especially since even Dr PE3 had confirmed that the non-recording had nothing to do with patient safety.

34. As for the frequency of recording, it was not in dispute that the Respondent had done so at 15 minutes intervals rather than the 5 minutes intervals advocated by Dr PE3. Given that the specific interval was not mandated by the prevailing 2002 Guidelines and the testimony of Dr DE2 in relation to the prevailing practice in the private sector at that time for these to be charted at 10-15 minutes intervals, we were of the view that the Respondent's failure to observe this was not sufficient to constitute professional misconduct.

35. We also agreed with the Respondent's submissions that the 2002 Guidelines did not specifically mandate the documentation of conscious state and given the evidence that the Patient was connected to a monitoring machine that displayed her parameters visually and Ms DW1 (the Respondent's Nurse) was present throughout the Procedure to monitor her condition, we were not prepared to fault the Respondent on this score.

36. As the requirement for 5 minutes recording of parameters and the documentation of conscious state was only mandated on 19 May 2014 by the "Guidelines on Safe Sedation Practice for Non-Anaesthesiologists in Medical Clinics" ("2014 Guidelines"), we felt that the Respondent should be given the benefit of the doubt and not be held to a higher standard that only came into effect later. In light of the aforesaid, we found the Respondent not guilty in relation to the third charge.

<u>Verdict</u>

37. In view of the above, we convicted the Respondent on the first and second charges, and acquitted him on the third charge. Following the delivery of our decision in relation to the charges, we proceeded to deal with the issue of sentencing.

Sentencing

38. In submitting on sentence, the Prosecution tendered two sets of summaries and bundles of sentencing precedents, i.e. one for the first charge and one for the second charge, with some degree of overlap including the reference to a case involving the Respondent in serial number 1 of both sets of the documents. It was not in dispute and admitted by the Respondent that on 19 August 2014, he was found guilty of professional misconduct for offences under s 45(1)(d) of the MRA. After a hearing commencing in July 2013, he was convicted on 4 charges and acquitted on 2 for which he was sentenced to a fine of $10,000; censured, required to give an undertaking as well as ordered to pay 70% of the costs and expenses of and incidental to the proceedings, including the costs of counsel to the Council and the Legal Assessor.

39. It was not in dispute that the charges in the Respondent's earlier case and the instant case were quite different. More importantly, it was also not in dispute that the timing of the Respondent's earlier case and the present hearing ran somewhat in parallel. The earlier case concerned actions that occurred in March 2009 while the present case concerned actions in 2010, with the complaint to the SMC only being made in September 2012. In light of the peculiar circumstances in terms of the overlap in timing, we declined to accept the Prosecution's invitation to view the earlier conviction as an aggravating factor or relevant antecedent. As the Respondent might not have even been aware of the first case at the time of the actions that gave rise to the current case in 2010, and the conviction only occurred in 2014, we agreed with the Respondent's submissions that no reoffending could be inferred. As such, there was no need in our case to apply the tests in *Tan Kay Beng v Public Prosecutor* [2006] 4 SLR (R) 10 and *Public Prosecutor v NF [2006]* 4 SLR (R) 849 to ascertain if the Respondent's dissimilar antecedent was relevant for the purposes of sentencing.

40. Insofar as the appropriate sentence was concerned, the Prosecution submitted that a suspension of something more than the minimum 3 months was warranted. Counsel for the Respondent, on the other hand, submitted that a fine was more appropriate. In this regard, Counsel for the Respondent raised the point, without citing any specific authority, that the delay in the prosecution of the case was punishment in itself which warranted a lighter sentence. In response, the Prosecution explained that the complaint in this case was only made in September 2012 and the Notice of Inquiry was issued within 2 years. In the absence of direct authority on point and clear evidence of actual delay as

contended, the Tribunal saw no reason to award the Respondent any lighter sentence on this score.

41. In arriving at the appropriate sentence, the Tribunal gave full regard to the Respondent's voluntary service and the strong testimonials on his behalf from members of the medical profession, his staff and patients. We were conscious that he was a relatively young doctor in 2010 pursuing his interest in aesthetic medicine. We were also mindful of the fact that he has since changed his practice and would engage an anaesthetist to undertake the sedation for his aesthetic procedures.

42. Insofar as the cases cited by the Prosecution were concerned, it was axiomatic that each case must be considered on its own facts and circumstances. To this end, while the cases cited by the Prosecution could serve as trend indicators, especially the decisions involving Dr L E (where a 3 months suspension was imposed) and Dr K (where a fine of $10,000 was imposed), we had to determine what was appropriate in all the circumstances of the case. On this point, we were in broad agreement with Counsel for the Respondent that the other cases highlighted by the Prosecution were distinguishable on the facts. We also agreed that there did not seem to be any direct precedents in relation to the second charge.

43. On the other hand, given the gravity of the two offences, a fine as urged by Counsel for the Respondent would not sufficiently register the seriousness of the conduct or punish the Respondent, nor would it deter such lapses or preserve public confidence in the medical profession. A suspension of 4 months was thus the most appropriate sentence in the circumstances, balancing the objectives of sentencing to punish the Respondent, deter other members and protect public confidence in the medical profession. Considering that the safety of the Patient had been put at risk, particularly with regard to the second charge, we were of the view that anything less would not be adequate.

44. We further ordered that the Respondent be censured and that he provides the usual undertaking. We also ordered that he bears the full costs of the proceedings. On the question of costs, we were conscious that the Respondent had been acquitted on 1 of the 3 charges that he faced. Considering however the overlap in work and the common witnesses for the second and third charges, we exercised our discretion not to order any apportionment of costs.

<u>Orders by this Disciplinary Tribunal</u>

45. Accordingly, the Disciplinary Tribunal determines that the Respondent:-

    (a) be suspended for 4 months;

(b) be censured;

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

(d) pays the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Publication of Decision

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

47. The hearing is hereby concluded.

Dated this 20th day of November 2015.