SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL INQUIRY FOR DR JEN SHEK WEI HELD ON 9 MAY 2016, 17 TO 19 MAY 2016, 15 AUGUST 2016 AND 1 NOVEMBER 2016

Disciplinary Tribunal:
Dr Joseph Sheares (Chairman)
Dr Swah Teck Sin
Mr Siva Shanmugam (Legal Service Officer)

Counsel for the Singapore Medical Council:
Mr Edmund Kronenburg
Mr Kevin Ho
Mr Lynette Zheng
(M/s Braddell Brothers LLP)

Counsel for the Respondent:
Mr Charles Lin
Mr Phang Cun Kuang
Ms Ijechi Nazirah
(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. Dr Jen Shek Wei ("Dr Jen") had been charged with professional misconduct under section 53(1)(*d*) of the Medical Registration Act ("MRA") for committing conduct constituting (i) serious negligence; and (ii) an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency. The Disciplinary Tribunal ("DT") inquiry commenced on 9 May 2016.

The Charges

2. The two charges preferred against Dr Jen and the particulars are set out as follows:

"***1ST CHARGE (Amended)***

*1. That you, **DR JEN SHEK WEI**, are charged that you, between 30 and 31 August 2010, whilst practising as a gynaecologist at Women's Clinic of Singapore ("**Clinic**"), advised your patient, one **P** ("**Patient**"), to undergo surgery to remove the pelvic mass ("**Mass**") seen on Magnetic Resonance Imaging performed on her on or about 27 August 2010, without carrying out further evaluation and investigation of the Patient's condition when such further assessment was indicated.*

Particulars

You failed to conduct an adequate evaluation and investigation of the Patient's condition when such further evaluation and investigation was indicated in view of :-

(a) the Patient's age and pre-menopausal status;

(b) the clinical symptoms from, and the history, size and suspected pathology of, the Mass;

(c) the Patient's medical history (including, but not limited to, her drug and/or family history); and/or

(d) the possibility that the Patient's ovaries had a marked / excessive response to the Clomid medication you had prescribed her from in or around July 2010 to August 2010;

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, and that in relation to the facts alleged you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174).

2ND CHARGE

2. *That you, **DR JEN SHEK WEI**, are charged that you, on or about 31 August 2010, whilst practising as a gynaecologist at the Clinic performed a left oophorectomy ("**Procedure**") on the Patient, at Hospital A, without obtaining the required informed consent from the Patient for the Procedure, in breach of Guideline 4.2.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines **("ECEG")**.*

Particulars

You failed to:-

(a) adequately explain to the Patient prior to the Procedure, the nature, risks and possible consequences of the Procedure, including but not limited to, the fact that the Procedure could involve the complete removal of the Patient's left ovary;

(b) adequately explain to the Patient the consequences of the removal of her left ovary; and/or

(c) *obtain specific consent from the Patient or her husband to remove the Patient's left ovary, and to record such consent in the Patient's medical notes.*

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)."

Issues

3. The Court of Three Judges in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R)612, held that professional misconduct can be made out in the following two situations:

(a) Where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency (i.e. the "First Limb"); and

(b) Where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner (i.e. the "Second Limb").

4. The DT agreed with the Singapore Medical Council ("SMC")'s framing of the issues as follows:

<u>First Charge</u>

(1) Did Dr Jen advise Ms P to have the Mass removed without conducting an adequate evaluation and investigation of the Patient's condition?

(2) If the answer to (1) above is "Yes", did Dr Jen's conduct amount to such serious negligence that it "*objectively portrays an abuse of the privileges that accompany registration as a medical practitioner*"?

<u>Second Charge</u>

(3) Did Dr Jen satisfy Guideline 4.2.2 of the ECEG before performing the left oophorectomy on the Patient?

(4) If the answer to (3) above is "No", did Dr Jen's conduct amount to an "*intentional deliberate departure from standards observed or approved by members of the profession of good repute and competency*"?

The Salient Facts

5. In the Letter of Complaint by the Patient dated 12 December 2011 to the SMC, the Patient informed that she first consulted Dr Jen on or about 7 June 2010 for problems of difficulty in conceiving a child and was accompanied by her husband, Mr PW1. Dr Jen investigated her with an ultrasound on the same day which did not reveal any ovarian abnormality. Her blood CA125 and Pap smear results were normal.

6. On or about 27 August 2010, she consulted one Dr F1 ("Dr F1"), an orthopaedic surgeon for backache and an x-ray of the Lateral Lumbar Spine was reported by one Dr F2 ("Dr F2"), a Radiologist, to show a lobulated soft tissue density in the pelvis raising suspicion of a mass, probably arising from the genital tract. MRI scans of the lumbosacral spines performed on 27 August 2010 were also reported by Dr F2 to have a suggestion of a septated cystic mass in the pelvis anterior to the sacrum, which probably corresponded to the soft tissue shadow and this might be ovarian in origin. Dr F2 advised that this should be evaluated. Dr F1 referred the Patient to Dr Jen with a letter stating that the Patient had consulted Dr F1 for backache and Right Sciatica; that an MRI scan showed a septated cystic mass in the pelvis, and he asked Dr Jen to see and manage her. The Patient and her husband then went to see Dr Jen on 30 August 2010. She did not report that she had mentioned her backache or leg pain to Dr Jen.

7. According to the Patient's Letter of Complaint dated 12 December 2011, Dr Jen performed an ultrasound scan on her abdominal surface and concluded that there was a lump at both her ovaries. She asked him what was the cause of the entire thing and she was told *"…. a lot of negative remarks on these two lumps, and told that it may be a cancer, he wouldn't know, he's very much reluctant in explaining the possible causes, a lot of time, my consultation with him can easily last less than 5 minutes and he has given us the impression that a Patient should not know too much of it.*" She continued: "***HE IS TAKING ME IN AS A CANCER PATIENT***." (Patient's own Bold notation). She was told that it had to be removed as soon as possible and he offered her two choices [Exhibit AB, Tab 1]:

   (i) "*he can do a keyhole surgery for it to be removed, however, there will be a possibility for the cancer cells to be spread and hence there's a risk by performing this surgery;*
   (ii) *he can do a normal open operation whereby he will cut about 5-8 cm on my abdominal and remove the 2 lumps."*

   Dr Jen then asked them regarding the presence of a pathologist at the operation and the Patient stated:- "*(i) we can have the pathologist to be around in the operation theatre so that he can do a lab test on the spot to see if it is cancerous and if so, they will proceed with the best by removing my womb area; (ii) if we want to have the lumps to be sent to the lab for test and the result will be out within 2-3 days.*" The Patient and her husband decided to have the lumps sent to the lab after the surgery for the pathologist to do the test and they were absolutely fine "*for the result to be out in the next couple of days than taking the risk of having the pathologist around in the operation theatre as I (the Patient) was told by Dr Jen that it will be 99.9% accurate only.*" She

stated Dr Jen then arranged for the booking of her operation at Hospital A ("Hospital A") on the 31 August 2010 at 3.30pm. After her operation on 31 August 2010 and after she woke up that evening, a nurse showed her two lumps in a small container and was told that they would send it to the laboratory for test. On the third post-operative day, Dr Jen saw her with the lab report and said: "*its ok*" and "*the lumps were benign*".

8. There was no mention in the Patient's Letter of Complaint that Dr Jen had offered her any other treatment, such as a "wait and see option", before arranging her operation on 31 August 2010. Dr Jen had testified that he told the Patient he could not be sure whether the 6cm by 4cm Mass was one of her ovaries and whether this Mass was actually malignant, but based on the trans-vaginal ultrasound image of the Mass, there was a significant risk that it could be malignant in nature. He had testified that he told the Patient there was a Mass but he could not be certain that it was a cancer and that it was the ovary. He further testified that what went through his mind was the complex solid structure could be a rare presentation of a haemorrhagic corpus luteum cyst. However, there was no documentation of this diagnosis or any other differential diagnoses in his own clinical notes, written explanation to the SMC's Investigation Unit ("IU"), or in the case notes from Hospital A. As he could not be certain that this Mass was malignant, one of the options available to her was to wait and continue monitoring the Mass. He had qualified this by informing the Patient that if she decided to wait, she would have to bear with her severe backache and sciatica which might be related to the Mass. However, the Patient and her husband in their testimonies denied this discussion had occurred and that they had been offered a "wait and monitor option". There was no documentation in Dr Jen's own clinical notes that he had offered this management option as well. The Patient disagreed that Dr Jen had given her two options, the first being to undergo a surgery and the second being to wait and see. She testified that he did not mention that she should just wait and see, but he straightaway gave her the two options of whether she should go for a keyhole or open surgery[1]. Her husband testified that when Dr Jen told them the Mass could be a cancer, he and his wife were sad and concerned and they wanted it to be removed as soon as possible. He too denied Dr Jen had told them that one of the alternatives was to wait and see.

9. On or about January 2011, the Patient's general practitioner had detected she was about six weeks pregnant. The Patient then went to see Dr Jen who over a course of a two-weeks' check told her that the foetus was not growing and there was a tendency for her to have a miscarriage. She and her husband decided to seek a second opinion and consulted Dr F3 ("Dr F3"), a gynaecologist who was practising at Institution A. Dr F3 warned the Patient to be prepared for a miscarriage. This did occur and she was treated for this at Hospital B. The Patient then returned for a medical review by Dr F3, who after a detailed ultrasound scan could not find her left ovary. After he had read her pathology report of her 31 August 2010 operation, he informed her that her left ovary had been removed. The Patient claimed that it was not Dr Jen but Dr F3 who had informed her that her left ovary had been removed and that the latter had told her the term "left oophorectomy" meant the left ovary had been removed. The Patient further claimed she was not told by Dr Jen there was a need to remove her left ovary; and that

[1] NE of 9 May 2016 (page 91 line 16-25, page 92 line 1-3 & page 191 line 1-16)

it was removed without her consent. She was stunned over her missing ovary and it had wiped out a 50% chance of her getting pregnant.

10. In Dr Jen's written explanation dated 2 August 2012 to the SMC's IU, he stated that the Patient had consulted him on 7 June 2010 for subfertility and she also complained of period pains over six months. A trans-abdominal Sonogram did not reveal any ovarian abnormality and he did start her on Clomiphene (Clomid) 50mg for five days, and ovulation was confirmed with a good mid Luteal Phase Progesterone assay done on 27 July 2010. On the 30 August 2010, the Patient came back to see him with a report of an MRI ordered by Dr F1 whom she had earlier seen for leg pain with a "*very bad backache*". Dr Jen stated that the radiologist, Dr F2's impression was a "*septated cystic pelvic mass*" and she had recommended further evaluation of it.

11. Dr Jen did not state in his written explanation to the IU that he had assessed the Patient's leg pains with any examination or test on 30 August 2010. He stated that the ultrasound scan of the Mass showing uneven walls and irregular septa meant that the risk of malignancy was higher, especially with her history of severe back pain. Dr Jen had testified that on 30 August 2010, the Patient was walking with a limp and that he did perform a physical examination with a Straight Leg Raising test of the Patient which confirmed that it was sciatica. However, in his own clinical notes dated 30 August 2010 at 11.15am, he had only documented "*leg pain 27/8/10"*. There was no documentation of his examination with a Straight Leg Raising test of the Patient, nor was there a note to state that the leg pain had raised his high suspicions of malignancy of the pelvic mass. The Patient had testified at the hearing on 9 May 2016 that in Dr Jen's consultation room on 30 August 2010, she showed her MRI report to Dr Jen and he did an ultrasound on her. She did not say in her testimony that he had performed a Straight Leg Raising Examination. Dr Jen stated that he performed a trans-vaginal scan (which he did mention in his written explanation to the IU) which revealed a complex hyper-echoic tumour to the left-posterior adnexa to her womb. It measured 68 by 39 mm, and had a predominately hyper-echoic pattern, mixed with small patches of anechoic areas, with irregular thicken walls and septate projections. There was no fluid surrounding the mass which appeared to be adherent to the surrounding structures. Ultrasound pattern was that of a complex growth. He claimed he informed the Patient that this was not a simple cyst but instead it was a suspicious complex mass, probably arising from the ovary. The dense echoes suggested a solid or dense fluid tumour. Uneven walls and irregular septa meant that the risk of malignancy was higher, especially with a history of severe back pain.

12. Dr Jen claimed that he told the Patient that it would be best to have the Mass removed for histological examination to confirm the diagnosis, as other non-invasive methods would not give a definitive answer. He explained to her two methods of surgery – laparoscopic or open laparotomy. He informed her that if she chose laparoscopy, there was no way to guarantee the prevention of spillage of tissue. He further claimed that she realised that this would be a bad option in the case of a solid tumour and possible malignancy and that she had therefore elected for an open laparotomy with the full knowledge and had consented that depending on the operative findings, her ovary might be needed to be removed. Dr Jen further claimed that this consent was explained to her by two different nurses, the anaesthesiologist and by him on two separate

occasions. Dr Jen also claimed that he had actually recommended open laparotomy with Frozen Section Histology, but the Patient chose not to have the pathologist in the Operation Theatre ("OT") as stated in her Letter of Complaint. Dr Jen further claimed that the absence of the pathologist in OT removed the option of conserving her ovary if the gross pathology was suspicious of cancer, and that she understood this because she had stated in her complaint that she and her husband decided to have the lumps sent to the lab after surgery for the pathologists to do the tests and she was absolutely fine for the result to be out in the next couple of days rather than taking the risk of having the pathologist around in the OT.

13. Dr Jen did not state in his written explanation to the IU that, on 30 August 2010, apart from the trans-vaginal scan, he had performed any further evaluation and investigation of the Patient's condition and he did not mention that he had taken into consideration her pre-menopausal status, symptoms, history, size and suspected pathology of the pelvic mass, and the possibility that the Patient's ovaries had a marked / excessive response due to the Clomid medication he had prescribed in or around July 2010 to August 2010. He also did not state that he had offered her any other treatment options e.g. the option of "wait and see".

14. In his written explanation, Dr Jen stated that at the operation, he had decided to remove her whole ovary on the left side instead of partially because of the following indications that raised his index of suspicion that the Mass was malignant:

    (a) A large pool of haemo-serous peritoneal fluid present, some of which he had sent for analysis for malignant cells;

    (b) The left ovary was not free and mobile as a normal benign tumour would likely be, and the whole Mass was adherent to the posterior wall of the pelvis and this adhesion was the likely cause of her backache;

    (c) The surface of the ovary showed sign of rupture and herniation of tissue; and

    (d) There was no clear demarcation between normal and abnormal ovarian tissue, making it impossible to know how to separate the healthy from the unhealthy tissue without spillage. He therefore "*decided to take the safer option of removing the whole ovary on the left in view of the above 4 highly suspicious features*".

15. Dr Jen summarised the Patient's main complaints accompanied by his own responses as follows [Exhibit AB, Tab 3]:

    (a) "*My ovary was removed without getting our consensus and I was not told that my ovary was removed. - The Patient signed informed consent for the removal of her left ovary, and not just removal of a cyst. There are three other independent witnesses who can testify that they explained this to her. She was also given documentary and pictorial proof that her left ovary was removed. Prior to surgery I had engaged in a detailed discussion on the possibility of cancer, together with the need of Frozen Section with the Patient and her husband, and this enhanced*

the improbability of her claim that she was unaware of the need for possible radical surgery on the ovary."

(b) "*Why was my normal ovary removed? – Her left ovary was not 'normal' and was almost entirely occupied by a large cystic tumour which mimicked a malignancy and produced severe backache with leg pain. The whole ovary was therefore abnormal and diseased. Her left tubo-ovarian unit was severely affected by pelvic adhesive disease.*"

(c) "*My fertility is reduced 50%. – This is patently incorrect since the Patient achieved pregnancy almost immediately after the surgery, whereas she could not for the past 12 months before surgery. She only sought a 2nd opinion when I had to give her the sad news that her pregnancy was not progressing well, which was not related to her fertility.*"

16. Dr Jen stated that in the Patient's case "*there was ample suspicious evidence to warrant an operation. If cancer is seen, then surgery needs to be radical, whilst if the condition is clearly benign, then minimal removal is called for. In the borderline cases, Frozen Section by a pathologist in OT would give the answer. However, the Patient and her husband clearly stated that they were happy not to have this option, in spite of the option being offered.*" [Exhibit AB, Tab 1]. Dr Jen did not mention that, apart from the Sonogram scan, he had performed further evaluation or any other investigation to determine pre-operatively whether the Patient had a malignant or a benign pelvic mass in view of the fact that the Patient had refused a Frozen Section pathological report at operation. Dr Jen also claimed that her presentation of severe backache with leg pain and the MRI evidence of a pelvic mass were resolved after the operation but he did not state how he had determined her backache and leg pain had resolved. The Patient however, testified that she still had severe backache up to the present time and she had been seeing Dr F4 from Institution B[2].

Assessment of Evidence and Findings

17. At the outset, the DT found no reason not to accept the evidence of the SMC's expert witness, Prof PE ("Prof PE"). The DT found Prof PE's evidence to be clear, compelling and substantiated by relevant medical literature. The DT also found the Patient to be a credible witness. She was internally consistent and her evidence was corroborated by her husband, Mr PW1. Their reaction and subsequent conduct upon learning that the Patient's ovary had been removed was consistent with their account of the events. On the other hand, the DT was unable to accept Dr Jen as a credible witness. His evidence was both internally inconsistent and at variance with the extrinsic evidence before the DT.

[2] NE of 9 May 2016 page 79 line 1-10

First Charge: Dr Jen's advice to surgically remove the pelvic mass without adequate evaluation / investigation

18. The SMC's expert witness opinion of Prof PE dated 29 May 2016 and his subsequent testimony indicated that a competent and responsible gynaecologist should not have advised the removal of the Mass as the risk of malignancy was low in the Patient's case based on the accepted Risk of Malignancy Index ("RMI") which has been in existence since 1990s, and is advocated by the Royal College of Obstetricians and Gynaecologists ("RCOG"). This Index is based on the ultrasound score X age X CA125 level. In the Patient's case, her ultrasound score was 5, her pre-menopausal age score was 1, and her CA125 level was 15 in June 2010. Her RMI index was 5 X 1 X 15 = 75, and the accepted level for malignancy is 200 or higher. This RMI did not need to take into account the symptoms of backache or sciatica. Prof PE went on to say that as a gynaecologist oncologist, he did not think that sciatica played a part in the risk of malignancy. There was no documentary evidence or testimony by Dr Jen that he had used this RMI index or any other acceptable Risk of Malignancy analysis of the Patient's pelvic mass. Dr Jen had agreed that a malignant ovary was an uncommon occurrence in a pre-menopausal woman but he did not present any evaluative analysis or investigation result to show there was a high risk of malignancy of the Patient's Mass.

19. Prof PE further testified that his advice to the Patient would have been to tell her the estimation of risk of malignancy of her pelvic mass was low and that she probably had something benign. Then he would have discussed with her the option of observation of the Mass; and a second option would be to have the ovarian cyst removed since it was 6cm in size; or have the cyst removed with a Frozen Section examination keeping-in-view of what the Frozen Section reported and then decide on the further management.

20. The evaluation of the pelvic mass should have taken into account the Patient's pre-menopausal status, the Patient's medical history, any medications, including Clomid, taken, symptoms, serum tumour markers such as alpha-fetoprotein, Beta HCG and dehydrogenase, as well as the morphological ultrasound scan features of the pelvic mass. Prof PE explained these factors were absolutely necessary because in a young woman like the Patient, most ovarian masses are benign or functional which do not require any intervention including surgery. Surgery carried significant morbidity and mortality, hence the clinical practice in gynaecology in managing women with an ovarian cyst is always on how to avoid doing an unnecessary surgery. Prof PE pointed out the risk of malignancy in the Patient was very low because she was young and pre-menopausal, the pelvic mass was asymptomatic, and she had a marked ovarian response to the Clomid 50mg for five days in July and August 2010 resulting in an elevated serum progesterone to 266.0 nmol/l, and this explained the hyper-echoic features of the Mass (seen on the ultrasound scan performed by Dr Jen on 30 August 2010) and the corpus luteum cyst could haemorrhage and clot when it became large enough. A biopsy of the mass would not be performed if the suspicion of it being a cancer was low. When the suspicion was low judging from the whole history of the Patient, tumour marker tests, menstruation history and the past use of Clomid, and the risk profile for ovarian cancer in the Patient was low, Prof PE opined that he would have informed her of the low risk and asked whether this low risk was acceptable to her. If the risk was acceptable to the Patient, then the management would be that for a normal

physiological cyst that was likely to regress within the next one or two menstrual cycles, after which an ultrasound scan would be repeated to prove the mass had regressed.

21. During the cross-examination of Prof PE by the Respondent's Counsel Mr Charles Lin, Prof PE admitted he did not focus on the Patient's sciatica and it was because based on gynaecological practice, there was no gynaecological reason for the Patient to have sciatica. Prof PE opined that from a gynaecologist's point of view, he would have evaluated the risk and manage this ovarian cyst and the orthopaedic surgeon Dr F1 was to continue to manage the Patient's spinal problems and her sciatica. Prof PE said it was extremely rare for an ovarian mass to cause a pain in the leg. The nerve to the leg is in a different anatomical compartment to the ovarian mass and it would be a retroperitoneal mass (behind the peritoneum) which could cause pain in the leg. The Patient's ovarian mass was intra pelvis, inside the pelvis, in a different anatomical compartment, and even if an ovarian mass was much larger than the Patient's, it would not cause sciatica. Prof PE did not think a 6cm ovarian mass was sufficient to cause sciatica. A remote gynaecological cause of sciatica was retroperitoneal endometriosis. Although sciatica was a common symptom, Prof PE said it was not a common symptom related to pelvic masses. In a malignant ovary, the Patient would have had many other symptoms like bloating of the abdomen, eating disorder, bowel and urinary symptoms before complaining of sciatica. Looking at just sciatica exaggerated the risk of malignancy, but taking into account the Patient's low risk of malignancy and her entire clinical picture would provide a more balanced view.

22. Dr Jen had raised for the first time in his Opening Statement at the inquiry itself that the Patient's sciatica could be possible nerve damage caused by the Mass if it was not removed, and the clinical symptoms of severe backache complicated by sciatica also supported his clinical judgment that the Mass was not consistent with a physiological cyst. However, he had not documented in his own clinical case notes his concern about the Patient's sciatica. He could not explain why his operation records or post-operative notes had not recorded any intra-operative findings or observations regarding the connection between the pelvic mass and the sciatic nerve. He had not performed any evaluation after the Patient's operation whether the sciatica had resolved. The Patient had testified that she presently continues to have leg pain and seeks treatment for it. In the contemporaneous document "Medical Certification of Treatment" dated 23 September 2010 filled in by Dr Jen, after the operation, he had stated that the Patient was asymptomatic, and this contradicted his claim that he was concerned about her sciatica raising the suspicion of malignancy of the pelvic mass[3]. The DT found it difficult to accept Dr Jen's claims that he was justified to advise urgent surgery to the Patient on the basis of her sciatica. Instead, it would have been sound practice for him to have evaluated her sciatica to determine whether the sciatica was or was not caused by the pelvic mass.

23. The Respondent's expert witness, Dr DE ("Dr DE") in his report stated that he would not have been able to offer a specific diagnosis based only on the ultrasound findings, and he would have recommended further evaluation and follow up. Such follow up and further evaluation would possibly include further imaging with CT scan of the pelvis or

[3] Exhibit S2 page 8

MRI scan of the pelvis to further and better characterise the Mass, and blood tests, e.g. CA125. He would also advise follow-up repeat ultrasound scan at a later date to assess for change in size and appearance of the Mass given that most functional haemorrhagic cysts would be expected to reduce in size or resolve after six to eight weeks. Dr Jen had not performed these investigations. Dr DE also testified that the Mass could have been due to a variety of causes, and that complicated haemorrhagic functional cysts could have ultrasound features suspicious for an ovarian tumour and is also a common cause of a pelvic mass in a woman of the Patient's age group.

24. In cross-examination, Dr DE stated that it would be unlikely for Dr F2 to miss reporting a radiological connection between the pelvic mass and the sciatic nerve of the leg if such a connection existed. Dr DE had further testified that based on the x-ray report by Dr F2, the pelvic mass might not have caused the Patient's sciatica and it was hard to link sciatica specifically to the pelvic mass[4].

25. With regard to the First Charge, there was no evidence, apart from Dr Jen's bare assertion, that he had advised any treatment or management options of the Patient's pelvic mass other than to undergo surgery to remove the complex hyper-echoic tumour to the left-posterior adnexa to the Patient's womb (i.e. the Mass) seen on a trans-vaginal ultrasound scan performed on 30 August 2010. This then raised the issue of whether his advice followed upon acceptable evaluation / investigation of the Mass and conformed to acceptable medical practice having regard to the following circumstances:

    (a) Dr Jen could not be sure of the diagnosis of the Mass based on his trans-vaginal ultrasound scan;

    (b) He might have been sure the Mass arose from the ovary and not from another tissue;

    (c) He was not sure it was benign or malignant;

    (d) He suspected malignancy because of the Patient's sciatica;

    (e) His agreement that malignancy in the ovary is uncommon in a pre-menopausal woman;

    (f) His agreement that sciatica is a rare symptom in ovarian tumours; and

    (g) His lack of documentation showing that he had taken into account her whole medical history including his previous Clomid therapy for the Patient's infertility.

32. The most important evaluation Dr Jen had to determine was whether the Patient's pelvic mass was a malignant or benign tumour, assuming it was a septated cystic mass in the pelvis anterior to the sacrum as seen on the MRI performed on or about 27 August 2010, and it was a complex hyper-echoic tumour to the left-posterior adnexa to

[4] NE of 15 August 2016 page 61 – page 63

her womb based on Dr Jen's assessment of the trans-vaginal ultrasound scan he had performed on the Patient on or about 30 August 2010. Dr Jen had informed the Patient that the Mass probably arose from the ovary but he could not be sure of the diagnosis of this Mass based on his trans-vaginal ultrasound scan.

33. Prof PE had lucidly testified that the evaluation of the pelvic mass should have taken into account the Patient's pre-menopausal status, the medical history, any medications including Clomid treatment, serum tumour markers such as CA125, alpha-fetoprotein, Beta HCG and dehydrogenase, as well as the morphological ultrasound features of the pelvic mass. Apart from the latter, there was no documentary evidence Dr Jen had investigated any of these factors on 30 and 31 August 2010. Prof PE explained that these factors were absolutely necessary because in a young woman like the Patient, most ovarian masses are benign or functional, not requiring any intervention including surgery. Surgery carried significant mortality and morbidity so the clinical practice in gynaecology in managing women with an ovarian cyst is always on how to avoid doing an unnecessary surgery. He noted that the Patient had a marked response to the Clomid 50mg for five days in July and August 2010, resulting in an elevated serum progesterone to 266.0 nmol/l, and this explained the hyper-echoic features of the Mass, and the corpus luteum cyst could haemorrhage and clot when it became large enough. Prof PE also pointed out the risk of malignancy in the Patient was very low because she was young and pre-menopausal.

34. Dr Jen had emphasised in his testimony that the Patient's history of sciatica raised a high suspicion of malignancy of the pelvic mass. However, he did not present any investigation or evaluation to show a connection between the pelvic mass and the sciatica. Both the reports of the x-ray and MRI of the Lumbar Vertebrae did not indicate that the pelvic mass was connected to or affected the sciatic nerve of the leg. However, it was reported by Dr F2 that there were sclerotic degenerative changes observed in the facet joints at L4-5 and L5-S1 bilaterally and the L5-S1 disc space appeared marginally reduced in height; and the L4-5 and L5-S1 discs were slightly bulging. Dr Jen did not verify with the orthopaedic surgeon (i.e. Dr F1) whether the pelvic mass or the degenerative changes in the bones had caused the sciatica. Prof PE had explained that the sciatica was not caused by the pelvic mass because both are in different anatomical compartments in the pelvis, and ovarian masses larger than the Patient's do not usually cause sciatica. Dr Jen had agreed that sciatica is a common symptom but was an uncommon symptom of an ovarian tumour. The Patient did not agree that she had complained of sciatica to Dr Jen on 30 August 2010. She denied that he had evaluated her sciatica with a Straight-Leg Raising investigation before or after her surgery. Dr Jen had not made a reference to the relationship of the Patient's pelvic mass and her sciatic nerve in his Hospital Operation Report and in his own clinical post-op notes. In the Hospital A's document concerning the Patient's surgery, Dr Jen had documented that the Patient was asymptomatic[5]. The DT found it unacceptable that a history of sciatica by itself would indicate a high risk of malignancy without supporting evaluative evidence in this Patient. Dr Jen had not presented any convincing evidence of this.

[5] Exhibit S2 page 8

35. Prof PE had testified that the clinical practice in gynaecology in managing women with an ovarian cyst is always on how to avoid doing an unnecessary surgery because surgery carried significant morbidity and mortality. He further testified that a competent and responsible gynaecologist should not have advised the removal of the Patient's Mass as the risk of malignancy was low in the Patient's case based on the RMI. Dr Jen had not presented any investigation or evaluation to determine the risk of malignancy in the Patient. Instead, he relied on his suspicion of malignancy based on the complaint of sciatica without performing any investigation or evaluation to determine any relevant connection of it to the Mass. Dr Jen had not taken into account and evaluated the Patient's age, pre-menopausal status, medical history including the Clomid effect on her ovaries and failed to investigate with the necessary blood tests, repeat scans, and risk of malignancy assessments to enable him to advise an acceptable management plan for his Patient. He had failed to show any credible evaluation of the differential diagnosis of his Patient's Mass that there was a high probability of malignancy. Whilst the DT had allowed Dr Jen to give his views on sonogram pictures of ovarian masses in Exhibit D3, the DT was unable to accord any weight to the same as Dr Jen's views were not supported by any independent evidence.

36. In relation to the First Charge, the DT was satisfied on the evidence that Dr Jen, between 30 and 31 August 2010, whilst practising as a gynaecologist, had advised the Patient to undergo surgery to remove the pelvic mass seen on MRI performed on her on or about 27 August 2010, without carrying out further evaluation and investigation of the Patient's condition when such further assessment was indicated. On the totality of the evidence adduced, the DT was satisfied that Dr Jen's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

Second Charge: Dr Jen had performed a left Oophorectomy ("the Procedure") on the Patient without obtaining the required informed consent from the Patient

37. The Patient's testimony was set out as follows:

    (a) Dr Jen had told the Patient she had a Mass in her left ovary and gave her the impression it was critical and it should be removed through surgery due to the possibility of cancer. The Patient thought the Mass was able to be removed from her ovary and she believed her consent for surgery was to remove the Mass only. She was not aware Dr Jen would remove her whole ovary. During the consultation on 30 August 2010, Dr Jen did not tell her he would or might remove her left ovary during the surgery.

    (b) Dr Jen only gave the Patient the options of a keyhole or open surgery, and whether to have or not have a pathologist to provide a Frozen Section report at the surgery, and Dr Jen did not provide any other options such as conservative treatment or further evaluative test / examination.

    (c) Dr Jen only informed the Patient there was a risk of spillage of cancerous cells if she chose a keyhole surgery, and if she opted to have the pathologist present at

the surgery and cancerous cells were found, Dr Jen might remove her womb. Dr Jen told her that the accuracy of the pathologist report was 99.9% only, as such, the Patient did not want to take the risk to remove any part of her womb and hence, she decided not to have the pathologist present at the surgery.

38. Guideline 4.2.2 of the ECEG on informed consent states that:

> "*It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him.*"

39. Guideline 4.1.2 of the ECEG provides how medical records are to be maintained:

> "*Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented.*"

40. The Court of Three Judges in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [82] made the following observations on the significance of the ECEG:

> "*The Code and Guidelines represent "the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore" and "the minimum standards required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore" (see para 1 of the Code and Guidelines). As the Code and Guidelines represent so fundamentally* ***the most basic aspects of clinical practice****, we emphasise that an errant practising doctor would be hard put to argue that he has no knowledge of matters which are covered by the said Code and Guidelines. On the contrary, there would be a strong presumption that he has knowledge of the matters contained therein. It would otherwise be all too convenient for an errant doctor to allege that he did not depart from the applicable standard intentionally on the basis that he did not know of the applicable standard at the relevant time.*"

41. Apart from the Hospital A's Consent Form dated 31 August 2010 and signed by the Patient, there was no contemporaneous evidence that Dr Jen had obtained informed consent through a process of explaining the nature, risks, benefits and possible complications of the Procedure, and any alternatives in a way that was understandable and clear to the Patient. The Patient claimed the Hospital A Consent Form was blank with regard to the operation procedure but she signed it because she was informed that was the standard procedure. There was a lack of contemporaneous evidence to show Dr Jen had obtained informed consent and he relied on his "recollection"' in his oral testimony as evidence of having obtained informed consent.

42. The Patient was not aware that Dr Jen had surgically removed her left ovary until another gynaecologist, Dr F3, whom she had consulted had informed her approximately eight months after the Procedure.

43. It was not clear what surgical procedure Dr Jen had advised the Patient based on the documentations he had made:

(a) In his own clinical notes of 30 August 2010, he had written "*open oophorectomy*", "*KIV THBSOR*", "*must prep pat for radical op*" and "*prob need ov removal*". There was no identification if it was the right, left or both ovaries.

(b) The admission letter from Dr Jen's clinic to Hospital A stated the operation "*lap L oophorectomy*" and a diagnosis of "*? L ov mass*".

(c) In the Hospital A Consent Form under the field "Operation/Procedure", the operation "*Open left oophorectomy*" was stated. In the Hospital A Anaesthetic Record, the operation was "*Open Left Oophorectomy*" and the diagnosis "*L Ovarian Cyst*".

(d) In the Hospital A Operation Record, the operation was stated as "*R Oophorectomy L Cystectomy*" and diagnosis was "*Bilateral Ov tumour*".

(e) In the Hospital A Inpatient Discharge Summary, the procedure was stated as "*1. L oophorectomy 2.R Cystectomy*" and the diagnosis "*Bilateral Ov Tumour*".

44. The DT noted that the documented operation procedure ranged from "Open Oophorectomy" to "Open Left Oophorectomy" to "Laparoscopic Left Oophorectomy" to "Bilateral Ovarian Cystectomy" to "Right Oophorectomy & Left Cystectomy" and to "Left Oophorectomy & Right Cystectomy", and the diagnosis ranged from "Left ovarian mass" to "Left ovarian cyst" to "Bilateral ovarian tumour". For a lay person like the Patient, it would have been difficult for her to understand the difference between an ovarian mass and an ovarian cyst and even bilateral ovarian tumour. It would also be difficult for her to understand the difference between a cystectomy and oophorectomy. In his testimony, Dr Jen stated that the Patient probably did not understand that the Mass and the ovary were one and referred to the same thing[6]. He also said that when she herself said that Dr Jen removed the ovarian Mass she felt the ovary was one part, and one (other) part is the Mass. The lack of proper understanding by the Patient indicates an unacceptable standard of explanations given pre-operatively to her concerning the diagnosis of her disease and the surgical procedure planned.

45. The confusion in the operation procedure and diagnosis of the Patient's disease and the lack of proper understanding by her of the nature of her disease and the type of surgical treatment made it difficult for the DT to accept that sufficient information and details had been clearly given to the Patient to enable her to make informed decisions concerning her treatment.

[6] NE of 18 May 2016, page 106:12 to page 108:2

46. Dr Jen claimed that he told the Patient she could choose to "wait and see", or proceed with the surgery, but the Patient did not remember if Dr Jen had asked her to wait[7]. The Patient denied this "wait and see" discussion had occurred[8]. She also testified that he emphasised there was a high risk of cancer and he was treating her as a cancer Patient. There was no documentation that Dr Jen had offered any alternative treatment besides surgery.

47. A further source of confusion in the informed consent process arose when Dr Jen was cross-examined and asked to explain and clarify the discrepancies concerning the nature of the operation procedure. He claimed that the procedure he had intended was "investigative". However, in the Medical Certification of Treatment Form filled in by Dr Jen dated 23 September 2010, he had stated the procedure was not an investigation[9]. He then changed his testimony to say the procedure was both investigative and therapeutic, but this raises the question of what he had informed the Patient and whether she understood the significance of the information.

48. During cross-examination, Dr Jen had been repeatedly asked whether and what he had explained to the Patient regarding the nature, risks and possible consequences of a left oophorectomy[10]. His answer was somewhat evasive and repetitive. His assertion was that she understood the concept of cancer and the risk of losing her womb and ovary. When queried by the DT what he told the Patient on what the consequences of removal of her ovary would be, he claimed that he told her and her husband that there would be a reduction in her fertility. He was then asked what their response to this was and he replied that they were more concerned about her pain and the cancer. This seeming disinterest about the reduction in fertility by the Patient appeared to be at odds with her initial concern for her infertility and inability to conceive, and her refusal to accept a 0.01% error by the pathologist's Frozen Section report that would cause Dr Jen to remove some parts of her reproductive organs. The Patient had testified to her fear of having her reproductive organs removed without her knowledge while she was unconscious. The Hospital A Consent Form and the case notes from Hospital A had no documentation of details of the risks of the operation. There was no documentary evidence in Dr Jen's own clinical notes of what were the risks and possible complications of a left oophorectomy apart from "-*explained risks*". It was clear to the DT that Dr Jen had not told the Patient clearly the consequences of her left ovary being removed. The Patient further testified that the only risks mentioned by Dr Jen was a possible spillage of cancerous cells with the keyhole surgery and to the accuracy of the pathologists' Frozen Section report.

49. Dr Jen called a total of four witnesses to address the issue of informed consent raised by the Patient. Dr Jen's clinic nurse, Ms DW2 was not in his consultation room on 30 August 2010 and she was unable to recall what she had said to the Patient and her husband. The anaesthetist, Dr DW1 could not recollect what exactly he had said to the Patient and whether she had confirmed she understood the procedure she would

[7] NE of 9 May 2016 page 81 line 1-7

[8] NE of 9 May 2016 page 91 line 16-25, page 92 line 1-3, page 109 line 21-22, page 111 line 12-16 & page 191 line 1-16)

[9] Exhibit S2 page 7

[10] NE of 18 May 2016, page 47:8 to page 48:24

undergo. Senior Staff Nurse DW3 from Hospital A testified that she did not attend to the Patient on 31 August 2010 and was unable to recall she had ever seen the Patient. Ms DW4, the OT Nurse Manager also did not personally attend to the Patient. She explained the standard OT processes at Hospital A in August 2010 but conceded there were times where standard processes were not followed. Nurse DW5 who did attend to the Patient on 31 August 2010, did not testify because she was on hospitalisation leave in India.

50. Dr Jen had testified that informed consent was a process and not just the hospital's consent form and that he was familiar with the ECEG's informed consent requirements[11]. However, he did not ensure that the Patient who was under his care was adequately informed about her medical condition and options for treatment so that she was able to participate and make informed decisions about her treatment. Dr Jen appeared indifferent to the Patient's welfare. The Patient was not made aware of the risks and possible complications of her left oophorectomy and any alternatives available to her. Dr Jen's medical records were not clear, especially details concerning the surgery advised and in obtaining informed consent were not documented. Additionally, the DT noted that some notes were inaccurate, or illegible and some notes appeared less than contemporaneous. All considered, the DT found that Dr Jen was in breach of Guideline 4.2.2 of the ECEG. The DT was satisfied that Dr Jen's conduct constituted an intentional, deliberate departure from standards observed or approved by reputable and competent members of the profession.

Mitigation by Counsel for Dr Jen

51. In mitigation, Counsel for Dr Jen submitted that Dr Jen has been in practice for more than 37 years with an unblemished record. Dr Jen's contributions to charitable and non-profit organisations was also highlighted. The DT was urged to take into account the punishment endured by Dr Jen in having to go through the disciplinary process itself. It was submitted that the extended duration of the disciplinary process had inflicted prolonged anxiety on Dr Jen. The DT was urged to impose the sanction of a fine only.

Submissions on Sentencing by Counsel for SMC

52. In the submission on sentencing, Counsel for SMC highlighted several aggravating factors and submitted that the present case warranted a suspension sentence of eight to ten months, a fine of not less than $10,000.00, and the usual orders of imposition of censure, undertaking and payment of costs in line with precedents for similar cases.

Reasons for the DT's Orders

[11] NE of 19 May 2016 page 92:20 to page 93:3

53. The DT was mindful of the observations made by the High Court in the case of *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 at paragraph 88:

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

54. The DT reviewed the sentencing precedents tendered by parties and their relevance to the circumstances of the present case:

(a) In the case against Dr AAD, Dr AAD was found guilty of professional misconduct for his gross negligence in failing to refer the patient to a consultant paediatric ophthalmologist for a Retinopathy of Prematurity screening in an expeditious and timely manner. The Disciplinary Committee ("DC") was concerned that the defence raised by the respondent (doctor) rested on an assessment, which was possibly flawed, and ignored several clinical features of great significance. In so doing, the DC noted that the practice of medicine has always been holistic, and management is rarely based, if ever, on a single factor. Dr AAD was suspended for three months.

In Dr Jen's case, his assessment, which was very likely mistaken, rested on a single factor, a referral letter on the Patient's complaint of backache and sciatica, even though she had not complained of this when she consulted Dr Jen on 30 August 2010. He should have considered holistically her history of her age, past Clomid therapy, tumour marker investigations, and Risk of Malignancy Index instead of just relying on her history of sciatica.

(b) In the case against Dr ABK, Dr ABK was found guilty of professional misconduct in that he had failed to inform his patient of any alternate treatment options or sufficiently explain to him the possible risks and complications involved in a staple haemorrhoidectomy, and thereby had failed to obtain informed consent of his patient. The patient was made to sign a consent form within a short period from undressing and then to undergo the operation. This manner of obtaining consent was a serious breach of Guideline 4.2.2 of the ECEG and the DC stated the circumstance of the case warranted a strong deterrent signal to be sent to members of the profession that a patient's consent must be obtained properly, both in spirit as well as procedurally. Dr ABK was suspended for three months.

Similarly in Dr Jen's case, there was no evidence, apart from his own recollection, that he had offered his Patient a "wait and see" or conservative treatment option,

a very important option because Dr Jen had stated that he could not be sure her pelvic mass was malignant or benign. The Patient also testified that her consultation with Dr Jen on 30 August 2010 lasted a short period. The explanations given to her by Dr Jen were not sufficiently clear. She misunderstood the Mass in her pelvis was separate from her left ovary and that it could be removed leaving the left ovary intact. She was not informed of the consequences to her fertility and ability to conceive if her left ovary and fallopian tube were to be removed and this could have affected her consent to surgery given that her complaint to Dr Jen in June 2010 was for infertility, and because she did not want a Frozen Section biopsy of the Mass in case the pathologist made a mistake causing a subsequent removal of part of her womb. The evidence showed that on 30 August 2010 the left oophorectomy surgery was not clearly explained to her, including whether it was investigative or therapeutic, and the explanations given to her on 31 August 2010 to obtain consent for surgery just prior to her operation were inadequate and not appropriate both in spirit as well as procedurally. This manner of obtaining consent did not provide her with sufficient information and time for her to be able to participate in making informed decisions concerning her treatment.

(c) In the case against Dr AAX, DR AAX had pleaded guilty to two charges during the period 3 February 2005 to 26 May 2005 for: (a) failure to make an adequate clinical evaluation of the patient's medical condition, by failing to carry out the appropriate clinical examination and/or clinical tests pertaining to the treatment of the patient's condition of stage IVA low-grade lymphoma; and (b) failure to exercise due care by failing to properly manage the Hepatitis-B infection that the patient developed during the course of treatment of stage IVA low-grade lymphoma. The DC found that Dr AAX had failed to screen his Patient for Hepatitis B despite chemotherapy being a well-known cause for reactivation of Hepatitis B, and there was sufficient medical literature urging testing before chemotherapy albeit not uniformly practised in Singapore before 2005. He was suspended for three months.

In assessing his Patient's diagnosis, Dr Jen had failed to apply the guideline of the Risk of Malignancy Index which had been internationally applied since 1994; and he admitted he was not familiar with the Ultrasound Guidelines in the International Ovarian Tumour Analysis although he had claimed to be experienced in the practice of Ultrasonography. Although Dr Jen claimed to know the guidelines in the American College of Obstetricians and Gynaecology on the Management of adnexal masses, 2007, he could not quote them apart from some ultrasound parameters of such masses when asked. He had also earlier testified that these features could not conclusively prove malignancy[12]. There was sufficient OBGYN medical literature and guidelines in 2010 to assess the risk of malignancy in ovarian masse. There was no justification for Dr Jen to fail to apply the relevant guideline in assessing his Patient especially since he could not be sure the Mass was malignant. This was an egregious failure in keeping up to date with medical knowledge and failure to evaluate with appropriate investigations

[12] NE of 19 May 2016 page 91 line 9-21 & page 92 line 1-5

and with acceptable guidelines in medical practice before commencing treatment thereby compromising the safe and approved standard of care to his Patient. The DT was not persuaded by Dr Jen's submission that the Patient's agreement to surgery made it unnecessary to do any further investigations apart from the previous trans-vaginal ultrasound scan.

(d) In the case concerning one Dr Looi Kok Poh ("Dr Looi"), Dr Looi had pleaded guilty to and was convicted of three charges: (a) failed to advise the patient of the benefits, risks and possible complications of the surgical procedure known as "Ulnar Neurolysis and Repair", and / or to advise the patient of any alternatives to this surgical procedure which might have been available to him; (b) falsified his medical records pertaining to his consultations with the patient in the period from 19 April 2006 to 18 July 2006 and failed to retain his original set of medical records, and instigated, aided or abetted a nurse to falsify and did cause her to falsify and alter the original Gleneagles Hospital Consent Form stating "Tenolysis Right Wrist" to "Ulnar Neurolysis and Repair"; and (c) failed to arrange appropriate and timely investigations and management of the patient's condition prior to and during the surgery. The DC considered his professional misconduct to be objectionable and repugnant. After performing the said procedure without the Complainant's informed (or indeed any) consent (a procedure in relation to which the Respondent had failed to provide competent and / or appropriate care to the Complainant), Dr Looi then instructed a nurse, who was an employee of the Gleneagles Hospital where the procedure was performed, to alter the patient's original consent form to reflect that the patient had consented to the said procedure when no such consent was given. Dr Looi was suspended for a period of 12 months.

In the present case, Dr Jen had not explained the risks and possible complications of the surgery. His advice was not fully understood or appreciated by his Patient. There was also no convincing evidence that he had given her advice of any alternative to surgical treatment by way of conservative management. Although the Hospital A Consent Form showed "*Open Left Oophorectomy*", Dr Jen had excised her left ovary and left fallopian tube as well as part of her right ovary on 31 August 2010. Furthermore, the Hospital A Operation Record of 31 August 2010 stated that the operation was "*R Oophorectomy and L Cystectomy*". The Patient denied that she had understood she had consented to these surgical procedures and it was her understanding that only the Mass would be removed from her left ovary. There was no evidence that sufficient information had been given to her regarding her pelvic mass, the risks and possible complications including fertility effects of surgery to her left ovary and alternative management options available to her so that she could participate in making informed decision on her treatment.

(e) In the case against Dr Gan Keng Seng Eric ("Dr Gan"), Dr Gan had pleaded guilty to and was convicted of two charges: (a) that he did cause the Endovenous Laser Treatment (the ELVT procedure) to be performed on the right long saphenous vein of the patient together with stab avulsions of the varicosities in both calves of the patient without explaining to him the possible risks and complications

involved in the surgery, and thereby failed to obtain the informed consent of the patient for the surgery that was performed on him; and (b) that he did cause the ELVT procedure to be performed on the right long saphenous vein of the patient, without informing the patient that another doctor would be performing the ELVT procedure, and thereby he failed to provide adequate information to the patient which would allow the patient to make an informed choice about his medical management. The DC fined Dr Gan $5,000.00 and censured him but did not suspend him. The DC came to these decisions for the following reasons:

(a) the patient came specifically asking about the ELVT procedure, and Dr Gan's medical management spanned several consultations over two months.

(b) Dr Gan did not immediately advise the ELVT procedure, but recommended non-invasive and conservative treatment as well as gave advice regarding the conventional operation of Stripping and high ligation of the long saphenous vein.

(c) Dr Gan did not deliberately suppress information nor tried to push the Patient into doing a certain procedure.

(d) He also did not suppress information that his colleague would be performing the ELVT procedure although this information was inadequately given. Dr Gan's mistake in this regard was more of the nature of an oversight and was not intentional nor egregious.

(e) The ELVT procedure was not an inappropriate treatment under the circumstances.

(f) Dr Gan had appeared to act in good faith with the best interests of the Patient at heart rather than intentionally fail to appraise the Patient adequately.

(g) He displayed genuine remorse for his actions and had amended relevant aspects of his practice.

(h) He had pleaded guilty to the two charges which saved time and cost for the SMC and DC.

In Dr Gan's case, the DC made it clear that its decision not to impose a suspension on Dr Gan should not be taken to mean that it regarded the failure to obtain informed consent as a non-serious duty. The duties to obtain informed consent and provide adequate information are extremely serious duties expected of doctors; and these duties are amongst the core pillars of the doctor-patient relationship which is based on trust. The circumstances of Dr Jen's case were entirely different from Dr Gan's case considering the following:

(a) Dr Jen saw his Patient on 30 August 2010 and within 24 hours had persuaded her to undergo a left oophorectomy operation without ensuring his duty of informing her of the treatment option of conservative management and of obtaining informed consent from her.

(b) Surgically removing her left ovary and fallopian tube for a benign Haemorrhagic Corpus Luteum condition was a grossly inappropriate treatment, especially since he knew she did not want any part of her womb area to be removed because of her fertility concerns. This showed an indifference to her welfare and best interests. He had made no evaluation using acceptable guidelines to determine whether her pelvic mass was likely benign or had a high risk of malignancy before advising surgery and this demonstrated he did not have her best interests at heart.

(c) Dr Jen had not shown any remorse over the removal of her left ovary and fallopian tube for a benign condition, and had callously suggested that he had improved her fertility.

55. Having regard to all the facts and circumstances of the case, the DT was of the view that a significant period of suspension would be appropriate in order to adequately address Dr Jen's offending conduct.

Orders by the DT

56. The DT accordingly ordered that Dr Jen:

(a) be suspended for a period of **eight (8) months**;

(b) pay a fine of $10,000;

(c) be censured;

(d) give a written undertaking to the SMC not to engage in the conduct complained of or any similar conduct; and

(e) pay the costs and expenses of and incidental to these proceedings, including the costs of the SMC's solicitors.

Publication of Grounds of Decision

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

58. The hearing is hereby concluded.

Dated this 22nd day of December 2016.