SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR CHIA FOONG LIN FROM 28 TO 31 MARCH 2016 AND ON 30 JUNE 2016

Disciplinary Tribunal:
Dr Tham Tat Yean (Chairman)
Prof Lee Hin Peng
Mr Victor Yeo Khee Eng (Legal Service Officer)

Counsel for SMC:
Mr Philip Fong
Ms Shazana Anuar
Mr Yap Zong En Samuel
(M/s Harry Elias Partnership LLP)

Counsel for the Respondent:
Mr Charles Lin
Ms Tracia Lim
Mr Phang Cun Kuang
(M/s MyintSoe & Selveraj)

GROUNDS OF DECISION OF THE DISCIPLINARY TRIBUNAL

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

Introduction

1. Dr Chia Foong Lin ("the Respondent") is a registered medical practitioner. She is also registered in the Register of Specialists and practising as a paediatrician. She claimed trial to a single charge under section 53(1)(d) of the Medical Registration Act (Cap 174). The charge and the particulars are as follows:

*"**CHARGE***

*That you **Dr Chia Foong Lin** are charged that, whilst practising as a paediatrician on paediatric call at Gleneagles Hospital and having your registered place of practice at Chia Baby And Child Clinic, 431 Clementi Avenue 3, #01-308, Singapore 120431 ("the Clinic"), you failed to exercise due care in the management of your patient, namely one Mr P ("the Patient") during the period of the Patient's hospital admission from 25 February 2013 to 1 March 2013 ("the Period of Hospitalisation") and during a clinic review on 3 March 2013 in that:-*

Whereas you had attended to the Patient for the Period of Hospitalisation and during a clinic review on 3 March 2013, including when he presented with non-specific symptoms of fever of 3-day duration and was first admitted to the Accident & Emergency Department of Gleneagles Hospital

on 25 February 2013, and whereas Kawasaki's Disease is a common prolonged febrile illness seen in infants which may result in late occurrence of coronary artery dilatation in 15 to 30% of patients, you had acted in breach of sections 4.1.1.1 and 4.1.1.5 of the Singapore Medical Council Ethical Code and Ethical Guidelines in that you had:

PARTICULARS

i. Failed to include Kawasaki's Disease as the foremost differential diagnosis despite observing and noting in your clinical notes that the Patient had bilateral conjunctivitis (commonly known as red eye) on 25 February 2013 being Day 3 of the Patient's fever;

ii. Failed to include Kawasaki's Disease as a probable diagnosis despite observing and noting in your clinical notes that the Patient had a maculopapular rash over the body on 27 February 2013 being Day 5 of the Patient's fever;

iii. Failed to make a diagnosis of "Incomplete Kawasaki's Disease" for the Patient on 28 February 2013 being Day 6 of the Patient's fever;

iv. Failed to take active steps to discuss the treatment options for the Patient of standard therapy with Intravenous Immunoglobin and Aspirin with the Patient's parents such that they were able to make an informed treatment choice and consequently, failed to provide active treatment for Kawasaki's Disease on 1 March 2013 being Day 7 of the Patient's fever;

v. Discharged the Patient on 1 March 2013 being Day 7 of the Patient's fever with a diagnosis of Viral Fever and failed to consider Kawasaki's Disease as a possible diagnosis and consequently, failed to (a) address the possibility of Kawasaki's Disease with the Patient's parents, (b) advise the Patient's parents of the signs of Kawasaki's Disease to look out for upon discharge and (c) devise a follow up plan for the treatment of the Patient for Kawasaki's Disease; and

vi. Failed to seriously consider a diagnosis of Kawasaki's Disease and consequently, failed to provide appropriate treatment for the Patient on 3 March 2013 being Day 9 of the Patient's fever when the Patient attended at your Clinic for a review;

thereby resulting in a late diagnosis of Kawasaki's Disease by another paediatrician, one Dr PW1 on 4 March 2013 being Day 10 of the Patient's fever and exposing the Patient to probable serious consequences which may arise in the absence of appropriate and/or timely treatment including increasing the risk of coronary aneurysm and cardiac morbidity;

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, 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)."

Background and Salient Facts

2. The background and salient facts leading to the complaint by Mr P ("the Patient")'s mother, Mdm PW2, were largely not in dispute. At all material times, the Respondent was practising at a clinic known as "Chia Baby And Child Clinic" located at 431 Clementi Avenue 3, #01-308, Singapore 120431.

3. On the night of 25 February 2013, the Patient, who had just turned one year old, was admitted to the Accident & Emergency Department of Gleneagles Hospital. Prior to the admission, the patient's parents had earlier taken him to Hospital A. The Respondent was on paediatric call that night and attended to the Patient. The Patient had high fever for three days from 23 to 25 February 2013 with mild bilateral conjunctivitis, mild cough, a single episode of diarrhea, poor intake and vomiting. The Respondent's diagnosis was that of a viral infection and the Patient was given symptomatic supportive treatment including intravenous hydration.

4. On 27 February 2013 (Day 3 of admission), the Patient had a spike of fever overnight, with slight cough and vomiting. He was fretful on examination and his lips were red. The conjunctivitis had improved and features such as strawberry tongue, oedema or peripheries and lymphadenopathy were absent. The Respondent's diagnosis remained the same i.e. viral fever and the Respondent continued with monitoring. Later that night, a maculopapular rash was observed by the nurses and the Respondent ordered hydrocortisone cream for the Patient.

5. On 28 February 2013 (Day 4 of admission), there was a spike of fever in the early morning. In view of the rash appearing with red and cracked lips, the Respondent considered a differential diagnosis of Kawasaki Disease ("KD") and looked out for features of KD. There was no significant lymphadenopathy and oedema of the peripheries and the Respondent's diagnosis remained as viral infection as the Respondent noted that there were no full features of KD.

6. On 1 March 2013 (Day 5 of admission), the Respondent noted that the Patient's fever settled. The eyes were better and no rashes were seen. The lips were still slightly red and cracked. The diagnosis by the Respondent was again viral infection, with no evidence of KD. The Respondent discharged the Patient with an appointment two days later at her clinic.

7. On 3 March 2013, the Patient was reviewed as an outpatient at the Respondent's clinic. There was fever recorded during the two nights after the Patient's discharge from the hospital. According to the Respondent, the Patient's conjunctivitis and rashes had resolved and his lips had improved. The Respondent's diagnosis

remained that of viral fever as all the criteria for the diagnosis of KD were not present. The Patient was sent home with a review date scheduled on 5 March 2013.

8. On the morning of 4 March 2013, the Patient still had high fever. His parents decided to send him to Hospital B for a second opinion. Upon admission, Dr PW1, the Consultant Paediatrician, observed that clinically, the Patient was febrile and irritable. There was a maculopapular rash on his upper trunk, mild redness of his palms and soles. A short systolic cardiac murmur was heard. The cervical lymph nodes on the right were slightly prominent. A clinical diagnosis of KD was suspected and Dr PW1 initiated treatment of KD. A 2-D Echocardiogram was done, which showed bilateral coronary artery dilatation. Blood tests were done and a C-Reactive Protein ("CRP") test, an inflammatory marker, was also performed. The Patient's CRP reading was significantly raised at 151.6 mg/L (NR 0 – 10).

9. The Patient was admitted to Hospital B from 4 to 6 March 2013 and treated with intravenous immunoglobulin ("IVIG") and high dose aspirin for five days. The Patient responded well to the treatment and the fever settled.

10. The Patient's mother subsequently filed a complaint against the Respondent, upon which the SMC proceeded with this single charge.

Kawasaki Disease ("KD")

11. KD is an acute self-limited vasculitis of childhood that is characterised by fever, bilateral nonexudative conjunctivitis, erythema of the lips and oral mucosa, changes in the extremities, rash, and cervical lymphadenopathy. Coronary artery aneurysms or ectasia develop in approximately 15% to 20% of untreated children and may lead to ischemic heart disease or sudden death.

12. The etiology of the disease is as yet unknown. It affects predominantly children below the age of five. The disease was first described by Dr Tomisaku Kawasaki ("Dr Kawasaki") in 1967 and the incidence of KD is highest in Japan and Korea. In Singapore, the incidence of KD is at least 32.5 per 100,000 children less than five years old per year. It is now considered to be the main cause of acquired heart disease in developed countries and the most common cause of acquired heart disease in young children.

13. There is no specific diagnostic or confirmatory test for KD. KD is diagnosed clinically using the criteria originally set forth by Dr Kawasaki and adopted and modified by the American Heart Association Committee on Rheumatic Fever, Endocarditis, and Kawasaki Disease. The diagnosis is based on a history of persistent fever for five days or more, with four or more of the five principal clinical features which include:

    (a) rash – polymorphous exanthema;
    (b) bilateral conjunctivitis;
    (c) changes in lips and oral mucosa;
    (d) cervical lymphadenopathy; and

(e) changes in extremities.

14. There is an entity of “incomplete” KD where patients diagnosed with KD do not fulfill the classical diagnostic criteria mentioned above. These patients present fever and two of the classical signs, and the diagnosis is often made based on an echocardiogram finding of coronary dilatation or aneurysm. To be sure, “incomplete” KD and “classic” KD are the same type of disease, and the same diagnostic and treatment protocols apply to both. The difference lies in the number of the clinical features presented in the patients. The various signs may evolve over time and are non-specific, and there may be other differential diagnoses with similar signs and symptoms which mimic KD. Notable examples include streptococcal and scarlet fever, measles, adenovirus, enterovirus, and other viral infections.

15. The primary treatment for patients with KD is IVIG. When IVIG is administered in the acute phase of the disease, it reduces the risk of coronary aneurysm by at least three to fivefold. IVIG is unlikely to prevent coronary disease after the acute inflammatory response is over. Once KD is diagnosed, high dose of aspirin should also be started in the acute phase for its anti-inflammatory and anti-pyretic effects.

Preliminary Objection – Whether the charge is defective and ambiguous

16. The Tribunal would first deal with a preliminary issue raised by the Counsel for the Respondent that the charge preferred by the SMC was defective and ambiguous in that it did not set out a “clear and precise” offence for the Respondent to address.

17. Having carefully perused the charge and the particulars set out above, and having regard to the various issues canvassed at the trial, the Tribunal was not able to agree with this submission. The case before the Tribunal concerns the management of a clinical condition that has, as its characteristic, the evolution of diagnostic clinical features over time. The different particulars of the charge did not refer to different conditions but the evolving clinical presentations of the same disease entity, i.e. incomplete KD or KD. As such, the particulars, and all the circumstances, would have to be considered together, for the whole period of the Patient’s admission on 25 February 2013, to the Patient’s discharge on 1 March 2013, and the post-discharge clinical review on 3 March 2013.

18. Accordingly, the Tribunal was of the view that the charge preferred by the SMC was sufficiently detailed and clear, and appropriately captured the evolving nature of the disease entity. There was no question in our minds that the Respondent was misled or prejudiced by the charge and the particulars set out therein. In any event, the burden remained entirely on the SMC to prove its case against the Respondent beyond a reasonable doubt.

The SMC's Case

19. The crux of the SMC's case was that during the period that the Patient was under the care and management of the Respondent, the evidence showed that the Patient presented with clear symptoms pointing to a diagnosis of incomplete KD or KD which a reasonable paediatrician in the Respondent's position would have made and instituted treatment. However, the Respondent failed to do so and that the Respondent was guilty of serious negligence under the second limb of the test of professional misconduct as set out in the leading case of *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612, and that the Respondent's negligence was an abuse of the privileges she enjoys being registered as a specialist.

20. At the inquiry, the Counsel for SMC called three witnesses, namely, the Patient's mother, Mdm PW2, Dr PW1, the Consultant Paediatrician who treated the Patient for KD, and the expert opinion of Associate Professor PE ("A/Prof PE"), Senior Consultant, Hospital C.

21. A/Prof PE was of the opinion that it was evident that there was a lapse in clinical judgment, a lack of clear diagnosis, and consequently, ineffective management of the Patient during admission and on follow up. It would be negligent on the part of the Respondent as it appeared that the follow up plan was a generic one with no focus on the possibility of KD and it was not clearly communicated to the parents of the Patient.

The Respondent's Case

22. Counsel for the Respondent contended that the Respondent's management of the Patient from 25 February 2013 to 1 March 2013 and on 3 March 2013 was reasonable and not seriously negligent and did not constitute an abuse of the privileges of being registered as a medical practitioner.

23. Counsel relied on the evidence of the Respondent and the expert opinion of Associate Professor DE ("A/Prof DE"), Head and Senior Consultant, Hospital D. The crux of the Respondent's case was that the Respondent had considered incomplete KD and KD as a differential diagnosis but her clinical judgment was that viral fever was a more probable diagnosis.

24. In this regard, Counsel for the Respondent argued that KD is difficult to diagnose and that incomplete KD is even more difficult to diagnose. As commented by A/Prof DE, the clinical diagnosis of KD is not always straightforward. Given that many conditions may mimic KD, and there is no diagnostic test that can confirm KD, it is understandable why the diagnosis may be delayed or even missed.

Findings of the Disciplinary Tribunal

25. As a starting premise, the Tribunal was mindful that when assessing the evidence adduced in this case, the Respondent was not to be judged with the benefit of hindsight. While a correct diagnosis was eventually made and appropriate treatment instituted for KD by Dr PW1 on 4 March 2013, the Tribunal was mindful not to rely on this fact when evaluating the Respondent's management of the Patient from the period of 25 February 2013 to 1 March 2013 and on 3 March 2013.

Difficulty of Diagnosis of KD and Sub-Specialisations of Paediatricians

26. It was common ground from both experts that the diagnosis of KD is not straightforward. While the etiology of the disease is unknown, KD is not an uncommon disease in infants and young children. It is certainly a well recognised clinical entity. Although there is no definitive diagnostic test that can be used to diagnose KD and the disease evolves over time, there are useful specific supportive tests (e.g. CRP test and 2D Echocardiogram) to either confirm or rule out KD. The clinical diagnosis of KD is also not in dispute and both experts agree that KD can mimic other conditions. Suffice to note, this Tribunal accepts that the diagnosis of KD can be challenging.

27. The general guidelines on the management of KD are also internationally well-known, regardless of the availability of local medical literature, publications and guidelines on KD. With appropriate and timely treatment, the risk of the child developing coronary artery complications such as coronary aneurysm can be significantly and effectively reduced. Considering that KD is the most commonly acquired cardiac condition in children under five years of age, and given the serious implications of significant cardiac morbidity seen in KD, it should be reasonably expected of a paediatrician to be able to diagnose KD competently and to provide the treatment effectively.

28. This brought the Tribunal to the issue raised by Counsel for the Respondent on whether the Respondent, who is a paediatrician under the Register of Specialists, should be held to the standard of an "experienced" paediatrician who "specialise" in KD. With all due respect to the learned Counsel and A/Prof DE's observations about the medical landscape on sub-specialisations, the Tribunal was not able to agree with this argument.

29. Firstly, under the Register of Specialists for Paediatricians, there are no further sub-divisions into different types of paediatricians, certainly not in terms of sub-specialties. It would be wrong for the Tribunal to arbitrarily create sub-specialists for the purpose of this inquiry. Instead, the Tribunal would have to consider the Respondent's role as that reasonably expected of a paediatrician, and not a General Practitioner or a doctor in training. In other words, the Respondent who is a specialist and registered on the Register of Specialists in the field of Paediatric Medicine ought to be held to the same level of competence as any other paediatrician listed on the same register.

30. Secondly, the Tribunal noted from the Respondent's curriculum vitae that she is an experienced paediatrician of 23 years' standing and was on the Roll of Specialists

since 1997. The Respondent has been a part-time clinical tutor for medical undergraduates at the Yong Loo Lin School of Medicine since 2009. Given her experience and credentials, it would not be unreasonable to expect that the Respondent as a paediatrician would have the competence to correctly diagnose and treat KD patients, regardless of the number of KD patients that she had diagnosed and treated prior to her management of this particular patient.

31. As such, when the parents of the Patient brought the child from the Hospital A to the Gleneagles Hospital Accident & Emergency Department and was referred to the Respondent who is a paediatrician, it would be reasonable for them to expect that the Respondent would have the competence to diagnose and treat the illness inflicting their one-year-old child. To that extent, the Tribunal agreed with the learned Counsel for SMC that it would be wholly inappropriate to carve out within the field of paediatrics, different standards for experienced and inexperienced paediatricians. It can be reasonably expected of all doctors, specialists or otherwise, to include in their competence, the ability to refer a patient to a more experienced medical practitioner in cases with difficulty in management.

Differential Diagnosis of KD

32. Turning to the material evidence adduced in this inquiry, on the date of admission on 25 February 2013, the initial diagnosis made by the Respondent was viral fever. Both experts agreed that the initial diagnosis was reasonable. The Tribunal agreed with the opinion of both experts and that the Respondent could not be faulted for not including KD as a differential diagnosis on 25 February 2013.

33. By 27 February 2013, when the maculopapular rash over the body emerged, the Patient would have had five days of fever, with the diagnostic features of conjunctivitis, red lips and rash. It was clear that the Respondent did consider KD and was looking out for other signs of KD. On 28 February 2013, the Respondent again documented that there were “no full features of Kawasaki” when quite clearly a diagnosis of incomplete KD should be seriously considered. Even on 1 March 2013, being day 7 of the fever and the presentation of clinical evidence of KD, the Respondent again noted that there was no evidence of KD.

34. Suffice to say, having carefully perused the evidence, the Tribunal seriously doubted if the Respondent had truly appreciated or indeed considered a diagnosis of incomplete KD as testified by the Respondent during the inquiry. The Tribunal was deeply troubled by the fact that despite the Respondent having considered KD as a differential diagnosis, she did not discuss the matter with the parents so that they could make an informed treatment choice or suggest a plan of management, including performing further tests or further investigations to rule out KD. Instead, the Respondent was content to continue managing the Patient for viral fever when the clinical features clearly did not point to a simple case of viral infection.

35. While the Tribunal appreciates that acute inflammatory markers such as ESR and CRP, and 2D Echocardiogram are supportive tests and not diagnostic tests, nevertheless, these tests are unquestionably important investigations for KD and

undoubtedly would have been important supportive evidence of KD, while making the diagnosis of viral infection very unlikely. Considering that the diagnosis of viral fever and KD are two very different diagnoses and are totally different disease entities, and given the very significant coronary artery complications associated with KD as opposed to a self-limiting viral fever, one would reasonably expect a competent physician to either exclude the differential diagnosis or to confirm it. Instead of differentiating between the two diagnoses, the Respondent merely entertained the possibility of KD and continued to look out for the "full features" of KD.

36. With due respect to the learned Counsel for the Respondent, the Tribunal could not accept the reasons for the Respondent relying on her "hunch" and not conducting the supportive tests, neither was the Tribunal persuaded by the submission that imposing such a standard would result in doctors practising "defensive medicine". The Tribunal agreed with the submission of the Counsel for SMC that given that KD is a relatively common and potentially life-threatening paediatric vasculitis, the Respondent had failed to maintain a high index of suspicion when the Patient presented with features of KD during the period of the Patient's hospitalisation.

37. Given the clinical presentations of the Patient and the significant risks of adverse and severe consequences resulting from delayed or missed diagnosis of KD, it would be reasonably expected of the Respondent to order such tests during the course of the Patient's hospitalisation at Gleneagles Hospital. The Tribunal was of the view that such a failure amounted to a serious negligence on the part of the Respondent.

38. Furthermore, the evidence also revealed that by the time the Patient was seen by Dr PW1 on 4 March 2013, the 2D Echocardiogram performed by the cardiologist showed trivial mitral and tricuspid regurgitation and bilateral coronary dilatation. The results of the CRP test were significantly raised, clearly confirming the diagnosis of KD.

39. Given that the Respondent had failed to pursue further with any investigations to rule out KD, it would not be open to the Counsel for the Respondent to argue that had the Respondent conducted such tests, the test results would still have supported her diagnosis of viral fever. In short, the Tribunal was not able to accept the Respondent's unconvincing excuses for not conducting such important tests on the Patient. In the Tribunal's view, the Respondent was in clear breach of her duty to provide competent and appropriate medical care in the management of the Patient.

40. The Tribunal agreed with the observations of A/Prof PE that the Patient's fever did not totally settle when he was discharged on 1 March 2013 with a diagnosis of viral fever. This was also consistent with the Patient having had fever over the next two days after his discharge and on 4 March 2013 when the parents sought a second opinion at Hospital B. In this regard, the Tribunal was of the view that by discharging the Patient on 1 March 2013 when the Respondent had not adequately addressed the possibility of KD and without any advice or discussion about KD, bearing in mind the potentially serious consequences of KD, the Respondent clearly fell short of the reasonable standard of due care and attention expected of her and this clearly amounted to serious negligence on the part of the Respondent.

41. Post-discharge on 3 March 2013, the last occasion when the Patient attended at the Respondent's clinic, despite the prolonged fever, the Respondent again did not see it fit to conduct any tests or investigations to rule out KD and repeated her diagnosis of viral fever. The Respondent, rather unpersuasively, maintained that all the criteria for the diagnosis of KD were not present. Quite clearly, as observed by A/Prof PE, the follow-up plan by the Respondent was a generic one with no focus on the possibility of KD. The Tribunal was in agreement with A/Prof PE that it was wholly unacceptable for the Respondent to allow an infant of one-year-old to have prolonged fever without ordering further investigations.

Observations of the witnesses

42. At this juncture, the Tribunal would like to make a few observations about the witnesses, in particular, Mdm PW2 and both expert witnesses.

43. The Tribunal found that Mdm PW2 was a truthful witness having heard her testimony and having observed her demeanour when she gave her evidence. In so far as KD was concerned, Mdm PW2 was unequivocal in her testimony that there was no mention of KD by the Respondent during the entire period between 25 February 2013 and 3 March 2013. The parents of the Patient only learnt about the disease for the first time from Dr PW1 when she made the correct diagnosis and instituted treatment on 4 March 2013. This was not disputed by the Respondent during cross-examination. The Tribunal accepted that this represented the truth, and saw no reason to doubt the creditability of Mdm PW2. The Tribunal was unimpressed by Counsel for the Respondent's attempt to discredit Mdm PW2 and the portrayal of her as an evasive and unreliable witness.

44. The Tribunal found no merit in the submission by the Counsel for the Respondent that A/Prof PE was not an objective witness and had adopted an institutionalised view on the diagnosis of KD which led to her overly generalised comments. Neither could the Tribunal agree with the Counsel for the Respondent that A/Prof PE was evasive, defensive and inconsistent in her testimony. On the contrary, we found that A/Prof PE was knowledgeable and objective; open and balanced in her views when addressing the material issues in this case.

45. The same could be said of A/Prof DE, except that the Tribunal was of the opinion that A/Prof DE took a more sympathetic and charitable view of the case at hand. Although the Tribunal did not entirely agree with A/Prof DE's views on the medical landscape on sub-specialties and non-institutional practices, nonetheless, we found A/Prof DE to be eminently qualified as an expert witness in this case.

Verdict

46. In summary, having carefully considered all the evidence adduced in this inquiry, the Tribunal was satisfied that the Respondent's management of the Patient in this case amounted to such serious negligence that it objectively portrayed an abuse of privileges which accompany registration as medical practitioner within the second

limb of the test laid down in *Low Cze Hong v Singapore Medical Council*. Accordingly, the Tribunal found the Respondent guilty of the charge.

47. Having found the Respondent guilty of the charge, the Tribunal proceeded to deal with the issue of sentencing.

Mitigation

48. In mitigation, the learned Counsel for the Respondent reiterated that KD is a complex disease and that the Respondent did consider KD during the management of the Patient and had acted in good faith and to the best of her ability. The learned Counsel submitted that the circumstances of the case reflected a lower level of culpability.

49. The Counsel for the Respondent urged the Tribunal to consider that the Respondent had an unblemished record of medical practice from 1985 until the incident in 2013 and relied on the many testimonials and character references for the Respondent and her good character and her contribution to society.

50. Finally, the Counsel for the Respondent submitted that the crux of the case was that the Respondent had made an error of clinical judgment. The learned Counsel further submitted that there were no precedents directly on point where the doctor failed to consider a sub-set of the disease entity, and submitted for a fine of $5,000 at the maximum, censure and undertaking not to repeat the conduct complained of.

Submissions on Sentencing

51. In the submission on sentencing, the Counsel for SMC highlighted several aggravating factors, in particular, that the Respondent had failed to keep herself updated on the current knowledge relating to KD to the detriment of her Patient. The SMC highlighted the Respondent's seniority as a senior medical practitioner and an experienced paediatrician of 23 years' standing.

52. Counsel for SMC submitted that the Respondent appeared to have taken a dismissive attitude towards the Patient's clinical presentation during the period of admission at the Gleneagles Hospital. Further, the Respondent had discharged the Patient on 1 March 2013 when there was no basis for doing so. Counsel for SMC also highlighted that the Respondent had every opportunity at the Gleneagles Hospital to refer the Patient to a more senior colleague for a second opinion but did not do so.

53. Counsel for SMC urged the Tribunal to consider that the Respondent failed to advise the Patient's parents of his condition and the possibility that the child might have KD. The SMC highlighted that the Respondent had many opportunities to pursue the possibility of KD with further tests and investigations but did not do so.

54. Finally, the Counsel for SMC also submitted several precedents relating to medical practitioners who had in managing their patients, missed a diagnosis or given a wrong diagnosis, failed to provide adequate advice and/or failed to provide appropriate and timely treatment in breached of Article 4.1.1.1 and 4.1.1.5 of the SMC Ethical Code and Ethical Guidelines. The SMC sought a suspension for a period of at least four months, censure and a written undertaking that the Respondent will not repeat such conduct.

Reasons for the Orders

55. In deciding on the appropriate sentence to impose, the Tribunal took into account the several mitigating factors highlighted by the Counsel for the Respondent. In this regard, the Tribunal gave full weight to the fact the Respondent has an unblemished record of medical practice and is a first offender. The Tribunal also considered the many testimonials and character references of the Respondent's good character and her contributions to the community.

56. As mentioned above, the Tribunal took cognisance that the diagnosis of KD can be challenging and noted that this was not a case where there was an intentional and deliberate departure from the standards observed or approved by members of the profession of good repute and competency. To a limited extent, the Tribunal agreed with the Counsel for the Respondent that her conduct fell on the lower side of culpability.

57. The Tribunal also noted A/Prof DE's opinion that the outcome and long-term prognosis of the Patient is excellent. However, the Tribunal was of the view that this was not a mitigating factor that the Respondent could claim credit for. It was the parents of the Patient who made the sound decision to seek a second opinion from another paediatrician one day after the outpatient review which resulted in Dr PW1 instituting treatment for KD on 4 March 2013. Quite clearly, the timely intervention by Dr PW1 was purely fortuitous. Suffice to note, if the evidence had shown that the child suffered significant and irreparable harm as a result of the Respondent's serious negligence, then clearly that would be an aggravating factor that the Tribunal would be entitled to take into account.

58. Whilst the Tribunal did not entirely agree with the submission of the Counsel for SMC that the Respondent had taken a dismissive attitude towards the Patient's clinical presentation during his stay at the Gleneagles Hospital, nevertheless, there were several aggravating factors that the Tribunal could not ignore.

59. Firstly, the Tribunal noted that the Patient, who was barely one year old, had suffered prolonged fever and presented clinical features of KD during the early period of hospitalisation, and under the care and management of the Respondent. Despite the Respondent having considered a differential diagnosis of two very different disease entities, with one that is self-limiting contrasted with another potentially life-threatening one, the Respondent did not see it fit to conduct any tests and investigations to either exclude the diagnosis or to confirm it.

60. Secondly, the Tribunal considered that there were at least three occasions of serious lapses on the part of the Respondent, once on either 27 or 28 February 2013; when the Respondent discharged the Patient on 1 March 2013; and on 3 March 2013 when the Patient was reviewed by the Respondent at her clinic.

61. Thirdly, having carefully considered the precedents cited by both Counsel for the SMC and the Respondent, the Tribunal observed that the preponderance of the cases cited were dealt with by way of suspension instead of a fine. The Tribunal further noted that in the limited cases where a fine was imposed, these cases were somewhat dated and were not directly on point, and hence, the Tribunal did not find these cases to be helpful.

62. In this regard, the Tribunal was of the view that while the number of charges may be a relevant consideration in sentencing, and that the Respondent was convicted on a singular charge, that could not be the sole determinant factor when considering the appropriate sentence to impose. Instead, the Tribunal would have to consider the other important factors of sentencing, such as the nature of the disease entity in question, the potential harm and the potentially life-threatening illness inflicting the Patient, and all the facts and circumstances of the case, and in particular, the serious lapses on the part of the Respondent.

63. Finally, the Tribunal was mindful of the observations made by the Court of Three Judges in the seminal case of *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at para. 88:

> "*The medical profession is a historically venerated institution. Its hallowed status is founded upon a bedrock of unequivocal trust and a presumption of unremitting professional competence. The basic premise underpinning the doctor and patient relationship is that all medical practitioners will infallibly discharge their duties in the time-honoured and immaculate traditions of this singularly noble profession. Unfortunately, this is not always the reality…*
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> *From time to time, professional lapses and incompetence surface. Needless to say, such errant conduct must be painstakingly policed and effectively deterred if the medical profession is to continue to rightfully occupy its unique position in society. All it needs is a few recalcitrant practitioners to diminish the stature and standing of a revered and respected institution.*"

64. The Tribunal agreed with the above observations made by the Court of Three Judges, and in the final analysis, the Tribunal concluded that an order of suspension would be warranted in order to maintain the highest professional standards expected of medical professionals. It would clearly be in the public interest to uphold and maintain the trust and confidence in the medical profession, and to preserve the reputation of this revered and respected profession.

65. The Tribunal next considered the period of suspension. Having considered all the facts and circumstances of the case, the Tribunal was of the view that a short period of suspension would be fair and appropriate. Accordingly, the Tribunal ordered that the Respondent be suspended for the minimum period prescribed by law.

Orders by this Disciplinary Tribunal

66. In the circumstances of this case, the decision of the DT was that the Respondent:-

a) be suspended from medical practice for a period of three (3) months;
b) be censured;
c) give a written undertaking to the SMC that she will not engage in the conduct complained of and any similar conduct; and
d) pay the cost and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

Publication of Decision

67. We also order that the Grounds of Decision be published.

68. The hearing is hereby concluded.

Dated this 18th day of July 2016.