SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR SANJAY SRINIVASAN HELD FROM 17 TO 21 OCTOBER 2016 AND ON 17 FEBRUARY 2017

Disciplinary Tribunal:
Dr Joseph Sheares (Chairman)
Dr Khoo Chong Yew
Mr Victor Yeo Khee Eng (Legal Service Officer)

Counsel for SMC:
Mr Chia Voon Jiet
Ms Koh Choon Min
(M/s Drew & Napier LLC)

Counsel for the Respondent:
Mr Eric Tin
Ms Sarah Nair
Ms Shanice Ang
(M/s Donaldson & Burkinshaw 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 The Respondent, Dr Sanjay Srinivasan ("**Dr Sanjay**"), is a registered practitioner who claimed trial to two charges of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap 174) ("**MRA**"). The Notice of Inquiry ("**NOI**") was first served on Dr Sanjay on 11 December 2015 and the two charges in the NOI were subsequently amended on 22 June 2016.

2 The 1st amended charge essentially alleged that Dr Sanjay, whilst practising at the Department of Ophthalmology and Visual Sciences, Khoo Teck Puat Hospital ("**KTPH**"), had acted in breach of section 4.1.1.1 of the 2002 edition of the Singapore Medical Council ("**SMC**") Ethical Code and Ethical Guidelines ("**ECEG**") in not providing adequate clinical evaluation, as would be expected from a reasonable and competent doctor in the practice of ophthalmology, to his patient, one Mr P ("**the Patient**") when he failed to conduct an optical coherence tomography and/or further examination before reaching a diagnosis of the Patient's condition.

3 The 2nd amended charge essentially alleged that Dr Sanjay had acted in breach of section 4.1.1.5 of the ECEG in not providing the Patient with competent and appropriate care, as would be expected from a reasonable and competent doctor in the practice of ophthalmology, when he arranged for the Patient to return six weeks later for his next clinical review and allowed the Patient to continue driving instead him of putting him on medical leave during these weeks.

The Agreed Statement of Facts

4 Dr Sanjay was at the material time, a Senior Resident Physician at the Department of Ophthalmology and Visual Sciences at KTPH. He is presently designated as a Senior Staff Physician at the Department of Ophthalmology and Visual Sciences at KTPH.

5 The complainant is the Patient. At the material time, the Patient worked as a private shuttle bus driver.

The initial visit at Polyclinic A on 16 October 2013

6 On 16 October 2013, the Patient visited Polyclinic A complaining of sudden blurring of vision in his right eye which had started two days prior, and of seeing multiple black spots in the field of vision in his right eye. He was seen by Dr FW1 at 12.18pm, and the following observations were made:

(a) The Patient's visual acuity in the right eye was found to be 6/36 (unaided) and 6/18 (with pinhole). His visual acuity in his left eye was 6/6 (unaided).
(b) Tonometry was normal.
(c) Diabetic retinal photography showed non-proliferative retinopathy in the right eye, with normal cup-disc ratio.

7 The Patient was referred by Polyclinic A to the Eye Specialist Outpatient Clinic at KTPH on an urgent basis. His appointment at KTPH was scheduled for 2.15pm that same day.

Consultation with Dr Sanjay on 16 October 2013

8 The Patient was seen by Dr Sanjay at KTPH at 2.35pm.

9 The Patient's detailed medical history and the referral letter from Polyclinic A were sent to KTPH, and subsequently, to Dr Sanjay. The referral letter from Polyclinic A stated that the Patient "*works as a Hospital APt feeder Bus driver*", "*Complaints of Sudden visual blurring of Right eye*", and of "*Seeing dark black spot ++*". It should be noted that during the course of the inquiry, it was agreed from the various testimonies of Dr Sanjay and two expert witnesses, namely Dr PE and Dr DE, that the term "*dark black spot ++*" was ambiguous and could mean either many dark black spots or one very dark intensity black spot. The Prosecution's expert, Dr PE, is an ophthalmologist and a sub-specialist in cornea and refractive surgery while Dr Sanjay's expert, Dr DE, is an ophthalmologist and vitreo-retinal sub-specialist. The significance of this will be dealt with in the decision below.

10 The referral letter from Polyclinic A to KTPH was provided to Dr Sanjay, and Dr Sanjay was aware or ought to be aware of its contents.

11 Based on a detailed history collected from the Patient, the referral letter from Polyclinic A, and an eye examination with dilation of pupils, Dr Sanjay made the following observations and findings:

(a) The Patient had 6/24 unaided and 6/12 pinhole visual acuity in his right eye, and 6/6 unaided visual acuity in his left eye.
(b) Auto-refraction showed mild hyperopia in the Patient's right eye.
(c) Intraocular pressures of 11 mmHg were measured in both of the Patient's eyes and were normal.
(d) Slit-lamp examination showed an early cataract in the Patient's right eye.
(e) Dilated fundoscopy of the Patient's right eye revealed a posterior vitreous detachment ("**PVD**") with no evidence of retinal tears, holes or detachment.
(f) The Patient had a few drusen and there was no evidence of diabetic retinopathy in both eyes.

12 Dr Sanjay informed the Patient that he had a mild cataract and an acute onset of a floater in his right eye. Dr Sanjay gave the Patient advice regarding the symptoms of a possible future retinal break or detachment. He also asked the Patient to return in six weeks' time for another evaluation, and the Patient was told to return earlier if new symptoms were to occur.

13 Dr Sanjay also gave the Patient the option of making spectacles and allowed him to continue his normal activities, including driving, for the following reasons:

(a) The cataract in the Patient's right eye was mild and could be largely corrected with spectacles; and
(b) The Patient's vision had improved with a pinhole to 6/12 in the right eye, and the visual acuity standards required for Group 2 driving licence is 6/12 in each eye.

14 Dr Sanjay verbally informed the Patient that if his vision was not improved after making the spectacles, the follow-up evaluation would seek to address it. He was told to return earlier if new symptoms were to occur.

15 Dr Sanjay also felt that due to the risk of possible retinal break or detachment, it was more appropriate to decide on cataract surgery at the next evaluation in six weeks after a proper refractive assessment to the potential vision. Additionally, the Patient's last HbA1c done on 7 August 2013 was 10.8% and Dr Sanjay wanted to re-evaluate his vision and retina after six weeks.

16 Dr Sanjay gave the Patient one day of medical leave for 16 October 2013 as he assessed the Patient to be fit for work the next day.

Consultation with Dr FW4

17 On 17 October 2013, in a report by Dr FW Consultant and Head at Polyclinic A, the Patient returned to Polyclinic A for a second consultation, and was seen by Dr FW2. The Patient now complained of a dark spot in the middle of his visual field which had apparently started on the previous day (16 October 2013). He informed Dr FW2 that

he had consulted at KTPH on 16 October 2013, and was told he had myopia and advised to see an optician. The Patient added that he had difficulty working as a bus driver because of his impaired vision. The Patient did not complain of any eye pain, and his eyes appeared grossly normal, with no redness or other obvious external abnormality seen.

18 Dr FW2 then referred the Patient to the Accident and Emergency ("**A&E**") Department of Hospital A.

19 On that same day, 17 October 2013, the Patient attended the A&E Department of Hospital A at 5.20pm with a complaint of a central scotoma in his right eye that had been present for three days. At Hospital A, the following observations were recorded:

(a) The Patient's visual acuity was recorded as 6/48 in his right eye and 6/6 in his left eye.
(b) The Patient's anterior segment examination was unremarkable with normal intraocular pressures of 15 mmHg in each eye.
(c) There were no cellular activities in the anterior chamber, and the Patient's lenses were both clear.
(d) Dilated fundoscopy showed swelling in the right macula.
(e) The fundus examination in the left eye was unremarkable.
(f) The Patient's optic discs were noted to be pink and not cupped bilaterally.

20 Amongst others, the A&E Department of Hospital A picked up a diagnosis of a right choroidal neovascularisation, a differential diagnosis of diabetic diffuse cystoid macular oedema which was "*less likely*", and a differential diagnosis of central serous chorioretinopathy ("**CSCR**") which was "*v. unlikely. Does not look like it.*"

21 A follow-up appointment at the **Institution B** was scheduled for the next day, on 18 October 2013, for further investigation.

22 On 18 October 2013, the Patient attended at the Institution B at 7.52am. At the Institution B, the Patient's visual acuity was recorded at 6/45 with pinhole improvement to 6/21 for his right eye, and 6/7.5 for his left eye. Fundus examination remained largely unchanged from the findings at the A&E Department of Hospital A. An optical coherence tomography ("**OCT**") scan revealed a large neurosensory detachment involving the right macula which was about 3 disc diameters in extent. Based on Institution B's medical records, the Patient was seen by one "Dr A" and the OCT scan was reviewed by one "D", both of whom appear to be Senior Consultant Ophthalmologists at the Institution B.

23 The Patient was then referred to Dr FW4 of Institution B. Dr FW4 examined the Patient on the same day after she assessed the initial examination and the results of the OCT scan.

24 Dr FW4 ordered fluorescein angiography and indocyanine green angiography in order to investigate the source of the swelling. The fluorescein angiography confirmed the presence of a neurosensory detachment which was noted on slit-lamp. A small pigment epithelial detachment was also noted towards the superior aspect within the

neurosensory detachment. More significantly, there was an area of pinpoint leakage at the level of the retinal pigment epithelium along a branch of the supero-temporal arcade. The indocyanine green angiography showed that there was hyperpermeability of the large choroidal vessels. Dr FW4 found that, taken together, these findings were compatible with a diagnosis of CSCR.

25 Dr FW4 then discussed the prognosis of the Patient's condition with him. As the Patient was a shuttle bus driver and wanted to achieve visual recovery as soon as possible, Dr FW4 offered focal laser treatment to the Patient to hasten his visual recovery. The Patient agreed to the treatment. Focal laser treatment on the Patient's right retina was performed the same day.

26 The Patient was issued a Medical Certificate by Dr FW4 for 15 days of medical leave from 18 October 2013 to 1 November 2013.

27 On 25 October 2013, the Patient visited the Institution B for a review. His visual acuity was recorded at 6/18 unaided for his right eye and 6/7.5 for his left eye. With hyperopic correction, his refracted visual acuity could be improved to 6/7.5 for his right eye and 6/6 for his left eye. A fundus examination showed evidence of faint laser treatment and continued to show the presence of a neurosensory detachment. An OCT scan was repeated, and results showed that although the neurosensory retinal detachment did not resolve, there was a significant reduction in the volume of the area of detachment. The corresponding central retinal thickness had also reduced from 674 microns at presentation to 590 microns at this visit.

28 As the Patient was keen to resume driving as soon as possible, Dr FW4 asked the optometrist to advise him on getting a pair of spectacles to maximise his visual acuity in the interim. The Patient was also advised that his degree was likely to continue to change as his eye responded to the focal laser treatment administered on 18 October 2013.

29 On 22 November 2013, the Patient visited the Institution B for a further review. At this visit, his unaided vision had improved to 6/9 for his right eye and 6/6 for his left eye. Fundoscopy showed that there was marked improvement in resolution of the neurosensory detachment. An OCT scan was repeated, and results showed that the neurosensory detachment had almost completely resolved leaving just a sliver of subretinal fluid. The corresponding central retinal thickness had reduced to the normal range of 238 microns. Examination of the left eye was unremarkable.

30 A further follow-up appointment for the Patient was scheduled at Institution B on 14 February 2014. The Patient did not attend this follow-up appointment.

31 At the inquiry, there were two factual witnesses, namely the Patient and Dr Sanjay; and two expert witnesses, namely Dr PE and Dr DE. It was agreed that both specialists had the necessary qualifications to opine on the adequacy of the steps taken by Dr Sanjay in his clinical evaluation and management of the Patient.

The Evidence of the Patient

32 In the Patient's complaint letter accompanied with his Statutory Declaration dated 28 January 2014 to the SMC, he referred to his Member of Parliament's letter dated 5 November 2013 which stated that the Patient has consulted the polyclinic doctor for having blur vision in his right eye and the doctor advised him not to drive at that point of time. The Patient was then referred to KTPH for further investigation and treatment and was attended to by Dr Sanjay. The Patient further wrote in his complaint letter that Dr Sanjay said that his eye was beyond help and no cure. Dr Sanjay told him to get spectacles instead and advised that he could continue to drive. Upon hearing his words, the Patient was very upset. When the Patient went to make his spectacles, he was told that his eye condition was not the case. Hence, the Patient went to see another specialist. Copies of the KTPH Tax Invoice and Medical Certificate both dated 16 October 2013 were also enclosed in the Patient's complaint letter.

33 The Patient testified through a Mandarin interpreter that he had not told Dr Sanjay that his "*right eye was blur*" and he had seen multiple black spots. He had told Dr Sanjay that there was a black patch in the middle of his right eye and that he could see with both eyes. However, he could not see if he was to cover one of his eyes. Although the Patient had communicated this in simple English to Dr Sanjay, he had the impression that Dr Sanjay could not understand him and that Dr Sanjay thought that the Patient was puzzled. As such, he called for a Mandarin interpreter at the end of the eye examination to help in the explanations.

34 The Patient denied that Dr Sanjay had asked whether the multiple black spots were like the Chinese expression "*fei wen zi*" which meant flying mosquitoes in his right eye. When the Patient was asked whether he could remember what he had told Dr Sanjay three years ago, the Patient replied that he was quite sure that he did not tell Dr Sanjay about the blurring of vision and the small white spots, because when he went to Dr Sanjay at that time, he could not see, and that "*it was only one big patch*", *it was like the circular shape on the door, it was "one black patch*". When asked if that was what he had told Dr Sanjay, and it would only be logical that Dr Sanjay would record it, the Patient replied that he did not know how Dr Sanjay did his recordings. In this regard, it was noted that in the Hospital A A&E Eye Notes by Dr FW3, dated 17 October 2013, that the Patient complained of "central scotoma" for three days, which would include the time when the Patient had consulted Dr Sanjay on 16 October 2013.

35 The Patient further testified that he only remembered that Dr Sanjay told him that he could drive and that he should make a pair of spectacles. However, Dr Sanjay did not specifically state in such a way that making the spectacles was a qualification for being able to drive. The Patient denied that Dr Sanjay had advised him to come back earlier if new symptoms were to occur or that he should come back earlier if his vision did not improve after making the spectacles.

The Evidence of Dr Sanjay

36 In Dr Sanjay's letter of explanation to the SMC dated 24 June 2014, Dr Sanjay stated that the Patient was "*referred by Polyclinic A for sudden visual blurring and seeing a dark black spot in the right eye of two days duration*". This implied that Dr Sanjay had interpreted Dr FW1's "*dark black spot ++*" to be a single spot. However, Dr Sanjay had also stated in his letter of explanation that the Patient was seen by him on 16 October 2013 with a history of blurring of vision and floaters in the right eye of two days duration which was not progressive.

37 The Patient was informed that he had a mild cataract and posterior vitreous detachment in the right eye, and as the Patient presented with an acute onset of *a floater* (posterior vitreous detachment), he was given advice regarding the symptoms of a possible future retinal break or retinal detachment and was asked to return in six weeks' time for another evaluation. He was told to return earlier if new symptoms were to occur.

38 The DT noted that in the letter of explanation to SMC, Dr Sanjay had later stated that the patient had a posterior vitreous detachment which caused his symptoms of *floaters* in his right eye. Although in the KTPH's notes of 16 October 2013, Dr Sanjay had written "*Floater (RE)*" without any description or characterisation of it. In these notes, there were no further descriptions or characterisations of the blurring of vision or of the floater. The DT further noted that it was indicated in the KTPH's notes that the consultant-in-charge was Dr DW. The relevance of this would be discussed later in the Grounds of Decision when the DT deals with the evidence of the Respondent's expert, Dr DE.

39 When questioned, Dr Sanjay said that he had used "floater" and "floaters" interchangeably. However, both Dr PE and Dr DE agreed that there was a difference between "floater" and "floaters", the former being one black spot and the latter being multiple black spots. Dr DE further agreed that he personally would not use the two terms interchangeably.

40 In his letter of explanation to SMC, Dr Sanjay further stated that the option of making spectacles was given to the Patient since his vision had improved with a pinhole; and that meanwhile, he could continue his normal activities including driving. The option of cataract surgery was not considered at that consultation as Dr Sanjay wanted to re-evaluate the Patient's vision and retina after six weeks. It was also communicated verbally to the Patient that if his vision was not improved after making the spectacles, the follow-up visit would seek to address it.

41 Dr Sanjay also explained that he was quite sure that he had not used the terms like "*beyond help*" and "*no cure*". He might have suggested to the Patient that floaters were an age-related process which may not warrant any treatment in the absence of any retinal tear.

The SMC's Case

42 The crux of the case was that Dr Sanjay had provided inadequate clinical evaluation when he failed to conduct further examinations such as OCT on the Patient before diagnosing the Patient's eye condition. Counsel for SMC contended that the circumstances should have prompted Dr Sanjay to be more conscientious and proactive in his clinical assessment of his patient before reaching a diagnosis of the Patient's condition and that such failure amounted to serious negligence that it objectively portrayed an abuse of privileges as a medical practitioner.

43 Furthermore, Dr Sanjay had given incompetent and inappropriate care to the Patient when he assessed the Patient as fit to work and permitted the Patient to continue driving without ensuring that the Patient could achieve the minimal visual standards required of a bus driver. Counsel for SMC contended that Dr Sanjay should have put the Patient on medical leave until it could be shown that the Patient could achieve the minimum visual standards for a bus driver given the potential transport safety implications arising from the Patient's occupation as a shuttle bus driver.

44 Instead, Dr Sanjay had given the Patient only one day of medical leave and only provided the Patient with the option of making spectacles and assessed that the Patient's fitness to drive was not contingent on the Patient obtaining spectacles. Counsel for SMC contended that such conduct amounted to serious negligence that it objectively portrayed an abuse of privileges as a medical practitioner.

The Respondent's Case

45 Counsel for Dr Sanjay contended that Dr Sanjay arrived at a reasonable diagnosis of the Patient and that the clinical evaluation was adequate and consistent with the patient's history taken and clinical examination.

46 Similarly, Dr Sanjay's management plan and advice to the Patient was appropriate given the diagnosis of PVD and early posterior sub-capsular cataract ("**PSC**"), even if Dr Sanjay had made any error of judgment in his diagnosis. In this regard, Dr Sanjay's issuance of one day medical leave was based on medical grounds as assessed by Dr Sanjay.

Findings of the Disciplinary Tribunal

47 The DT is mindful that for the 1st amended charge to be made out, Counsel for SMC must prove beyond a reasonable doubt that there was serious negligence on the part of Dr Sanjay in failing to conduct an OCT and/or further examinations before reaching a diagnosis of the Patient's eye condition on 16 October 2013; and that such negligence objectively portrayed an abuse of privileges as a medical practitioner.

48 Likewise, for the 2nd amended charge to be made out, Counsel for SMC must prove beyond a reasonable doubt that there was serious negligence on the part of Dr Sanjay in failing to put the Patient on medical leave until it was shown that he could achieve

the minimum visual standards of at least 6/12 in each eye for a bus driver given the potential public transport safety implications arising from the Patient's occupation as a shuttle bus driver on 16 October 2013; and that such negligence objectively portrayed an abuse of privileges as a medical practitioner.

49 The DT is also mindful that an error of judgment by itself is not sufficient to constitute professional misconduct, and mere negligence or professional incompetence or deficiencies is not professional misconduct.

Assessment of the evidence of the Patient and Dr Sanjay

50 Having heard and observed how the Patient had given his evidence, the DT found the Patient to be a credible witness. The DT found his evidence to be reliable, in particular, the circumstances that led to the discovery of his eye condition, the nature of his eye condition, and the steps taken after his consultation with Dr Sanjay. There was little to suggest that the Patient would falsely implicate Dr Sanjay about what he had told Dr Sanjay during the consultation.

51 The Patient maintained that, throughout the consultation, he had told Dr Sanjay that there was a black patch in the middle of his right eye. This was not inconsistent with his complaint to Dr FW3, whom he saw at the A&E Department of the Hospital A on 17 October 2013, and who recorded that the Patient had complained of "central scotoma" for three days. This would include the period when the Patient had consulted Dr Sanjay on 16 October 2013.

52 The same could not be said of Dr Sanjay. The DT noted that notwithstanding Dr Sanjay's letter of explanation of 24 June 2014, wherein he stated that the Patient was referred by the Polyclinic A for sudden visual blurring and seeing a dark black spot in the right eye of two days duration. This was consistent with Dr Sanjay's notes, where he had written "Floater (RE)" without any description or characterisation. Dr Sanjay testified that he had interpreted it to mean multiple black spots, and that the Patient had provided him with a history of blurring of vision and floaters in the right eye of two days duration which was not progressive.

53 The DT found Dr Sanjay's explanation that he had used "floater" and "floaters" interchangeably, and that there was nothing significant about that to be most perplexing and troubling, considering that the accurate description of such term or symptom would be important for a proper diagnosis of the Patient's condition. It is also pertinent to note that both experts agreed that there was a difference between the term "floater" and "floaters", and even Dr Sanjay's own expert, Dr DE, admitted that he would not have used the two terms interchangeably.

54 It could well be that there was a genuine miscommunication between the Patient and Dr Sanjay as to whether the Patient saw a "floater" or "dark black patch". Be that as it may, Dr Sanjay must know that patients may find it difficult to explain clinical symptoms about their eye conditions, and that this could be further compounded by the language barriers between him and his patients. As such, when Dr Sanjay realised that he needed an interpreter to interpret the management plan and diagnosis in Mandarin to the Patient, Dr Sanjay ought to have also re-taken the history of the Patient.

55 An unambiguous and accurate history is an essential part of clinical assessment before a diagnosis or differential diagnoses may be made. To that extent, the DT could not agree with Dr Sanjay's submission that history taking was irrelevant and not within the ambit of the 1st amended charge. An accurate history taking, coupled with the results of Dr Sanjay's medical examination, form the essential elements of a clinical evaluation.

56 In the DT's view, the key issue is whether there were grounds for Dr Sanjay to doubt his diagnosis of PVD and mild PSC cataract such that he should have conducted an OCT and/or further examinations. The DT agreed with Dr PE that it is for the doctor to integrate, assimilate and assess the information obtained from the patient and through a thorough examination before arriving at a diagnosis, and in this case, Dr Sanjay clearly fell below the standards expected of him.

57 The DT agreed with the Counsel for SMC's submission that Dr Sanjay was an evasive and defensive witness at times. In particular, the DT did not find his explanations on the inconsistencies of his evidence on the stand and his written letter of explanation to the SMC to be convincing. If indeed Dr Sanjay's alleged difficulty to articulate himself in English was to be believed, then it would be more troubling that his history taking from the Patient was done without the assistance of a Mandarin interpreter.

58 There were several aspects of Dr Sanjay's history taking and documentation in the clinical notes that the DT found to be unsatisfactory. First, the DT noted that there was no documentation in the notes of a differential diagnosis, or of prescribing spectacles for the Patient, or any advice on the resumption of the bus driving by the Patient. Dr Sanjay himself conceded that he did not document the exact words used by the Patient to describe his eye condition and he could not remember accurately what the Patient had described to him in his history. To that extent, the DT preferred the evidence of the Patient as to what he had told Dr Sanjay over to Dr Sanjay's recollection of his conversation with the Patient.

59 The DT noted Dr Sanjay's explanation that he felt that his examination was adequate and that he did not see any swelling of the retina or macula, and as such, there was no valid indication for the ordering of an OCT and he did not come up with a differential diagnosis because he could arrive at a primary diagnosis.

60 However, it was apparent to the DT that Dr Sanjay had not considered that his examination of the retina with a dilated fundoscopy was a subjective analysis and should have been co-related with the patient's history and other findings like the VA right eye of 6/24.

61 The DT also evaluated the results of Dr Sanjay's examinations to see whether they supported the diagnosis of PVD and mild PSC cataract. Apart from the history provided by the Patient, including the referral letter by Dr FW1, Dr Sanjay arrived at his diagnosis from his eye examinations of the Patient at KTPH. Dr Sanjay found on slit-lamp examination an early and mild PSC cataract. He also found on a dilated fundoscopy of the Patient's right eye a PVD with no evidence of retinal tears, holes or detachment. He also found that the Patient had visual acuity ("**VA**") 6/24 unaided and 6/12+2 pinhole in the right eye; and 6/6 unaided in his left eye.

62 Since such a significant drop in VA in the right eye is not associated with a PVD, Dr Sanjay attributed the VA loss to an early and mild PSC cataract. While an early and mild cataract may be visually disabling due to contrast sensitivity and glare, it does not typically caused visual loss, much less a significant one of VA 6/24. A cataract also does not typically produce a sudden loss of vision which was what happened in the Patient's case on 15 October 2013.

63 The DT was of the view that if there was a significant enough PSC cataract to cause an unaided VA 6/24 in the Patient's right eye, this PSC cataract would have been very clinically obvious and apparent to all the other doctors who examined the Patient. However, it was significant that none of the doctors at Hospital A A&E or at Institution B recorded any observation of any cataract. On the contrary, one of them even recorded the Patient's eye lenses as clear in both eyes. The Patient himself also stated that he was not suffering from any cataract. In the DT's view, the subjective nature of the cataract assessment together with the unlikelihood of an early and mild PSC cataract causing a loss of VA 6/24 should have alerted Dr Sanjay to the possibility that he may have wrongly diagnosed an early and mild cataract and that he should have performed further examinations of the Patient's right eye.

64 The DT did not accept Dr Sanjay's explanation that the Patient's reduced visual acuity could be partly caused by his early cataract and partly caused by his uncorrected right eye hyperopia of +1.00. Firstly, Dr Sanjay did not elucidate from the Patient whether he had pre-existing or un-induced hyperopia, and it was unsafe for Dr Sanjay to assume this even if there was a study of the incidence of hyperopia in Chinese Singaporeans. Secondly, a person with a VA of 6/24 would typically present with an un-induced hyperopia of +2.00 or +3.00 and not +1.00. Thirdly, Dr Sanjay himself could not be sure that the Patient's early and mild PSC cataract would cause a hyperopia of +1.00. Given the uncertainty as to the cause of the Patient's hyperopia of +1.00, and the VA 6/24 in the right eye, the DT was of the view that Dr Sanjay should have re-considered the causes of hyperopia and explored alternative diagnoses and further examinations instead of arriving at his diagnosis of PVD and mild PSC cataract.

65 For the above reasons, the DT was of the view that Dr Sanjay had not provided adequate clinical evaluation as would be expected from a reasonable and competent doctor in the practice of ophthalmology to the Patient during the consultation on 16 October 2013 when he failed to conduct an OCT and/or further examination of the Patient before reaching a diagnosis of PVD and PSC cataract. Accordingly, the DT was satisfied that Counsel for SMC had proven the 1st amended charge against Dr Sanjay beyond a reasonable doubt.

66 The DT next considered the 2nd amended charge against Dr Sanjay and was of the view that Counsel for SMC had no difficulty in proving this charge beyond a reasonable doubt. The DT was persuaded by Counsel for SMC's submission that regardless of the diagnosis by Dr Sanjay, it was indisputable that the Patient's right eye had a marked loss of VA to 6/24 and that his ability to drive safely was diminished on 16 October 2013. Thus, unless and until it is assured that the Patient could sufficiently regain the loss of VA in his right eye, the Patient should not be permitted to drive.

67 The Singapore Medical Association ("**SMA**") guidelines for fitness to drive for Group 2 License for drivers of buses is that they should have VA of at least 6/12 in each eye; and the medical standard for Group 2 drivers is more stringent than for Group 1 drivers. Dr Sanjay confirmed that he was aware of the VA 6/12 standard. However, Dr Sanjay merely gave the Patient the option of making spectacles and allowed him to continue his normal activities, including driving. Dr Sanjay also gave the Patient one day of medical leave for 16 October 2013 as he assessed the Patient to be fit for work the next day.

68 It was apparent from the evidence adduced in this inquiry that Dr Sanjay only verbally provided the Patient the option of making spectacles and the Patient's fitness to drive was not contingent on the Patient obtaining a pair of spectacles. In other words, Dr Sanjay did not make it mandatory for the Patient to make a pair of spectacles before he resumed driving after the expiry of his one-day medical leave.

69 Therein lies the nub and gravamen of this charge. Dr Sanjay assumed that the Patient would be able to make a pair of prescription glasses in less than half a day after the consultation at KTPH. He failed to provide the Patient with any instructions on making the spectacles except that he could obtain a pair at any optical shop. He assumed that the optician would know that the Patient was a bus driver who needed to attain the 6/12 VA standard required for a Group 2 licensed drivers.

70 More significantly, Dr Sanjay assumed that the Patient could achieve a VA of 6/12+2 with spectacles based on a pinhole test, when Dr Sanjay acknowledged himself that many variables could affect the results of a pinhole test and that pinhole VA is not the same as best spectacle-corrected VA. There could be no dispute that a manifest refraction is the gold standard for testing and measuring refractive error.

71 The DT agreed with the Counsel for SMC's submission that Dr Sanjay should have ensured that the Patient could meet the 6/12 VA standard before allowing him to drive and that the failure to put the Patient on medical leave until he could ensure that the Patient met the 6/12 standard amounted to serious negligence in this case.

72 The DT needed to go no further than to compare the steps taken by Dr FW4 in managing the Patient's eye condition. Dr FW4 prescribed 15 days of medical leave to the Patient on 18 October 2013. During the follow-up appointment at Institution B, Dr FW4 arranged for an optometrist to advise the Patient on getting a pair of spectacles. After the optician conducted a manifest refraction, a spectacle prescription was provided to the Patient that could be used directly to make his spectacles. Meanwhile, Dr FW4 advised the Patient that he should not drive without obtaining a pair of spectacles. All these measures were absent in Dr Sanjay's management of the Patient.

73 The DT could neither agree with Dr Sanjay's Counsel's submission that the SMC's characterisation of key issues was a shift in goalpost nor agree that the care rendered by Dr Sanjay to the Patient, when taken in totality, was at the very most an error of clinical judgment.

74 At this juncture, the DT should point out that we could not agree with Dr DE's position on the applicable standard, whose testimony on this was wholly unsatisfactory. Dr DE's

position on this was variable and unclear. He further raised doubts about the authority of the SMA and the Traffic Police regarding the Guideline of the VA 6/12 standard. The DT was disappointed with his evasiveness about the applicable standard and received very little assistance from Dr DE as an expert witness on this point. The DT formed the view that the opinion expressed by Dr DE on the applicable standards were not acceptable and clearly revealed his lack of independence in this inquiry.

Assessment of the Experts' evidence

75 Turning to the evidence of the experts, the DT found Dr Sanjay's Counsel's submission that Dr PE's opinion was unfair, unbalanced and biased against Dr Sanjay, to be unfounded and without merit.

76 On the contrary, the DT found Dr PE to be an independent, impartial and credible expert. He was fair and balanced in his expert opinion and we did not detect any biased against Dr Sanjay whatsoever.

77 The same could not be said of Dr Sanjay's expert, Dr DE. The DT was of the view that there was clearly a strong conflict of interest given Dr DE's close working relationship with Dr DW, who was Dr Sanjay's consultant-in-charge, and Dr DE's colleague at the Centre C. As the consultant-in-charge, Dr DW would have a vested interest in the outcome of this inquiry, and it was not lost on Dr DE that it would not be good for Centre C if Dr DW was implicated in any way.

78 Furthermore, Dr DE was also involved in processing Dr Sanjay's work application and collaborated frequently with Dr Sanjay on a number of publications. These facts were only discovered and disclosed during the cross-examination by Counsel for the SMC and regrettably, it certainly raised the question of whether there was a deliberate concealment on the part of Dr DE.

79 Suffice to note, as highlighted in the submission of the Counsel for SMC, there were several instances where Dr DE was evasive, and his evidence was tainted with bias, which betrayed Dr DE's lack of independence, and his partiality towards Dr Sanjay.

80 Given these circumstances, the DT was persuaded by and preferred the expert opinion of Dr PE.

Verdict

81 Having carefully considered all the evidence adduced in this inquiry, and having carefully considered the detailed submissions and replies of both parties, the DT was satisfied that the Counsel for SMC has proven both amended charges beyond a reasonable doubt. Accordingly, the DT found Dr Sanjay guilty of both charges.

82 Having found Dr Sanjay guilty of both charges, the DT proceeded to deal with the issue of sentencing.

Mitigation

83 In mitigation, Counsel for Dr Sanjay submitted that Dr Sanjay has been in the medical profession for 22 years and between 1995 and 2005, he had practised in clinics and hospitals in India, specialising in ophthalmology. Dr Sanjay came to Singapore sometime in May 2005 to join Hospital B's Department of Ophthalmology and Visual Sciences before serving in KTPH. Dr Sanjay is a hardworking and dedicated doctor, and also a responsible and caring doctor.

84 A reliable team player, Dr Sanjay also mentors his juniors, medical students and medical officers and is passionate in medical education and research projects. He is a prolific contributor in eye research publications and is one who constantly strives for excellence. His Counsel further submitted that Dr Sanjay had made significant contributions to public healthcare and awareness.

85 More significantly, Dr Sanjay is of good character and has a clean record. He is 45 years of age, married and a father of twin boys aged X years and X months. His Counsel submitted that Dr Sanjay's actions was an isolated incident and his offending conduct was not so egregious to merit suspension. There was no resultant physical or mental harm to the Patient and a fine would be sufficient to serve as a general deterrence, and that a specific deterrence was not necessary. Even if the DT finds that specific deterrence is necessary in this case, a fine would also be adequate.

Submissions on Sentencing

86 In their submission on sentencing, Counsel for SMC submitted that Dr Sanjay be sentenced to a fine of $8,000 for the 1st amended charge and to a four-month suspension for the 2nd amended charge, and the usual consequential order that Dr Sanjay be censured; provide a written undertaking to abstain in future from the conduct complained of or in any similar conduct; and that Dr Sanjay pay the costs of this inquiry.

87 Counsel for SMC submitted that Dr Sanjay's misconduct under the 1st amended charge was broadly aligned with the cases where there was a failure to adequately assess the Patient's medical condition or to diagnose the Patient's condition and that a fine would provide sufficient deterrence to ensure that Dr Sanjay adopts a more proactive attitude in future cases.

88 However, in respect of the 2nd amended charge, Counsel for SMC submitted that the nature of Dr Sanjay's misconduct was substantially more severe to warrant an imposition of a suspension and that a four-month suspension is consistent with the relevant sentencing precedents.

Reasons for the DT Orders

89 In deciding on the appropriate sentence to impose, the DT was cognizant of the latest decision of ***Yong Thiam Look Peter v SMC*** [2017] SCGH 10, where the Court of Three Judges reiterated the point that the sentences in previous precedents may not be

adequate to reflect the seriousness of the public interests that are at stake in these cases. The principal concern in medical disciplinary cases is to ensure that professional standards are maintained so as to safeguard those who avail themselves of health services.

90 The Honorable the Chief Justice, delivering the judgment of the court *ex tempore*, noted in ***Lee Kim Kwong v SMC*** [2014] 4 SLR 113 that although a measure of consistency with sentencing precedents is a consideration, "fidelity to precedent ought not to lead to ossification of the law", and that the Court of Three Judges have previously recalibrated sentences in cases such as ***SMC v Kwan Kah Yee*** [2015] 5 SLR 201 and also in ***SMC v Wong Him Choon*** [2016] 4 SLR 1086, departing from precedents which did not reflect the demands of the presently prevailing circumstances and state of medical practice. His Honour concluded that the medical profession is held in high regard and the trust that is vested in doctors makes it incumbent on the profession to maintain the highest standards of professional practice and conduct. Failures must then be visited with sanctions of sufficient gravity.

91 The DT was also mindful of the observations made by the Court of Three Judges in ***Lee Kim Kwong***, that any reference to sentencing precedents must be undertaken only on the basis that the facts and circumstances as a whole are truly comparable.

92 In this regard, the DT carefully reviewed the cases cited by both Counsels and was of the view that the facts and circumstances of this case, taken as whole, were quite different from the case precedents cited. As rightly pointed out by Dr Sanjay's Counsel, there was no specific benchmark that fell squarely on all fours of the factual matrix of Dr Sanjay's case. Hence, the DT was careful to not over rely on the cases cited by the parties as these cases were not entirely relevant and strictly applicable to the case at hand.

93 The DT first considered whether it would be appropriate to impose a separate sanction for each of the charges proceeded with as submitted by the Counsel for SMC. In this regard, having found Dr Sanjay guilty of both charges, the DT was of the view that given the facts and circumstances of this case, the professional misconduct of Dr Sanjay should be judged as a whole, from the time Dr Sanjay provided inadequate clinical evaluation before reaching a diagnosis of the Patient's condition, to the management of the Patient as characterised in the 2nd amended charge.

94 While there was some merit in the Counsel for SMC's submission that the offences are distinct in nature in that Dr Sanjay had acted in breach of different sections of the ECEG, and thereby warrant separate sanctions for each of these charges, given the particular facts and circumstances of this case, the DT preferred to view the professional misconduct of Dr Sanjay as a single and continuous transaction, arising from a single consultation of the Patient. The DT approached the issue of sentencing by considering what would be an appropriate sanction against Dr Sanjay, having regard to the mitigation and the established and applicable sentencing principles.

95 Moreover, insofar as the 1st amended charge was concerned, the DT was of the view that it is important to send a message that the proper and careful clinical evaluation of a patient is vital for the proper standard of care rendered and should not be treated

lightly. In this instance where an element of public safety is involved, the DT was careful not to negate or diminish the importance of this message with an imposition of a fine for the 1st amended charge as submitted by Counsel for SMC.

96 While the DT was prepared to take into account that there could have been some miscommunication between Dr Sanjay and the Patient at the initial consultation, this could not be taken as an excuse as it is the duty of the doctor to ensure that the Patient understands the medical advice. In this case, the Patient was not proficient in the English language. If there was any ambiguity in the patient's symptoms based on the history taking and the findings, it would be reasonable to expect the doctor to re-take the history, seek clarification with the patient, and verify the results of his medical examination, including coming up with a differential diagnosis. Dr Sanjay failed to do any of this and in the DT's view, Dr Sanjay's conduct clearly fell below the acceptable standard of duty of care to his Patient and amounted to such serious negligence that it objectively portrayed an abuse of privileges as a medical practitioner.

97 Dr Sanjay also knew that the Patient was working as a bus driver and was instructed not to drive. It was irrefutable that the Patient's vision in his right eye, with a VA of 6/24, clearly did not meet the VA required of a bus driver. Yet, Dr Sanjay gave a one-day medical leave with an appointment in six weeks' time and allowed the Patient to resume his driving based on several assumptions, including the assumption that the Patient could make his spectacles within half a day.

98 By doing so, Dr Sanjay was not only endangering the bus driver, but also his passengers and other road users. The DT was of the view that this was simply unacceptable and given the public safety implications, the DT was unanimously of the view that the professional misconduct was sufficiently serious to warrant a suspension in order to serve as a general and specific deterrent.

99 In this regard, the DT considered the case of ***SMC v Wong Him Choon*** cited by the Counsel for SMC, where the Court of Three Judges allowed the SMC's appeal and convicted Dr Wong of professional misconduct in the management of his patient. The essence of the charge against Dr Wong was that Dr Wong had inappropriately gave the patient insufficient hospitalisation post-surgery for a distal radius fracture and a metacarpal fracture, and certified him fit to perform light duties. Dr Wong was suspended for a period of six months.

100 The DT noted that there were several aggravating factors in Dr Wong's case that justified the six months' suspension, specifically, that Dr Wong's failure to provide medical certificate to cover the patient post-surgery demonstrated a wilful disregard for the patient's welfare and interests, in particular, the need for proper rest and rehabilitation; that Dr Wong had chosen not to give the patient medical leave for a multitude of extraneous, irrelevant, unfounded, less than proper, as well as non-medical considerations; that Dr Wong was unremorseful and sought to pin the blame on the patient for his own failure to adequately manage his post-operative recovery; and that the professional misconduct caused harm to the patient as the patient suffered pain in his injured hand.

101 Dr Wong's case pertained to a post-operative surgery situation and the facts in that case was clearly more aggravating than Dr Sanjay's case. While the DT agreed that the absence of harm to the Patient in this case should not be considered as a mitigating factor, the DT also could not agree with the Counsel for SMC that Dr Sanjay's lack of remorse by electing to claim trial should be considered as an aggravating factor.

102 The DT was prepared to accept that Dr Sanjay was remorseful in that he has realised that he could communicate better with his patients and would take steps to improve himself. The DT also gave full weight to Dr Sanjay's unblemished record, that he is a first time offender, and the many testimonials and references of his good character and contributions to research and the community.

103 All considered, the DT 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.

104 Having regard to all the facts and circumstances of the case, the DT was of the unanimous view that a short period of suspension would be fair and appropriate. Accordingly, the DT ordered that Dr Sanjay be suspended for the minimum period prescribed by law.

Orders by this Disciplinary Tribunal

105 In the circumstances, the decision of the DT was that Dr Sanjay:

(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 he 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

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

107 The hearing is hereby concluded.

Dated this 20th day of June 2017.