SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR FERNANDES MARK LEE HELD ON 24 MARCH 2017

Disciplinary Tribunal:
Prof Roy Joseph (Chairman)
Dr Tan Chin Lock Arthur
Mr Ng Peng Hong (Legal Service Officer)

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

Counsel for the Respondent:
Ms Kang Yanyi
(M/s Allen & Gledhill LLP)

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 Fernandes Mark Lee (the "**Respondent**") pleaded guilty to the following charge:

"CHARGE

"1. That you DR FERNANDES MARK LEE (MCR No. 09675Z) are charged that whilst practising as a Gastroenterologist with Asia HealthPartners Pte Ltd, 304 Orchard Road #05-06, Lucky Plaza, Singapore 238863 ("the Clinic"), you failed to exercise due care in the management of your patient, namely one MR P ("the Patient"), in that in breach of Guideline 4.1.1.5 of the Singapore Medical Council's Ethical Code and Ethical Guidelines, you failed to ensure that the Patient's test results in respect of a health screening were accurately communicated to him;

AMENDED PARTICULARS

(i) On 9 February 2012, the Patient attended at the Clinic for a health screening;
(ii) At the end of the health screening on 9 February 2012, the Patient was advised by the staff at the Clinic to choose either a review date for a discussion of the results ("the First Option") or for the results to be posted to him if the results were normal ("the Second Option") and the Patient chose the Second Option.
(iii) The test results were posted directly to the Patient's residence;

(iv) The test results were set out in the medical report dated 9 February 2012 and completed on 20 February 2012 (the "Medical Report"), which you prepared and signed off on;

(v) The summary page of the Medical Report stated that the Patient's cancer markers were "normal", even though the laboratory results that were annexed with the Medical Report stated that the Patient's Carcino-Embryonic Antigen ("CEA") level was 16.5 ng/ml and that it was an "abnormal" result;

(vi) A CEA level of 16.5 ng/ml is outside the normal range and is considered to be high;

(vii) You failed to ensure that the information regarding the Patient's abnormal CEA test result was accurately communicated to him;

(viii) You failed to arrange for a review with the Patient in person to discuss and provide appropriate medical counselling in respect of his abnormal CEA test result;

(ix) You failed to arrange appropriate and timely investigations for the Patient in respect of his abnormal CEA test result;

and that in relation of the facts alleged, you have failed to provide medical services of the quality which is reasonable to expect of you under section 53(1)(e) of the Medical Registration Act (Cap. 174)."

Agreed Statement of Facts (ASOF)

2. The Respondent admitted to the following ASOF:

"AGREED STATEMENT OF FACTS

"*1. The respondent, Dr Fernandes Mark Lee (the "Respondent") is a registered medical practitioner who was practising at Asia HealthPartners Pte Ltd, 304 Orchard Road #05-06, Lucky Plaza, Singapore 238863 (the "Clinic") at the material time.*

The Complaint

*2. The complainant is Mr P who was a patient ("the **Patient**") of the Respondent at the material time. The complaint was made against the Respondent for failing to "perform proper due diligent (sic) checks and prudence in their execution of the entire medical checkup process" as stated in the Patient's letter dated 18 June 2014 to the Singapore Medical Council ("**SMC**"). Specifically, the Patient had alleged that:*

(a) He had gone for an annual medical check-up at the Clinic and was subsequently informed by the Clinic over the telephone that his medical results were good.

(b) He was advised that a review with a doctor was not necessary.

(c) *However, he was later diagnosed with colorectal cancer for which he had to undergo surgery and a 6-month course of chemotherapy.*

(d) *On closer reading of his medical report, he discovered that the actual lab report indicated that his cancer markers were at a high reading of 16.5, where the normal range was 0.0 to 5.0.*

(e) *Such a reading was abnormal and further tests should have been conducted and recommended to mitigate the problem at an early stage.*

The Inquiry

3. *In accordance with the Medical Registration Act (Cap. 174) (the "**MRA**"), the matter was referred to the Complaints Committee ("**CC**") for further investigation. On 20 October 2014, the CC's Investigation Unit ("**IU**") sent the Respondent a Notice of Complaint to inform him that a complaint had been made against him and invited the Respondent, pursuant to section 44(2) of the MRA, to furnish a written explanation. On 8 November 2014, the Respondent submitted a written explanation to the IU.*

4. *Subsequently, the CC directed that a formal inquiry be held by a Disciplinary Tribunal ("**DT**") to further investigate the matter and the Respondent was notified of the CC's decision on 2 February 2016.*

5. *A Notice of Inquiry dated 8 December 2016 ("the "**NOI**") in respect of the Complaint was served on the Respondent on the same date.*

6. *On 9 March 2017, the SMC received written representations from the Respondent (through his solicitors) seeking an amendment of certain particulars of the Charge. The SMC had considered the Respondent's representations and pursuant to Regulation 33 of the Medical Registration Regulations 2010, the SMC agreed to amend certain particulars of the Charge. The Amended Charge is set out in the Notice of Inquiry re-dated 15 March 2017.*

The Amended Charge

7. *In this Inquiry, the SMC has preferred one charge against the Respondent for failing to exercise due care in the management of the Patient.*

8. *The particulars in support of the Amended Charge are:*

(a) *On 9 February 2012, the Patient attended at the Clinic for a health screening.*

(b) *At the end of the health screening on 9 February 2012, the Patient was advised by the staff at the Clinic to choose either a review date for a discussion of the results (the "**First Option**") or for the results to be posted to him if the results were normal (the "**Second Option**") and the Patient chose the Second Option.*

(c) *The test results were posted directly to the Patient's residence.*

(d) *The test results were set out in the medical report dated 9 February 2012 and completed on 20 February 2012 (the "**Medical Report**"), which the Respondent prepared and signed off on.*

(e) *The summary page of the Medical Report stated that the Patient's cancer markers were "normal", even though the laboratory results that were annexed with the Medical Report stated that the Patient's Carcino-Embryonic Antigen ("**CEA**") was 16.5 ng/ml and that it was an "abnormal" result.*

(f) *A CEA level of 16.5 ng/ml is outside the normal range and is considered to be high.*

9. *The gravamen of the charge against the Respondent is that he had:*

(a) *failed to ensure that the information regarding the Patient's abnormal CEA test result was accurately communicated to him;*

(b) *failed to arrange for a review with the Patient in person to discuss and provide appropriate medical counselling in respect of his abnormal CEA test result; and*

(c) *failed to arrange appropriate and timely investigations for the Patient in respect of his abnormal CEA test result.*

The SMC's Ethical Code and Ethical Guidelines

10. *The SMC's Ethical Code and Ethical Guidelines 2002 edition ("**ECEG**") is a guide to SMC's minimum standards required of all registered medical practitioners in the discharge of their professional duties and responsibilities.*

11. *Guideline 4.1.1.5 (Duty of Care) of the ECEG (being the version in force at the material time in 2012) informs that a doctor shall provide competent, compassionate and appropriate care to his patient. This includes making necessary and timely visits, arranging appropriate and timely investigations and ensuring that results of tests are communicated to the patient (emphasis added) and the most appropriate management is expeditiously provided.*

The Respondent's Written Explanation dated 8 November 2014

12. *In his Written Explanation, the Respondent admits that he "overlooked the CEA readings", indicating that the Patient's "cancer markers were normal", when they were in fact outside the normal range."*

3. The Disciplinary Tribunal ("DT") had considered the parties' submissions and the facts of the case. In the circumstances, the DT found the Respondent to have failed to provide professional medical services of a quality which is reasonable to expect of him under section 53(1)(*e*) of the Medical Registration Act ("MRA"). The DT was of the view

that the appropriate sentence to be meted out to the Respondent would be a fine of $10,000, a censure, a written undertaking to the SMC that he would not repeat such conduct or any similar conduct and to bear all the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Reasons for the DT's Decision on Sentence

4. In coming to the decision on sentence, the DT considered the following submitted by parties:

   (a) Counsel for the Respondent's written mitigation plea as well as oral submissions on sentencing; and
   (b) Counsel for the SMC's submissions (both oral and written) on the sentencing and sentencing precedents.

5. The DT was of the view that a breach of Guideline 4.1.1.5 of the 2002 edition of the SMC Ethical Code and Ethical Guidelines ("ECEG"), in this case, is a serious violation. It requires a doctor to provide, among other things, competent and appropriate care to his patient including ensuring the patient's test results in respect of his health screening were accurately communicated to him and if necessary, to arrange for consultations to review the results. Failure to provide such care could damage public trust and confidence in the medical profession and would be contrary to the goal of having early intervention by undergoing health screenings. Such breach of the said ECEG should not be condoned.

6. In the present case, the Respondent did not accurately communicate the results of the Patient's health screening by erroneously stating that the Patient's cancer markers were normal when in fact, the laboratory results that were annexed to the medical report showed that the Patient's Carcino-Embryonic Antigen ("CEA") level was 16.5 ng/ml which was an "abnormal" result. No arrangement was also made to explain the results in greater detail to the Patient and to advise him on the appropriate follow up treatment or management.

7. As a result of the error in the Respondent's report and the lack of a detailed, in-person review of the results with the Patient, the Patient lost the opportunity to take earlier appropriate follow-up action. In fact, the Patient saw a specialist only about 20 months later.

8. Taking into account the Respondent's plea of guilt, his unblemished record, his good character references, the measures taken by him to improve his practice and his contributions to society and the medical community, the DT was of the view that it was not necessary to impose a suspension. The DT also noted that for about three years, the Respondent had to deal with the stress and anxiety of the proceedings.

9. The DT had also considered the sentencing precedents cited by the parties. The DT found that none of the cases had the same features as in the present case. The DT was aware that the penalties to be imposed in each case must be determined on its

own facts and circumstances. The DT was mindful of the statements made by the Court of Three Judges that the sentencing regime for cases of medical discipline in the past had tended to be somewhat lax and the sentences in the previous precedents might not adequately reflect the seriousness of the public interest at stake in these cases. (See Yong Thiam Look Peter v Singapore Medical Council [2017] SGHC 10).

10. The DT noted that in the case of Dr Cheah Way Mun, the SMC Disciplinary Committee's decision dated 19 March 2014 was decided under the old MRA wherein the maximum fine was capped at $10,000. For the present case which was heard under the current MRA, the maximum penalty has been increased to $100,000. In the case concerning Dr Garuna Murthee Kavitha ("Dr Kavitha") which was heard by the SMC DT on 21 April 2015, the DT noted that the doctor involved was found to be a "*young medical doctor at the time of incident*", unlike the present case where the Respondent is a senior doctor and an experienced Gastroenterologist of 10 years' standing. The DT also noted that the DT for Dr Kavitha's case did not have the benefit of the decision of the Court of Three Judges in the case of Dr Yong Thiam Look Peter, supra, highlighting that the sentences in the previous precedents might not adequately reflect the seriousness of the public interest at stake.

Orders by this DT

11. Having considered the mitigating factors, the Respondent's culpability and the prescribed penalties and powers provided by section 53(2) MRA, the DT ordered that the Respondent:-

    (a) pay a fine of $10,000;
    (b) be censured;
    (c) give a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and
    (d) pay all costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

Publication of Grounds of Decision

12. The DT also ordered that the Grounds of Decision be published.

13. The DT is grateful to both Counsel for the assistance rendered.

14. The hearing is hereby concluded.

Dated this 24th day of April 2017.