**SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR SIM KWANG SOON HELD ON 24 MARCH 2016, 9 SEPTEMBER 2016, 13 JANUARY 2017 AND 18 AUGUST 2017**

**Disciplinary Tribunal:**
Prof Walter Tan (Chairman)
Dr Tan Chin Lock Arthur
Mr Bala Reddy (Legal Service Officer)

**Counsel for SMC:**
Mr Philip Fong
Mr Kevin Lim
Mr Sui Yi Siong
(M/s Harry Elias Partnership LLP)

**Counsel for the Respondent:**
Mr Charles Lin
(M/s MyintSoe & Selvaraj)

## 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 Sim Kwang Soon ("**Dr Sim**"), is a general practitioner who was practising at a medical clinic known as Alliance Clinic & Surgery at the material time when the subject matter of this complaint arose. On 16 June 2010, Dr Sim had diagnosed Mdm P ("**the Patient**") to be suffering from a corneal ulcer in her left eye but had not referred the Patient to see an eye specialist immediately. He advised the Patient that the corneal ulcer was small and would not affect her vision. He also advised her that she should return to consult him if her condition did not improve whereby he would then refer her to a specialist. A complaint dated 28 May 2013 was filed by the Patient in relation to Dr Sim's treatment of the Patient's eye condition ("**the Complaint**"). Arising out of the Complaint, the Singapore Medical Council ("**SMC**") proceeded on one charge against Dr Sim before the Disciplinary Tribunal ("**the Tribunal**") of failure to refer the Patient to a specialist for management of the Patient's medical issues in a timely manner. Another charge of failing to exercise due care in the management of the Patient by failing to carry out an adequate history-taking of the Patient ("**the First Charge**") was taken into consideration for the purposes of sentencing.

2 Dr Sim pleaded guilty to the charge and the Tribunal after due consideration, ordered that Dr Sim:

(a) be fined **$30,000**;
(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 the costs and expenses incidental to these proceedings, including the costs of the solicitors of the SMC.

3 We now set out our reasons below.

**Proceedings before the Tribunal**

4 At the Tribunal Inquiry on 9 September 2016, Dr Sim pleaded guilty to the following charge:

"***SECOND CHARGE***

*That you, Dr Sim Kwang Soon, are charged that whilst practising as a General Practitioner at Alliance Clinic & Surgery, Block 652 Jalan Tenaga, 01-50, Singapore 410652, you had failed to refer your patient, namely one* ***P*** *("the Patient") to another doctor with sufficient expertise, in breach of section 4.1.1.6 of the Singapore Medical Council's Ethical Code and Ethical Guidelines, in that:-*

***PARTICULARS***

*(i) you failed during the consultation with the Patient on Wednesday 16 June 2010, to refer her to a specialist immediately upon diagnosing her to be suffering from a corneal ulcer in her left eye and instead, you:*

*(a) erroneously advised the Patient that the corneal ulcer which you assessed to be small and in the periphery would not affect her vision;*
*(b) erroneously advised the Patient that you could still treat and observe her for a few more days;*
*(c) erroneously advised the Patient to monitor her condition for herself for the next 3 days and return to consult you if her condition did not improve whereby only then would you refer her to a specialist.*

*(ii) As a result of your breach, the Patient did not receive appropriate and timely care and management of her corneal ulcer and subsequently, required a corneal transplant and a cataract operation,*

*and your aforesaid conduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174).*"

5 Dr Sim admitted to the Agreed Statement of Facts ("**ASOF**") tendered by SMC's Counsel, Mr Kevin Lim. Dr Sim acknowledged that his failure to make a timely referral of the Patient's eye condition to an eye specialist was in breach of section 4.1.1.6 of the SMC's Ethical Code and Ethical Guidelines (2002 edition) ("**2002 ECEG**") which states the following:

> "*A doctor should practise within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise.*"

**Facts of the Present Case**

6 After receiving the Complaint from the Patient, the Complaints Committee ("**CC**") directed the SMC's Investigation Unit to send a Notice of Complaint dated 18 October 2013 to Dr Sim. Dr Sim provided a written letter of explanation dated 26 November 2013 in response to the Notice of Complaint. Following Dr Sim's explanation to the CC, the matter was referred to this Tribunal to consider the aforementioned charge (see [4] above). The relevant paragraphs of the ASOF relating to the charges were as follows:

> "***The Second Charge***
>
> *7. The gravamen of the second charge is the Respondent's failure to refer the Patient to another doctor with sufficient expertise upon diagnosing her on 16 June 2010 to be suffering from a corneal ulcer in her left eye. Instead of referring the Patient to see a specialist immediately, he had erroneously advised the Patient that the corneal ulcer was small and would not affect her vision. He also advised her that he could still treat and observe her eye condition for a few more days and even advised her that she could monitor her condition for*

*herself for the next 3 days and to return to consult him if her condition did not improve whereby he would then refer her to a specialist.*

8. *The Respondent should have made a timely referral of the Patient's eye condition to an eye specialist. As a consequence, the Patient did not receive appropriate and timely care and management of her corneal ulcer, and subsequently required a corneal transplant and a cataract operation.*

9. *The Respondent's failure to take positive steps to act in the Patient's best interest is in breach of section 4.1.1.6 of the Singapore Medical Council's Ethical Code and Ethical Guidelines (SMC ECEG) which provides that:*

'A doctor should practise within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise.'"

7 Dr Sim admitted that he had acted in breach of his obligations under the 2002 ECEG and hence was guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap 174) ("**MRA**").

8 We heard the address on sentence by SMC's Counsel as well as the mitigation plea by Dr Sim's Counsel, Mr Charles Lin. We carefully considered all the submissions in arriving at the appropriate sentence to be meted out in the present case.

**Submissions on Sentence**

9 SMC's Counsel submitted that the appropriate sentence in this case should be a period of suspension of three to four months having regard to the degree of severity of the offence, and in particular, the following aggravating factors:

(a) Dr Sim's advice to the Patient that the corneal ulcer would not affect the vision in her left eye as a result of its small size and its peripheral location was erroneous and was without excuse. Dr PE2, the SMC's second expert, had expressly stated in his report dated 9 July 2014 that it was "*well-known*" that a corneal ulcer had the potential to cause possible loss of vision, and rapidly.

(b) Dr Sim did not insist on close review and monitoring and lacked a clear sense of urgency when dealing with the Patient's condition. Instead, he was contented to leave it to the Patient, a layman, to monitor her condition and decide whether and when she should come back for further treatment.

(c) Dr Sim's failure to refer the Patient to a specialist in a timely manner caused a further aggravation of the ulcer, and ultimately, after a therapeutic corneal transplant, the Patient suffered permanent disability in her left eye with a decreased rate of functionality of only 20% post-surgery.

10 The SMC's position was that sanctions in medical Disciplinary Tribunal proceedings served two functions: (a) to ensure that the offender does not repeat the offence so as to protect the public from the potentially severe outcomes arising from the actions of errant doctors; and (b) to uphold the standing of the medical profession (*Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201 ("*Kwan Kah Yee*") at [50]). In this respect, both general and specific deterrence could be considered. In addition, in order to discern the appropriate sentence for the breach of an ethical rule, recourse ought to be had to the purpose underlying the rule that had been contravened.

11 Turning to the case precedents, the SMC's Counsel highlighted two groups of cases: (a) cases involving doctors' failure to exercise due care in the management of their patients; and (b) cases involving doctors' failure to refer patients to another doctor with sufficient expertise for further treatment and management. Both types of conduct would involve breaches of the 2002 ECEG — the former category of cases involving breaches of section 4.1.1.1 and the latter category of cases involving breaches of section 4.1.1.6. The SMC's Counsel submitted that the present case called for the same degree of reprobation as the cases in the latter category in which suspension terms of three to four months were imposed. The doctor's failure to practise within the scope of his competence was a very serious form of professional misconduct which called for a suspension term at the minimum because of the significant harm that may result to the patient as a result of delayed treatment. It shook the "*very core*" of the foundation of the doctor-patient relationship which was based on the patient's trust in the doctor being sufficiently qualified to treat him, and that if the doctor was unsure or lacked the necessary expertise, the doctor should refer him to someone with the relevant expertise. In fact, the SMC submitted that the case precedents were unduly lenient and ought to be calibrated upwards in line with the ruling of the Court of Three Judges ("**C3J**") in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*") so that the starting point for a breach of the ethical duty to practise within the scope of one's competence should be a suspension term of three months.

12 Finally, the SMC's Counsel argued that the mitigating factors relied on by Dr Sim ought to be given little weight, especially given that Disciplinary Tribunals are primarily concerned with the protection of public confidence in the medical profession (*Kwan Kah Yee* at [58]). In particular, there is a clear public interest in ensuring that general practitioners like Dr Sim practise within the limits of their competency for the protection of patients' interests. General practitioners are, for the vast majority of Singaporeans, the first point of contact in community healthcare and it is therefore imperative that they understand when their own knowledge is insufficient so that a patient can be referred to the appropriate specialist as soon as possible. In regard to the factors raised in Dr Sim's mitigation, the SMC's Counsel submitted that neither his unblemished record nor his remorse in pleading guilty could be something that Dr Sim should be given credit for. Doctors were expected to be of good character and to serve their patients diligently, and further, where there was overwhelming evidence against an accused person, little weight should be given to the plea of guilt. The SMC relied on the undisputed facts in the ASOF to support its assertion that the evidence was overwhelming.

**Mitigation and Response to Submission on Sentence**

13 Dr Sim's Counsel submitted that the duty to act in the patients' best interests had always been paramount for Dr Sim throughout the course of his 20 years of practice. The fact that there had not been any complaint or claim made against him in this time was a testament to Dr Sim's compassion and professionalism towards his patients. Testimonials from Dr Sim's patients were provided to show the respect and affection Dr Sim had from his patients and the good work being done, in the hope that this Tribunal would allow Dr Sim to continue to work without interruption so that his patients would not be deprived of his continued care.

14 In relation to the charge, Dr Sim's Counsel repeatedly stated that Dr Sim's error in the present case signified a momentary lapse of judgment. Given that Dr Sim was clearly a doctor of good character, the error in this case should be considered a mere lapse of clinical judgment, and classified as a management plan for the Patient which on hindsight turned out to be "*an overzealous desire to help the Patient*".

15 On the facts of the case, Dr Sim's Counsel submitted that Dr Sim's breach of the duty to give the Patient a timely referral to a specialist did not cause a delay in treatment and/or the subsequent loss of vision in the Patient's left eye. The Patient was referred to the Accident & Emergency ("**A&E**") department at Hospital A one day after her consultation with Dr Sim, and did not obtain an immediate referral to Institution A on the same day. Subsequently, after

consultation with the eye specialist, Dr B, the Patient was treated during a hospitalisation period which lasted for more than two weeks. The subsequent loss of vision was therefore caused not by the delay in referral by Dr Sim but by the Patient's lack of response to the eye drops and systematic anti-fungal medication prescribed during her hospitalisation period at the Institution A.

16 In his submissions on sentence, Dr Sim's Counsel submitted that the present trend was not to inflict harsh punishment on doctors who failed to comply with the standards caused by a momentary lapse of judgment. Having to foot legal costs and endure the embarrassment and adverse publicity that the publication of a conviction would entail was sufficient punishment. For "one-off" offenders, prosecution for the offences committed was in itself a form of deterrence (*Wuu David v Public Prosecutor* [2008] 4 SLR 83).

17 In particular, Dr Sim's Counsel highlighted that in the present case, there was an absence of any financial motivation in Dr Sim's actions, and Dr Sim had acted in good faith to do what he honestly thought was in the Patient's interests. Dr Sim's Counsel made reference to the case of *Dr Eric Gan Keng Seng* (11 February 2015) in which the Disciplinary Tribunal ("DT") acknowledged that Dr Gan appeared to have acted in good faith with the patient's best interests at heart and had not intentionally suppressed information from the patient. Dr Gan was fined $5,000, censured and ordered to give the usual undertaking even though he was convicted of two charges. Similarly, in the case of *Dr Goh Min Yih Peter* (17 September 2013, 22 to 24 October 2013 and 18 February 2014) ("Dr Peter Goh"), Dr Peter Goh had been of the mistaken view that he was qualified to carry out certain procedures and was only fined $15,000, censured, and ordered to provide an undertaking to not repeat the conduct. Another charge for publishing a false or misleading advertisement to state that he was qualified to carry out the procedures was taken into account in sentencing.

18 Dr Sim's Counsel also distinguished the cases cited by the SMC's Counsel from the facts of the present case to argue that Dr Sim's culpability was of a much lower level. The case of *Dr Teh Tze Chen Kevin* (18 to 22 May 2015 and 20 November 2015) ("Dr Kevin Teh 2015") could be distinguished because Dr Teh had claimed trial, was convicted of two charges, and had the opportunity to review the patient for a week before deciding to refer her to the SGH Burns Centre after high fever and infection had already set in. In contrast, Dr Sim did not see the Patient again after 16 June 2010, pleaded guilty at the earliest opportunity, and only faced one charge with another taken into consideration for sentencing. The case of *Dr Fong Wai Yin* (25 July 2016) ("Dr Fong") was distinguished on the basis that there was a knowledge gap in that case because Dr Fong had wrongly assumed that the patient had acute conjunctivitis and thereby had made an incorrect diagnosis. Dr Fong's failure to refer had also caused a 13-day delay in diagnosis and treatment and was facing three charges.

In contrast, Dr Sim had not made an incorrect diagnosis in the present case, and his actions had merely caused a one-day delay in treatment.

19 Finally, Dr Sim's Counsel raised two points: first, that Dr Sim had shown true and sincere remorse through his early plea of guilt and through settling the Patient's civil claim against him in the District Court; and second, that Dr Sim was the sole breadwinner of his household and had to care for his elderly mother who was 79 years old this year. In response to the aggravating factor raised by SMC as to the harm that the Patient suffered, it was submitted that the aggravating factor was not unequivocal and in any event, did not outweigh the mitigating factors when viewed in the light of the overall circumstances of the case.

20 Based on the foregoing and the case precedents wherein fines of $2,000 and $15,000 were meted out without a term of suspension being imposed, Dr Sim's Counsel initially submitted that a moderate fine of not more than $7,000, a censure, and appropriate undertaking would be fair and adequate in the present case. His submission was subsequently varied to a fine of $20,000 to $25,000, taking into account the decision of the C3J in *Wong Him Choon* which highlighted the need to recalibrate sentences in relation to professional misconduct concerning doctors. The final variation to the quantum of the fine to be imposed was stated to be $15,000 as Dr Sim's Counsel argued that a "*recalibration of sentences* [did not] ipso facto *mean that all sentences* [were] *immediately enhanced.*"

**Reasons for the sentence imposed**

21 The main issue of contention between SMC's Counsel and Dr Sim's Counsel was whether the circumstances were sufficiently serious to warrant a suspension. The SMC has consistently sought a suspension term of three to four months, whereas Dr Sim's Counsel adopted as his latest position the submission that a fine of $15,000 would suffice as the appropriate sentence (see [9] and [20] above).

22 In light of the above, this Tribunal had, by way of a letter dated 16 February 2017, directed parties to make further submissions, so that we may be assisted on the following issues posed to the SMC. The SMC's Counsel tendered written submissions on 2 March 2017, and Dr Sim's Counsel tendered reply submissions on 16 March 2017. The issues were as follows:

(a) For the SMC to "[articulate] *its position on what the test is to consider the imposition of a suspension order and as to when the threshold is crossed for a suspension of the medical practitioner to be considered in addition to any other sanction that may be imposed. In this respect,* [the SMC is to]

*highlight clearly what* [it] *considers to be the factors in this particular case that shows that the threshold is crossed for such a suspension to be imposed despite other sanctions available*".[1]

(b) For the SMC to make "*submissions on the relevant factors that the DT should take into account in assessing the length of any such suspension that should be considered for a given case, especially in the light of the Court of Three Judges' recent pronouncements in* Lee Lim Kwong, Kwan Kah Yee, Wong Him Choon *and* Peter Yong Thiam Look *for the need to recalibrate sentences in previous precedents to adequately reflect the seriousness of the public interests that are at stake in these cases.*"[2]

23 However, SMC's Counsel appeared to have misinterpreted this Tribunal's directions and submitted instead that there was "*no requirement in law that requires the SMC to come up with a test for when the suspension threshold is crossed*"[3] and that the C3J has "*never required the SMC to articulate the exact point at which the suspension threshold is crossed*".[4] SMC's Counsel further said that the C3J "*sentences medical practitioners based on the application of sentencing principles and benchmarks to the factual matrix of each case*"[5] and therefore "*even the* [C3J] *does not draw a bright line as to when the suspension threshold is crossed.*"[6]

24 Contrary to the submissions of SMC's Counsel, this Tribunal had not asked that the SMC provide an "*exact point at which the suspension threshold is crossed*". Indeed, we are no doubt well aware of the trite principle that each case will have to be decided on its own factual matrix, taking into account all circumstances. However, what we had asked for was their assistance on the relevant factors that have been taken into consideration by the courts and/or tribunals in assessing if the threshold is crossed to impose a suspension order (as opposed to other sanctions). This will also ensure a measure of consistency in sentencing.

25 Unfortunately, assistance had not been forthcoming from SMC's Counsel. Be that as it may, this Tribunal has undertaken a thorough review of all the authorities cited by both parties in the current proceedings in an attempt to distil the relevant factors to be considered in deciding whether a suspension order is appropriate.

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[1] Letter from the SMC DT to M/s Harry Elias Partnership LLP (copying M/s MyintSoe & Selvaraj) dated 16 February 2017 at [2].
[2] Letter from the SMC DT to M/s Harry Elias Partnership LLP (copying M/s MyintSoe & Selvaraj) dated 16 February 2017 at [3].
[3] Prosecution's Further Written Submissions dated 2 March 2017 at [4(a)].
[4] Prosecution's Further Written Submissions dated 2 March 2017 at p 5, header II(A).
[5] Prosecution's Further Written Submissions dated 2 March 2017 at [7].
[6] Prosecution's Further Written Submissions dated 2 March 2017 at [14].

26 In the sub-sections to follow, we will first set out the general principles that guide sanctions in medical disciplinary proceedings and then discuss the relevant factors that warrant the imposition of a suspension order. Finally, we will consider the circumstances of the present case and provide our reasons for the sentence imposed on Dr Sim.

*General principles*

27 In determining the appropriate sentence to be imposed, this Tribunal was mindful of the general principles articulated by the C3J in *Kwan Kah Yee* that guide sanctions in medical disciplinary proceedings.

28 First, the concept of public interest which guides the sentencing of medical misconduct extends further than just the danger which the doctor may pose to his patients (*Kwan Kah Yee* at [51]).

29 Second, considerations of general and specific deterrence may be taken into account when determining the appropriate sentence. In this regard, the following elaboration by V K Rajah J (as he then was) in *Tan Kay Beng v Public Prosecutor* [2006] 4 SLR(R) 10, cited with approval at [55] of *Kwan Kah Yee*, is apposite:

> "*31 … Deterrence, as a concept, has a multi-faceted dimension and it is inappropriate to invoke it without a proper appreciation of how and when it should be applied.* ***It is premised upon the upholding of certain statutory or public policy concerns or alternatively, upon judicial concern or disquiet about the prevalence of particular offences and the attendant need to prevent such offences from becoming contagious.*** *Deterrence, as a general sentencing principle, is also intended to create an awareness in the public and more particularly among potential offenders that punishment will be certain and unrelenting for certain offences and offenders.*
>
> *32 Deterrence however also has a more specific application.* ***Specific deterrence is directed at persuading a particular offender from contemplating further mischief.*** *This assumes that a potential offender can balance and weigh consequences before committing an offence. …*
> *…*
> ***34 In sentencing a particular offender, both general and specific deterrence must be scrupulously assessed and measured in the context of that particular factual matrix before deciding exactly how and to what extent each should figure in the equation. …***" [emphasis added]

30 We were mindful of the two functions of sanctions in disciplinary proceedings: first, to ensure that the offender does not repeat the offence; and second, to uphold the standing of the medical profession. With respect to the former, the ultimate aim is to ensure that the public is protected from the potentially severe outcomes arising from the actions of errant doctors (*Kwan Kah Yee* at [50]).

*When a suspension may be appropriate*

31 With the above general principles in mind, we considered the relevant factors which determine when a suspension order may be appropriate. At the outset, we noted the comments of the C3J in the recent decision of *Chia Foong Lin v Singapore Medical Council* [2017] SGHC 139 ("*Chia Foong Lin*") that the imposition of a suspension order is not dependent on the number of convicted charges but rather, the nature of the misconduct (at [66]):

> "*… there is no existing benchmark that a fine should be preferred over a term of suspension when a medical practitioner is convicted of one charge. Much will turn on the nature of the misconduct in question*."

32 In considering the nature of the misconduct, it is clear to us, from the authorities cited by both parties, that in general, and subject to any exceptional aggravating or mitigating factors, the courts and/or tribunals have imposed a suspension order where one or more of the following factors are present:

(a) Serious and direct breach of the relevant rules and/or statutory provisions;
(b) Negative consequences, including any pain and/or harm caused to the patient(s); and/or
(c) Elements of dishonesty.

33 These will be elaborated upon in turn below. We pause to note that these are merely broad factors and there is a spectrum of gravity of the offending conduct within each factor. In addition, each case will turn on its own unique set of facts. There have been instances where the courts and/or tribunals have deviated from imposing suspension orders notwithstanding the presence of one or more of the factors listed at [32] above, in light of the exceptional circumstances present in such cases.

<u>Serious and direct breach of the relevant rules and/or statutory provisions</u>

34 The courts and tribunals have often viewed serious and direct breaches of the relevant rules and/or statutory provisions as a significant factor in deciding to

impose a suspension term. This appeared to be a common thread amongst the cases which have been cited by counsel in these proceedings.

35 In *Kwan Kah Yee*, the C3J had regard to the "*seriousness of the offence*" in deciding to impose a consecutive suspension term of three years (for three convicted charges). In fact, the C3J commented that "*consideration could have been given to striking* [the respondent doctor] *off the medical register*", though this was not done owing to a lack of submissions on this point.

36 We also observed that the DT, in its inquiry for Dr Kevin Teh (2015), had found that a suspension would be appropriate "*given the gravity of the two offences*" as a fine "*would not sufficiently register the seriousness of the conduct*" (at [43] of the Grounds of Decision). The doctor in that case was suspended for four months.

37 Similarly, the DT, in its inquiry for Dr Heng Boon Wah Joseph (26 July 2016), held that the act admitted to by the respondent doctor (involving 47 charges of inappropriately prescribing hypnotics) was a "*serious misconduct*" (at [10] of the Grounds of Decision). The DT in that case eventually imposed, *inter alia*, a suspension term of four months.

38 In deciding whether a breach of the relevant rule and/or statutory provision is serious, the authorities showed that two factors are of relevance. First, regard will have to be had to the *purpose* underlying the respective rules and/or statutory provisions. Second, the *motivations or reasons* behind the doctor's breach should also be considered.

39 The first factor was reiterated in the recent decision of *Yong Thiam Look Peter v Singapore Medical Council* [2017] SGHC 10 ("*Peter Yong*"), where the C3J first noted the purpose underlying each of the rules that were contravened in each of the charges, and held that the violations of each of the ethical rules were serious, having regard to their underlying purpose (*Peter Yong* at [8]–[9]). The C3J in that case upheld the six-month suspension which was ordered by the DT.

40 The second factor was highlighted unequivocally by the C3J in *Kwan Kah Yee*, where it was held that the "*motivations behind [the doctor's] acts would undoubtedly be an important factor in determining the sentence to be meted out against an errant doctor*" (at [70]). Unfortunately, no investigations had been conducted by the SMC on the motivations of the impugned doctor in *Kwan Kah Yee*.

41 The importance of the reasons behind the doctor's acts was again emphasised in *Wong Him Choon*, where the C3J held that "*the reason for an intentional departure from the requisite standard, while not directly relevant to conviction, is*

*relevant to sentencing*" (at [99]). The C3J found that the doctor, in certifying the patient fit for light duties without first establishing the availability of the same, had been advancing the interests of the employer and had wanted the patient to return to work as soon as possible. The doctor's main concern had not been the patient's welfare and interest. The C3J allowed the SMC's appeal and imposed a suspension term of six months.

Negative consequences, including any pain and/or harm caused to the patient(s)

42 Another principle that this Tribunal has distilled from the authorities is that the courts and/or tribunals have generally imposed a suspension term where there are negative consequences following from the doctor's actions. These include, but are not limited to, any pain and/or harm caused to the patients.

43 For example, there was no pain and/or harm caused to any patients in *Kwan Kah Yee* as it involved the improper certification of death for two separate patients. Nonetheless, the C3J held that there were "*extensive negative consequences that may flow from an improperly certified death*" (at [34]). For example, from a legal standpoint, such negative consequences may include the potential cover-up of a homicide and an erroneous determination of liability in civil lawsuits (*eg*, in cases of malpractice). It was also in this context that the C3J commented that the "*concept of public interest which guides sentencing of medical misconduct extends further than just the danger which the doctor may pose to his patients*" (at [51]). A consecutive three-year suspension term was imposed in this case.

44 With regard to cases where pain has been suffered by the patients, we noted that the DT, in its inquiry for Dr Peter Goh, had gone so far to hold that "*[i]f there was evidence of harm to patients, a period of suspension must be incorporated as part of the punishment*" (at [53(b)]). In that case, the doctor had performed a blepharoplasty procedure[7] on 22 patients even though he was not qualified to do so. However, there was no evidence of harm to the patients, and the DT eventually only imposed a fine of $15,000.

45 The courts and tribunals have also repeatedly emphasised the importance of the consequence to the patient in determining the appropriate sentence. This Tribunal has observed from the cases cited that where pain has resulted to the patients, a suspension term will typically be imposed. The C3J in *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745 ("*Eric Gan*") held (at [56]):

> "*… the* ***consequence to the patient as a result of the professional misconduct should be disclosed. This is a highly***

[7] A blepharoplasty (also known as an eyelid surgery) is a surgical procedure to improve the appearance of the eyelids.

> ***material fact**. Only where this information is furnished would that precedent be of assistance to the Disciplinary Committee, and, in turn, the court, **to determine the appropriate sentence**, or to determine if the sentence imposed by the Disciplinary Committee on an appeal to this court is* manifestly excessive." [emphasis added]

46 In *Eric Gan*, the doctor had performed a pre-cut sphincterotomy[8] on his patient which concluded unsuccessfully. Two hours later, he was informed that his patient was unwell, but did not examine the patient until the next day, nearly 17 hours after the procedure. The CT scan was not ordered until 25 hours after the procedure, following which the patient was sent for emergency surgery. The patient eventually passed away about 1.5 months later from septicaemia.[9] The C3J upheld the six-month suspension order imposed by the Disciplinary Committee ("**DC**").

47 The C3J in a subsequent case of *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 ("*Lee Kim Kwong*") also considered that the decision in *Eric Gan* provided some assistance as it similarly "*involved serious harm to the patients*". In *Lee Kim Kwong*, the gynaecologist had commenced a Caesarean section on his patient without first testing if the anaesthetic had taken full effect, thereby inflicting significant pain on his patient. The C3J upheld the DC's imposition of a five-month suspension term.

48 Most recently, in *Peter Yong*, the C3J held that "*if harm to the patient did ensue in such a case where harm was not an element of the charge, this would be a serious aggravating factor*" (at [12]).

Elements of dishonesty

49 A third factor which we identified from the cases cited is that the courts and tribunals have taken a stern view of dishonesty, and have been inclined to impose a suspension term where there is dishonesty.

50 Indeed, the C3J in *Kwan Kah Yee* even considered that erasure from the medical register should be the starting point where the impugned doctor had been dishonest (at [49]):

> "*49 In our judgment, the improper issuance of a false death certificate based on non-existent medical records goes against the*

[8] A pre-cut sphincterotomy is an endoscopic technique used to gain access to the bile duct, and in rare cases, to the pancreatic duct.
[9] Septicaemia is a blood infection caused by bacteria.

> *very essence of these standards and constitutes a very serious breach of the* [2002 ECEG]. *This is seriously aggravated if the doctor then fabricates or conjures up records in an attempt to justify the false certification. In this case,* ***the element of dishonesty was scarcely accounted for by the DT when it held that it led to the crossing of the threshold from a mere censure or a fine to a suspension****. This was overly lenient to the point of being wrong in principle. It is* ***out of line with Sir Donald Irvine's suggested approach of erasure from the medical register as the starting point before adjusting for proportionality*** *… It is* ***also out of line with the approach we take to dishonest lawyers who are invariably struck off the rolls regardless of the mitigating circumstances*** *…*" [emphasis added]

Concluding remarks on the three factors identified for the imposition of a suspension order

51 The three factors elaborated at [31] to [50] above are useful in determining whether the imposition of a suspension term is warranted on the facts of a particular case. Nonetheless, this Tribunal would like to reiterate our observations at [33] above. Each case will have to be decided upon its own set of unique facts, having regard to all circumstances. For the avoidance of doubt, we wish to make clear that the presence of one or more of these three factors does not necessarily mean that a suspension order will be imposed, especially where exceptional circumstances are present.

52 Examples of such exceptional circumstances that have been taken into account by the courts and tribunals were discussed by the C3J in *Lee Kim Kwong*, where the C3J considered (at [29] to [32]) three "*comparatively lenient*" precedents where no suspension term was imposed, notwithstanding that the patients had suffered permanent damage or died. The "*unique*" factors in those cases included: (a) acting at all times in good faith and out of an honest but ultimately misguided intent to give effect to the patient's wishes (see the case of Dr Koh Gim Hwee discussed at [30] of *Lee Kim Kwong*); (b) very complicated surgical procedures (see the case of Dr S discussed at [31] of *Lee Kim Kwong*); and (c) conditions which are difficult to diagnose (see the case of Dr K discussed at [32] of *Lee Kim Kwong*).

53 The case of Dr Teh Tze Chen Kevin (18 to 19 July, 26 August and 20 December 2013, 23 to 24 January, 9 July and 19 August 2014) was another example where the DC "*made a choice to be lenient with Dr Teh … on the specific facts of the case*" (at [140] and [144]). This was notwithstanding that the patient had sustained permanent damage to his blood circulation and the thenar muscles in his hand, and that there had been some dishonesty on the part of Dr Teh in

tampering with the case notes. The DC recognised that this was a "*borderline*" case (at [141]) and they were "*initially inclined to impose the minimum suspension of 3 months*", but "*felt that the mitigating factors were compelling*" (at [144]). The DC considered favourably the fact that Dr Teh had reformed much of the clinic's standard operating procedures since the complaint, which suggested that he had learnt from his mistakes.

Other jurisdictions

54 We also considered the position in England, where the Medical Practitioners Tribunals ("**MPT**") are guided by the "*Sanctions guidance*" (May 2017) http://www.mpts-uk.org/DC4198_Sanctions_Guidance_23008260.pdf (the "UK Sanctions Guidance"). The UK Sanctions Guidance was developed by a steering group of staff from the Medical Practitioners Tribunal Service ("**MPTS**") and the General Medical Council ("**GMC**"), and approved by the Council of the GMC.

55 Before we elaborate on the guidelines under the UK Sanctions Guidance, we pause to note certain differences in the medical disciplinary regime in England and in Singapore. In Singapore, the charges brought by the SMC must be proved beyond reasonable doubt (*ie*, the criminal standard of proof) (see, for example, *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 at [39]). In contrast, the standard of proof before the adjudication panel in England is on a balance of probabilities (*ie*, the civil standard) (see J.K. Mason and G.T. Laurie, *Law and Medical Ethics* (Oxford University Press, 8th Ed, 2011) at para 1.40).

56 The sentencing powers of the MPT in England also differ from that of the DT in Singapore. Under section 35D(2)(b) of the Medical Act 1983 (c 54) (UK), the MPT is empowered to suspend the doctor's registration for a period not exceeding 12 months at any one time, although under section 35D(5)(a), it may, if appropriate, extend the period of suspension from the time when it would otherwise expire. The MPTS also has the power to arrange for the MPT or an Interim Orders Tribunal to make an interim suspension order for a period not exceeding 18 months if it is satisfied that it is necessary for the protection of the public or it is otherwise in the public interest to do so.

57 In comparison, the DT's sentencing jurisdiction is found in section 53(2)(*b*) of the MRA, under which it may suspend the doctor's registration for not less than three months and not more than three years. The DT also does not have express powers under the MRA to make an interim suspension order.

58 Notwithstanding the above differences, the UK Sanctions Guidance may still serve as a broad guide in deciding on the issue of when the threshold for imposing a suspension order has been crossed. We note, at the outset, that the rationale for imposing sanctions as enunciated in the UK Sanctions Guidance is

similar to that in Singapore, namely, to "*protect the public*", "*maintain public confidence in the medical profession*" and "*maintain proper professional standards and conduct for members of the profession*" (at para 14).

59 Accordingly, the UK Sanctions Guidance considers that (at para 92):

> "*Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration…*"

60 The UK Sanctions Guidance further sets out a non-exhaustive list of factors which would indicate when suspension may be appropriate (at para 97):

> "*a.* ***A serious breach of*** **Good medical practice***, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
>
> *b. In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.*
>
> *…*
>
> *e. No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> *f. No evidence of repetition of similar behaviour since incident.*
>
> *g. The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*"
>
> [emphasis added]

61 We also reproduce herein a table from the UK Sanctions Guidance setting out examples of aggravating factors that will be relevant to the length of suspension (at p 30):

| *Area* | *Factor* |
|---|---|
| *Seriousness of the findings* | • ***The extent to which the doctor departed from the principles of* Good medical practice**<br>• *The extent to which the doctor failed to take prompt action when patient safety, dignity or comfort was seriously compromised*<br>• *Whether the doctor showed a lack of responsibility toward clinical duties/patient care*<br>• *The extent to which the doctor's actions risked patient safety or public confidence*<br>• ***The extent of the doctor's significant or sustained acts of dishonesty or misconduct***<br>• *The* ***seriousness*** *of the doctor's inappropriate behaviour*<br>• *The extent of the doctor's predatory behaviour*<br>• ***The impact that the doctor's actions had on vulnerable people and the risk of harm*** |
| *Subsequent steps taken* | • *Whether the doctor is reluctant to take remedial action*<br>• *Whether the doctor is reluctant to apologise*<br>• *The extent to which the doctor failed to address serious concerns over a period of time* |
| *Extent to which the doctor has complied* | • *The extent to which the doctor failed to comply with restrictions/requirements*<br>• ***Whether the doctor showed a deliberate or reckless disregard for restrictions/requirements***<br>• *Whether the doctor failed to be open and honest with GMC and local investigations* |

[emphasis added]

62 From the above discussion, it clearly emerges that the three factors identified at [31] to [50] above are broadly mirrored in the UK Sanctions Guidance. Accordingly, the Singapore courts and tribunals have, from the cases cited to us,

taken into account similar factors as those espoused in the UK Sanctions Guidance in considering the imposition of a suspension order.

63 We then proceeded to consider the Australian position. As with England, the standard of proof in Australia is the civil standard, on a balance of probabilities (see, for example, *Medical Board of Australia v Myers* [2014] WASAT 137 at [8]). This is in contrast to the criminal standard in Singapore.

64 The sentencing jurisdiction of the Australian courts and tribunals is also different from that in Singapore. The Australian Health Practitioner Regulation National Law Act 2009 (the "**National Law**") provides at s 196(2) that the tribunal may "*require the practitioner to pay a fine of not more than $30,000*" or "*suspend the practitioner's registration for a specified period*". All eight Australian states and territories have enacted the National Law, save that New South Wales is a co-regulatory jurisdiction and is not participating in certain parts of the National Law, including s 196. Unlike Singapore, there are no limits to the period of suspension to be imposed by the Australian courts and tribunals.

65 In interpreting and applying section 196 of the National Law, the Western Australia State Administrative Tribunal ("**WASAT**") had, in *Medical Board of Australia v Myers* [2014] WASAT 137 (S) ("*Myers*"), commented that the "*proper use of suspension is in cases where the practitioner has fallen below the high standards to be expected of such a practitioner, but not in such a way as to indicate that he/she lacks the qualities of character which are the responsibilities of a practitioner*" (at [21]). The WASAT also confirmed that the "*jurisdiction of the Tribunal is protective rather than punitive, and such protection runs to both the public and the profession*" (at [8]).

66 The WASAT also reviewed Australian case law and set out a list of 12 non-exhaustive matters which may require consideration in determining an appropriate sanction. The tribunal did not go so far as to highlight the factors which will suggest the imposition of a suspension order. Nonetheless, we observed that the 12 matters broadly resemble those in the UK Sanctions Guidance. The 12 matters are (at [12]):

> "*1) any need to **protect the public against further misconduct by the practitioner**…*
>
> *2) the need to **protect the public through general deterrence** of other practitioners from similar conduct…*
>
> *3) the need to **protect the public and maintain public confidence in the profession** by reinforcing high professional standard and denouncing transgressions and*

*thereby articulating the high standards expected of the profession … such that, even where there may be no need to deter a practitioner from repeating the conduct, the conduct is of such a nature that the Tribunal should give an emphatic indication of its disapproval…*

4) *in the case of conduct involving misleading conduct, including **dishonesty**, whether the public and fellow practitioners can place reliance on the word of the practitioner…*

5) ***whether the practitioner has breached any: a) Act; b) Regulations; c) Guidelines or Code of Conduct**, issued by the relevant professional body; and d) whether the practitioner has done so knowingly;*

6) *whether the practitioner's conduct demonstrated incompetence, and if so, to what level;*

7) *whether or not the incident was isolated such that the Tribunal can be satisfied of his or her worthiness or reliability for the future …*

8) *the practitioner's disciplinary history…*

9) *whether or not the practitioner understands the error of his ways, including an assessment of any remorse and insight (or a lack thereof) shown by the practitioner, since a practitioner who fails to understand the significance and consequences of misconduct is a risk to the community …*

10) *the desirability of making available to the public any special skills possessed by the practitioner;*

11) *the practitioner's personal circumstances at the time of the conduct and at the time of imposing the sanction. However, the weight given to personal circumstances cannot override the fundamental obligation of the Tribunal to provide appropriate protection of the public interest in the honesty and integrity of legal practitioners and in the maintenance of proper standards of legal practice …; and*

12) *The Tribunal may consider any other matters relevant to the practitioner's fitness to practise and other matters which may be regarded as aggravating the conduct or mitigating its*

*seriousness … In general, mitigating factors such as no previous misconduct or service to the profession are of considerably less significance than in the criminal process because the jurisdiction is protective not punitive…*"

[emphasis added]

67 From the above, it is clear that the courts and tribunals in Australia have similarly taken into consideration the concepts of general and specific deterrence in determining the appropriate sentence. The Australian courts and tribunals have also placed emphasis on the need to protect the public and maintain the integrity of the medical profession in disciplinary proceedings. Points (4) and (5) of the 12 matters raised in *Myers* also broadly mirror two out of three of the factors which we have identified at [34]–[41] (*ie*, serious and direct breach of the relevant rules and/or statutory provisions) and [49]–[50] (*ie*, dishonesty) above.

*Precedents*

68 Having set out the framework above, we turn to consider the sentencing precedents brought to our attention for cases involving similar misconduct, namely, failure to refer the patient to a specialist in a timeous manner. In the three cases cited to us by SMC's Counsel (namely the DT inquiries for Dr Kevin Teh (2015), Dr AAD and Dr Fong), suspension terms of three to four months were imposed, with no additional fine. The usual orders for a censure, an undertaking not to reoffend and costs were also imposed.

69 In response, Dr Sim's Counsel submitted that Dr Sim's culpability in the present case is lower than that in the three precedent cases cited by the SMC and Dr Sim should therefore not be sentenced to a term of suspension as imposed on the medical practitioners in the three precedent cases.[10] Dr Sim's Counsel also submitted that Dr Sim's case is instead more analogous to precedents involving medical practitioners performing procedures that they were not qualified to carry out, as Dr Sim was in short not qualified as a general practitioner to treat corneal ulcers. These precedents typically involved a fine, with no suspension imposed.[11]

70 Having carefully considered parties' submissions, we agreed with Dr Sim's Counsel that Dr Sim's culpability in the present case is lower than the medical practitioners in the three precedent cases cited by the SMC. We elaborate our reasons below.

[10] Respondent's Further Written Submissions for the Fourth Tranche Hearing dated 16 March 2017 at [56]–[64].
[11] Respondent's Supplementary Mitigation Plea dated 9 September 2016 at [15].

71 In the case of Dr Kevin Teh (2015), Dr Teh had claimed trial to three charges and was found guilty of two charges, one of which related to the failure to refer his patient to a specialist in a timely manner. Dr Teh had performed a Vaser liposelection[12] procedure on both of the patient's thighs on 14 October 2010. On 15 October 2010, Dr Teh observed blisters, swelling and bruising on the patient's thighs. Over the next five days, he reviewed the patient daily but the patient's condition did not improve. It was only on 21 October 2010 (i.e. seven days later) that the patient was admitted to the SGH Burns Centre (accompanied by Dr Teh), where she was diagnosed to have full thickness burns on both thighs. The patient then underwent a skin graft surgery the next morning. Dr Teh was sentenced to a suspension of four months.

72 In Dr AAD's case, Dr AAD had claimed trial and was found to be guilty of one charge of professional misconduct for failing to refer his infant patient to a specialist (a consultant paediatric ophthalmologist) for Retinopathy of Prematurity ("ROP")[13] screening in a timely manner. Based on the evidence, such referral should have been made within four to six weeks postnatal or 31 to 34 weeks gestational age, whichever is the later. However, Dr AAD had only made the referral some five months later than the requisite time. It was also in evidence before the DC that the patient had no useful vision in the left eye. Dr AAD was sentenced to a suspension of three months.

73 In Dr Fong's case, he pleaded guilty to three charges, one of which related to his failure to refer his patient to a specialist in a timely manner. The patient had consulted Dr Fong, a general practitioner, at his clinic on three occasions over five days on 13, 15 and 18 March 2013. During these consultations, the patient presented with red eyes and high pressure in her eyes, blurred vision, severe and persistent headache, and vomiting. There was no apparent improvement in the patient's conditions in the course of the consultations. However, Dr Fong never referred the patient to a specialist, and it was only on 25 March 2013 that the patient was referred to a specialist clinic by another general practitioner. On 26 March 2013, the patient was diagnosed with Bilateral Acute Angle Closure Glaucoma[14] by the specialist. The DT found that "*[a]s a result of [Dr Fong's] wrong assumption of conjunctivitis and his continued treatment for her for this condition, the patient suffered an injury or loss in her vision*" (at [32]). Dr Fong was sentenced to a suspension of three months.

74 We observed that the level of culpability of the doctors in the three precedent cases above were more serious than Dr Sim's in two areas. First, the delays in

[12] Vaser liposelection is a form of liposuction technique.
[13] ROP is a disease arising from an abnormal growth of blood vessels in a baby's eye. It is most common in babies who are very premature.
[14] Acute angle-closure glaucoma occurs when the fluid pressure inside the eye becomes too high very quickly.

the case of Dr Teh, Dr AAD and Dr Fong were more substantial and there was no evidence that these doctors had any intention of referring their patients to a specialist at the material time. After her operation, Dr Teh reviewed the patient daily and noted that her condition did not improve. However, he only sent the patient to the SGH Burns Centre seven days later. Dr AAD had only referred the infant patient to the specialist after five months. Dr Fong saw the patient over five days but never referred the patient to a specialist even though there was no apparent improvement in the patient's condition.

75 In contrast, Dr Sim did not have the chance to review the Patient's condition again after he diagnosed her with corneal ulcer on 16 June 2010. The Patient had consulted another general practitioner the very next day (i.e. 17 June 2010) and was referred to Hospital A on the same day. Significantly, it was not in dispute at all that Dr Sim had, at the material time, intended to refer the Patient to a specialist if her condition did not improve.[15]

76 Second, the medical practitioners in the three precedent cases either faced more charges or claimed trial to the charge(s) brought against them. Dr Sim has pleaded guilty to one charge, with the other charge taken into consideration. However, Dr Kevin Teh (2015) contested three charges and was found guilty of two charges. Dr AAD contested the single charge against him and was found guilty of that charge after trial. Dr Fong pleaded guilty to three charges.

*Circumstances of the present case*

77 Having considered the framework and precedents, we examined the appropriate sentence to be imposed in the present case.

78 As explained at [31]–[50] above, we have distilled three broad factors from the authorities cited to us by counsel for both parties; the presence of one or more of these factors have, subject to any exceptional factors, generally warranted the imposition of a suspension term. As there was no evidence of any dishonesty before this Tribunal, we shall only focus our discussion in this section on the remaining two factors.

<u>Whether there has been such serious and direct breach of section 4.1.1.6 of the 2002 ECEG to warrant a suspension term</u>

79 We first considered if there has been such serious and direct breach of section 4.1.1.6 of the 2002 ECEG to warrant a suspension term in the present case,

[15] ASOF at [7].

having regard to (a) the purpose underlying the guideline, and (b) the motivations or reasons behind Dr Sim's breach.

80 Section 4.1.1.6 of the 2002 ECEG provides:

> "*4.1.1.6 Practise within competence and referral of patients*
>
> *A doctor should practise within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another doctor with the necessary expertise. A doctor shall not persist in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having the required experience…*"

81 The rule therefore requires a doctor to "*appreciate the limits of his own competency*" (see *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at [73]) and offer to refer the patient to another doctor with the necessary expertise where he believes that such limits are exceeded.

82 In the present case, the gravamen of the proceeded charge is Dr Sim's failure to refer the Patient to another doctor with sufficient expertise upon diagnosing her on 16 June 2010 to be suffering from a corneal ulcer in her left eye. We noted that the two expert opinions tendered by the SMC had differing opinions as regards the way Dr Sim had managed the Patient. Dr PE1 took a more critical view, and commented that "*once Dr Sim has diagnosed a corneal ulcer, an* ***urgent referral must be made immediately*** *to an ophthalmologist for further assessment and management as severe visual disability could occur with delayed specialist care*" [emphasis added]. Dr PE1 further disagreed with Dr Sim's explanation[16] that he "*could continue to treat the corneal ulcer as it was small and in the corneal periphery and would not affect her vision.*"[17]

83 On the other hand, Dr PE2 was more equivocal. Dr PE2 opined as follows:[18]

> "*Dr Sim decided to treat the ulcer, with anti-bacterial drops, as 'it was small and on the periphery' (not on the visual axis), but* ***regrettably did not insist on close review and monitoring, opting instead for observation for 'a few more days'***." [underline in original, emphasis in bold]

[16] Written explanation from Dr Sim dated 26 November 2013 (Agreed Bundle Tab 4).
[17] Expert report by Dr PE1 dated 26 June 2014 (Agreed Bundle Tab 6).
[18] Expert report by Dr PE2 dated 9 July 2014 (Agreed Bundle Tab 7).

84 It appeared to us that Dr PE2 did not take objection with Dr Sim's decision to treat the corneal ulcer *per se* (as opposed to an immediate referral to a specialist), but was of the opinion that Dr Sim had instead failed to insist on close review and monitoring.

85 It is no doubt important that doctors practice within the limits of their competency, and refer patients to specialists where such limits have been exceeded. This will enable patients to receive adequate and timely treatment. However, the difference in the expert opinions showed that the point at which such limits are crossed may not be entirely clear. Dr PE1 was of the view that referral should be made immediately upon diagnosis of corneal ulcer. Dr PE2 did not specify a time when referral ought to be made, but opined that Dr Sim should have insisted on close review and monitoring of the Patient. We noted that the SMC has relied equally on the expert opinions of both Dr PE1 and Dr PE2[19] and has not preferred the views of one over the other. Unfortunately, no further evidence was led on this issue, and we are not in a position to make any conclusive findings on whether the 2002 ECEG standard would have required Dr Sim to refer the Patient to a specialist immediately on the facts of this case.

86 Notwithstanding the above, we considered it clear from both expert opinions that Dr Sim's decision to observe the Patient's eye condition "*for a few more days*"[20] was erroneous. Even on Dr PE2's view, Dr Sim should have reviewed and monitored the Patient more closely. In our view, this would at least allow Dr Sim more opportunities to refer the Patient to a specialist timeously in the interim where necessary.

87 With regard to the motivations or reasons behind Dr Sim's breach, we have mentioned above (at [75] that Dr Sim had intended to refer the Patient to a specialist if her condition did not improve over the next few days. This was not in dispute. This was not a case where Dr Sim had no intention to refer the Patient to a specialist at all. There was also no evidence before us which suggested that Dr Sim had withheld referral for reasons of personal gain, out of malice, or out of a total disregard for the Patient's wellbeing.

88 In light of the above, and based on (a) the purpose underlying the guideline, and (b) the motivations or reasons behind Dr Sim's breach, we did not regard Dr Sim's failure to refer the Patient to a specialist on the facts of this case as such a serious and direct breach of section 4.1.1.6 of the 2002 ECEG as to warrant a suspension term. Most crucially, we took into consideration the fact that Dr Sim had always intended to refer the Patient to a specialist if her condition did not improve. In addition, we were unable to make a conclusive finding on

[19] ASOF at [10]–[12].
[20] ASOF at [7].

whether Dr Sim ought to have referred the Patient to a specialist on the same day. The Patient was in any event seen at the A&E department of Hospital A the next day but did not get an immediate referral to Institution A on the same day either. While Dr Sim should have monitored the Patient more closely, we were of the opinion that, taken in totality, Dr Sim's acts did not constitute such a serious and direct breach of section 4.1.1.6 of the 2002 ECEG as to warrant a suspension term.

Whether negative consequences resulted

89 The ASOF states (at [8]):

> "*The Respondent should have made a timely referral of the Patient's eye condition to an eye specialist. As a consequence, the Patient did not receive appropriate and timely care and management of her corneal ulcer, and subsequently required a corneal transplant and a cataract operation.*"

90 Although not in the ASOF, we also noted that the Patient had, in the Complaint, stated that her "*left eye is still at 20% functionality*", with "*a chance of corneal graft failure, or secondary condition such as cataract & glaucoma, that can compromise vision*" in the long term.[21] Save for the Complaint, there was no other evidence of this before this Tribunal. There was also no evidence relating to the present condition of the Patient.

91 SMC's Counsel submitted that Dr Sim has, by virtue of [8] of the ASOF, admitted that the Patient required a corneal transplant and a cataract operation because of his failure to make a timely referral of her condition to an eye specialist, and it is not open to Dr Sim to now dispute the issue of causation.[22]

92 Dr Sim's Counsel, however, disagreed with the SMC's interpretation and submitted that the issue of causation is not as unequivocal as the SMC has made it out to be. What Dr Sim had agreed to at [8] of the ASOF was that his failure to make a timely referral of the Patient's eye condition to an eye specialist meant that the Patient did not receive appropriate and timely care and management of her corneal ulcer.[23] In addition, Dr Sim's Counsel submitted that causation has not been clearly established between the Patient's corneal transplant and cataract operation on one hand, and Dr Sim's failure to refer the Patient to a specialist on 16 June 2010 on the other.

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[21] The Complaint dated 28 May 2013 (Agreed Bundle Tab 2 at pp 14 and 18).
[22] Prosecution's Further Written Submissions dated 2 March 2017 at [51].
[23] Respondent's Further Written Submissions for the Fourth Tranche Hearing dated 16 March 2017 at [99].

93 From the authorities cited by both parties, the issue of how the causal link between the doctor's acts and the eventual harm to the patient affects sentencing is one that has not been considered in detail. However, as we have observed at [33] above, there is a spectrum of gravity within each factor. The authorities which have been cited to us showed that a stronger causal link would tip the balance in favour of a suspension term.

94 A clear example of a lack of a causal link may be found in the DT inquiry for Dr Garuna Murthee Kavitha (21 April 2015) ("Dr Garuna"), where the doctor had erroneously administered a chemotherapy medication to a patient intrathecally instead of intravenously. Dr Garuna pleaded guilty to one charge of professional misconduct under section 53(1)(*d*) of the MRA. The DT considered that Dr Garuna's mistake, while serious, did not lead directly to the demise of the patient, who ultimately succumbed to the underlying illness (at [16]). The DT held that a sentence of suspension would not be appropriate, and imposed a fine of $2,000 instead (at [18]).

95 In contrast, the causal link in the case of Dr Kevin Teh 2015 (see [71] above) was much stronger. In that case, Dr Teh had performed a Vaser liposelection procedure on the patient's thighs on 14 October 2010. On the next day, blisters, swelling and bruising were observed on the patient's thighs. It could be inferred that these would likely have arisen as a result of the procedure carried out by Dr Teh because there were no intervening events between the procedure carried out by Dr Teh and the harm suffered. When the patient was admitted to the SGH Burns Centre on 21 October 2010, she was diagnosed to have full thickness burns on both thighs, and had to undergo a skin graft surgery. Dr Teh was sentenced to a suspension of four months.

96 Having considered the evidence before us and parties' submissions, we did not think that the issue of causation has been proved by the SMC beyond reasonable doubt. In this regard, SMC's Counsel had raised two points in support of his submission that it was "*quite impermissible*" for Dr Sim to "*disclaim responsibility for causing harm to the patient*".[24] First, Dr Sim had already admitted to the same in [8] of the ASOF (see [91] above). Second, it was clarified during the second tranche hearing on 9 September 2016 that the cataract developed by the Patient arose from the corneal ulcer, and Dr Sim's Counsel did not dispute this then. No other evidence was tendered in support of this submission.

97 With regard to the first point raised by SMC's Counsel, we have noted the alternative interpretation of [8] of the ASOF as submitted by Dr Sim's Counsel (see [92] above). In light of the lack of evidence on this point, we were hesitant to find that there was causation simply based on [8] of the ASOF. With regard to

[24] Prosecution's Further Written Submissions dated 2 March 2017 at [51].

the second point, it appeared to us that the clarification related to the fact that the *cataract* arose from the corneal ulcer. This does not necessarily mean that Dr Sim's *failure to refer* the Patient to a specialist timeously caused the cataract, and necessitated the corneal transplant and cataract operation.

98 In addition, we noted the following facts of the present case, which may cast doubt on the issue of causation:

(a) The Patient had been referred by another general practitioner to Hospital A on 17 June 2010, just one day after Dr Sim had diagnosed the corneal ulcer.[25]

(b) The Patient had initially been discharged on 3 July 2010 after some improvement was noted. However, the corneal transplant was performed on 21 July 2010 after the left corneal infiltrate was noted to be enlarging despite medical treatment.[26]

99 In the premises, while the Patient has suffered harm as a result of the corneal transplant and cataract operation, in view of the insufficient evidence led before us, we were unable to satisfy ourselves that the harm was caused by Dr Sim's failure to refer the Patient to a specialist timeously.

*The Sentence*

100 This case, in our view, was on the borderline. While there had been a breach of section 4.1.1.6 of the 2002 ECEG, it did not appear to us that there had been a serious and direct breach of the same, taking into account (a) the fact that there was some ambiguity as to whether the purpose behind the said rule would have required Dr Sim to refer the Patient immediately on the same day to a specialist in the circumstances, and (b) the motivations or reasons behind Dr Sim's breach — he had always intended to refer the Patient to a specialist if her condition did not improve (see [79]–[88] above).

101 Furthermore, while there had been harm caused to the Patient, we were unable to accept based on the evidence before us that the harm had been caused by Dr Sim's failure to refer the Patient to a specialist in a timeous fashion. We have explained that while the issue of causation has not been discussed in detail in the authorities cited to us (and indeed was not an element of the present charge), the cases show that a stronger causal link would tip the balance in favour of a suspension term for the purposes of sentencing (see [89]–[99] above).

[25] The Complaint dated 28 May 2013 (Agreed Bundle Tab 2 at pp 15–16).
[26] Exhibit P-1 at p 1.

102 While we have identified from the authorities cited that the presence of negative consequences, including any pain and/or harm caused to the patient(s), would generally lead to an imposition of a suspension term, this would always be subject to any exceptional circumstances. Each case would have to be considered holistically and decided on its own set of unique facts (see [51]–[53] above).

103 As explained above (at [68]–[76]), we considered Dr Sim's culpability in the present case to be lower than the medical practitioners in the three precedent cases cited by the SMC, which involved similar misconduct of a failure to refer a patient to a specialist in a timeous fashion. In the cases of Dr AAD and Dr Fong (see [72]–[73] above), the doctors had been sentenced to the minimum suspension term of three months, together with the usual orders of a censure, an undertaking not to reoffend and costs. No fine was imposed.

104 For completeness, we noted that the C3J had most recently, in *Chia Foong Lin* (see [31] above), upheld the DT's imposition of the minimum suspension term of three months. We were of the opinion that Dr Sim's culpability was lower than that of Dr Chia in *Chia Foong Lin*. Firstly, Dr Chia had failed to make a correct diagnosis of her infant patient even though she had 23 years of experience as a paediatrician and faced a disease that was not uncommon. Dr Chia had seen her patient on no less than three occasions and her patient had presented persistent fever throughout the time. Notwithstanding the above, Dr Chia failed to order the necessary supportive tests. In contrast, Dr Sim had rightly diagnosed the Patient with corneal ulcer but because of the ulcer's small size and peripheral position, had failed to refer the patient to a specialist immediately on the same day. He had, however, intended to refer the Patient to a specialist if her condition did not improve.

105 Secondly, Dr Chia was found guilty of one charge of professional misconduct which involved breaches of two different sections of the 2002 ECEG (i.e. sections 4.1.1.1 and 4.1.1.5). In contrast, the sole charge proceeded against Dr Sim related to a breach of one section of the 2002 ECEG (i.e. section 4.1.1.6). Thirdly, Dr Chia had claimed trial and was found guilty of the charge. Dr Sim, on the other hand, had pleaded guilty.

106 To this end, we had regard to the observations of the C3J in *Kwan Kah Yee* on the range of the sentencing powers accorded to the DT pursuant to the 2010 legislative changes to the MRA (at [46]):

> "*… In our judgment, it would be* ***appropriate to use the full range of the sentencing powers to ensure that these are commensurate with the gravity of the offence****, and there is no reason to shy away from exercising this power where necessary.*

*Indeed, the 2010 legislative changes envisage this and they were crafted to achieve this end. The* [parliamentary debates for the second reading of the Medical Registration (Amendment) Bill dated 11 January 2010] *at cols 1899–1901 reads:*

> *Second, we propose to expand the range of orders for SMC, its Complaints Committees, Disciplinary Tribunals and Health Committees so as to grant them more powers to be able to deal more effectively and appropriately with errant doctors.*
> *…*
> *Under the current Medical Registration Act, the Disciplinary Committee can impose a financial penalty not exceeding $10,000 on a medical practitioner who is convicted. The next level of penalty is a suspension of between three months and three years.* ***There is, therefore, a significant gap in the range of penalties in the current Act****.*
>
> ***The new section 53 will allow the Tribunal to impose a fine of up to $100,000, thereby enabling the Tribunal to mete out a penalty that is appropriate to the severity of the case****. This section will also allow the Disciplinary Tribunal to impose other orders … The SMC … can thus impose appropriate conditions or restrictions on the practitioner. … All this enhances the powers of the Tribunal by expanding the array of possible orders.*"

[emphasis added]

107 This Tribunal also considered and gave full credit to Dr Sim for pleading guilty at an early stage, for his long good standing in the medical profession and the good testimonials tendered on his behalf. Given that there was no evidence of dishonesty in the present case, and that we were not made aware of any further complaints of possible misconduct from 16 June 2010 (i.e. the date of the offence) to date, we were satisfied that Dr Sim did not manifest a propensity to re-offend (*Ang Peng Tiam v Singapore Medical Council* [2017] SGHC 143 at [105]).

108 Having considered all circumstances of the case, and taking into consideration the First Charge for the purposes of sentencing, we were satisfied that a fine of $30,000 was an appropriate sentence. In light of the observations of the court in *Kwan Kah Yee*, we found that this penalty was "*appropriate to the severity of the case*". The fine of $30,000 also reflected the lower culpability of Dr Sim as compared to Dr AAD, Dr Fong and Dr Chia, who were all given the minimum suspension term of three months. For the avoidance of doubt, we did not think that the present factual matrix warranted an upward calibration of the sentence

in line with the observations of the C3J in *Wong Him Choon*. The sentence imposed in this case does not therefore reflect any revisit of the sentencing regime for such cases.

109 Finally, it appeared to us, throughout the course of these proceedings, that there was a lack of guidance in Singapore as regards the sentencing of doctors in disciplinary proceedings. Different sanctions (e.g. removal from the register, suspension, fine, censure *etc.*) have different consequences on the public and on the medical practitioner. It is therefore important for there to be guidance based on case precedents and policy considerations so that medical practitioners may be aware of the severity of their misconduct. This will also ensure that sentences meted out by the DTs and courts are consistent with how the medical profession perceives instances of professional misconduct. In contrast, MPTs in the UK are guided by the UK Sanctions Guidance (developed by a steering group of MPTS and GMC staff), which sets out the rationale underlying each sanction and the broad factors which may lead to the imposition of each sanction. In light of the above, the SMC may wish to consider formulating its own set of guidelines.

**Sentence imposed**

110 Taking into account the nature of the complaint together with Dr Sim's conduct and the need to impose a sanction which was not only sufficiently deterrent but also proportionate in all the circumstances of this case, this Tribunal ordered that Dr Sim:

(a) be fined **$30,000**;
(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 the costs and expenses incidental to these proceedings, including the costs of the solicitors of the SMC.

**Publication of Decision**

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

112 The hearing is hereby concluded.

Dated this 18th day of August 2017.