IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2018] SMCDT 7

Between

Singapore Medical Council

And

Dr R

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct

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Singapore Medical Council
v
Dr R

[2018] SMCDT 7

Disciplinary Tribunal — DT Inquiry No 7 of 2018
A/Prof Roy Joseph (Chairman), Dr Wu Dar Ching, Mr Bala Reddy (Legal Service Officer)
31 October 2017, 5-7 March 2018, 20 March 2018, 22-23 March 2018, 6 April 2018, 24 April 2018, 18 May 2018 and 12 June 2018

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct

27 August 2018

INTRODUCTION

1 The Respondent, Dr R, is a specialist in plastic surgery, who was practising at his own medical clinic (the "Clinic"), at the material time when the subject matter of this complaint arose.

2 Between 5 January 2008 and 24 August 2013, Dr R treated Ms P (the "Patient") for her condition of enlarged parotid glands with the use of botulinum toxin ("Botox") injections (the "Botox Treatments"), and had substantially reduced them.

3 On 7 April 2014, the Patient filed a complaint (the "Complaint") alleging that Dr R had, without her consent, used her confidential medical information and unanonymised photographs without her consent in a chapter Facial and Lower Limb Contouring of his

book, R, *Botulinum Toxins in Clinical Aesthetic Practice* (Informa UK Ltd, 2nd Ed, 2011) at pp 206 to 222 (the "Book Chapter") and in at least two medical presentations.

4 By a letter dated 9 October 2014, the Complaints Committee invited Dr R to provide his written explanation on the Complaint, which he did by his letter dated 11 December 2014 ("Written Explanation"). In essence, Dr R's case is that he had obtained the Patient's consent to use her unanonymised photographs and to describe her case in medical publications and presentations.

5 Arising from the Complaint, the Singapore Medical Council (the "SMC") preferred five charges against Dr R, as set out in a Notice of Inquiry dated 25 May 2017.

6 On 16 August 2017, the Notice of Inquiry was amended (the "Amended Notice of Inquiry"). The original first charge was amended to Charge 1 and alternative Charge 1A to include the dates over which the alleged conduct had occurred. The other four charges (*ie,* Charges 2 to 5) were also amended to include the dates over which the alleged conduct had occurred. The charges in the Amended Notice of Inquiry (collectively, the "Charges") are annexed hereto at Annex A. They can be broadly grouped into three categories:

(a) Charges 1 and 1A relate to Dr R's alleged failure to maintain clear and accurate records of the Patient's consent given for the use of her photographs and medical information in breach of Guideline 4.1.2 of the SMC Ethical Code and Ethical Guidelines (2002 edition) (the "2002 ECEG") from 27 April 2009 to 24 August 2013;

(b) Charges 2 and 4 relate to Dr R's alleged failure to obtain the Patient's informed consent before using her unanonymised photographs and medical information unrelated to her condition of enlarged parotid glands ("Unrelated Medical Information") in his Book Chapter, from 4 August 2008 to 2011; and

(c) Charges 3 and 5 relate to Dr R's alleged failure to obtain the Patient's informed consent before using her unanonymised photographs and medical information on her condition of enlarged parotid glands ("Medical Information")

and/or her Unrelated Medical Information in at least two medical presentations in 2010 and 2013.

7 Charge 1 states that Dr R's conduct "demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency" pursuant to the first limb of the test for professional misconduct in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*").

8 In respect of the same facts as those relating to Charge 1, Charge 1A states that his conduct "demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner", pursuant to the second limb of the test for professional misconduct in *Low Cze Hong*.

9 Charges 2 to 5 are premised on the second limb of the test for professional misconduct in *Low Cze Hong*.

10 Dr R claimed trial to all of the Charges.

11 The overarching issues in the present case are:

(a) Whether Dr R had obtained the Patient's informed consent to use her unanonymised photographs, Medical Information, and Unrelated Medical Information in medical / scientific publications and presentations; and

(b) If so, whether such consent had been properly documented.

12 This Disciplinary Tribunal (this "Tribunal") has carefully considered all of the material before us. We arrive at the unanimous decision that the SMC has not proven the Charges beyond a reasonable doubt, and we therefore find Dr R not guilty on any of the Charges.

13 In summary, our findings are as follows:

(a) On 4 August 2008, Dr R took the Patient's informed consent to use her unanonymised photographs, Medical Information, and Unrelated Medical Information in medical or scientific publications and presentations. He had done

so in a manner that did not demonstrate serious negligence that objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

(b) Dr R had recorded the Patient's consent in writing in his case notes on the Patient's medical records in a manner that had satisfied the applicable standard observed or approved by members of the profession of good repute and competency at the material time in 2008. Alternatively, his conduct did not demonstrate serious negligence that objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

(c) The Patient did not revoke or modify her consent until her e-mail to Dr R dated 22 September 2013. Accordingly, Dr R had not acted in breach of the consent that the Patient had given him as alleged in the Charges.

14 We set out our reasons below.

PRELIMINARY OBJECTIONS TO THE FIRST CHARGE

15 At the start of the disciplinary inquiry hearing (the "Inquiry Hearing") on 5 March 2018, counsel for Dr R raised preliminary objections to Charge 1 and Charge 1A of the Notice of Inquiry (hereinafter the "First Charge"), contending that it was fundamentally defective and unsustainable as a matter of law.

16 We do not repeat the parties' submissions in detail, because the parties canvassed broadly similar arguments during the Inquiry Hearing in relation to Charge 1, which we discuss at [377] below. In summary:

(a) The gist of Dr R's objections was that Guideline 4.1.2 of the 2002 ECEG (which formed the basis of the First Charge) only regulates the documentation of a patient's consent for the use of the patient's photographs and/or medical information in relation to the *medical care and treatment* of that patient, and not in relation to medical publications and presentations.

(b) Counsel for the SMC maintained that the First Charge was proper, and averred that on both a literal and purposive interpretation of Guideline 4.1.2, a

doctor's obligation to maintain proper medical records extends to *all* informed consents.

Our decision

17 We dismissed Dr R's preliminary objections to the First Charge on 31 October 2017. Having reviewed the voluminous contents of parties' submissions and their expert witnesses' opinions, we considered the determination of the scope of "informed consents" under Guideline 4.1.2 of the 2002 ECEG to be a serious question involving complex considerations that was not suited for summary disposal.

18 This Tribunal took the view that the construction of "informed consents" in the 2002 ECEG was a point of law that would involve protracted argument as well as numerous documents which were likely to delay these proceedings. Moreover, we were cognisant that further facts could emerge at trial which might throw light upon the evidence that had to be considered. A true construction of Guideline 4.1.2 of the 2002 ECEG as it applied in 2008 would involve questions of both law and fact, and no satisfactory answer could be given without a detailed investigation, including, among other things, further affidavit evidence of expert witnesses and corroborated by cross-examination on the use of the term "informed consent" in the medical community, as well as the nature of accepted practice in the medical community and publishing industry as regards "informed consent" under Guideline 4.1.2 of the 2002 ECEG in 2008.

19 Given the considerable time and expense that would likely have been spent for the preliminary objection proceedings alone, and in the interest of facilitating the just, expeditious and economical disposal of the inquiry, we decided that parties would be better served by seeking to have the action tried as soon as possible. Accordingly, in exercise of our case management powers under regulation 29 of the Medical Registration Regulations 2010 (GN No S 733, 2010), we dismissed Dr R's preliminary objections.

The Respondent's Appeal to the High Court

20 Dissatisfied with this Tribunal's decision, Dr R sought to appeal to the High Court against this Tribunal's order by Originating Summons C3J/OS X/2017A dated 23 November 2017 (the "OS"). On 26 December 2017, the SMC and Dr R agreed to hold the appeal proceedings in abeyance pending disposal of the present Inquiry against Dr R.

21 We need only deal briefly with the OS, which we found to be misconceived and without statutory basis.

22 It is trite law that the right of appeal is a creature of statute and not part of the inherent jurisdiction of an appellate court. As the Court of Appeal explained in *Blenwel Agencies Pte Ltd v Tan Lee King* [2008] 2 SLR 529 at [23] – [25], any right of appeal must have its source in legislative authority:

> 23 This precept is part of a broader and more fundamental principle that has been emphasised ever so frequently – and one which we take pains to reiterate yet again. **The Court of Appeal is a creature of statute and, hence, is only seised of the jurisdiction that has been conferred upon it by the relevant provisions in the legislation creating it**: see, for example, Microsoft Corp v SM Summit Holdings [2000] 1 SLR(R) 423 at [17], Abdullah bin A Rahman v PP [1994] 2 SLR(R) 1017 at [7] and Ng Chye Huey v PP [2007] 2 SLR(R) 106 at [17]. **A jurisdiction-conferring provision, whether derived from the Act or elsewhere, is a crucial prerequisite that a would-be appellant must satisfy so as to have, before this court, a legal basis upon which to canvass the substantive merits of his or her application** (see the decision of this court in Ng Chin Siau v How Kim Chuan [2007] 4 SLR(R) 809 at [42] for a similar expression of this principle in the context of arbitration proceedings generally).
>
> 24 If the would-be appellant's application is intended to constitute an appeal against the decision of a lower court, it can only be heard by the Court of Appeal if the would-be appellant possesses a legitimate right of appeal in the first place. **In this connection, it is trite law that there is no inherent right to appeal from judicial determinations made by our courts**: see, for example, the Straits Settlements Supreme Court decision of Chop Sum Thye v Rex [1933] MLJ 87 and the Malaysian Federal Court decision of Kulasingam v Public Prosecutor [1978] 2 MLJ 243. **A right of appeal must, therefore, have its source in legislative authority**: see, for example, Knight Glenn Jeyasingam v PP [1998] 3 SLR(R) 196 at [13] and Ting Sie Huong v State Attorney-General [1985] 1 MLJ 431. In As Lord Goddard CJ poignantly observed in the English decision of R v West Kent Quarter Sessions Appeal Committee [1951] 2 All ER 728 at 730:
>
> It is most elementary that no appeal from a court lies to any other court unless there is a statutory provision which gives a right to appeal. **The decision of every court is final if it has jurisdiction, unless an appeal is given by statute**. [emphasis added]

23 The above passage relating to appeals between civil courts applies with equal force to appeals from tribunals to the High Court. Section 20(*c*) of the Supreme Court of Judicature Act (Cap 322, 2007 Rev Ed) (the "SCJA"), states that the appellate civil powers of the High Court over tribunal appeals must be conferred by statutory provision:

> Appellate civil jurisdiction
>
> 20. The appellate civil jurisdiction of the High Court shall consist of —

…

(*c*) the hearing of appeals from other tribunals as may from time to time be prescribed by any written law.

24 Turning to the medical disciplinary tribunals, section 55(1) of the Medical Registration Act (Cap 174, 2014 Rev Ed) (the "MRA") confers on registered medical practitioners a right of appeal to the High Court against specific disciplinary tribunal orders:

> Appeal against order by Disciplinary Tribunal
>
> 55.—(1) A registered medical practitioner or the Medical Council who is dissatisfied with **a decision of the Disciplinary Tribunal referred to in section 53(2), (4) or (5) or 54 (referred to in this section as the decision of the Disciplinary Tribunal)** may, within 30 days after the service on the registered medical practitioner of the notice of the order, appeal to the High Court against the order (referred to in this section as an appeal to the High Court). [emphasis added]

25 The limited categories of appealable orders as set out in sections 53(2), (4), (5) and 54 of the MRA includes orders imposing a fine or suspension on a registered medical practitioner (section 53(2)), orders acquitting the practitioner (section 52(4)), orders as to the payment costs and expenses of and incidental to disciplinary tribunal proceedings (section 53(5)), and orders consequent on the practitioner's failure to comply with certain orders of a disciplinary tribunal (section 54).

26 The MRA does not confer any right to registered medical practitioners to appeal against a disciplinary tribunal's dismissal of preliminary objections to a charge. Without such an express prescription in written law, the High Court does not assume appellate civil jurisdiction on the matter under section 20 of the SCJA, and the Tribunal's decision on such interlocutory matters is non-appealable.

The Inquiry Hearing

27 For the Inquiry Hearing, the SMC and Dr R tendered their witness statements on 13 February 2018[1]. The hearing took place over 9 days between 5 March 2018 and 18 May 2018. The SMC called three witnesses: the Patient; the Patient's husband; and an expert witness, Dr PE. Apart from giving his own defence, Dr R called two nurses, Ms DNurse1 and Ms DNurse2, and two expert witnesses, Prof DE1 and Dr DE2. Following

[1] Letters from the SMC and Dr R to this Tribunal enclosing witness statements, both dated 13 February 2018.

the hearing, the parties submitted their written closing and reply submissions on 6 June 2018 and 12 June 2018 respectively. This Tribunal reserved its decision.

THE LAW

Test for professional misconduct

28 In respect of the two limbs of *Low Cze Hong*, the Court of Three Judges (the "C3J") in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("***Wong Him Choon***") held that the following findings are to be made before the SMC could be found to have proven a charge for professional misconduct (at [49]):

> (a) In relation to the first limb of Low Cze Hong... :
>
> (i) what the applicable standard of conduct was among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct relates to;
>
> (ii) if the applicable standard of conduct required the said doctor to do something and at what point in time such duty crystallised; and
>
> (iii) whether the said doctor's conduct constituted an intentional and deliberate departure from the applicable standard of conduct.
>
> (b) In relation to the second limb of Low Cze Hong:
>
> (i) whether there was serious negligence on the part of the doctor; and
>
> (ii) whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

Burden and standard of proof

29 It is well established that the legal burden of proof in respect of the Charges rests on the SMC throughout, and the SMC must discharge this burden of proof beyond reasonable doubt (*Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 at [61] – [62]).

30 Not all doubts about the prosecution's case may amount to reasonable doubts. One must distinguish between a "real or reasonable" doubt and a "merely fanciful" doubt (*Teo Keng Pong v PP* [1996] 3 SLR 329 at [68]). As to what constitutes a reasonable doubt, the High Court in *Jagatheesan s/o Krishnasamy v Public Prosecutor* [2006] SGHC 129

("*Jagatheesan*") found useful the following statement by Wood JA in *R v Brydon*, (1995) 2 BCLR (3d) 243 (at [53]):

> [I]t is difficult to think of a more accurate statement than that which defines reasonable doubt as a doubt for which one can give a reason, so long as the reason given is logically connected to the evidence.

31 The standard of proof beyond a reasonable doubt obliges a tribunal to find the respondent not guilty if one or more reasonable doubts remain after it has applied its mind to the evidence, to the relevant legal and ethical principles and to the submissions presented to it.

32 This standard is unlikely to be satisfied if all that is before a tribunal are two competing and equally plausible versions of material facts (*Lam Kwok Tai Leslie v Singapore Medical Council* [2017] 5 SLR 1168 ("*Leslie Lam*") at [38]). In such a situation, the C3J explained the approach it should take, as follows (at [38]):

> It is incumbent on the court in such circumstances to examine each side's contentions in the light of other objective facts and consider the extent to which it can properly be said that the party bearing the burden of proof has in fact discharged it.

33 On the other hand, proof beyond reasonable doubt does not mean that every fact and every piece of evidence must be proved beyond reasonable doubt (*Nadasan Chandra Secharan v Public Prosecutor* [1997] 1 SLR 723 (CA), at [85]).

34 We find the following summary in *Jagatheesan* instructive (at [61]):

> To summarise, the Prosecution bears the burden of proving its case beyond reasonable doubt. While this does *not* mean that the Prosecution has to dispel all conceivable doubts, the doctrine mandates that, at the very least, those doubts for which there is a reason that is, in turn, relatable to and supported by the evidence presented, must be excluded. Reasonable doubt might also arise by virtue of the *lack* of evidence submitted, when such evidence is necessary to support the Prosecution's theory of guilt. Such a definition of reasonable doubt requires the trial judge to apply his mind to the evidence; to carefully sift and reason through the evidence to ensure and affirm that his finding of guilt or innocence is grounded entirely in logic and fact. A trial judge must also bear in mind that the starting point of the analysis is not neutral. An accused is presumed innocent and this presumption is not displaced until the Prosecution has discharged its burden of proof. Therefore, if the evidence throws up a reasonable doubt, it is not so much that the accused should be given the benefit of the doubt as much as the Prosecution's case simply not being proved. In the final analysis, the doctrine of reasonable doubt is neither abstract nor theoretical. It has real, practical and profound implications in sifting the innocent from the

> guilty; in deciding who should suffer punishment and who should not. The doctrine is a bedrock principle of the criminal justice system in Singapore because while it protects and preserves the interests and rights of the accused, it also serves public interest by engendering confidence that our criminal justice system punishes only those who are guilty.

Duty to take informed consent

35 Although the present case relates solely to informed consent for the use of a patient's photographs and medical information for educational or academic purposes, we nonetheless found it instructive to consider the approach taken by the C3J in cases where a doctor had been charged for professional misconduct for failing to obtain a patient's informed consent for medical care and treatment.

36 In *Leslie Lam*, the C3J allowed the doctor's appeal against his conviction and suspension of three months in respect of one charge of professional misconduct for failing to obtain informed consent from his patient prior to carrying out an invasive percutaneous coronary intervention procedure.

37 In allowing the appeal, the C3J held that the disciplinary tribunal ought to have considered the totality of the evidence before it as to whether the doctor had obtained the patient's informed consent (*Leslie Lam* at [34]). While the absence of contemporaneous notes documenting the taking of consent was relevant, the C3J found that the disciplinary tribunal had placed undue emphasis and weight on the same (at [34]). In particular, the disciplinary tribunal had failed to consider the significance of the fact that the patient signed a consent form for a "Coronary Angiogram Keep in View Coronary Angioplasty", which stated in general terms that the patient had been informed of the nature, purpose, risk and alternatives pertaining to a percutaneous coronary intervention (at [44]). It was in this case where the patient and the doctor's accounts of events were competing that the C3J opined on its duty before it could find that the burden of proof had been discharged (at [38]), as discussed at [32] above.

38 The C3J distinguished two prior decisions that the SMC had relied on to support its contention that the lack of documentation pointed to a lack of informed consent in *Singapore Medical Council v Dr Koh Gim Hwee* (13 June 2011) and *Singapore Medical Council v Eu Kong Weng* (10 July 2010). In those cases, the C3J noted that, even though the lack of documentation was important, the disciplinary committee (as it was then

known) had concluded that there had been no informed consent only after considering the totality of the evidence (at [40]):

> …in *Singapore Medical Council v Dr Koh Gim Hwee* (13 June 2011) ("*Koh Gim Hwee*") and *Singapore Medical Council v Eu Kong Weng* (10 July 2010) ("*Eu Kong Weng (DC)*"), the lack of accurate and contemporaneous documentation of consent-taking was found to be relevant in determining whether informed consent had in fact been obtained. However, in those cases, other factors were also taken into account.

39 Therefore, in allowing the doctor's appeal, the C3J found that the disciplinary tribunal had failed to consider the documentary evidence, and the doctor's unchallenged evidence on his consistent practice of obtaining informed consent (*Leslie Lam* at [65], [67]).

40 The C3J set out three factors that would be relevant in respect of a disciplinary tribunal sentencing a doctor convicted of professional misconduct for failing to obtain informed consent, as follows (*Leslie Lam* at [90]):

> (a) the materiality of the information that was not explained to the patient, namely, whether there is evidence that the patient would have taken a different course of action had such information been conveyed;
>
> (b) the extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and
>
> (c) the possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information. This follows from the court's observation in Yong Thiam Look Peter v Singapore Medical Council [2017] 4 SLR 66 (at [12]) that when harm ensues in a case where the harm does not form an element of the charge, the causation of such harm would be a "seriously aggravating" factor; on the other hand, the absence of such harm would "generally be a neutral consideration without any mitigating value".

41 In *Low Cze Hong*, the C3J considered a doctor's appeal in relation to two charges of professional misconduct for inappropriate treatment of a patient's blind right eye, and failure to obtain that patient's informed consent. The C3J considered that two of the patient's children who had attended the consultations with the doctor gave evidence that the doctor had not discussed other treatment options (at [80]). One of these witnesses sent an e-mail to her siblings after the first consultation, which made no reference to any options offered (at [77]). The C3J concluded that, while the charge was not for failure to keep proper records, the doctor's lack of proper records bolstered by the absence of any

mention of the same in the witness' e-mail did not assist him in his assertion that he had discussed other treatment options with the patient (at [80]).

42 In *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Jen Shek Wei*"), the C3J upheld the conviction and sentence against a doctor in respect of two charges for professional misconduct relating to the doctor advising the patient to undergo surgery to remove a pelvic mass without conducting further investigation, and the doctor's failure to obtain informed consent to remove the patient's left ovary. The patient claimed that she had not been aware that the doctor had removed her left ovary during surgery until eight months thereafter when she had consulted with a different doctor who had pointed out her missing ovary to her. In his defence, the doctor claimed that the patient had signed a consent form. However, the C3J considered that, while the signed consent form was a contemporaneous record of consent, the form alone did not raise a reasonable doubt in the doctor's favour (at [100]). In that case, the form was, at best, an indicator that the obligation to explain a medical treatment has been discharged, but was not a conclusive defence to a charge of failing to take informed consent (at [104]). Whether the form is sufficient to raise a reasonable doubt has to be considered in the context of the other evidence (at [104]). Therefore, in that case, the C3J considered whether the patient knew that she was going for a left oophorectomy: if she had not, it logically followed that the doctor had not explained matters for the procedure; if she had, it would only show that he obtained her consent, but not her *informed* consent (at [109]). If the C3J found the latter, her credibility would have been seriously called into question, because she had insisted from the start that he had never informed her about the left oophorectomy, and that would have raised a reasonable doubt in the doctor's favour (at [109]).

43 However, the doctor admitted that when the patient thought that she was removing a mass in her ovary, she may not have understood that the mass and the ovary were in fact the same thing (at [131]). In his defence, the doctor argued that, during the process of taking consent, the patient and her husband had been more concerned with pain and cancer than about the reduction in fertility (at [133]). In considering the totality of the evidence, the C3J agreed with the disciplinary tribunal that the doctor's explanation of the patient's concerns had been at odds with the patient's earlier behaviour in refusing to accept a procedure that involved even a 0.1% risk of error that may affect fertility (at [133]). Therefore, the C3J affirmed the disciplinary tribunal's acceptance of the patient's

and the second doctor's testimony that the patient had indeed been shocked to find out from that second doctor only eight months later that her ovary had been removed (at [135]).

44 In finding that the doctor's notes did not assist him, the C3J agreed with the disciplinary tribunal's finding that the presence of the words "open oophorectomy", "explained risks" and other such phrases in the doctor's case notes was not conclusive of the fact that he had explained matters to the patient (at [113] – [114]). In the light of Guideline 4.1.2 of the 2002 ECEG, the C3J held that any doctor reading the phrase "explained risks" would not have been able to tell what had been explained (at [118]). The C3J also noted that it had previously found in *Low Cze Hong* that it was insufficient for a doctor to record informed consent in a single phrase (at [119]).

45 In postscript, the C3J noted that the parties did not have the opportunity to address the C3J on the effect of the judgment in *Leslie Lam*, which was released subsequently (at [146]). The C3J noted that the disciplinary tribunal below it had not committed the same error as the disciplinary tribunal had done in *Leslie Lam* by treating the lack of documentation as conclusive of the failure to take informed consent (*Jen Shek Wei* at [147] – [148]). Instead, the disciplinary tribunal had rightly weighed all the evidence before it, including the patient's lack of understanding about what a left oophorectomy was, the doctor's admissions that the patient may not have understood that the mass and the ovary were the same, and the implausibility of the patient agreeing to that procedure given her earlier reluctance about affecting her fertility (at [148]).

OUR DECISION

46 We first assess the parties' widely differing factual accounts before turning to consider whether the Charges have been proven beyond a reasonable doubt.

47 The credit of the witnesses was significant in the present case as parties' accounts relied substantially on oral testimony. In this regard, it could not escape our attention that Dr R was previously convicted of an offence under the Road Traffic Act (Cap 276, 2004 Rev Ed). As that offence involved fraud or dishonesty, Dr R was subsequently subject to disciplinary tribunal proceedings in *Dr R* (21 February 2014). In that case, the disciplinary tribunal remarked that it was "completely incredible" that Dr R claimed he committed the

offence out of ignorance and not from intentional deceit (at [7(a)]). The disciplinary tribunal took a dim view of Dr R's conduct of "subverting the course of justice through his act of dishonesty, a conduct that the medical profession will not condone" (at [7(b)]). The disciplinary tribunal concluded that that was "a fitting case" to impose a suspension sentence as a deterrence (at [7(e)]), and condemned Dr R, stating that his "dishonesty had tarnished the good name of the profession" (at [10]). In sentencing him, the disciplinary tribunal considered his seniority and standing in the medical profession, and his lack of remorse when personally addressing the disciplinary tribunal as aggravating considerations (at [10] and [11]). The disciplinary tribunal ordered that Dr R be suspended for four months, be censured, give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct, and pay costs and expenses (at [18]).

48 From the outset therefore, we treated Dr R's evidence with a measure of caution, and were particularly careful to test his veracity by reference to objective facts proved independently of his testimony.

49 In assessing credibility, this Tribunal was mindful to give room for discrepancies as would be expected of witnesses giving their recollections of events that took place between 2003 and 2013. We were slow to discredit the evidence of witnesses based on minor inaccuracies surfacing on cross-examination, and more so on points which had no material bearing on the main issues. As the Court of Appeal observed in *Sandz Solutions (Singapore) Pte Ltd v Strategic Worldwide Assets Ltd* [2014] 3 SLR 562 at [56]:

> ….a witness should not be found to be less credible merely because of gaps in his memory, particularly where a long period of time has passed since the occurrence of the events in question. We reiterate that ultimately, the trial judge has to consider the *totality* of the evidence in determining the veracity, reliability and credibility of a particular witness's evidence. This includes contemporaneous objective documentary evidence.

50 We also note the following observation by V K Rajah JC (as he then was) in *Cheong Ghim Fah and Another v Murugian s/o Rangasamy* [2004] 1 SLR(R) at [19]:

> I would like to make an observation about cross-examination techniques sometimes employed by counsel. Counsel should appreciate that when a witness is cross-examined at length about an incident that has happened in almost the blink of an eye, they cannot expect the witness to recollect what has transpired with punctilious accuracy and consistency. While counsel are allowed to probe a witness for consistency and credibility,

> the micro-dissection of the evidence of an unschooled witness will often produce some inconsistencies. Indeed, it has been often said, on high authority, that a witness who can give flawless evidence may be treated with some caution, as perhaps a rehearsed witness…

51 We agree that a clinical dissection of the factual matrix that happened over a period of five to ten years ago is not particularly useful in assessing parties' credibility in the present case. The overall tenor and consistency of their evidence had to be considered.

52 Finally, utmost weight was placed on contemporaneous and objective documentary evidence in determining the inherent plausibility of the parties' respective accounts. As the court in *Ng Chee Chuan v Ng Ai Tee (administratrix of the estate of Yap Yoon Moi, deceased)* [2009] 2 SLR (R) 918 stated at [19]:

> … the crucial question of whether the oral agreement alleged by the respondent existed depended as much, if not more, on the inferences which could reasonably be drawn from the available objective evidence that than the apparent credibility of witnesses *per se*.

53 We add that contemporaneous written documentation is significant not only where it is present, but also where it is absent. Indeed, reasonable doubt might arise by virtue of the lack of evidence submitted, when such evidence is necessary to support the prosecution's theory of guilt (*Jagatheesan* at [61]). As Arden LJ explained in *Wetton (as Liquidator of Memtaz Properties) v Ahmed & Ors* [2011] EWCA Civ 61 at [14]:

> In my judgment, contemporaneous written documentation is of the very greatest importance in assessing credibility. Moreover, it can be significant not only where it is present, and the oral evidence can be checked against it. It can also be significant if written documentation is absent. For instance, if the judge is satisfied that certain contemporaneous documentation is likely to have existed were the oral evidence correct, and that the party adducing oral evidence is responsible for its non-production, then the documentation may be conspicuous by its absence and the judge may be able to draw inferences from its absence.

The facts

54 On the totality of the evidence before us, we find that on 4 August 2008, Dr R obtained the Patient's informed consent to use her unanonymised photographs and to describe her case, including her Medical Information and Unrelated Medical Information, in medical/scientific publications and presentations. We find that the Patient only revoked such consent by her e-mail to Dr R dated 22 September 2013.

55 We set out our analysis below.

(1) The Patient

56 The Patient is currently self-employed. She claims she was a homemaker since 2001 and at the time of her first consultation with Dr R on 25 October 2003. Describing herself as rather naïve[2], her case is that she unequivocally and unreservedly trusted Dr R on matters relating to her confidentiality.

57 Dr R's case is that the Patient is not as unwitting, gullible or submissive as she portrays herself to be, and that she was at all material times a highly intelligent individual, who was familiar with the concept of confidentiality, and who was not afraid to express her disagreements and dissatisfactions to Dr R.

58 Having had the opportunity to examine the Patient closely on the witness stand, and based on incontrovertible objective evidence disclosed at the Inquiry Hearing, it seemed plain to us that far from being naïve, the Patient was at all material times a sophisticated, capable, and highly educated professional with a mind of her own, who understood the concept of confidentiality and was not afraid to express her disagreements and dissatisfactions to Dr R.

Stellar educational qualifications and career history

59 The Patient's Curriculum Vitae available on her online LinkedIn profile ("Patient's CV") was disclosed by Counsel for Dr R during the Inquiry Hearing. The Patient confirmed its accuracy[3].

60 The Patient's CV revealed the Patient to be a Institution W scholar who graduated with a First Class Honours undergraduate degree in Engineering and Computer Science from Imperial College London in 1994[4]. She obtained a Masters Degree in Operational Research from the London School of Economics and Political Science in 1995[5].

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[2] Transcript dated 5 March 2018, 99:1-4.
[3] Transcript dated 5 March 2018, 102:5-8
[4] Newspaper Article, Exhibit R1, pages 1 to 2; Patient's CV, Exhibit R2, page 2.
[5] Patient's CV, Exhibit R2, page 2.

61 In terms of professional experience, the Patient completed a six-year bond in Institution W from 1995 to 2001[6], starting out as a financial analyst, and eventually becoming a business development manager in Institution X. Her scholar profile and work experience was even chronicled in a Straits Times article ("Newspaper Article")[7]. In the Newspaper Article, the Patient said that in October 1996, she moved into banking and finance where she handled financing for corporations in South-east Asia, including credit analysis of companies as well as research work on the industrial sector in which those companies operated. Such was the Patient's stellar educational qualifications and work background prior to meeting Dr R in 2003.

62 In 2006, the Patient was awarded the Chartered Financial Analyst designation. Between 2006 to 2008, the Patient worked as an investment associate in Institution Y, where she had, among other things, "evaluated deals by undertaking all aspects of due diligence, including financial due diligence, business due diligence and legal due diligence", and "prepared investment memos, investor presentations, pitches and summary findings"[8].

63 The irresistible conclusion we draw from the Patient's education and work history is that she has been a highly educated and intelligent professional at all material times.

Experience in drafting confidentiality agreements

64 The Patient's CV showed that she had, prior to 2008, experience in handling the drafting of confidentiality agreements, including non-disclosure agreements[9].

65 On cross-examination, the Patient agreed that prior to 2008 she had already understood the concept and importance of confidentiality[10]. She accepted that she fully understood the written consent that she had signed on 4 August 2008[11] ("Written

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[6] Patient's CV, Exhibit R2, page 2.
[7] Newspaper Article, Exhibit R1, page 3.
[8] Patient's CV, Exhibit R2 page 2.
[9] Patient's CV, Exhibit R2, page 1, under Institution Y "Handled Confidentiality Agreement negotiation and drafting".
[10] Transcript dated 5 March 2018, 100:14-17.
[11] Transcript dated 5 March 2018, 175:9-176:11.

Consent"). Indeed her evidence is that on reviewing the Written Consent, she even pointed out to Dr R particulars which she felt to be lacking[12].

66 Given her undisputed practical experience with confidentiality agreements, we were unimpressed with her attempts to downplay her familiarity with the concept of confidentiality, such as by qualifying that she "didn't really negotiate"[13] confidentiality agreements even though her CV plainly declared that she did[14], or confining her experience to the business world and claiming that dealing with a doctor had been a "different context entirely"[15]. According to her own case, she and Dr R had been parties to a quasi-commercial bargain or "win-win" arrangement where she allowed him to use her medical information in exchange for obtaining treatment of her condition of enlarged parotid glands at cost price.

Capable of exercising independent judgement

67 The undisputed evidence shows that the Patient was someone who knew what she wanted from aesthetic treatments, and was capable of exercising independent judgment as to her medical treatment:

(a) **Research and selection of doctors:** Prior to her consultation with Dr R in 2003, the Patient had researched cosmetic surgeons to find out "whether they have done botch jobs or not"[16]. This indicates to us that she had been deliberate and selective in her choice of specialist doctors, weeding out those who she perceived to be incompetent upon investigation. She had also shortlisted three plastic surgeons before choosing Dr R who was the "only doctor who was willing to perform all the cosmetic procedures that [she] had requested"[17], and who was "unlike the other two doctors who were more conservative and would indicate that certain procedures that [she] wanted were not necessary"[18]. This shows that the

[12] Statement of Ms P dated 13 February 2018 (the "Patient's Statement"), Bundle of Statements and Reports, Volume 1 ("1 BSR"), para 33 to 36.
[13] Transcript dated 5 March 2018, 101:1-3.
[14] Patient's CV, Exhibit R2, page 1, under Institution Y "Handled Confidentiality Agreement negotiation and drafting".
[15] Transcript dated 6 March 2018, 23:8-12.
[16] Transcript dated 5 March 2018, 122:22-123:3.
[17] The Patient's Statement, 1 BSR, Tab 1, para 6.
[18] The Patient's Statement, 1 BSR, Tab 1, para 7.

Patient knew what she had wanted out of her cosmetic treatment and had chosen a doctor to do all the procedures that she desired.

(b) **Seeking a second opinion on her own accord:** When it came to the diagnosis and treatment for her condition of enlarged parotid glands, she had "disregarded [Dr R's] diagnosis" for her parotid glands and sought a second opinion from a specialist in the area as she "didn't really believe [Dr R's] diagnosis of the situation"[19]. This demonstrates that she exercised independent judgment and did not always accept at face value medical advice given to her by Dr R. If the Patient did not even fully trust Dr R on matters concerning medical diagnosis and treatment, it is difficult to accept that she would blindly trust him in matters concerning her personal privacy.

68 Consistent with a discerning person who exercised independent judgment, the Patient was clearly aware of her other options for aesthetic treatment and did not feel bound to Dr R. She had consulted Dr W1 for non-surgical aesthetic procedures in the period from 19 December 2007 to 25 August 2013[20].

69 For completeness, we would add that the Patient had her husband with her on almost all occasions. Patient's husband himself was a Vice-President of an international investment bank at the material time. From our observations on his demeanour on the stand, and the fact that he was assertive enough to ask Dr R for discounts on various occasions, he did not appear to be a person who would have been easily taken advantage of. Where he had accompanied the Patient to consultations, it seemed highly unlikely that the Patient would have been unwittingly reliant on Dr R.

Unafraid of expressing her dissatisfaction to Dr R

70 The Patient's actions were consistent with those of an individual who knew what she wanted, and who was not afraid to express her views, dissatisfaction and disagreements to Dr R.

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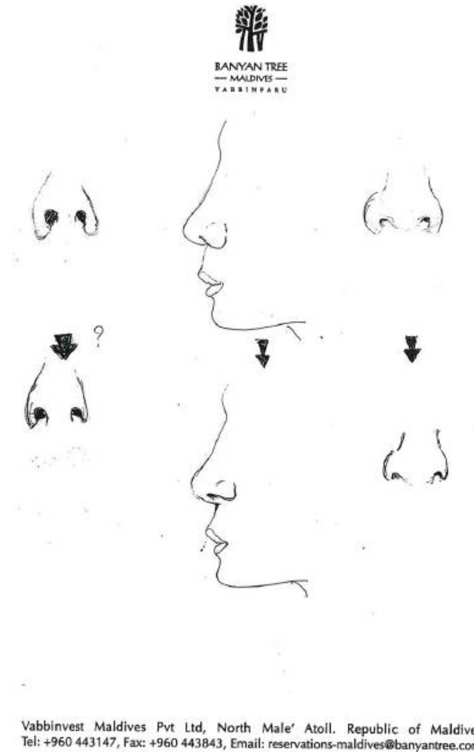
[19] Transcript dated 6 March 2018, 17:58, 91:1-10.
[20] Transcript dated 5 March 2018, 130:21-131:3.

71 After her first augmentation rhinoplasty performed by Dr R on 5 November 2003, the Patient had returned to see Dr R on or around 10 April 2004 for further alterations to her nose. For this purpose, she had drawn and brought along a diagram of her face and nose to show Dr R:



72 Dr R explained that the Patient had brought the drawings to show how thin she wanted her nostrils to be after further surgery. This was supported by Dr R's consultation note dated 10 April 2004 with the words "wants to do alar reduction"[21]. On cross-examination, the Patient admitted that she had been trying to convey with the drawing that she "didn't think that [Dr R's] job was up to her satisfaction"[22], and that she had brought the diagram to highlight to Dr R what could have been improved regarding her nose operation[23].

73 Aside from the diagram, the Patient had also taken photographs[24] of parts of her face post-operation to bring to Dr R. She admitted she had done this to have an in-depth discussion with Dr R about what she wanted done[25].

[21] Transcript dated 20 March 2018, 31:5-19.
[22] Transcript dated 5 March 2018, 124:11-13.
[23] Transcript dated 5 March 2018, 126:12-15.
[24] Respondent's Supplementary Bundle ("RSB"), Tab 29, pages 7-13.
[25] Transcript dated 5 March 2018, 125:6-126:8.

74 The preparation of the diagram and self-taken pictures and the Patient's testimony about their purpose suggests the Patient took a pro-active approach in her treatments and was perfectly comfortable raising her dissatisfactions and suggesting improvements to Dr R to get the nose she desired. It is rather consistent with DNurse2's description of her as opinionated and as someone who had no difficulty telling Dr R what she wanted to be done to her nose[26].

75 Taking the evidence as a whole, we find that the Patient was a sophisticated professional with a mind of her own, who understood the concept of confidentiality and was unafraid to express her dissatisfactions to Dr R. We reject the Patient's self-serving testimony that she was rather naïve, and would treat with circumspect her other assertions that she:

(a) "[felt] that [she] had no right to question [Dr R's] actions"[27];

(b) "felt she had "no right to question what [Dr R did] with [her confidential patient information and photographs]"[28];

(c) "didn't know that [she] had a right to say how [she] felt"[29];

(d) "had no right to ask for a proper viewing of the [Book] Chapter"[30]; and

(e) "felt she had "no right to tell [Dr R] that [she doesn't] want … him to use [her] un-anonymised pictures"[31].

76 With this in mind, we turn to consider the issues in dispute.

[26] Transcript dated 6 April 2018, 64:21–65:12.
[27] 1 BSR Tab 1, page 14, para 45.
[28] 1 BSR Tab 1, page 15, para 49.
[29] Transcript dated 6 March 2018, 39:8-9.
[30] 1 BSR Tab 1, page 18, para 56.
[31] Transcript 6 March 2018, 88:4-7.

(2) Cosmetic surgeries in 2003 and 2004

Was the Patient a homemaker when she first met Dr R?

77 Given our finding on the Patient's capability and character described above, the significance of whether or not the Patient had been a homemaker or investment analyst at the time she met Dr R is solely one of credibility.

78 Dr R's evidence was that when he first met the Patient in 2003, she was an investment analyst in a financial institution[32]. DNurse2's testimony was similarly that the Patient had told her she "did investments"[33] and was an "investment banker"[34] at some point.

79 In the Patient's Statement, the Patient claimed that when she first consulted Dr R on 25 October 2003, she was a "homemaker", and had been one since July 2001[35]. At the Inquiry Hearing, she maintained on oath that she was a homemaker from July 2001 to 2006[36]. She challenged Dr R's contemporaneous written records that described her as an investment analyst as inaccurate, saying she had told him it was her previous job[37].

80 The Patient's evidence plainly contradicted her own CV, which surfaced during the Inquiry Hearing, and in which she stated that she worked as an investment analyst in Institution Z, Malaysia from 2002 to 2006[38]. This clearly supported Dr R and DNurse2's evidence as to her line of work.

81 Upon being confronted with her own CV, the Patient tried to extricate herself by saying that Institution Z was her father's company and so she did not consider that to be a full-time job[39]. She also made the somewhat surprising submission that she had embellished her CV[40]. We find such explanations, coming only after being confronted with her own CV, to be afterthoughts used to salvage her statements from the realm of the outright lie to that of the half-truth.

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[32] Dr R's Written Explanation, [6].
[33] Transcript dated 6 April 2018, 65:13-16.
[34] Transcript dated 6 April 2018, 68:16-21.
[35] The Patient's Statement, 1 BSR, para 3.
[36] Transcript dated 5 March 2018, 93:22-94:5.
[37] Transcript dated 5 March 2018, 93:6-10.
[38] Patient's CV, Exhibit R2 page 2.
[39] Transcript dated 5 March 2018, 106:2-8.
[40] Transcript dated 6 March 2017, 87:8-14.

82 We note that the Patient had put a dash (-) under the field for occupation in the patient registration form for the Clinic dated 25 October 2003[41], and her explanation was that she did not want to state that she had been unemployed[42]. In our view, a dash (-) lent itself to alternative or competing explanations. We prefer the evidence of the Patient's CV and Dr R's contemporaneous notes of 25 October 2003 that specifically point to her being an investment analyst at the time. In this regard, we wholly agree with Counsel for Dr R's submission that the precise term "investment analyst" on Dr R's records, which exactly corresponds with her CV, could only have come from the Patient herself[43].

83 For completeness, we should mention that the Patient told this Tribunal that she had not been working between 2001 and 2006 because she had been suffering depression during that time[44]. This was not evidenced by any medical record and was a bare assertion.

84 Even granting the Patient the benefit of the doubt that she had been a part-time investment analyst in 2003, this Tribunal finds that she had been less than forthcoming in continuing to insist she had been a homemaker without qualification despite ample opportunity to set the record straight. The Patient was clearly prepared to tell half-truths as it had suited her. We are persuaded that a logical and likely motive for the Patient presenting herself as a homemaker, describing herself as naïve, and concealing other details of her work life experience was to perpetuate a façade of naiveté to support her complaint against Dr R.

Were the cosmetic surgery consent forms explained to the Patient?

85 The Patient and the Patient's husband allege that the consent forms she signed before undergoing the cosmetic procedures on each of the four occasions in 2003 and 2004 were not explained to her. The Patient further claims that she had not been "in the right frame of mind at that time to fully read and understand any document, as [she] was far too anxious and nervous about the impending surgery."[45]

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[41] Agreed Bundle of Documents, page 1.
[42] Transcript dated 6 March 2018, 85:14-16.
[43] Transcript dated 5 March 2018, 93:11-21.
[44] Transcript dated 5 March 2018, 99:20-22.
[45] The Patient's Statement, 1 BSR, Tab 1, para 10.

86 Dr R and DNurse2's position was that the consent forms were explained to the Patient.

87 We prefer Dr R and DNurse2's evidence on this point as their account was consistent with the objective documentary evidence.

88 As a starting point, each of the one-page consent forms was based on an identical template and contained the following paragraph on the reverse page, immediately before the signature portion:

> I, CERTIFY THAT I HAVE READ THIS FORM, OR IT WAS READ TO ME, AND THAT I FULLY UNDERSTAND IT, THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND THE ANSWERS AND ADDITIONAL INFORMATION PROVIDED HAVE MET WITH MY SATISFACTION.

89 By signing each of the forms, the Patient certified that it had been read to her, or that she had read it herself and, whichever the case, had fully understood it.

90 Further, clauses 3, 4 and 5 of each consent form stated that the following had been explained to her:

> 3. I further consent to the administration of such drugs, infusions, plasma, blood transfusions, or any other treatment, injection or procedure deemed necessary in the judgment of the attending physicians. The possible need for, risks of, and alternatives to blood transfusion **have been explained to me.**
>
> 4. **The attending physician or his/her designee has provided sufficient information to give me a general understanding of the nature and purpose of the operations and/or procedures**, the benefits thereof and the usual and most frequent risks and hazards involved. Alternative methods of treatment and the risks and benefits of these alternatives **have also been explained to me.**
>
> 5. **It has been explained to me** that during the course of the procedure unforeseen conditions may arise which may necessitate surgical or other procedures in addition to or different from those contemplated. I therefore further authorise the above-named physician and/or associates or assistants to perform such additional surgery or other procedures as (s)he or they deemed necessary or desirable. [emphasis added]

91 The Patient's allegations that the consent forms had neither been read by her nor read to her directly contradicts what she has signed. We accordingly treat her evidence with natural suspicion and reserve.

92 As for Dr R's evidence, Dr R had no personal knowledge of whether the forms had been explained. He admitted that he had left the explaining to the nurses who "should have" explained the forms to the Patient[46].

93 DNurse2 testified that it was her practice, gleaned from her time in the Hospital A[47], to go through the consent form with patients before treatment commenced[48]. Her evidence was that while she may not have been present for the taking of the consents, she had gone through all the consent forms with the Patient[49], and would have explained each and every paragraph[50]. She gave evidence that she had been the scrub nurse for three of the four occasions[51] where the Patient had cosmetic procedures and had to sign the form. On the fourth occasion, she testified to having been the circulating nurse.

94 The operation notes attached to the consent forms revealed that DNurse2 had been the scrub nurse for two (rather than three) of the four procedures[52], and that a "DNurse3" had been the scrub nurse for the other two procedures.

95 Counsel for the SMC submitted that, as DNurse2's recollection was wrong, her testimony that she would explain every item on the consent form to the Patient was doubtful. As for the two occasions where DNurse2 had not been the scrub nurse, it was submitted that since DNurse3 had not been called to testify in the inquiry, there was no direct evidence to contradict that of the Patient and her husband that the consent forms had not been explained. We do not accept these submissions for the reasons set out below.

96 First, we find that DNurse2's inability to recall precisely how many times she was a scrub nurse was a minor discrepancy that does not detract from the overall cogency of her evidence on the matter. For instance:

(a) DNurse2's recollection in general about being the scrub nurse for the Patient was supported by contemporaneous operation notes that showed she was the scrub nurse for the Patient on 3 December 2003 and 9 December 2003.

[46] Transcript dated 22 March 2018, 10:13-16.
[47] Transcript dated 6 April 2018, 25:13-15.
[48] Transcript dated 6 April 2018, 80:21-25.
[49] Transcript dated 6 April 2018, 81:4-11.
[50] Transcript dated 6 April 2018, 80:17-19.
[51] Transcript dated 6 April 2018, 84:15-22.
[52] Prosecutions Bundle of documents ("PBOD"), pages 6, 9.

(b) DNurse2's claim that DNurse3 had been the scrub nurse for the "*chin augmentation*" procedure[53], was likewise supported by the operation notes dated 5 November 2003[54].

(c) DNurse2's claim that she had not been present for the taking of all consents for the Patient was consistent with the fact that just one consent form in respect of the procedure on 5 November 2003[55], out of the four procedures, bore DNurse2's signature as witness.

97 Second, the argument that there was a lack of direct evidence on whether the forms had been explained during the times when DNurse3 had been the scrub nurse seems to stem from an assumption that only a scrub nurse explained the forms. DNurse2's testimony was that it was her general practice to explain the consent form to all patients, *especially* if she was the scrub nurse[56]. According to DNurse2, she would go through the form when patients sign the consent form, and would go through them again as a scrub nurse or circulating nurse[57]. We see no reason to disbelieve her testimony with regard to this practice of consent-taking, which was also not challenged in cross-examination.

98 Accordingly, for the two occasions on 5 November 2003 and 11 June 2004 where DNurse3 had been the scrub nurse, DNurse2's evidence still challenges the Patient and the Patient's husband's evidence. In particular, we note the consent form dated 5 November 2003 bears DNurse2's signature as witness. DNurse2 said the word "self" was also in her handwriting[58]. The authenticity of DNurse2's signature and handwriting was not challenged by Counsel for the SMC. We accept DNurse2's evidence that she signed off on the form, and find that the form must have been explained to the Patient.

99 On the whole, the Patient's assertion that the consent forms were not explained to her was not supported by objective evidence and was less believable than Dr R's account, which was consistent with the signed consent forms and supported by DNurse2's cogent

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[53] Transcript dated 6 April 2018, 84:19-22.
[54] PBOD, pages 1-3.
[55] PBOD, page 2.
[56] Transcript dated 6 April 2018, 81:1-2.
[57] Transcript dated 6 April 2018, 25:9-15.
[58] Transcript dated 6 April 2018, 24:20.

testimony. We accordingly find that the consent forms relating to the cosmetic procedures in 2003 and 2004 had been explained to the Patient.

Discussion on Caucasian features

100 Extensive submissions were made by parties on whether the Patient said she wanted cosmetic surgery for her face to achieve a more Caucasian look.

101 The Patient's evidence was that she had consulted Dr R to see if Dr R could perform cosmetic surgical procedures on her eyes, ears and nose[59], and she did not consult him because she wanted to look more Caucasian. Dr R's evidence was that the Patient had sought a more Caucasian look, and this matter came up as part of the discussion of how the Patient had wanted her features to be changed[60].

102 Nothing turns on this issue. Suffice it to say, we are satisfied that the topic must have come up as part of a discussion on the Patient's features on 25 October 2003.

103 The case notes of 25 October 2003 state: "wants to improve features – nose, eyes, ears"[61]. It follows that a two-way discussion must have taken place on the Patient's expectations of exactly how she wanted these features to be improved. In this connection, we are persuaded by Dr R's explanation that the topic of looking Caucasian came up as part of the comparison and evaluation of ethnic versus Caucasian facial features in anticipation of cosmetic surgery:

> Q. So you claim that Ms P told you she wanted a more Caucasian look during your first consultation with her?
>
> A. That's what she said at the end of the consultation because we went through a number of issues, eyes, nose. I said what exactly -- **when we do somebody's eyes, for example, there are different ways of doing eyelids. If you are Chinese and you want to retain your ethnic look, we will do the eye in a certain way. If you want a more deep set eye, which is more Caucasian, we'll have to do it in a different way.** So this came up as part of the consultation of the various features. She wanted Caucasian-style eyelids and she wanted a nose that was high and strong and she used the term "like a Caucasian", so I assume that she wants to look like a Caucasian. [emphasis added]

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[59] The Patient's Statement, 1 BSR, Tab 1, para 5.
[60] Transcript dated 20 March 2018, 107:14-108:5, 108:15-16.
[61] Statement of Dr R dated 9 February 2018 ("Dr R's Statement"), 1 BSR, Tab 4, page 303.

104 Accordingly, we find the matter of “looking Caucasian” must have come up as part of a discussion about the Patient’s facial features in anticipation of her cosmetic surgery. We make no finding on the credibility of the witnesses as regards their testimony on this immaterial point.

(3) Consultation on 19 December 2007

105 After a period of about three years in which the Patient did not consult Dr R, the Patient visited the Clinic on 19 December 2007. It was not disputed that the Patient’s husband had accompanied her and had been present in the consultation room that day[62].

Was DNurse2 in the consultation room?

106 The Patient and the Patient’s husband were unwavering in their position that they did not see DNurse2 on 19 December 2007 or at any subsequent consultation with Dr R.

107 Dr R and DNurse2, on the other hand, maintained that DNurse2 was present in the consultation room on 19 December 2007 and 4 August 2008.

108 We find that DNurse2 was present in the consultation room on 19 December 2007 and 4 August 2008 for the reasons set out below.

DNURSE2’S CPF STATEMENTS

109 DNurse2 had continually been employed by Dr R’s Clinic in the period between December 2007 and the early part of July 2009.

110 There is irrefutable evidence for this in the form of DNurse2’s Central Provident Fund (“CPF”) statements for 2008[63] and 2009[64], and four consent forms bearing DNurse2’s signature[65] dated 25 October 2008, 10 December 2008, 23 January 2009 and 5 March 2009. The evidence accords with DNurse2’s testimony that she had only left her employment with the Clinic at the end of July 2009 and had not been in the Clinic in the last two weeks as she had been serving out her notice period[66].

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[62] Transcript dated 22 March 2018, 41:19-42:4.
[63] Respondent’s Bundle (“RB”), Tab 13, page 30.
[64] RB, Tab 16, page 36.
[65] RB Tab 11, 12, 14, 15.
[66] Transcript dated 6 April 2018, 33:2-7.

111 Given that DNurse2 was still working for the Clinic in December 2007, Dr R clearly could not have informed the Patient on 19 December 2007 that the older nurses like DNurse2 left a long time ago as the Patient had claimed[67].

112 Faced with DNurse2's CPF statements tendered on 20 February 2018, which was subsequent to the Patient submitting her written statement on 13 February 2018, the Patient altered her testimony to say that Dr R did not specifically mention DNurse2 as one of the older nurses that left, and that it was her *impression* that DNurse2 was no longer working at the Clinic, or that DNurse2 was working part-time[68]. We found these vacillations to be a highly unsatisfactory attempt to cover up her obvious mistake.

113 As DNurse2 had been working *full time* at the Clinic until July 2009, it is difficult to accept that the Patient and the Patient's husband *never* saw DNurse2 again at consultations from 19 December 2007 onwards[69]. The prospect is all the more unbelievable when we consider that DNurse2's handwriting appears on an invoice relating to the Patient's Botox Treatment on 4 August 2008. DNurse2's testimony was that the words "*(the Patient's name)*" and "*4/8/08*" on invoice no. 43973 dated 4 August 2008 had been written by her in the consultation room[70]. Her account was supported by Dr R, who testified that he recognised her handwriting[71], and their evidence was not challenged by the SMC.

114 In our view, DNurse2's CPF statements place DNurse2 in the Clinic on 19 December 2007 and on 4 August 2008. The further inference we draw from DNurse2's handwriting being on the Patient's 4 August 2008 invoice is that the Patient and DNurse2 were in proximity on that day, and that in all likelihood, the Patient and the Patient's husband must have seen DNurse2 on that day. We reject the Patient and her husband's account that they never saw DNurse2 again since 19 December 2007 as dubious and incompatible with critical objective evidence. The remainder of their testimony as regards DNurse2's presence must be greatly discounted.

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[67] Patient's Statement, 1 BSR, Tab 1, para 19.

[68] Transcript dated 6 March 2018, 28:2-22.

[69] Transcript dated 6 March 2018, 128:4-5; Statement of Mr Patient's husband dated 13 February 2018 ("Patient's husband's Statement"), 1 BSR, Tab 2, para 11; Transcript dated 6 March 2018, 29:13-17.

[70] Dr R's Statement, 1 BSR, Tab 4, page 358; Transcript dated 6 April 2018, 10:16-25.

[71] Transcript dated 20 March 2018, 29:19-30:21.

115 We turn our attention to whether DNurse2 had been in the *consultation room* with the Patient on 19 December 2007 and 4 August 2008.

CLINIC'S CHAPERONE POLICY

116 Dr R's evidence was that his Clinic's policy and standard practice was to have a chaperone in the consultation room for both male and female patients. The Patient and her husband claimed that Dr R had never used a chaperone during all of the Patient's consultations[72].

117 Dr R explained that the policy protected him against a patient's allegation of molest, etc.[73], and that having nurses present during consultations would allow for continuity of care in that the nurses would be able to answer patients' queries when Dr R was not available to attend to the patients[74].

118 The existence of such a clinical policy was corroborated by DNurse2 and DNurse1[75], Dr R's nurses who would have personal knowledge of the Clinic's protocol and procedures. Both nurses were consistent in their testimony that there was a practice for chaperones to be in the consultation room for male and female patients.

119 Counsel for the SMC raised four inconsistencies in Dr R, DNurse2 and DNurse1's account of the alleged chaperone policy:

(a) **Male or female patients:** Dr R's Statement seemed to suggest that the practice of having a chaperone was only for female patients. During cross-examination, however, he said it was for both male and female patients[76].

(b) **Standing or sitting:** Dr R said that "*none of his chaperones would sit during a consultation*"[77]. This was directly contradicted by DNurse2's testimony that she would "*sometimes choose to sit*"[78] if she were the chaperone.

[72] Transcript dated 5 March 2018, 114:9-16 (the Patient); Transcript dated 6 March 2018, 128:6- 12 (Patient's husband).
[73] Transcript dated 22 March 2018, 37:1-10.
[74] Transcript dated 6 April 2018, 7:23 to 8:17.
[75] Transcript dated 4 April 2018, 175:21-25, 298:14-15.
[76] Transcript dated 20 March 2018, 37:10-11; Transcript dated 22 March 2018, 35:12-16.
[77] Transcript dated 22 March 2018, 106:23-24.
[78] Transcript dated 6 April 2018, 173:18-23.

(c) **Patient's husband's behaviour:** DNurse2 and DNurse1 gave completely different descriptions of how Patient's husband behaved in the consultation room. DNurse2 testified that the Patient's husband "*[kept] quiet most of the time throughout consultations*"[79]. DNurse1 testified that the Patient's husband would usually interrupt when the Patient and Dr R were talking[80], and said she would not describe him as quiet during consultations[81].

(d) **No "time in":** Dr R's case sheets did not contain a single "time-in". As both DNurse2 and DNurse1 testified, "time-in" referred to the time the patient walks into the consultation room. Dr R was supposed to write the "time-in" but he was very bad at writing "time-in". If there had always been a chaperone, it may be asked why the chaperone could not have filled in the time-in after the consultation.

120 We address each of these points, as follows:

(a) As for (a), we see no real discrepancy here. Dr R's statement on the presence of chaperones was "[d]uring these consultations, the Patient sought a more Caucasian look … Whenever I see a female patient, my standard is to have a female clinic staff member be present with me at all times as a chaperone."[82] The statement was made in the context of his consultations with the Patient, a female, and, as a matter of common sense, did not preclude the possibility that a chaperone was present for male patients as well.

(b) As for (b), we find that whether the chaperone was standing all of the time or whether at some point over the years a chaperone had sat down to be a trivial discrepancy that did not detract from DNurse2 and DNurse1's overall credibility on the matter.

(c) As for (c), we accept Counsel for Dr R's explanation that the differing observations may have arisen because of the different time points and circumstances where they each had observed the Patient's husband in the

[79] Transcript dated 6 April 2018, 8:21-22; 121:8.
[80] Transcript dated 6 April 2018, 357:3-5.
[81] Transcript dated 6 April 2018, 357:19-21.
[82] Dr R's Statement, 1 BSR, Tab 4, para 5.

consultation room. DNurse2 had been the chaperone during the period up to 25 July 2009, and DNurse1 had been the chaperone as costs of the Botox Treatments continued to mount in excess of the Patient's husband's insurance claim limits, which may explain why she witnessed him being more vocal and difficult during the consultations[83].

(d) As for (d), the lack of a time-in on the consultation sheet most likely reflects an aberration in Dr R's clinical administrative process at the material time. It is separate from, and certainly does not preclude the possibility of there being a chaperone in the room.

121 We do not see fit to rationalise or iron out each crease in Dr R, DNurse2 and DNurse1's testimony. Taking a holistic view of their evidence, we are persuaded that it was reasonably possible for there to have been a chaperone policy in the Clinic.

SIZE AND LAYOUT OF THE CLINIC'S CONSULTATION ROOM

122 We move on to the Patient's husband's proclamation that the consultation room was "rather small and could not easily fit more than three chairs"[84]. It was clear to us from the tenor of the Patient's husband's evidence that he wanted to convey the impression of a small room to drive home the point that there was no space for a chaperone.

123 As it turned out, the Patient's husband's allegation was demonstrably inaccurate. Based on the actual photographs of the consultation room provided by Dr R, we are satisfied that there was more than enough space for a chaperone or two to be in the consultation room with Dr R, the Patient and the Patient's husband.

124 Not only was the Patient's husband's recollection of the room being "rather small and could not easily fit more than three chairs"[85] erroneous, his evidence was also directly contradicted by his wife during cross examination[86].

125 Our reservations as to the Patient's husband's credibility as a truthful witness was deepened upon observing that, when a photograph of the room was put to the Patient's

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[83] Respondent's Reply Submissions ("RRS"), [29].
[84] Patient's husband's Statement, 1 BSR, Tab 2, para 8.
[85] Patient's husband's Statement, 1 BSR, Tab 2, para 8.
[86] Transcript dated 5 March 2018, 113:25-114:5.

husband to establish that his evidence that the room "could not easily fit more than three chairs" was incorrect, he claimed that he was actually imagining "three more comfortable chairs"[87].

126 Counsel for the SMC argued that in taking the photos, Dr R had deliberately pushed the moveable screen in the room backwards to make the room look bigger than it actually was. However, they denied allowing Dr R to produce four new photographs to correct the screen position. We are of the view that even if the screen had been shifted forward, there would clearly still be enough room for one or two chaperones to be in the room alongside Dr R and patients. We agree with DNurse2's evidence that there was still "a lot of room to walk around", when the screen was moved inward almost quite close to the door behind the Patient[88].

127 The existence of Dr R's alleged policy regarding chaperones is consistent with the size of the consultation room and supported by the testimony of Dr R's nurses. Given our findings that DNurse2 was at the Clinic on 4 August 2008 and 19 December 2009, the cumulative weight of the material before us scaled decisively in favour of Dr R's account that DNurse2 had been at the consultation room on 4 August 2008 as well as on 19 December 2007.

Discussion on the Patient's facial swelling

128 We turn to the question of who first raised the matter of the Patient's enlarged parotid glands on 19 December 2007. Dr R and the Patient both claim that the other had raised it first.

129 We are satisfied that there was a discussion on the Patient's enlarged parotid glands on this day. This is undisputed and supported by Dr R's contemporaneous case notes for 19 December 2007. Contrary to what parties would have us believe, we find the question of who raised the matter first in the course of the consultation to be a factual peccadillo which answer could not affect the credibility of witnesses in a substantial way.

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[87] Transcript dated 6 March 2018, 134:4.
[88] Transcript dated 6 April 2018, 60:19-22; RSB, Tabs 33 to 42.

130 We would observe, however, that even if Dr R raised the matter of the Patient's facial swelling first, her statement that this observation "came as a surprise" to her[89] is entirely unconvincing. This is because the swellings had been objectively significant and unlikely to have been missed by the Patient. Dr W2 at Clinic W2(" said her parotid glands were "three times the normal size" and "will invite stares"[90], and the Patient herself felt that her condition was "very unsightly, disfiguring, and it affected [her] self-esteem"[91]. The Patient must also have been alive to possible dissatisfactions with her appearance as she had specifically visited Dr R on this day to "find out if there were any cosmetic procedures to improve her facial appearance for her upcoming wedding in August 2008"[92]. We are therefore sceptical of the Patient's claim of being surprised, which appears inconsistent with other parts of her evidence.

Did Dr R raise the cost of the Botox Treatments?

131 It was not disputed that on 19 December 2007, Dr R informed the Patient of his novel technique of treating enlarged parotid glands with Botox injections, and that the use of Botox to treat parotid glands was at an exploratory stage[93].

132 In this connection, we find that Dr R must have also raised the potential costs of his novel Botox treatment to the Patient and the Patient's husband at the consultation.

133 The Patient's evidence was that she did not recall whether this had been the first discussion on costs of treatment[94], and she had not been in the right frame of mind to discuss the costs of the Botox Treatments on this day as she had wanted to see an Ear, Nose and Throat ("ENT") doctor to find out what was wrong with her[95].

134 However, the existence of a costs discussion is recorded in Dr R's clinic notes of 19 December 2007 which had the numbers "2,500, 2500, 2,500" and "1, 2, 3". Dr R's explanation that this meant that he would charge $2,500 for the first three treatments was not challenged by the SMC.

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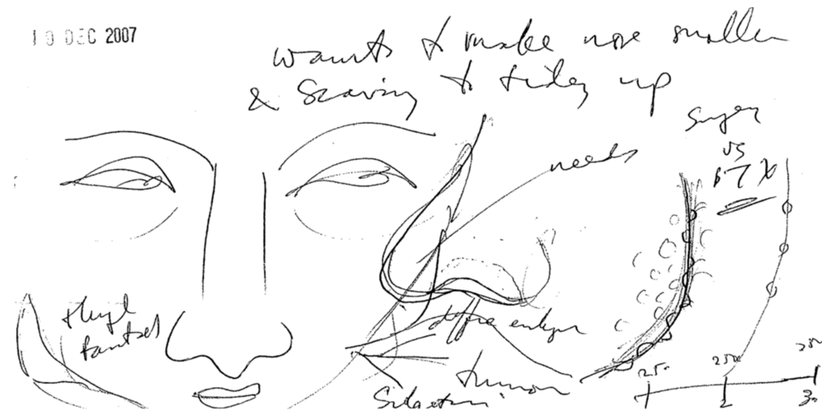
[89] The Patient's Statement, 1 BSR, Tab 1, para 15.
[90] The Patient's Statement, 1 BSR, Tab 1, para 18.
[91] The Patient's Statement, 1 BSR, Tab 1, para 24.
[92] The Patient's Statement, 1 BSR, Tab 1, para 14.
[93] The Patient's Statement, 1 BSR, Tab 1, para 15; Patient's husband's Statement, 1 BSR, Tab 2, para 13.
[94] Transcript dated 5 March 2018, 139:9-14.
[95] Transcript dated 5 March 2018, 140:2-14.



135 It seems doubtful to us that the Patient was keen to understand more about her condition without wanting to know the options for treating it (which would necessarily include the issue of costs), especially given that she was someone who was deliberate and pro-active when it came to her medical treatment.

136 Further, it is undisputed that after the 19 December 2007 consultation, on 31 December 2007, the Patient and the Patient's husband obtained a referral letter from the Patient's husband's General Practitioner, Dr W3, for the Patient to undergo the Botox Treatments for her condition of enlarged parotid glands[96]. After receiving the referral letter, the Patient's husband submitted it to his insurance company and checked whether they would consider claims if they were to see Dr R for the Botox Treatments[97]. This was to us another factor which suggested that the Patient and her husband were aware of the estimated costs of the Botox Treatments before they came to see Dr R on 5 January 2008 to start the Botox Treatments.

137 In the light of the above, we have no hesitation finding that the matter of costs was discussed on the 19 December 2007 consultation.

138 Following the consultation, on the same day, the Patient and the Patient's husband had obtained a referral letter from Dr W3, to see Dr W2. On the same day. Dr W2 informed the Patient that her condition of the enlarged parotid glands had not been malignant[98]. He had offered her the option of having them surgically resized and explained the risks involved which included definite facial scarring and possible facial

[96] Patient's husband's Statement, 1 BSR, Tab 2, para 16.
[97] Transcript 6 March 2018, 131:15-21.
[98] The Patient's Statement, 1 BSR, Tab 1, para 18.

paralysis[99]. The Patient was not keen on having her parotid glands surgically resized, and instead decided to visit Dr R to find out more about Dr R's approach of treating the enlarged parotid glands using Botox injections[100].

(4) Consultation on 5 January 2008

Did Dr R propose a "win-win" arrangement?

139 According to the Patient, Dr R had proposed a "win-win" arrangement on 5 January 2008. Under this alleged arrangement:

(a) Dr R would charge "at cost" for each of the Botox Treatments; and

(b) the Patient would allow Dr R to feature her case of enlarged parotid glands on two conditions:

(i) he could only use her case in one medical paper; and

(ii) he would not mention her past cosmetic procedures with him.

140 The Patient claims Dr R assured her, in the Patient's husband's presence, that he would only use her case for that one medical paper and would not mention her past cosmetic procedures. The Patient's husband likewise testified that there was such a "win-win" arrangement as the Patient described, and he understood "at cost" to mean the rate Dr R paid to his suppliers for the Botox[101].

141 Dr R completely disagrees with the existence of this alleged "win-win" arrangement.

142 We find it is not proved beyond a reasonable doubt that Dr R proposed such a "win-win" arrangement on 5 January 2008.

143 First, there is absolutely no documentary evidence supporting the existence of the alleged "win-win" arrangement. The best evidence of what had transpired on 5 January

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[99] The Patient's Statement, 1 BSR, Tab 1, para 18.
[100] The Patient's Statement, 1 BSR, Tab 1, para 20.
[101] Patient's husband's Statement, 1 BSR, Tab 2, para 19.

2008 was Dr R's contemporaneous clinical notes of that day, and no "win-win" agreement was reflected therein.

144 As we will explain below, the figures on the notes in fact militate against the existence of any alleged "at cost" arrangement. What is reflected in the notes are general discounts offered to the Patient, which supports Dr R's account that he had offered the Patient a good rate for the Botox Treatments from the start.

145 The clinical notes of 19 December 2007 indicate that Dr R would charge $2,500 for the first 3 treatments. The clinical notes of 5 January 2008 states "2,350, 2000 – 2350, 1800 – 2000", which Dr R explained to be the reduced fees for the three treatments. This explanation was not challenged by Counsel for the SMC. The final invoices for the treatment showed that Dr R had charged, and the Patient's husband had paid, exactly what was recorded in Dr R notes of 5 January 2008 with a further discount on the third treatment.

146 The original fees quoted on 19 December 2007 and the discounted rate quoted on 5 January 2008 are as follows:

No.	**Date**	**Original fee (19 Dec 2007)**	**Revised fee (5 Jan 2008)**	**Discount**	**Final fee (invoiced)**
1	5 Jan 2008	$2,500	$2,350	$150	$2,350
2	2 Feb 2008	$2,500	$2,000 - $2350	$150 - $500	$2,000
3	1 Mar 2008	$2,500	$1,800 - $2,000	$500 - $700	$1,600

147 Clearly, only a modest discount of $150 had been given for the treatment on 5 January 2008 which could hardly be considered charging at cost. The discounts for the second ($150-$500) and third ($500-$700) treatment were more substantial but it was unlikely that they had been charged "at cost" since a further discount of $200 had been given on the invoice for the third treatment. If the 5 January 2008 figures reflected cost price, this would have meant that Dr R had inexplicably charged *below* cost price for the third treatment. All in all, a cogent conclusion may be drawn that the prices reflected on the 5 January 2008 clinic notes and on the invoices were not at cost.

148 The simple and most plausible explanation for why the rates charged and paid for were not at cost is that there was no "win-win" arrangement to charge at cost to begin with.

149 Second, the existence of any alleged "win-win" arrangement is inconsistent with the Patient and the Patient's husband's subsequent conduct. It is inconceivable that the Patient would continue to seek, and the Patient's husband continue to pay, for Botox Treatments over a period of five years until 24 August 2013, if Dr R was overcharging them since the first treatment in breach of their alleged "win-win" arrangement, and despite them having asked Dr R about the matter of costs on a number of occasions[102].

150 Third, given our findings on the Patient's intelligence, experience and personality as stated above, it is glaring that there is no record of either her or her husband bringing up Dr R's alleged breach of the "win-win" arrangement at the material time. In contrast, Dr R's written records show the Patient and/or her husband asking for more discounts on 1 December 2010 and 24 August 2013. This evidence bears out Dr R's account that "after [he] had given her a good rate, she then asked for further discounts which I agreed to on account that she was a long-standing patient"[103].

151 Fourth and finally, we accept Dr R's Counsel's submission that there was no good reason for a prominent plastic surgeon like Dr R to have agreed to charge at cost to write about a treatment that had not even begun and where he had "no inkling at the time that the procedure would even work."[104] This, together with the fact that any information he could use in that one alleged article would be without the Patient's identification, photographs, or mention of the Patient's previous cosmetic surgeries, appears dubious as there was nothing objectively win-win about this arrangement at all.

152 In the light of the above, we are satisfied that there is critical doubt as to whether there was such an alleged "win-win" arrangement between the Patient and Dr R.

153 We turn to consider whether an adverse inference should be drawn against Dr R in relation to his failure to refute the "win-win" arrangement in his Written Explanation,

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[102] The Patient's Statement, 1 BSR, Tab 1, para 23; Patient's husband's Statement, 1 BSR, Tab 2, para 19.
[103] Dr R's Written Explanation, [22].
[104] Dr R's Written Explanation, [25].

as sought by Counsel for the SMC. Counsel for the SMC pointed out that he had failed to deny the arrangement at the earliest opportunity, even though the "win-win" arrangement was described in detail in the Patient's Complaint, and even though he had the assistance of lawyers in preparing the Written Explanation[105]. It was submitted that this lack of a denial, along with no plausible explanation for the same, was corroborative of there being such a "win-win" arrangement.

154 Dr R's explanation is that to him the thrust of the Complaint was about the validity of consent given for the use of her unanonymised photographs and medical information in medical / scientific publications and presentations[106]. He claims he was focused on responding to specific allegations in the Complaint[107], none of which referred to the "win-win" arrangement.

155 While these disciplinary proceedings are not in the nature of criminal proceedings, and the Criminal Procedure Code (Cap 68, 2012 Rev Ed) ("CPC") does not apply, it bears note that in criminal proceedings that, once an accused is informed that he may be prosecuted for an offence, the police or other law enforcement authority must serve and read to him a notice in writing under section 23 of the CPC, warning him that:

> If you keep quiet now about any fact or matter in your defence and you reveal this fact or matter in your defence only at your trial, the judge may be less likely to believe you. This may have a bad effect on your case in court. Therefore it may be better for you to mention such fact or matter now.

156 The accused's statement is then recorded as a cautioned statement. If the accused is able to but does not give an explanation for his conduct at the time he is informed that he may be prosecuted then, unless his failure was reasonable in the circumstances, the Court may, pursuant to section 261(1) of the CPC, draw adverse inferences against the accused or treat the failure as corroborating the evidence against him[108].

157 In the context of medical disciplinary proceedings, the written explanation is the respondent doctor's first submission to the SMC after being informed that a complaint has been made against him. Notably, the notice of complaint issued pursuant to section

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[105] Transcript dated 22 March 2018, 64:23-25.
[106] Transcript dated 22 March 2018, 63:10-17.
[107] Respondent's Closing Submissions ("RCS"), [68].
[108] Pinsler, *Evidence and the Litigation Process*, (4th Ed, 2013) at [189].

44(2) of the MRA does not contain as extensive a warning to the doctor being complained about as regards the effect of keeping silent at this stage. The notice of complaint states:

> [W]e invite you to submit a written explanation in response to the complaint. Please note that, if any action should follow, your written explanation and any accompanying enclosures may be used as evidence in the course of proceedings.

158 The lack of express warning regarding silence in the notice of complaint under section 44(2) of the MRA must be taken into account where the disciplinary tribunal considers drawing any adverse inference against a doctor for failing to mention any exculpatory fact in the letter of explanation.

159 In *Leslie Lam*, the disciplinary tribunal made a finding that as the medical practitioner's brief written explanation to the SMC made no mention that he had told the patient of the risks, complications and alternatives of a particular procedure, this lent support to the SMC's submission that his detailed assertions to the contrary in his written statement of evidence in chief (prepared years later) was an afterthought. On appeal, the C3J held that there was no basis for the disciplinary tribunal to have drawn any adverse inference against the medical practitioner from the brevity of his explanatory statement in relation to that charge, because, among other things, the explanatory statement was drafted without the benefit of legal advice (at [75]). The C3J found that it was "not unreasonable" for the medical practitioner to explain that his attention had been focused on other allegations at the time as he thought the sting of the complaint against him was directed at his clinical expertise and management of the patient (at [76]).

160 In the present case, Dr R had legal advice when preparing the Written Explanation. On a fair reading of the Complaint, it is evident that its sting lay in the allegation of his failure to obtain informed consent for the use of the Patient's case in presentations and publications. We agree with Counsel for Dr R that, having denied the Patient's allegations in his Written Explanation, the "win-win" arrangement would be a point which required no specific comment.

161 In any event, we find that Dr R had implicitly addressed the "win-win" arrangement in his Written Explanation:

(a) Dr R offered his account of the pricing arrangement between him and the Patient, which itself is a denial of the "win-win" arrangement. He mentions that he "gave [the Patient] a good discount from the start because [he] empathised with her condition, she was [his] longstanding patient and [he] did not want her to abandon treatment simply because of cost"[109], and that the fact that he gave a discount from the start was "significant because there was no inkling at that time that the procedure would even work"[110]. He also mentioned that he had "agreed to cap his fees even though this was close to covering just the cost of the Botox and other basic costs and consumables"[111] and that on 1 December 2010 he told the Patient's husband that he "could not reduce [his] price any further as [he] had to cover the cost of the Botox"[112].

(b) Dr R addressed the issue of his alleged assurances to the Patient on featuring her case in only "one medical paper" by asserting that the full story was that on 4 August 2008 he had consent to use "her full face photographs in medical or scientific publications and in medical presentations,"[113] and that "her only request was that [he] gave a copy of the full face photographs for her retention and reference"[114].

162 The above statements implicitly rebut the Patient's points made in relation to the alleged "win-win" arrangement.

163 The lack of specific denial of the "win-win" arrangement must be read in the light of the overall manner in which Dr R had chosen to structure and present his response to the Complaint. The Complaint sets out the Patient's version of what happened before listing out eight specific complaints at the end. The complaints did not include the "win-win" arrangement. We accept as reasonable Dr R's explanation that, in the Written Explanation, he was simply stating his version of what happened, and then responding to the eight specific complaints, somewhat mirroring the structure of the Patient's

[109] Dr R's Written Explanation, [25].
[110] Dr R's Written Explanation, [25].
[111] Dr R's Written Explanation, [22].
[112] Dr R's Written Explanation, [23].
[113] Dr R's Written Explanation, [30].
[114] Dr R's Written Explanation, [30].

Complaint. Accordingly, we see no cause for drawing an adverse inference against him for failing to specifically deny the "win-win" arrangement.

164 We note that even the Patient did not mention the "win-win" arrangement in her first e-mail to Dr R dated 22 September 2013, or in the letters from her lawyers, Law Firm A, to Dr R dated 22 October 2013, 4 November 2013, 6 November 2013, 15 November 2013, 26 November 2013, and 12 December 2013. The "win-win" arrangement was raised for the first time in her Complaint, even though it allegedly formed the mutual understanding on which she began her Botox Treatments with Dr R.

165 Even if we drew an adverse inference against Dr R for the lack of specific denial of the "win-win" arrangement, we are far from satisfied that the "win-win" arrangement has been proved beyond a reasonable doubt. There being no objective evidence supporting the arrangement, its existence rested exclusively on the testimony of the Patient and the Patient's husband, and in the light of the incongruities with Dr R's case notes and their subsequent conduct, their testimony alone was hardly of such a compelling nature that the existence of the "win-win" arrangement could be based solely on it.

(5) Consultations from 23 February 2010 to 26 March 2011

Did Dr R provide consultation to the Patient?

166 The Patient claims that although she did not receive any Botox Treatment or consultation from Dr R on 23 February, 20 March 2010, 8 January 2011 and 26 March 2011, he still charged [her] his consultation fee[115].

167 Counsel for Dr R submitted that the Patient was lying about these consultations, and that contemporaneous case notes and clinic invoices show that these were regular follow-up consultations where Dr R examined the Patient's face and provided medical advice.

168 We agree that the documentary evidence relating to these four sessions show that medical advice had been given during the consultations, and Dr R was entitled to charge a consultation fee:

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[115] The Patient's Statement, 1 BSR, Tab 1, para 27.

Date	Documentary evidence	Time
23 February 2010	Case note[116] shows that Dr R discussed Botox treatment on her parotid glands and masseter muscles, with the markings "p" and "m" on a diagram of her face. There was also a discussion of whether surgery was a long-term option, the costs involved, and records that the Patient did not want surgery. Invoice no. 003023 of 23 January 2010[117] shows this appointment started at 9.30am. The time out on the case note states 10:03am.	9.30 - 10:03
20 March 2010	Case note[118] shows on a diagram of the Patient's face and that Dr R observed the Patient's parotid glands very flat but there was submandibular prominence. Two graphs were drawn during the discussions with the first graph containing the words "small" and "large". Invoice no. 003583 of 23 February 2010[119] shows this appointment started at 9.30am. The time out on the case note states 10:39am.	9.30 - 10:39
8 January 2011	Case note[120] shows on a diagram of the Patient's face and that Dr R noted that the size of the Patient's parotid glands had gone down but were still slightly bulky. Dr R discussed two options of doing more Botox treatment "*to do more see how far we can go*" or to leave the parotid glands alone "*just leave alone for a while*". Invoice no. 009029 of 1 December 2010 [121] shows that this appointment on 8 January 2011 started at 9am. The time out on the case note states 09:55am.	09:00 - 09:55
26 March 2011	Case note[122] shows on a diagram of the Patient's face and that Dr R noted the Patient's "*submandibular glands had significantly gone down*", the left side of her face had a "hollowing" and the right side of her face looks fuller because her masseter muscles were not as atrophic. The time out on the case note states 10:03am.	End time 10.03

169 In any event, it defies belief and logic that the Patient and the Patient's husband would have made payment when payment had not properly been due.

170 At this juncture, we pause to observe the disturbing pattern of incongruity between the Patient and the Patient's husband's testimony on one hand and critical objective evidence on the other. There being no plausible explanation for these inconsistencies, this Tribunal had little choice but to find that the Patient and the Patient's husband were not at all credible witnesses.

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[116] Dr R's Statement, 1 BSR, Tab 4, page 315.
[117] Dr R's Statement, 1 BSR, Tab 4, page 361.
[118] Dr R's Statement, 1 BSR, Tab 4, page 315.
[119] Dr R's Statement, 1 BSR, Tab 4, page 362.
[120] Dr R's Statement, 1 BSR, Tab 4, page 317.
[121] Dr R's Statement, 1 BSR, Tab 4, page 365.
[122] Dr R's Statement, 1 BSR, Tab 4, page 318.

(6) Consultation on 4 August 2008

171 There was little agreement between the witnesses as to what happened during this critical consultation. We first consider the parties' sequence of events before going into the scope of consent discussed and obtained on this day.

Was DNurse2 present in the consultation room?

172 As explained at [108] above, we found that DNurse2 was in the consultation room on 4 August 2008.

Was Patient's husband present in the consultation room?

173 The Patient and the Patient's husband were steadfast in their evidence that the Patient's husband was present in the consultation room. Counsel for the SMC argued that Dr R's evidence as to whether the Patient's husband was in the consultation room on 4 August 2008 was inconsistent:

(a) In his Written Explanation, Dr R said that "the Patient's husband would accompany [the Patient] to almost all clinic appointments and he would sit in during my consultations with [the Patient]"[123].

(b) In his Statement, Dr R changed his testimony to say that for the Botox Treatments from 2008 onwards, "[w]hile Patient's husband still often accompanied [the Patient] to my clinic, he no longer joined in my consultation sessions".

(c) While reading out his statement in examination in chief, he changed this to say the Patient's husband "would only occasionally join"[124] in his consultation sessions.

(d) During cross-examination, Dr R said that "occasionally" he meant the Patient's husband would be present "more than half the time", or "most of the time". When asked to clarify, he said "[Patient's husband] would usually sit in,

[123] Dr R's Written Explanation, [7].
[124] Transcript dated 20 March 2018, 14:14-19.

but he doesn't always sit in and there are occasions when it is just [the Patient] on her own."[125]

174 Dr R was clearly unable to recall how often the Patient's husband had accompanied the Patient at consultations from 2008 onwards. He also admitted that the Patient's husband may have been in the room for the first consultation on 4 August 2008[126]. DNurse2's evidence did not assist Dr R; she was not clear if the Patient's husband was in the consultation room on this day.

175 We find that the Patient's husband had joined the Patient in the consultation room at some point on 4 August 2008. We bore in mind that there was no reason why the Patient's husband would not be present in the consultation room since, as Dr R accepts, during the period from 2003 to 2004, the Patient's husband was always present in the consultation room when he accompanied the Patient for consultations.

Discussion on the Patient's face

176 The Patient's evidence is that *after* signing the Written Consent, Dr R took photographs of her face[127] and thereafter they had a brief talk about the Botox Treatments for the day. In the discussion, Dr R highlighted there was swelling in her sub-mandibular glands[128] and she mentioned to him that she needed Botox injections for her forehead as her wedding was in three weeks' time. The Patient then proceeded for treatment.

177 Dr R's sequence of events was that he had started the consultation with a physical examination of the Patients' face and discussed the Botox Treatments for the day before going for treatment. The Written Consent was signed at a later consultation *after* all this had happened.

178 The structure of Dr R's contemporaneous case notes of 4 August 2008[129] suggests Dr R had discussions with the Patient on the Botox Treatments on her parotid glands, submandibular glands, forehead, frown lines and crow's feet *before* the Written Consent was penned. Dr R's entry for 4 August 2008 is on the same page as his entry of the

[125] Transcript dated 22 March 2018, 24:2-5.
[126] Transcript dated 22 March 2018, 104:1-10.
[127] Transcript dated 5 March 2018, 159:1-13.
[128] Transcript dated 5 March 2018, 162:-24-25; Transcript dated 6 March 2018, 137:17-20.
[129] Dr R's Statement, 1 BSR, Tab 4, pages 312 and 313.

immediately preceding consultation of 29 May 2008[130]. The Written Consent is recorded next, on the following page of the clinic notes[131]. We agree with Counsel for Dr R that the natural sequence featured on the contemporaneous case notes suggests that a discussion of the Patient's face happened *before* the Written Consent was signed, not the other way around as the Patient suggested.

Was payment made before or after treatment?

THE CLINIC'S POLICY

179 The Patient and the Patient's husband's testimony was that they "**never** [made] payment before treatment"[132] [emphasis added].

180 Dr R avers that it was his Clinic's policy for patients to pay for their treatments before Dr R administers them. He claims that this practice started in 2002 after early experiences with patients who had left the Clinic without paying or had disputed the price of treatment after treatment had been administered[133].

181 Counsel for the SMC highlighted that even if there was such a policy, it was not strictly followed. Counsel for the SMC explained this with reference to a table showing the difference between the time on the Patient's husband's credit card receipt when payment was made and the "time out" recorded in Dr R's clinical notes when the Patient and the Patient's husband left the Clinic[134]:

Date of consultation and treatment	Time on receipt	"time out"	Time between receipt and "time out"
27 April 2009	1643	1705	22 minutes
25 July 2009	1014 to 1033	1045	12 minutes
23 January 2010	1035	1059	24 minutes
3 July 2010	1111	1150	39 minutes
1 December 2010	1008	1017	9 minutes
9 July 2011	1011	1017	6 minutes
29 October 2011	1003	1012	9 minutes
8 September 2012	0955	1009	14 minutes
2 March 2013	0956	0958	2 minutes
24 August 2013	1001	1012	11 minutes

[130] Dr R's Statement, 1 BSR, Tab 4, page 312.
[131] Dr R's Statement, 1 BSR, Tab 4, page 313.
[132] Transcript dated 5 March 2018, 155:20.
[133] Transcript dated 20 March 2018, 61:2-62:6.
[134] The table shows consultations after 4 August 2008 where the Botox Treatments were administered.

182 Based on the table, we agree with Counsel for the SMC that there clearly would not have been enough time for a treatment on 2 March 2013 and 9 July 2011 in the two and six minutes after payment respectively.

183 At the same time, we find that the table lends credence to Dr R's assertion of there being a policy for payment to be made before treatment:

(a) If payment was made after treatment, one would reasonably expect the Patient's husband and the Patient to head straight home after payment. Indeed on 4 August 2008, the Patient's husband said they headed home at 10.20am, two minutes after the bill was paid at 10.18am. The Patient's husband's describes the payment process as "I paid with my credit card, the credit card payment would go through, and we'd leave the clinic, and that would be it."[135] Yet the records on the table clearly show the Patient's husband and the Patient staying back at the Clinic for a period of time after payment on almost all occasions. We find this strongly suggestive of there being treatment after payment. It is inexplicable why the Patient's husband and the Patient would be lingering in the Clinic for up to 39 minutes after payment otherwise.

(b) The Patient's husband's evidence was that Dr R was "very quick at doing Botox injections" and estimated that the treatment on 4 August 2018 (for parotid glands and others) would have been "10 minutes at most". On the Patient's husband's estimate, there certainly would have been time for Botox treatment after payment in nearly all of the consultations. On the Patient's own estimate of about 10 to 15 minutes for Botox treatment for parotid glands, more than half of the consultations would suggest payment was made before treatment. On Dr R and DNurse2's estimate of an average of 15 minutes, there would have been time for treatment in only about three of ten of these consultations. However, bearing in mind that Dr R's estimate was an average figure, it would be fair to apply an estimate of between 10 to 20 minutes in the table, and in this case, where treatment could have been made after payment in more than half of the consultations.

[135] Transcript dated 6 March 2018, 158:17-159:8.

184 Contrary to the Patient and the Patient's husband's story that they never paid before treatment, we find that in all likelihood there were times where payment was made before treatment pursuant to Clinic policy. However, it is clear that the policy was not strictly followed and Dr R admitted as such[136].

THE PINK, WHITE AND BLUE SHEETS

185 We turn to consider Dr R's submissions on why, apart from the Clinic's policy, the Patient and the Patient's husband must have paid before treatment on 4 August 2008.

186 On 4 August 2008, two invoices were issued for the Patient's treatments: Invoice 43971 for cosmetic Botox injections to the Patient's forehead, and invoice 43973 for the Botox Treatment.

187 Dr R explained that the case sheets would be brought into his consultation room in triplicate – a white sheet on top, followed by a pink sheet and blue sheet underneath. He would sometimes indicate the interval until the follow-up "TCU 1/12" ("TCU") date on the top white sheet when he was with the patient at consultation. If he did so, the TCU date would appear in carbon copy ink on the pink sheet. The white sheet is given to the patient after payment and the pink sheet is kept by Dr R for his clinic records[137].

188 When the patient returns to the treatment room after payment, Dr R would not have the white sheet with him as it would already have been given to the patient. Accordingly, if Dr R had not already indicated the TCU date during the consultation, he would write it on the pink sheet in the treatment room, after the patient had made payment. The TCU date would then appear as "original" ink on his pink sheet.

189 In the present case, the pink sheet for invoice 43971 had no original ink, and contained a notation "TCU 1/12" in carbon ink. The pink sheet for invoice 43973 had "TCU 1/12" in original ink and had the appointment date "Appt: 12/9/08 Fri 900am" in carbon ink. Since the pink sheet for invoice 43973 had "TCU 1/12" in original ink on it. Dr R's position was that the Patient's husband had made payment before treatment and had received the white sheet.

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[136] Transcript dated 23 March 2018, 20:21-21:6.
[137] Transcript dated 23 March 2018, 23:1-24:5.

190 The case theory put up by Dr R could not be meaningfully challenged by Counsel for the SMC:

(a) Counsel for the SMC submits that it did not make sense for Dr R to give a follow-up date during the consultation on invoice 43971, and then give the same follow-up date after treatment on another invoice 43973. However, we find it perfectly plausible for Dr R to have considered setting two different follow up dates for the Patient's different type of Botox treatments (*ie*, cosmetic and enlarged parotid glands) and he may have fixed the date for the cosmetic Botox treatment during consultation, and thereafter decide to fix the parotid gland Botox Treatment with the same follow up date during treatment.

(b) Counsel for the SMC submits that DNurse2's evidence that the "the only time next appointment was given at the end of a consultation was when the patient was on a follow-up consultation where no treatment is needed" [138] was inconsistent with Dr R's evidence that he could sometimes indicate the follow-up date on the triplicate during the consultation or after treatment. We find this to be a minor inconsistency. On the whole, DNurse2's evidence corroborates Dr R's evidence, when she says that Dr R "would give appointment after he gives the injection"[139] and that "when the patient pays, we will actually give the first copy to the patient, which is not a carbonated copy. A carbonated copy usually will have Dr R's follow up in a pen"[140].

(c) Finally, Counsel for the SMC submits that according to Dr R's evidence, after he writes "TCU 1/12" in original ink on the pink sheet of invoice 43973 in the treatment room, the patient would have gone back outside and his staff would "give her the appointment date". Yet the appointment date "Appt: 12/9/08 Fri 900am" is written in carbon ink on the pink sheet of invoice 43973, which suggests the same must have been written on the white sheet in original ink. If payment was made before treatment, the white sheet would already have been given to the Patient and the Patient's husband, and the nurses could not have written the appointment date on the white sheet to cause the same to be on carbon

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[138] Transcript dated 6 April 2018, 143:18-144:13.
[139] Transcript dated 6 April 2018, 144:6-7
[140] Transcript dated 6 April 2018, 144:11-12

ink on the pink sheet. We accept Dr R's submission that at the reception counter, the nurses could have asked the Patient and the Patient's husband for the white copy of the invoice (which was already issued to them), and thereafter, re-assembled the white, pink and blue copies of the invoice to write down the appointment date on the white copy of the invoice and hence imprinting the appointment date in carbon in the pink and blue copies of the invoice.

191 Overall, the documentary evidence showing the Patient and the Patient's husband staying back at the Clinic for up to 39 minutes even after payment on several occasions, and the "TCU 1/12" notation in original ink on the pink sheet of invoice 43973 dated 4 August 2008 together undermines the Patient and the Patient's husband's assertion that they had left the Clinic immediately after treatment on 4 August 2008. We prefer Dr R's evidence and find that payment had been made before treatment.

How long did treatment take?

192 It is undisputed that on 4 August 2008, in addition to Botox injections for her parotid glands, the Patient received Botox injections on her forehead, frown lines, and crow's feet.

193 Dr R testified that his standard practice is to have 16 Botox injections (eight on each side) to treat the Patient's parotid glands, nine injections for the frown lines, ten injections for the forehead, ten injections for the crow's feet (five on each side) and five injections for the submandibular glands (five on each side). This was not challenged by Counsel for the SMC.

194 The Patient testified that she would typically spend 10 to 15 minutes in Dr R's treatment room for the administration of Botox injections on her parotid glands only[141]. This was consistent with Dr R's as well as DNurse2's estimate of 15 minutes for the treatment of parotid glands alone[142]. Patient's husband's estimate that the typical Botox treatment time was "10 minutes at most" [143] was clearly an outlier and to be disregarded.

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[141] Transcript dated 5 March 2018, 120:10-17.
[142] Transcript dated 22 March 2018, 146:4-15 (Dr R); Transcript dated 6 April 2018, 146:22-23 (DNurse2).
[143] Transcript dated 6 March 2018, 162:25-163:7.

195 On the Patient's case, it would take 10 to 15 minutes for Dr R to administer injections for the Patient's parotid glands alone (16 Botox injections). It is reasonable to suppose she would need to be in the room for at least five more minutes, *ie*, 15 to 20 minutes altogether, for the 39 additional Botox injections for her frown lines, forehead, crow's feet and submandibular glands on 4 August 2008. Consistent with this, Dr R's testimony was that the entire process of the 55 Botox injections took about 20 minutes.

196 Based on the above, we find it reasonable to conclude that the treatment on 4 August 2008 would have taken between 15 to 20 minutes.

Was there a second consultation?

THE OBJECTIVE TIME POINTS

197 There were three objective time points on 4 August 2008:

(a) Dr R took six photographs of the Patient's face timestamped 9.53am;

(b) Dr R took one photograph of the Patient's face timestamped 9.58am; and

(c) The Patient's husband's credit card receipt bore a timestamp of 10.18am.

198 In the Patient's account, all of the following occurred in the 20 minutes between 9.58am and 10.18am:

(a) She had a brief[144] discussion with Dr R on the day's treatment;

(b) She made her way to the treatment room;

(c) She received the Botox injections; and

(d) She left the treatment room to join her husband at the counter to make payment.

199 Given that the Botox injections alone would have already taken 15 to 20 minutes, it would be problematic fitting (a) (b) and (d) into the fixed 20 minute period, even on a conservative estimate of the times taken for each event. In the event of any delay, such as

[144] Transcript dated 5 March 2018, 150:6-10.

if the Patient's case file had not been at the payment counter as the Patient's husband testified sometimes happened[145] or if there had been any pockets of waiting time in between each event, it is highly unlikely that the Patient's sequence of events would fit within the known time points of the consultation.

200 In contrast, Dr R's account that treatment alone took place in the 20 minutes between 10.20am and 10.40am does not suffer from the same time constraints as the Patient's. We note for completeness, however, that on Dr R's account, there would have been a 22-minute gap from 9.58am to 10.20am from the time Dr R took the last photograph of the Patient's face and the time she was brought to the treatment room. In this connection, DNurse2's explanation was that Dr R may have started another consultation with another patient at the time[146] was not challenged by Counsel for the SMC.

201 Overall, Dr R's account that there was a second consultation fits better with the objective time points of the 4 August 2008 session.

THE FOUR E-MAILS

202 The existence of a second consultation is also more probable in the light of the timing of four e-mails (the "**Four E-mails**") sent by Dr R to the Patient.

203 Dr R's evidence was that the Four E-mails were sent while the Patient was in the consultation room[147]. The Patient's case was that when the e-mails were sent, she had already left the clinic[148].

204 On both their accounts, the discussion and signing of the Written Consent took place at around the same time the before and after photographs were shown to the Patient. The crucial difference was whether these events occurred between 9.40am to 9.53am (as per the Patient's account), or between 10.40am and 11.00am (as per Dr R's account).

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[145] Transcript dated 6 March 2018, 158:20-159:8, 127:16-17.
[146] Transcript dated 6 April 2018, 13:19-25.
[147] Dr R's Statement, 1 BSR, Tab 4, para 20.
[148] The Patient's Statement, 1 BSR, Tab 1, para 30, 39–42.

205 The e-mails containing the photographs are time-stamped at 10.51am, 10.52am, 10.58am and 10.59am.

206 Considering the timing of the e-mails alone, Dr R's account that the e-mails were sent to the Patient during a second consultation between 10.40am and 11.00am appeared more inherently probable to us. It made sense for Dr R to have sent the e-mails around the time that there was a discussion and signing of the Written Consent and the reviewing of the Patient's before and after photographs, as all these matters were closely linked.

207 The Patient's account was bizarre. She accepted she had "seen" Dr R send e-mails to her around the time of the discussion and signing of the Written Consent and the reviewing of before and after photographs. However, to explain how she could have seen him e-mail her between 9.40am and 9.53am and yet did not see e-mails when she was home around 11.30am to 12pm[149], she claimed that Dr R was *pretending* to e-mail her in the earlier part of the morning. According to her, his actions "were quite exaggerated in that he even made a deliberate high rebound of his hand after a loud smack on his keyboard as [she] assumed he pressed the "Enter" key and at the same time exclaiming the sending of [her] photographs was "done"[150].

208 No cogent explanation has been provided by the Counsel for the SMC for why Dr R might have put on a show of e-mailing the Patient, especially given that the e-mails were in fact sent to the Patient.

209 Counsel for the SMC pointed out that both Dr R and DNurse2 had not raised the matter of a second consultation in their Written Explanation and Statutory Declaration respectively, and the matter had only emerged in Dr R's Statement and DNurse2's testimony on the stand.

210 Dr R explained that he had "broadly stated" in his Written Explanation what had happened[151] and came up with the correct sequence when it became apparent that he had to go through the specific sequence of events[152]. DNurse2's explanation was that she did

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[149] Transcript dated 6 March 2018, 8:1-8.
[150] The Patient's Statement, 1 BSR, Tab 1, para 30.
[151] Transcript dated 22 March 2018, 109: 23.
[152] Transcript dated 22 March 2018, 110: 5-8.

not know she had to go into the "nitty gritty details" in her Statutory Declaration or that "she was going to be examined so closely"[153].

211 Given our findings on the crux of the Complaint, we believe it was reasonable for Dr R's responses to focus on whether consent was given, rather than offer a minute dissection of the exact sequence of consultation(s) and treatment on the 4 August 2008. The Patient herself, in describing what happened on 4 August 2008 in her Complaint, completely missed out that the Botox Treatments had taken place, let alone exactly when this might have happened. We find no cause for drawing any adverse inference from either party's failure to dissect the 4 August 2008 consultation earlier in the proceedings.

212 Counsel for the SMC further submitted that Dr R and DNurse2's account regarding the e-mails was riddled by inconsistencies:

(a) **Who sent the e-mails:** Initially, Dr R said he sent all Four E-mails after DNurse2 taught him how to attach PowerPoint slides to e-mails[154]. DNurse2 likewise initially said she taught Dr R how to send the PowerPoint slides[155], implying that Dr R sent them all himself. On the stand however, Dr R and DNurse2 changed their testimony. Dr R said the first two e-mails were "actually sent by DNurse2"[156]. DNurse2 said she assisted Dr R to send the first, and possibly the second e-mail, after which she escorted the Patient to the reception area[157].

(b) **The Patient's presence in the consultation room:** Dr R said the Patient was in the consultation room when the Four E-mails were sent between 10.51am to 11am[158]. In cross-examination, he added that in the seven minutes between the second e-mail at 10.52am and the third e-mail at 10.59am, he continued talking with the Patient as they were waiting for the two e-mails to go through.[159] However, DNurse2 testified that she had escorted the Patient to the reception area after the second e-mail was sent, closer to 10.59am[160].

[153] Transcript dated 6 April 2018, 130:13-15.
[154] Dr R's Statement, 1 BSR, Tab 4, para 20.
[155] DNurse2's Statement, 1 BSR, Tab 6, para 5.
[156] Transcript dated 22 March 2018, 121:15-16.
[157] Transcript dated 6 April 2018, 158:18-25.
[158] Dr R's Statement, 1 BSR, Tab 4, para 20.
[159] Transcript dated 22 March 2018, 123:14-24.
[160] Transcript dated 6 April 2018, 161:18-21.

(c) **Explanation for the seven minute gap:** Dr R explained the seven minute gap between the second e-mail at 10.52am and the third e-mail at 10.59am was due to the first two e-mails because "when we put two photos, two e-mails, close to each 4 other, 10.51 and 10.52, it was just jamming up the things."[161] DNurse2's testimony on the stand suggested that it was the third e-mail that was the cause of the delay as it "took a long while to go"[162]. Counsel for the SMC rejected Dr R's reason for the delay as tenuous and proffered its own explanation for the delay, stating it could have only come from difficulties in uploading the attachment for the third e-mail.

213 Aside from being minor, we find the above discrepancies to be expected of different interpretations of the same event happening years ago. In *Osman Bin Din v Public Prosecutor* [1995] 2 SLR 129, the Court of Appeal at [39] quoted with approval the following reminder in *Chean Siong Guan v PP* [1969] 2 MLJ 63:

> Discrepancies may, in my view, be found in any case for the simple reason that no two persons can describe the same thing in exactly the same way. **Sometimes what may appear to be discrepancies are in reality different ways of describing the same thing, or it may happen that the witnesses who are describing the same thing might have seen it in different ways and at different times and that is how discrepancies are likely to arise.** These discrepancies may either be minor or serious discrepancies. Absolute truth is I think beyond human perception and conflicting versions of an incident, even by honest and disinterested witnesses, is a common experience. .... [emphasis added]

214 However tenuous Dr R's evidence in relation to the sending of the e-mails might have been, it is imperative in the final analysis, that the SMC is able to adduce sufficient evidence to support its theory of guilt and to dispel any reasonable doubt, thereby properly discharging its burden of proof. In discharging that burden, we find that it is simply insufficient for the prosecution to point to the inadequacies of Dr R's testimony (*Yeo See Koon Jimmy v PP* [1994] 3 SLR(R) 173 at [33]).

215 We are persuaded that there was a second consultation on the day.

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[161] Transcript dated 22 March 2018, 123:21-124:7.
[162] Transcript dated 6 April 2018, 167:3-14, 168:24-169:4.

216 On the whole, we are persuaded that Dr R's stated version of the sequence of events of the 4 August 2008 consultation, albeit not entirely flawless, is more inherently probable than the Patient's when studied in light of the available objective evidence.

What was the scope of consent given by the Patient to Dr R?

217 The key points of the Patient's narrative on the scope of consent given to Dr R on 4 August 2008 was:

(a) At the start of the consultation, Dr R showed her photographs of her face before and after the Botox Treatment on his laptop. After seeing visible improvements in her condition, she requested a copy of the before and after photographs for her keeping;

(b) Dr R agreed to e-mail the photographs to her and pretended to e-mail the photographs to her during the consultation. After pretending to send the photographs, Dr R said that he better get her consent to use the photographs;

(c) She informed Dr R that she was not comfortable with the idea of her photographs being shown in public as she did not want to be identifiable, and Dr R assured her that he would either blank out her eyes or show her face from the nose downwards;

(d) Dr R penned the Written Consent.

(e) Dr R assured her that she could trust him[163] when upon reviewing the written consent she mentioned that it did not state that he would:

(i) Blank out her eyes in the photographs or use photographs that show her face from the nose downwards.

(ii) Only use information describing her condition of enlarged parotid glands and not her past cosmetic procedures.

(iii) Only use the photographs and information in one medical paper.

[163] Dr R's Statement, 1 BSR, Tab 4, para 36.

(f) Although Dr R did not specify which photographs he would be featuring in the medical paper, she was under the impression that he would consult her and seek her approval once he had selected the photographs.

(g) The Patient signed the Written Consent.

218 The key points of Dr R's narrative on the scope of consent was:

(a) While the Patient was in the treatment room, Dr R asked her if he could use her unanonymised photographs and describe her case in medical / scientific publications and presentations. The Patient agreed but wanted to see the photographs Dr R was referring to first.

(b) After treatment, Dr R, the Patient and DNurse2 moved back into the consultation room where Dr R explained to the Patient that he needed a written consent from her specifically for the use of her unanonymised photographs which carried the possibility that she would be recognised by others.

(c) Dr R showed the Patient on his laptop four draft PowerPoint presentation slides containing 15 of her before-and-after full-face photographs to show her the manner and style in which she would be presented. Dr R explained that he needed to use her unanonymised photographs to fully explain her case and the procedures that he had done on her. He did not say that he would only use these 15 photographs moving forward in his presentations of the Patient's case.

(d) The Patient informed Dr R that she did not want him to show her unanonymised photographs in newspapers or magazines. Dr R assured her that he would only use it in international plastic surgery meetings and respectable scientific journals or textbooks.

(e) After looking at the four draft PowerPoint slides, the Patient agreed to allow Dr R to use her unanonymised photographs and to describe her case in scientific / medical publications and presentations. Dr R and the Patient penned the Written Consent and both signed against it.

219 This Tribunal finds that the Written Consent, Four E-mails attaching presentation slides containing the Patient's unanonymised photographs, and the Patient and Patient's

husband's objective inaction at the material time, and for just over five years after the event incontrovertibly raise more than a reasonable doubt as to the Patient's account of the alleged oral assurances.

220 On the weight of the evidence, we find the version of events to be that as stated by Dr R in [218] above. We find that on 4 August 2008 the Patient gave her consent to Dr R to use her unanonymised photographs, and to describe her case (including her condition of enlarged parotid glands and past cosmetic surgeries) in one or more medical / scientific publications and presentations. We give our reasons below.

THE PATIENT AND PATIENT'S HUSBAND'S TESTIMONY IS NOT SUPPORTED BY DOCUMENTARY EVIDENCE

221 There is no objective evidence to support the Patient's case that Dr R provided separate oral assurances as per [217(e)] above.

222 The existence of these oral assurances is based solely on the Patient and the Patient's husband's testimony. In such circumstances, it is imperative on this Tribunal to find that the Patient and the Patient's husband's testimonies must be of such a compelling quality to the extent that their testimonies prove the alleged oral assurances beyond a reasonable doubt.

223 Unfortunately, this Tribunal finds their evidence to be utterly devoid of such compelling quality. The Patient and the Patient's husband's testimonies on various matters have been beset with material internal and external inconsistencies and lacked persuasiveness altogether. This, together with our observations as to their demeanour on the stand, made it difficult for us to trust their accounts as regards the scope of consent obtained on 4 August 2008.

224 The general unsatisfactory nature of their evidence aside, their account relating to the scope of consent on 4 August 2008 is also inherently unbelievable for the following reasons:

(a) If Dr R had indeed provided the alleged oral assurances to the Patient on 4 August 2008, it is highly unlikely that he would have voluntarily disclosed to the Patient that he had presented her case at a plastic surgery conference in mid-

2010, as the Patient alleged, and thereby caused the Patient to be aware that he had breached the oral assurances.

(b) Further, if this first reveal had caused the Patient to tear up, and Dr R had to placate her, it is all the more unlikely that Dr R would again gratuitously mention and show her the Book Chapter where he had failed to anonymise her photographs and had described her past cosmetic procedures. Finally, the idea that he would allegedly tell the Patient again on 24 August 2013 that he had presented her case in South America in breach of his oral assurances is baffling.

(c) It has not been adequately explained by the Patient why she signed on the Written Consent if it did not reflect what she agreed to. Bearing in mind her past experience with confidentiality agreements, and the importance of her confidentiality to her, it is difficult to believe that she simply trusted Dr R with her confidentiality.

225 We turn to consider the Written Consent, the Four E-mails and the parties' subsequent conduct at the material time.

THE WRITTEN CONSENT

226 The chief contemporaneous documentary evidence relating to the consent given by the Patient to Dr R on 4 August 2008 is the signed Written Consent:

- 4 AUG 2008

hereby allow

use my photos in medical/scientific publications & to describe my case.

Signature Signature

"I, (the Patient's name), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case".

227 The Written Consent is drafted widely. As worded, the Written Consent allows Dr R to use the Patient's unanonymised photographs and to describe her case, which would include information on her enlarged parotid glands and past cosmetic surgeries, in one or more medical / scientific publications. The Patient accepts that she fully understood what she was signing[164].

THE FOUR-EMAILS

228 The Written Consent alone does not expressly state that Dr R was allowed to, *in presentations*, use the Patient's unanonymised photographs and to describe her case.

229 In addition to the Written Consent, it is undisputed that Four E-mails containing 15 of the Patient's unanonymised full-face photographs in PowerPoint presentation slides were in fact sent by Dr R to the Patient between 10.51am and 11.00am on 4 August 2008.

230 The PowerPoint slides in the e-mails had the words "*R copyright*" appearing on them and the photographs included some that were taken before the Patient had parotid glands enlargement. It is not disputed that the Patient saw, when she received them in her e-mail inbox, that Dr R had included photographs of her taken in 2003 and 2004[165], *ie*, photographs relating to her past cosmetic surgeries with Dr R.

231 On both Dr R and the Patient's cases, there is undoubtedly a temporal connection between the reviewing of the before-and-after photographs on Dr R's laptop, the discussion of the Written Consent and the sending of the Four E-mails. The natural and logical inference to be drawn is that all the events were closely connected to each other. Indeed, on the Patient's own case, "Dr R went on to say that as he had sent the photographs to me he had better get my consent to use them"[166]. The Patient also said that she understood the Four E-mails to contain the type of photographs that Dr R wanted to use for his teaching and informing the profession[167].

232 As the Four E-mails contained PowerPoint slides showing the Patient's unanonymised photographs relating to her past cosmetic surgeries, this strongly suggests

[164] Transcript dated 5 March 2018, 175:9-176:11.
[165] The Patient's Statement, 1 BSR, Tab 1, para 42.
[166] The Patient's Statement, 1 BSR, Tab 1, para 30.
[167] Transcript dated 5 March 2018, 172: 17-173:8.

that Dr R would be presenting the Patient's unanonymised photographs and the Patient's case (including her condition of enlarged parotid glands and past cosmetic surgeries) in presentations – in addition to scientific / medical publications that is stated in the Written Consent.

233 Studied together, these pieces of documentary evidence corroborate Dr R's account that the Patient gave her broad consent to use her unanonymised photographs and to describe her case in medical / scientific publications and presentations.

234 Being contemporaneous documentary evidence, we find that the Written Consent and the Four E-mails alone are sufficient to raise a reasonable doubt against the Patient's account.

THE PATIENT'S OBJECTIVE INACTION OVER THE YEARS

235 The Patient and the Patient's husband's account of the alleged oral assurances is contradicted by their objective inaction between 4 August 2008 and 22 September 2013— a period of over five years.

236 If Dr R had indeed provided the alleged oral assurances to the Patient and later breached the same, it defies belief and logic that she would have continued to seek treatment from him over the next few years, especially given her own account of how the multiple alleged breaches by Dr R had made her feel:

(a) On 4 August 2008 itself, she felt "shocked" and "distraught" when she did not see Dr R's e-mails when she got home. She felt Dr R had lied and tricked her.

(b) In mid-2010, after the Patient learnt that Dr R had presented her case at a plastic surgery conference, as opposed to the one medical paper as promised, she found this to be a "wicked and cruel manipulation by Dr R"[168], and she "felt [her] whole world crumbling and started to tear up" and that there would be days where she would "fall into a deep depression, feeling that [her] life was gone" at the thought that Dr R could do anything he wanted with her information and

[168] The Patient's Statement, 1 BSR, Tab 1, para 51.

photographs. She felt that "one of the most precious things in [her] life – privacy – had been so cruelly taken away" [169].

(c) In or around late-2011, when Dr R told her that he intended to use her unanonymised full-face photographs in an article, she "froze upon hearing Dr R's words as [she] recalled how condescending and patronising he was to [her]" when she raised her concerns in 2010. When she asked why he used the photographs in the Book Chapter, Dr R "callously replied saying that he helped make [her] "famous" so that [she] actually "owed him"[170].

(d) In September 2012, the Patient was "shocked to find out that Dr R had not only used [her] un-anonymised photographs but that he had [also] disclosed [her] previous medical procedures that were unrelated to [her] condition of enlarged parotid glands i.e. all [her] past cosmetic procedures and other personal information revealed to him during their consultations"[171].

237 The lack of any contemporaneous evidence of the Patient's unhappiness as to Dr R's alleged breaches of his oral assurances and how poorly it made her feel is highly conspicuous and troubling, which renders her account unbelievable.

238 The first time the Patient raised her discontent was in her e-mail of 22 September 2013, over a year from the time she received a copy of the Book Chapter containing her unanonymised photographs on 8 September 2012, and over two years from the time she allegedly found out that he used her case in a medical conference in mid-2010.

239 The objective conduct of the Patient is not consistent with someone who has been tricked and played out by her doctor. Instead, we find that the most plausible explanation for the Patient and the Patient's husband's objective inaction is that she had willingly given her consent for Dr R to use her unanonymised photographs and to describe her case (including her Medical Information and Unrelated Medical Information) in medical and scientific publications and presentations.

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[169] The Patient's Statement, 1 BSR, Tab 1, para 49.
[170] The Patient's Statement, 1 BSR, Tab 1, para 57.
[171] The Patient's Statement, 1 BSR, Tab 1, para 59.

THE PATIENT'S EXPLANATION FOR CONTINUING TREATMENT WITH DR R

240 The Patient's explanation for her inaction was that she had no choice but to continue to seek treatment from Dr R to continue to keep her enlarged parotid glands under control with Botox.

241 This is wholly untenable for the following reasons:

(a) The Patient accepts that Dr R had never once insisted or pressured her to continue with Botox Treatments[172].

(b) The Patient had a choice of getting her condition of enlarged parotid glands surgically resized. Dr R had on several occasions advised her of her option to undergo surgery to re-size or remove her parotid glands. These discussions are evidenced in his contemporaneous case notes of 19 December 2007, 23 January 2010, and 1 December 2010 and the Patient herself conceded these discussions did take place[173].

(c) The Patient knew she had the option of not doing anything about her condition of enlarged parotid glands. Her condition was not life-threatening[174] and there was no real medical need to continue with the Botox Treatments for the condition. She says she does not recall that "doing nothing" was an option available to her[175], but the Patient's husband testified that she and he were "well aware" that doing nothing was an option[176]. We should think the option of doing nothing should have been self-evident, but in any event Dr R had discussed it with her as recorded in his contemporaneous case notes of 8 January 2011[177]. Finally, the fact that the Patient has not received any Botox Treatment for her condition of enlarged parotid glands since her last consultation with Dr R on 24 August 2013[178] is evidence itself that it was always open to her to not continue treatment with Dr R.

[172] Transcript dated 6 March 2018, 64:9-13.
[173] Transcript dated 5 March 2018, 141:5-142:20; Transcript dated 6 March 2018, 57:22-62:1.
[174] Transcript dated 22 March 2018, 74:15-18.
[175] Transcript dated 6 March 2018, 76:7-15.
[176] Transcript dated 6 March 2018, 152:7-23.
[177] Dr R's Statement, 1 BSR, Tab 4, page 317.
[178] Transcript dated 6 March 2018, 120:22-25; 152:7-14.

(d) The Patient had on several occasions not come back to see Dr R on her scheduled appointment date. The delays suggest she did not see a real need to visit him for the Botox Treatment:

(i) On 4 August 2008, she fixed an appointment date to see Dr R on 12 September 2008. However, she only returned on 27 April 2009, over 7 months after her scheduled date.

(ii) On 25 July 2009, she fixed an appointment date to see Dr R on 26 September 2009. However, she only returned on 23 January 2010, 4 months after her scheduled date.

(iii) On 29 October 2011, she fixed an appointment date to see Dr R on 17 December 2011. However, she only returned on 8 September 2012, nearly 9 months after her scheduled date.

(e) There were also long intervals between her consultations which the Patient explained was because she opted not to continue with the Botox Treatments and was fully aware that she had the option of not following up closely[179].

Consultation	Next consultation	Interval length
4 August 2008	27 April 2009	38 weeks
27 April 2009	25 July 2009	13 weeks
25 July 2009	23 January 2010	26 weeks
23 January 2010	23 February 2010	4 weeks
23 February 2010	20 March 2010	4 weeks
20 March 2010	3 July 2010	15 weeks
3 July 2010	6 August 2010	5 weeks
6 August 2010	1 December 2010	17 weeks
1 December 2010	8 January 2011	6 weeks
8 January 2011	26 March 2011	11 weeks
26 March 2011	9 July 2011	15 weeks
9 July 2011	29 October 2011	16 weeks
29 October 2011	8 September 2012	45 weeks
8 September 2012	1 March 2013	25 weeks
1 March 2013	24 August 2013	21 weeks

242 For the reasons mentioned above, we find there is no credible explanation for why the Patient continued seeking treatment from Dr R despite his alleged licentious breaches of the oral assurances made to her and how it made her feel.

[179] Transcript dated 6 March 2018, 57:13-17.

243 To recapitulate, the SMC has not proven its case as regards the Patient's statements as to the scope of consent beyond a reasonable doubt. The Written Consent, the Four E-mails containing unanonymised photographs of the Patient in PowerPoint slides as well as the Patient and the Patient's husband's objective inaction are sufficient to cast more than a reasonable doubt in respect of the Patient's account of events as stated at [217] above.

244 We find the facts to be that as stated by Dr R at [218] above. On the totality of the evidence, and in particular, the Patient's conduct in signing the Written Consent on 4 August 2008, the Patient's receipt of the Four E-mails, the Patient's receipt of the Book Chapter in September 2012, and the Patient and the Patient's husband's objective inaction until 22 September 2013, the Tribunal finds that the Patient had willingly given her consent for Dr R to use her unanonymised photographs and to describe her case (including her Medical Information and Unrelated Medical Information) in medical and scientific publications and presentations.

(7) Consultations in mid and late 2010

Did Dr R present the Patient's case in mid-2010?

245 Counsel for the SMC's case was that in mid-2010, the Patient discovered that Dr R had presented her case at a plastic surgery conference. Dr R denied that he had presented the Patient's case at a plastic surgery conference in mid-2010[180].

246 No evidence of this plastic surgery conference was adduced by Counsel for the SMC. The Patient herself did not provide any details of when or where such a conference might have been held. Accordingly, Counsel for the SMC has failed to discharge its burden to prove that Dr R had presented the Patient's case at a plastic surgery conference in mid-2010 beyond a reasonable doubt.

247 During cross examination, Dr R stated that he had presented the Patient's case at "possibly two" [181] presentations between 2008 and 2009 [182] . He identified the presentations to have "most likely" been on 25 September 2008 in Hong Kong and 3 to 7

[180] Transcript dated 20 March 2018, 63:12 to 64:25; Transcript dated 23 March 2018, 70:8-13.
[181] Transcript dated 23 March 2018. 59:10-12.
[182] Transcript dated 20 March 2018, 99:22-100:11.

June 2009 in Las Vegas[183]. He said he may have told the Patient about the presentations "at some stage" after the Las Vegas presentation in 2009[184].

248 We had difficulty with the reliability of Dr R's statements above. His identification of the two presentations were couched in terms of probabilities, and he clearly was only able to identify the potential presentations after scouring through his lengthy Curriculum Vitae ("Dr R's CV") for possibilities. As the presentation material for "25 September 2008, 3rd Regional Conference in Dermatological Laser and Facial Cosmetic Surgery… Hong Kong" and "3-7 June 2009, Facial Cosmetic Surgery 2009, Las Vegas Nevada" as stated in Dr R's CV were not available for our examination, and we did not have the benefit of ascertaining the origin, age or reliability of such material, we are unable to say with any certainty that Dr R's statements are accurate.

249 Accordingly Dr R's conjectures could not meaningfully assist the SMC in discharging its high standard of proof. The SMC's inability to pinpoint any particular presentations with certainty, compounded by the absence of any documentary evidence of the alleged presentations that the Patient might be referring to, gave room for serious doubts as to the existence of presentations in 2008, 2009 or 2010 where Dr R allegedly featured the Patient's case.

250 We should mention that even if there had been presentations in 2008 and 2009 or 2010 which featured the Patient's case, there was insufficient credible evidence to establish that it would have featured the Patient's past cosmetic surgeries.

251 If there had been a presentation, Dr R said that he would have used the Patient's unanonymised photographs[185]. However, whether the purported presentation would have discussed her previous cosmetic surgeries with Dr R was not at all clear.

252 Counsel for the SMC submits that Dr R would have mentioned the Patient's past cosmetic treatments in the hypothetical presentations because:

183 Transcript dated 23 March 2018, 63:24-64:18.
184 Transcript dated 23 March 2018, 65:14-23.
185 Transcript dated 23 March 2018, 56:13-15.

(a) In the letter from Dr R's lawyers to the Patient dated 26 November 2013, Dr R confirmed that the pictures presented in the four e-mails sent on 4 August 2008 represented the slides he had used. The PowerPoint slides included pictures of the Patient in 2003 and 2004. One of the photographs contained in the e-mail dated 4 August 2008 at 10:59am was captioned "25.10.03 before any ops"; and

(b) Dr R had explained that it was necessary to mention the Patient's past cosmetic procedures in his Book Chapter, as he felt he should be as complete as possible and that the Patient was a very unusual case which necessitated presenting her full face photographs and medical history[186].

253 Dr R's evidence is that, in the two possible presentations he had in 2008 and 2009, he did not refer to the Patient's earlier cosmetic treatments because:

(a) He may have used different slides for the presentation that were not the same as the slides featured in the four e-mails of 4 August 2008. The e-mailed slides were meant to show the Patient the manner and style in which she would be presented. There was never any discussion that, moving forward, these would be the only slides that he would show. The Patient also knew that her case was a work in progress.

(b) The presentations were of a different nature from the Book Chapter. He would have gone to greater detail in the Book Chapter, which was "more scholarly", while the presentation was "like a flash of a couple of seconds"[187]. The presentation(s) was not just about the Patient, but about a variety of issues[188]. He was presenting with a very limited period of time, and he "would have just shown the big parotid" and "resolved parotid"[189].

254 With competing plausible explanations for whether the Patient's previous cosmetic surgery was discussed in the presentations, and without any evidence of the presentation material that may have been used, we are not satisfied beyond a reasonable

[186] Transcript: 20 March 2018, 77:2-78:7.
[298] Transcript: 22 March 2018, 152:11–20.
[187] Transcript dated 23 March 2018, 58:1-19.
[188] Transcript dated 23 March 2018, 57:19-58:13.
[189] Transcript dated 23 March 2018, 56:22-25.

doubt that the hypothetical presentations would have included the Patient's previous cosmetic surgeries.

(8) Consultation in late-2011

Did Dr R inform the Patient about using her case in an article?

255 It is undisputed that the Book Chapter "*Botulinum Toxins in Clinical Aesthetic Practice (2nd Edition)*" was published in January 2011.

256 Counsel for the SMC submits that Dr R only informed the Patient that he was going to feature her case in an article ***after*** the article in the Book Chapter had been published. It was alleged that, in a consultation in late-2011 (which may have been on 29 October 2011), Dr R had informed the Patient that he was going to feature her case in an article, and very quickly showed her six unanonymised photographs that he intended to use while commenting that she had seen them before.

257 Dr R's recollection as to when he informed the Patient of the Book Chapter was not reliable:

(a) In his letter to the Patient dated 24 September 2013, Dr R had stated he informed her about the Book Chapter in mid-2011.

(b) He corrected this in his Written Explanation to say he informed the Patient on 20 March 2010 that he intended to use the same 16 photographs in the Book Chapter "*Botulinum Toxins in Clinical Aesthetic Practice (2nd Edition)*" that he showed her and sent her by e-mail on 4 August 2008. He says he even showed her the 16 photographs again to help her recall her earlier discussions (the slides however, only contained 15 photographs).

(c) In his examination in chief, Dr R altered his story again to say he had replaced five photographs from the original 15 photographs sent to her by e-mail with six new updated photographs.

258 There was no documentary evidence to support either the Patient or Dr R's account of events. Dr R claimed to have conversations with his publisher which might

have shed light on the time he told the Patient of the publication, but none was provided to this Tribunal.

259 In contrast with Dr R's shifting account of events, we prefer the Patient's evidence that she was informed of the publication in late-2011.

260 Whether or not the Patient was informed of the publication in mid-2010 or in late-2011, we do not believe the Patient's evidence that on seeing the photographs, she had "immediately reminded" Dr R that he was not to use her unanonymised photographs, because she had already given Dr R her consent to do so.

(9) Consultation on 8 September 2012

The Patient learned the Book Chapter was published

261 Dr R had difficulties stating a consistent position as to the date he showed the Patient the Book Chapter. However, he eventually agreed with the Patient's account that he showed the Patient the Book Chapter on 8 September 2012[190].

262 The Patient avers that while Dr R was scrolling through the pages on his laptop, she asked why he had not anonymised her photographs but he ignored her. When the Patient's husband repeated the question, Dr R callously replied that he made the Patient "famous" so she actually "owed him"[191]. Later, she had asked for a copy of the Book Chapter and Dr R gave it to her in a thumb drive on another day. On reviewing the Book Chapter at home, the Patient was "shocked" to find out that Dr R had used her unanonymised photographs and information on her past cosmetic procedures in the Book Chapter.

263 As we have found that Dr R had the Patient's consent to use her unanonymised photographs and information on past cosmetic procedures, we do not believe that this conversation happened at all.

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[190] Transcript dated 23 March 2018, 53:20-21.

[191] The Patient's Statement, 1 BSR, Tab 1, para 56-57; Patient's husband's Statement, 1 BSR, Tab 2, para 39.

264 We would emphasise that if Dr R had already seen the Patient's negative reaction in late-2011 to the featuring of her unanonymised photographs in the article he was writing for the Book Chapter, he could not have been so obtuse as to bring the Book Chapter to her and her husband's attention again. Upon seeing the Patient's negative reaction at the Book Chapter on 8 September 2012, it would be unusual for Dr R to agree to give her a copy of the same in a thumb drive – especially considering the Patient's previous evidence that in mid-2010, Dr R could allegedly flatly refuse giving her a copy of his alleged mid-2010 presentation slides, saying that they were his "property" or "presentation"[192].

(10) Consultation in 2013

Did Dr R present the Patient's case in 2013?

265 Counsel for the SMC submits that Dr R had presented the Patient's case at a conference in South America. Dr R denies this and says that he could not have made a presentation in South America about the Patient since that medical conference prohibited talk about "off-label" indications, being uses of Botox for purposes it had not been indicated for in South America. As the Patient's case was an off-label indication, Dr R explained that he could not have presented her case.

266 Counsel for the SMC has not adduced any evidence that a presentation was in fact made by Dr R in South America in 2013.

267 Counsel for the SMC's reliance on Dr R's failure to refute the point at an earlier stage is by itself sorely inadequate for us to find that there was such a presentation to begin with, much less decide on what the presentation might have contained. It has not been proven beyond a reasonable doubt that Dr R presented the Patient's case in South America in 2013.

(11) Did the Patient have a financial motive in filing the Complaint?

268 Separately, we considered Dr R's allegation that the Patient had a financial motive in making the Complaint against him. Counsel for the SMC denies there being any financial motive.

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[192] The Patient's Statement, 1 BSR, Tab 1, para 48; Transcript dated 6 March 2018, 151:1-7.

269 Dr R and his two nurses gave evidence that the Patient's husband had frequently asked Dr R for discounts for the Botox Treatments[193], on occasions even said Dr R should be paying the Patient instead as he was becoming famous or profiting by describing her case[194], on occasions asked for the treatments to be cheaper or event free of charge[195] and also asked the nurses at the reception counter for a further reduction in price of the Botox treatment[196]. Dr R also alleged that the Patient's husband had asked him to cap his fees at $3,000 per year which is what the Patient's husband's insurers allegedly allowed in claims.

270 The Patient and the Patient's husband's evidence was that they never asked for free treatment and they asked for discounts only because they felt Dr R was not charging them at cost as per the alleged "win-win" arrangement[197].

271 Without delving into each specific allegation by Dr R and his nurses of what the Patient or the Patient's husband said when asking for discounts, we are satisfied that the issue of money featured prominently in the course of the Patient's Botox Treatments with Dr R:

(a) **Patient's husband asked for discounts:** It is not disputed that Patient's husband paid for his wife's Botox Treatments and had asked for discounts. Dr R's contemporaneous case notes also reflects this:

(i) On 27 April 2009 Dr R recorded that the Patient "wants lower price"[198].

(ii) On 1 December 2010 Dr R recorded that "Husb pressure to $ again" and "told him we have to cover costs"[199].

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[193] DNurse1's statutory declaration, 1 BSR, Tab 5, para 10; DNurse2's statutory declaration, 1 BSR, Tab 6, paras 8 and 9.
[194] DNurse1's statutory declaration, 1 BSR, Tab 5, para 15; DNurse2's statutory declaration, 1 BSR, Tab 6, para 9.
[195] DNurse1's statutory declaration, 1 BSR, Tab 5, para 11, 16; Dr R's Written Explanation, [64].
[196] Transcript dated 6 April 2018, 281:1-2 (DNurse1); DNurse2' statutory declaration, 1 BSR, Tab 6, para 10;
[197] The Patient's Statement, 1 BSR, Tab 1, para 76; Patient's husband's Statement, 1 BSR, Tab 2, para 43.
[198] Dr R's case notes, Dr R's Statement, 1 BSR, Tab 4, page 313.
[199] Dr R's case notes, Dr R's Statement, 1 BSR, Tab 4, page 317.

(iii) On 24 August 2013 Dr R recorded that "price $$ needs more BTX", "expl that as Parotid ↑ then have to give more BTX so price also has to ↑" and "all these years been helping them to keep it low ↓↓"[200].

(b) **Using insurance to pay for the treatment**: Before the start of Botox Treatment, the Patient's husband had deliberately gone to check if the cost of Botox treatment would be covered under his then company's insurance policy. When treatment begun in or around January 2008, he made known his insurance claim limit of $3,200 per year to Dr R[201]. At the Patient and the Patient's husband's specific suggestion[202], two invoices were issued by the Clinic for 4 August 2008. One invoice (invoice no. 43971) was for the Patient's purely cosmetic treatment, which was not claimable under the Patient's husband's insurance while invoice no. 43973 the other invoice was for "Neurotoxin Therapy of enlarged parotid/ submandibular glands", *ie*, the parotid gland treatment, which would be claimable under the Patient's husband's insurance.

272 The objective evidence reveals that the Patient's husband had asked for discounts on multiple occasions and had arranged his affairs such that insurance would pay for the Botox Treatments for the Patient's enlarged parotid glands. This supports Dr R, DNurse2 and DNurse1's evidence as to the Patient's husband's repeated requests for discounts, and we are satisfied that price was made an issue in the course of the Patient's Botox Treatments with Dr R.

273 We turn to correspondence leading up to the Complaint.

274 In this connection, Dr R gave evidence that the Patient had written to him on 22 September 2013 "to demand compensation and this was followed by further demands made by her lawyers on her behalf. When [Dr R] refused to budge, she instructed her lawyers to demand compensation from the publishers instead."[203]

275 The Patient's 22 September 2013 letter and subsequent letters from the Patient's former lawyers did not mention anything about compensation and Dr R accepted as

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[200] Dr R's case notes, Dr R's Statement, 1 BSR, Tab 4, page 321.
[201] Transcript dated 22 March 2018, 68:11-69:7.
[202] Transcript dated 5 March 2018, 156:9-19.
[203] Dr R's Statement, 1 BSR, Tab 4, para 68.

much[204]. During cross-examination, Dr R was asked to explain why he felt the Patient was demanding compensation. It was here that Dr R referred to a call that he supposedly had with one of the Patient's former lawyers, Lawyer A after receiving the letter from Law Firm A dated 22 September 2013. Allegedly, Ms Lawyer A told him that "this [was] all about money", to "give her some compensation" [205], that she would "cap [her] legal fees at $2,500", and that he should "pay her something and make it go away" [206].

276 The SMC chose not to call Lawyer A to rebut the alleged phone conversation with Dr R even though he had stated on oath during cross-examination that monetary compensation had been demanded with the result that Dr R's evidence was not rebutted by the SMC[207].

277 Moving on to Dr R's second allegation that the Patient had demanded compensation from his publishers, the point seems to be directly corroborated by an e-mail from W4, a senior editor of Publisher A, to Dr R dated 26 June 2014 at 4:06pm:

> Dear R
>
> Just to keep you up to date, **we have heard nothing from their lawyers since we declined their request to pay a sum in settlement.**
>
> It looks as if this will not therefore need to proceed any further. Obviously I hope there is a similar outcome for you also! [emphasis added]

278 Faced with this e-mail annexed to Dr R's Written Explanation, the Patient admitted in her Statement that when she wrote via her lawyers to the publisher of the Book Chapter, Publisher B, she did seek a sum of GBP 3000, but this was to "defray [her] legal costs, as a gesture of goodwill", and that "monetary compensation never crossed [her] mind".[208]

279 We note that Counsel for the SMC did not adduce any of the Patient's letters to Publisher B to back up her explanation, even though such letters should have been readily available to her.

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[204] Transcript dated 23 March 2018, 80:2-13; 83:13-15 and 83:18-21.
[205] Transcript dated 23 March 2018, 17:46-17:48.
[206] Transcript dated 23 March 2018, 85:17-86:7.
[207] Transcript dated 18 May 2018, 187:11-188:14.
[208] The Patient's Statement, 1 BSR, Tab 1, para 76.

280 Finally, we do not accept Counsel for the SMC's submission that if the Patient had wanted financial compensation, she would have filed a civil suit for damages. The filing of an SMC Complaint against Dr R, which would embroil him in disciplinary proceedings that may potentially affect his reputation and livelihood, is a potential way of extracting compensation from him. The fact that the Patient has not filed a civil suit against Dr R to claim damages is neither here nor there.

281 On the whole, given that money was an issue that surfaced numerous times during the course of the Botox Treatments, and there was a letter on 26 June 2014 from Dr R's publishers advising Dr R that the Patient had through her lawyers requested a sum in settlement from them, we find it is possible that the Patient did have a financial motive in lodging a Complaint against Dr R. Had it been necessary for us to decide whether there was a financial motive, we would have found that such a motive cannot be completely discounted. On the basis of our findings above however, it is not necessary for us to deal with this point further.

282 We next turn to consider the issues that arise in the present case in respect of each of the Charges.

Issues

283 We consider the issues in respect of the Charges in the following order:

(a) Charge 2: Applying the second limb of *Low Cze Hong*, whether Dr R failed to obtain informed consent from the Patient before using her unanonymised photographs in the **Book Chapter from 4 August 2008 to 2011**, and if so, whether there was serious negligence on Dr R's part, and whether such negligence constituted an abuse of the privileges of being registered as a medical practitioner;

(b) Charge 4: Applying the second limb of *Low Cze Hong*, whether Dr R failed to obtain informed consent from the Patient before using Unrelated Medical Information reported in the case commentary in the **Book Chapter from 4 August 2008 to 2011**, and if so, whether there was serious negligence on Dr R's part, and whether such negligence constituted an abuse of the privileges of being registered as a medical practitioner;

(c) Charge 3: Applying the second limb of *Low Cze Hong*, whether Dr R failed to obtain informed consent from the Patient before using her unanonymised photographs in **at least two medical presentations in 2010 and 2013**, and if so, whether there was serious negligence on Dr R's part, and whether such negligence constituted an abuse of the privileges of being registered as a medical practitioner;

(d) Charge 5: Applying the second limb of Low Cze Hong, whether Dr R failed to obtain informed consent from the Patient before using her Medical Information and Unrelated Medical Information in **at least two medical presentations in 2010 and 2013**, and if so, whether there was serious negligence on Dr R's part, and whether such negligence constituted an abuse of the privileges of being registered as a medical practitioner;

(e) Charge 1: Applying the first limb of *Low Cze Hong*, what the applicable standard of conduct was for documenting the taking of informed consent for a case commentary, whether Dr R departed from that standard **from 27 April 2009 to 24 August 2013**, and if so, whether his departure had been intentional and deliberate; and

(f) Charge 1A: In the alternative to the issue set out in (e) above, applying the second limb of *Low Cze Hong*, whether there was serious negligence on Dr R's part in the manner in which he documented the taking of informed consent for a case commentary **from 27 April 2009 to 24 August 2013**, and whether such negligence constituted an abuse of the privileges of being registered as a medical practitioner.

Charge 2 – Whether Dr R failed to obtain informed consent to use the Patient's unanonymised photographs in the Book Chapter, and if so, whether this amounted to serious negligence

284 Counsel for the SMC argued that Dr R had failed to obtain informed consent from the Patient to use the 16 unanonymised photographs of her that were published in the Book Chapter as would have been expected from a reasonable and competent doctor[209].

[209] Prosecution's Closing Submissions ("PCS"), [319].

In doing so, Counsel for the SMC argued that Dr R should have fulfilled the following four requirements[210]:

(a) Informed the Patient that he intended to use the photographs in the Book Chapter either at the time of the signing the Written Statement or in subsequent consultations before such use;

(b) Obtained the Patient's consent to use the photographs in the Book Chapter;

(c) Informed the Patient of her right to withdraw her consent to use the photographs in the Book Chapter at any reasonable point; and

(d) Not used the photographs in the Book Chapter in the event the said consent was withdrawn.

285 On the other hand, Counsel for Dr R argued that:

(a) The Patient gave her consent to Dr R to use her unanonymised photographs to describe her case in one or more medical or scientific publications and in presentations[211];

(b) Dr R was not required to inform the Patient of the particular use of unanonymised photographs or medical information[212]; and

(c) Dr R was not required to inform the Patient of her right to withdraw her consent for the use of her unanonymised photographs and medical information[213].

286 As discussed above, the Tribunal made the following factual findings:

(a) On 4 August 2008, the Patient had given her consent for Dr R to use her unanonymised photographs in medical/scientific publications and to describe her case;

(b) The Patient knew that she had given Dr R consent to use the photographs contained in the PowerPoint slides in the Four Emails that Dr R had sent her;

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210 PCS, [320].
211 RCS, [146].
212 RCS, [149].
213 RCS, [162].

(c) The Patient received a copy of the Book Chapter in September 2012; and

(d) The Patient had not withdrawn her consent for Dr R to use her unanonymised photographs until her e-mail to him of 22 September 2013.

287 Thereafter, it had not been disputed that, by way of two letters from Dr R's former lawyers on 7 and 26 November 2013, Dr R confirmed that there was no further use of the Patient's photographs and medical information following her request of 22 September 2013[214]. Dr R confirmed that he would inform his publishers as such but that her revocation of consent did not operate retrospectively.

288 Accordingly, the remaining issues to be discussed in respect of Charge 2 are whether serious negligence arose on Dr R's part in the following respects:

(a) Whether Dr R ought to have informed the Patient of her right to withdraw her consent for him to use her unanonymised photographs in medical publications and presentations;

(b) Given the terms of the Written Consent, whether Dr R ought to have informed the Patient of each particular use of her unanonymised photographs in medical publications and presentations; and

(c) In the light of this Tribunal's findings on the applicable duty, whether Dr R obtained the Patient's consent to use her unanonymised photographs in the Book Chapter.

(a) Whether Dr R ought to have informed the Patient of her right to withdraw consent

289 Counsel for the SMC argued that the requirement to inform a patient of her right to withdraw consent to use her photographs in publications or presentations was an ethical obligation that, while not expressed in the 2002 ECEG, stemmed from respecting a patient's autonomy to make her own decision[215]. As consent for publication may involve the patient's photographs and information being used indefinitely, it was crucial that a patient was explicitly informed that her consent could be revoked at any time[216].

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[214] Agreed Statement of Facts ("ASOF"), at para 16.
[215] PCS, [334].
[216] PCS, [335].

290 On the other hand, Counsel for Dr R pointed out that the 2002 ECEG did not prescribe such a duty[217], and, in any event, Counsel for the SMC did not prove beyond reasonable doubt that this had been standard practice in Singapore or internationally in 2008[218].

291 We turn to the expert evidence on whether such a duty existed.

Expert evidence for the SMC

292 The SMC's sole expert witness is Dr PE, who has been a family medicine practitioner since 1991. While he also has a law degree, and a Masters in Healthcare Ethics and Law, he is not qualified to practise law[219]. He is currently an Adjunct Senior Lecturer in the Centre for BioMedical Ethics, at the National University of Singapore.

293 Dr PE opined that informed consent entailed an ongoing shared decision-making dialogue with the final decision being one shared by all parties, and which was open to change until the final act relating to the consent was commenced or completed, depending on the context[220]. Even though Dr PE acknowledged that the standard forms used by hospitals did not contain express provision that a patient could revoke consent, Dr PE insisted that it was part of a doctor's ethical duties to inform the patient of the same[221].

294 Dr PE conceded that any duty to inform a patient of her right to withdraw consent to use her photographs in publications or presentations was not provided for in the 2002 ECEG, and that he was not aware of any evidence of any other ethical requirement for the same[222]. While Dr PE referred to the model consent form provided in an article by the American College of Medical Genetics and Genomics ("ACMG") (Informed consent for medical photographs, November/December 2000, Vol 2, No. 6, p 353[223]), that model consent form was stated to have been provided "in the hope that it will be adopted by geneticists and other medical researchers to ensure fully informed consent for all their

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[217] RCS, [163].
[218] RCS, [164]-[165].
[219] Statement of Dr PE dated 13 February 2018 ("Dr PE's Statement"), 1 BSR, Tab 3, para 2; Transcript dated 7 March 2018, 34:21-35:8.
[220] PCS, [322].
[221] Transcript dated 7 March 2018, 117:13-23.
[222] Transcript dated 7 March 2018, 119:22-120:7.
[223] Dr PE's Statement, 1 BSR, Tab 3, p 229.

patient populations"[224]. In any event that model consent form does not state that the patient has a right to withdraw consent. Instead, it provides a contact point in the following manner:

> If I have any questions or wish to withdraw my consent in the future I may contact…

Expert evidence for Dr R

295 Dr R's first expert witness was Prof DE1, a senior consultant neurologist at the Institute N, and who practises at Hospital A at the time of the Inquiry[225]. Professor DE1 is also a Professor at the Duke-NUS Medical School and Yong Loo Lin School of Medicine, and an honorary professor at the Lee Kong Chian School of Medicine. He chairs several national committees relating to education, training and research. He was the chief editor of Annals Academy of Medicine, Singapore from 2011 to 2017, and holds other appointments as editor of several international journals. He has 400 peer-review publications, including book chapters.

296 Professor DE1 agreed with Counsel for the SMC that a doctor should inform a patient that she had the right to withdraw or modify her consent, and that Dr R ought to have done so in 2008[226]. However, he explained that his view had been based on his own best practices (as elaborated below), and that the Patient's "consent as it was taken itself met the minimum standards"[227].

297 Professor DE1 had adopted the practice of documenting the fact that he had informed a patient of her right to withdraw her consent based on the standard consent form used at the Texas Medical Centre in Houston, USA, where he had spent about one-and-a-half years. That centre had been the largest medical centre in the world in the 1990s, and operated in a highly litigious society where standard forms had been vetted by lawyers[228]. When he returned to the Hospital A in 2000, he adhered to that standard, which he described as the "highest standard"[229]. He noted that it had been a "higher bar than that used at the Hospital A" and that his colleagues did not adopt his practice. He

[224] Dr PE's Statement, 1 BSR, Tab 3, p 231.
[225] Professor DE1's statement, 1 BSR, Tab 6, para 1.
[226] PCS, [325(c)].
[227] Transcript dated 24 April 2018, 186:2-14.
[228] RCS, [225].
[229] RCS, [225].

pointed out that the standard consent form used by the Hospital A did not include a revocation statement[230]. Neither did the consent form provided by the pre-eminent medical journal in the world, the New England Journal of Medicine, as at December 2012[231].

298 The Tribunal drew the attention of the parties' experts to the article titled "Guidelines for Standard Photography in Plastic Surgery" (the "Article"), by Reha Yavuzer, MD, Stefani Smirnest, and Ian Thomas Jackson, MD ("Dr Jackson"), and invited the experts' comment on the same. Dr Jackson is a renowned craniofacial and plastic reconstructive surgeon who had taught in the Hospital A and lectured at conferences in Singapore on several occasions[232]. In 1993, the Ministry of Health invited him to be a visiting expert at the Department of Plastic Surgery in the Hospital A under the Health Manpower Development Plan to impart skills and improve Singapore's medical and health team's expertise[233]. Under that scheme, he gave lectures and tutorials, attended ward rounds, and demonstrated complicated procedures among other work. Importantly, he lectured Singapore plastic surgeons on taking photographs of patients and how to take patients' consent.

299 The Article referred to a "typical photographic consent form" for the use of pictures in "publications or presentations", which stated that:

> I, [patient's name], give permission to [doctor's or practice' name] for my picture to be used for teaching, for presentation to other doctors, or for publication.

300 When faced with the Article, Dr PE conceded that he had no other authority to contradict the proposition in the Article[234]. In fact, Dr PE conceded that the consent form in the Article provided the "minimum standard" that applied in Singapore in 2008.

301 In contrast, Professor DE1 gave evidence that the Hospital A used a standard consent form that was similar to the Written Consent, and which stated[235]:

> I, so-and-so, of IC so-and-so have agreed for photographs to be taken for academic and medical purpose

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230 RCS, [226].
231 RCS, [226].
232 RCS, [219].
233 RCS, [219(b)].
234 Transcript dated 7 March 2018, 172:21-24; RCS, [223].
235 RCS, [217].

302 Dr R's second expert witness, Dr DE2, is an Assistant Professor with the Centre for Biomedical Ethics, Yong Loo Lin School of Medicine, National University of Singapore[236]. He obtained a doctorate in legal studies with a focus on bioethics in 2012, and he has degrees in law, sociology and economics, but has never practised as a lawyer. From 2001 to 2011, Dr DE2 served as a researcher and a member of the secretariat of the Bioethics Advisory Committee ("BAC"), an expert body appointed by the Singapore Government in 2000 to advise and make recommendations on advances in biomedical sciences.

303 Dr DE2 generally agreed with Dr PE's explanation of the requirements expected of a doctor in taking informed consent as stated in [295] above as a matter of principle. However, he had drawn from his experience with the consent-taking guidelines issued by the BAC governing clinical research[237]. The BAC regulated human biomedical research and experimentation, which potentially included human stem cell research, reproductive and therapeutic cloning, human genetics research, and human-animal combination research. Such research and experimentation potentially involves large-scale experiments and experiments to obtain clinically significant findings. Such research and experimentation necessarily required more stringent consent-taking requirements.

304 Accordingly, the Tribunal disagrees with Dr DE2's view that the consent-taking guidelines issued by the BAC would be of assistance in the present case, and finds that the present case stood on entirely different ground.

305 What is more significant is that Dr DE2 agreed that it is not necessary to inform the Patient of the right to withdraw consent if the Patient already understood that consent may be withdrawn. This was consistent with the position under the 2002 ECEG where doctors are not required to mechanically convey information to the patient without regard to what the patient might already know.

Our findings

306 Having carefully considered the experts' opinions on this issue, it was clear to this Tribunal that the experts agreed that the 2002 ECEG did not require a doctor to inform

[236] Dr DE2's statement, Bundle of Statements and Reports, Volume 2 ("2 BSR"), Tab 8, para 1.
[237] PCS, [327].

his patient of her right to withdraw or modify her consent. While this Tribunal notes that it may have been a good practice, this Tribunal is satisfied that there is no compelling evidence that an ethical obligation existed apart from the 2002 ECEG that required a doctor to inform a patient of the same in 2008. All three experts had not been able to point the Tribunal to any authority or basis for finding that such an obligation existed in 2008.

307 The SMC could not escape the fact that the Article also did not prescribe any such language. In fact, Dr PE conceded that the standard in the Article represented "the minimum standard" that should be employed, and conceded that he had no other authority to contradict that standard[238].

308 Even if there existed such an ethical obligation, this Tribunal disagrees with the SMC's arguments that the obligation would have required a doctor to always inform a patient of the right to withdraw or modify consent.

309 In *Leslie Lam* at [77], the C3J explained that even the duty in Guideline 4.2.2 did not create an "unyielding obligation" to "mechanically convey" information to a patient regardless of what a patient may already know, as follows:

> … In our view, **the duty set out in Guideline 4.2.2 [referring to the guideline on "Informed Consent"] did not impose an absolute and unyielding obligation on Dr Lam to explain all the PCI benefits, risks, complications and alternatives to the Patient regardless of his existing knowledge**; instead, it imposed on him only an obligation to ensure that the Patient was apprised of the relevant information about PCIs. In our view, **this obligation would be satisfied if Dr Lam had reasonable grounds to believe that the Patient was already well acquainted with such information**. There was nothing in either Charge 3 or Guideline 4.2.2 which required Dr Lam to mechanically convey the PCI benefits, risks, complications and alternatives to the Patient without regard to what the Patient might already know. [emphasis added]

310 This Tribunal found that the Patient was well-educated, well-informed and had extensive commercial working experience, including in handling the drafting of confidentiality agreements. Therefore, even if an ethical obligation to inform a patient of her right to withdraw or modify her consent is implied to exist in 2008, the Tribunal finds that Dr R would not have been obliged to mechanically inform the Patient of the same on the facts in this case.

[238] Transcript dated 7 March 2018, 172:10-24.

(b) Whether Dr R ought to have informed the Patient of each particular use

311 Counsel for the SMC, in reliance on Dr PE's evidence, argued that Dr R ought to have obtained explicit permission for "blanket use" of the photographs and medical information in any medical or educational publication or presentation, if the information about the exact forum of use was unavailable[239]. Alternatively, Counsel for the SMC argued that Dr R should have obtained permission for the specific and full extent that he was using the patient's photographs or medical information, as proximally as possible before each particular use.

312 On the other hand, Counsel for Dr R argued that it had been the norm in 2008 to obtain photographs and medical information for "blanket use", and there had been no duty to inform a patient before each particular use.

Expert evidence for the SMC

313 Dr PE opined that Dr R ought to have obtained the Patient's consent in one of two ways. He should have obtained explicit permission for "blanket use" in any publication or presentation or educational forum, if the information about the exact forum of use was unavailable[240]. Specifically, Dr R ought to have told the Patient that the exact forum of use had not been established, and sought permission to use the same in any publication or presentation, or any educational forum. If no consent for "blanket use" was obtained as detailed above, Dr R ought to have obtained permission for the specific and full extent of use, as proximally as possible, before such use. If it had not been clear whether the initial consent covered such use, Dr R ought to have obtained further and specific consent to do so.

314 Although Dr PE had strong views of the applicable standard in 2008, he admitted that he had no personal experience taking consent from his patients for publication purposes. Neither had he been in the position of an editor nor publisher who would have been able to assess the practice of the Singapore medical community as it had existed in 2008[241]. He also conceded that he could not cite any authority for his views that a doctor must inform the patient of the exact forum of use, and if the exact forum was unknown at

239 PCS, [322(b)].
240 PCS, [322(b)].
241 RCS, [157].

the time of consent-taking, that a doctor must explicitly obtain consent for use in any presentation, publication or forum[242].

315 When Dr PE conceded that it was the norm in practice in 2008 for a doctor, upon having a patient's consent, to release the patient's medical information in a medical report without showing the patient the medical report, he contradicted his own view that a doctor ought to make full disclosure of the content and manner of what he intended to publish at the time of consent-taking[243].

316 Finally, turning to the present case, Dr PE admitted that his view was that the Patient had understood that she had given consent to use her photographs in an unanonymised manner[244].

317 Having admitted that he had no authority for his view, having contradicted his own view about what was acceptable in 2008, and having recognised that the Patient had known what she had signed, the Tribunal agrees with Counsel for Dr R that Dr PE's expertise to opine on the present issue is questionable[245].

318 Counsel for the SMC further argued that the patient's right to information is supported by—but not springing from—Guidelines 4.2.4.1 and 4.2.2 of the 2002 ECEG[246]. However, Counsel for the SMC made it clear that it was not their case that this ethical obligation was implied to exist on the basis of these guidelines. These guidelines state:

> 4.2.2 Informed consent
>
> 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…
>
> …
>
> 4.2.4 Patient's right to information and self determination
>
> 4.2.4.1 Right to information
>
> A doctor shall provide adequate information to a patient so that he can make informed choices about his further medical management. A doctor

[242] RCS, [157].
[243] RCS, [159].
[244] Transcript dated 7 March 18, 81:19-82:1.
[245] RCS, [160].
[246] PCS, [331].

> shall provide information to the best of his ability, communicate clearly and in a language that is understood by the patient.
>
> A doctor shall respect a patient's choice of accepting or rejecting advice/ treatment that is offered, after steps have been taken to ensure that there is no language barrier and the patient understands the consequences of his choice. He shall also facilitate a patient obtaining a second opinion if he desires it.
>
> If a doctor wishes to enter a patient into a clinical trial, adequate information must be given to the patient and informed consent must be obtained. The doctor needs to familiarise himself with the relevant sections of the current Guidelines on Good Clinical Practice and inform the patient accordingly before he or she joins the trial.

319 Counsel for the SMC argued that there was good reason to imply that this ethical obligation exists[247]. First, a doctor's use of a patient's photographs for publications or presentations is of no discernable benefit to the patient. In fact, the patient risks a loss of privacy if the information is not anonymised. Second, a patient is in a vulnerable position, because she may feel obliged to provide consent out of a fear that refusal to do so may compromise the quality of care from the doctor, who is also the attending physician.

Expert evidence for Dr R

320 Professor DE1 agreed that a doctor who wanted to use photographs that involved identification of a patient needed to inform the patient of the "exact photographs" to be used. However, if it may not be practical to do so when there is a large number of photographs, Professor DE1 opined that it would be sufficient to show the patient a couple of photographs and tell the patient that those photographs would be the nature of the photographs to be shown[248]. Professor DE1 also agreed that a doctor must obtain explicit consent for "blanket use" if it is not clear at the point of taking consent how the photographs would be used and in which publication or presentation[249]. Having said that, Professor DE1 agreed that if "blanket use" had been obtained, it would be reasonable for the doctor to rely on that instead of obtaining separate consent for each use[250].

321 Professor DE1 also opined that it was the norm to obtain a patient's consent for "blanket use" of unanonymised photographs[251]. Professor DE1 opined that the standards

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[247] PCS, [332].
[248] PCS, [325(a)].
[249] PCS, [325(b)].
[250] PCS, [325(b)].
[251] RCS, [150].

for using patients' data for case reports for academic and educational purposes varied across the world and are still evolving[252]. In 2008, there was no consensus on the standard of written consent for use of photographs and videos for academic purposes, and such consent was usually broad and generic[253]. The standard also depended on the experience of institutions in the particular year, and that he had used a high standard during his time with the Texas Medical Centre, which had been involved in many legal cases[254].

322 Further, Professor DE1 drew on his experience in publishing articles and textbook chapters to explain why the standard advocated by the SMC was impractical and unreasonable in practice. He explained that, as a doctor's manuscript would usually be amended just prior to publication, a doctor would usually be unable to inform a patient at the time of consent-taking of the exact manner and form the information would be presented[255]. Doctors would also require the flexibility to decide on the kind of information to be provided based on the type of presentation to be made. Professor DE1 also explained that the textbook or journal that the doctor's paper may eventually be published in may not even have existed at the time of consent-taking. Further, in an educational setting, where a doctor may wish to show a patient's unanonymised photographs or information to medical students or doctors, Professor DE1 opined that it would be impractical and unreasonable for a doctor to keep seeking the patient's specific consent.

323 Professor DE1 based his opinion on his extensive experience of the practice of the medical community in Singapore—he had personal experience taking consents from patients for use of their photographs and videos for educational, diagnostic and management purposes, and he had published widely locally and internationally[256]. In addition to his experience having 400 peer-review publications, including book chapters, as the immediate past chief editor of the Annals Academy of Medicine, the flagship medical journal in Singapore, he had been in a position to assess the practice in Singapore when he had to review the various types of patient consents submitted by doctors.

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[252] Professor DE1's statement, 1 BSR, Tab 7, at para 13.
[253] Professor DE1's statement, 1 BSR, Tab 7, at para 15.
[254] Transcript dated 24 April 18, 14:4-9.
[255] RCS, [153(a)].
[256] RCS, [154].

324 Although it appeared that Dr DE2 was agreeing with Dr PE's opinion that a doctor ought to provide a patient with information on which unanonymised photographs would be used, as well as how, and which forums they would be used in[257], it became clear that Dr DE2 had based his opinion on his experience with consent-taking for biomedical ethics scenarios. In particular, Dr DE2 explained that his opinion had been based on his experience with the consent-taking guidelines issued by the BAC governing clinical research[258]. As we found above, the Tribunal is unable to agree that those consent-taking guidelines had any applicability in the present case which did not concern human biomedical research.

Our findings

325 In the light of the above, the Tribunal found that Counsel for the SMC and Dr PE were unable to point to any basis for their view, whether in the 2002 ECEG, or drawn from experience in medical practice. Having considered the various experts' evidence, the Tribunal prefers the evidence of Professor DE1, whose opinion was drawn from his extensive personal experience with medical journals, and as a practitioner who regularly took his patients' consent to use their photographs and medical information in publications and presentations. In the circumstances, this Tribunal accepts the evidence of Professor DE1, that, in 2008, it had been accepted as the norm to obtain consent on the basis of "blanket use", and that there had been no need to specify exactly which photographs or medical information would be used, and in which specific publication or presentations[259]. Accordingly, the Tribunal finds that Dr R had not been under a duty to inform the Patient of her right to withdraw or modify her consent, or to inform her of each particular use of her photographs and medical information.

326 In any event, even if we are wrong and such a duty was implied to exist, the Tribunal finds that the Patient had consented to the use of her photographs in the Book Chapter, as we found at [244] above.

[257] PCS, [326].
[258] PCS, [327].
[259] RCS, [150].

(c) Whether Dr R obtained the Patient's consent to use her unanonymised photographs in the Book Chapter

327 Given our finding that the Patient's consent had been validly obtained, and that the Patient had not raised an objection until 22 September 2013, there had been no reason for Dr R to stop using her unanonymised photographs and medical information prior to the time that the Patient raised her objection. As discussed at [325] above, the Tribunal finds that Dr R did not have a duty to inform the Patient of her right to withdraw or modify her consent, or a duty to inform the Patient of each particular use of her photographs. The Tribunal finds that Dr R had obtained the Patient's informed consent to use her unanonymised photographs, and to describe her case in one or more medical or scientific publications and in presentations at medical or scientific conferences, which included use of her unanonymised photographs in the Book Chapter. Accordingly, the Tribunal finds that Dr R had not been in breach of any duty as charged, and had not been guilty of professional misconduct that amounted to serious negligence.

Charge 4 – Whether Dr R failed to obtain informed consent to use the Patient's unrelated medical information in his Book Chapter, and if so, whether it amounted to serious negligence

328 We now turn to Charge 4, which dealt with the use of the Patient's medical information in the Book Chapter, before addressing Charges 3 and 5, which relate to medical presentations.

329 In respect of Charge 4, the parties did not dispute that Dr R had in fact used the Unrelated Medical Information in the Book Chapter[260]. Neither did they dispute that Dr R required the Patient's informed consent to do so. The main issue was whether Dr R had obtained the Patient's consent to use her Unrelated Medical Information in the Book Chapter when she signed a Written Consent permitting him to "describe my case".

Case for the SMC

330 Counsel for the SMC argued that Dr R had not explained to the Patient that he would use the Unrelated Medical Information[261]. Instead, the Patient claimed to have understood him to have been referring to the enlarged parotid glands. She claimed that

[260] PCS, [365].
[261] PCS, [366].

that excluded her past cosmetic procedures and personal feelings regarding the condition and treatment. She also claimed to have stressed to him not to describe her past procedures[262].

331 The Patient further claimed that Dr R had not sought her consent to use the Unrelated Medical Information in the Book Chapter[263].

332 Counsel for the SMC argued that, as a senior plastic surgeon, Dr R would have been aware that his patients who consulted him for cosmetic surgery often did so in confidence, and liked to keep secret the fact of their surgery[264]. In the present case, the Patient's evidence was that she had told him so on 5 January 2008 and on 4 August 2008 of her objection. By Dr R's conduct, Counsel for the SMC argued that Dr R had demonstrated callous indifference to the Patient's interests, and caused harm to the Patient.

Case for Dr R

333 In contrast, Dr R explained that he needed to describe the Patient's medical information, including her past cosmetic procedures, to fully explain her case of enlarged parotid glands to the medical profession. As the exact cause of her condition of enlarged parotid glands was unclear to Dr R, and it remained an open point whether her past cosmetic procedures could have led or contributed to the condition, Dr R gave the history of those procedures to enable other plastic surgeons and aesthetic doctors to draw their own conclusions[265]. Dr R explained that he had been motivated by purely academic, medical and scientific grounds and that he had not intended to embarrass the Patient in any way[266].

334 Dr R's approach found support with Professor DE1, who agreed that, when a patient gave consent for her case to be described, the doctor may describe the entire history of the patient, because that would aid in the understanding of the case[267]. Professor DE1 opined that, in describing the Patient's case and clinical information on the efficacy

262 The Patient's Statement, 1 BSR, Tab 1, p 11, para 34.
263 PCS, [366].
264 PCS, [368].
265 RRS, [94].
266 RRS, [94].
267 Professor DE1's statement, 1 BSR, Tab 7, p 430, para 17.

of Botox on her parotid swellings, Dr R could mention her previous surgeries and complaints.

335 Professor DE1 acknowledged that if there had been no discussion of whether past procedures could be mentioned, the generic consent would have permitted Dr R to discuss the same[268]. While Professor DE1 suggested that a proviso could be added to state that the Patient's previous plastic surgery would be excluded (which Counsel for the SMC sought to rely on), Professor DE1 explained that his suggestion only arose if the Patient had raised concerns about describing her previous surgeries[269]. In the light of our findings that the Patient did not raise the concerns that she claimed, the Tribunal preferred Professor DE1's evidence that the Written Consent was sufficient.

Our findings

336 As discussed above, the Tribunal found that:

(a) On 4 August 2008, the Patient had given her consent to Dr R to describe her case, which included to use the Unrelated Medical Information.

(b) Despite receiving a copy of the Book Chapter in September 2012, the Patient had not objected to Dr R describing the Unrelated Medical Information in the same until her email to Dr R of 22 September 2013.

337 The Tribunal's conclusions relating to Charge 2 above applied equally here. First, Dr R did not have a duty to inform the Patient of her right to withdraw or modify her consent. Even if there is an implied duty to do so, the Patient had demonstrated herself to have been well-informed and capable, and did not require Dr R to discharge that duty mechanically and without regard to what she knew. Second, having obtained the Patient's consent generally, Dr R did not have a duty to obtain the Patient's consent for each particular use.

338 As the Tribunal found that Dr R had obtained the Patient's informed consent to use her unanonymised photographs, and to describe her case in one or more medical or scientific publications and in presentations at medical or scientific conferences at [327]

[268] Transcript dated 24 April 2018, 191:13-192:5.
[269] PCS, [280].

above, that use extended to use of her Unrelated Medical Information in the Book Chapter. Accordingly, the Tribunal finds that Dr R had not been in breach of any duty as charged, and had not been guilty of professional misconduct that amounted to serious negligence.

Charge 3 – Whether Dr R failed to obtain informed consent to use the Patient's unanonymised photographs in at least 2 medical presentations in 2010 and 2013, and if so, whether it amounted to serious negligence

339 The SMC's case is that Charge 3 is proven beyond reasonable doubt on the basis of Dr R's recollection that he probably presented the Patient's case at two presentations, albeit in 2008 and 2009[270].

340 On the other hand, Dr R's case is that Charge 3 must fail for the reason that he did not present the Patient's case in 2010 or 2013 as stated in Charge 3[271]. Even considering the presentations in 2008 and 2009, Counsel for Dr R argued that it had not been proven beyond reasonable doubt that Dr R had in fact presented the Patient's unanonymised photographs.

(a) Whether the Tribunal ought to amend Charge 3

Case for the SMC

341 While Charge 3 referred to medical presentations in 2010 and 2013, Counsel for the SMC failed to establish that Dr R had presented the Patient's case as charged[272]. In fact, Dr R had explained that he could not have presented the Patient's case in the medical conference in South America in 2013, because that conference had been sponsored by the maker of Botox, and he would not have been allowed to speak about using Botox for purposes that it had not been indicated for[273]. As Dr R recalled that he may have featured the Patient's case on 25 September 2008 in Hong Kong and 3 to 7 June 2009 in Las Vegas, Counsel for the SMC argued that this proved that he had therefore used her unanonymised photographs at those presentations instead of those stated in Charge 3[274].

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[270] Transcript dated 20 March 2018, 99:22-100:11; Transcript dated 23 March 2018, 56:5-15.
[271] RCS, [172].
[272] PCS, [93].
[273] RRS, [52].
[274] PCS, [140], [352].

342 Counsel for the SMC argued that it was not necessary to amend the Charge, on the authority of *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745 ("*Gan Keng Seng Eric*")[275]. In that case, the C3J upheld the doctor's suspension from medical practice even though the disciplinary committee had made a finding that had not been in the charge, because the C3J found that the doctor had not been misled in any way as to the case that he had to meet. Accordingly, in the present case, Counsel for the SMC argued that, as the Inquiry Hearing had proceeded on the basis of Dr R's concessions as to the conferences in 2008, 2009 and 2013, Dr R would not have been misled as to the case he had to meet. The Tribunal had the discretion to amend the Charge in its discretion as shown in strikethrough and underlined below, and convict Dr R on the amended Charge[276]:

> ....in at least two medical presentations ~~in 2010 and 2013~~ from 2008 to 2013, thereby resulting in a breach of the Patient's confidentiality and privacy...

Case for Dr R

343 On the other hand, Counsel for Dr R firmly rejected the argument that the Tribunal could amend Charge 3 without causing prejudice to Dr R. Counsel for Dr R also argued that reliance on *Gan Keng Seng Eric* was misplaced. In *Gan Keng Seng*, the doctor faced a charge stating that: "*for the period 6 December 2005 to 8 December 2005, you were in wilful neglect of your duties and had grossly mismanaged the post-operative treatment of the Patient*" (at [10]). That charge went on to state various particulars, but did not particularise his conduct on the night of 6 December 2005.

344 In contrast, in the present case, Charge 3 expressly alleged "at least two medical presentations in 2010 and 2013".

Our findings

345 Having considered the above arguments, Counsel for the SMC's submission to amend Charge 3 stood on different ground from that of the prosecution in *Gan Keng Seng Eric*. In that case, the doctor's conduct on the night of 6 December 2005 had clearly fallen within the dates specified on the charge, even though it had not been particularised. In the

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[275] PCS, [358].
[276] PCS, [357].

present case, the SMC had sought to disregard one of the dates expressly stated in Charge 3 (*ie*, 2010), and to rely on two additional dates (*ie*, 2008 and 2009) that were not even stated in Charge 3, but had arisen only through Dr R's candid estimations during the Inquiry Hearing. The Tribunal does not see it fit to exercise its discretion to amend Charge 3 as the SMC asked.

(b) In any event, whether Charge 3 proven beyond reasonable doubt

346 Even if an amendment of Charge 3 in the terms sought by the SMC was allowed, this Tribunal disagrees that Charge 3 would have been proven beyond reasonable doubt for two main reasons. First, this Tribunal had found at [327] above that the Patient had given her consent to Dr R to use her unanonymised photographs to describe her case in one or more medical or scientific publications and in presentations at medical or scientific conferences. Second, the SMC failed to prove beyond reasonable doubt its assertion as regards the presentations at which Dr R presented the Patient's case.

347 In *Jagatheesan*, VK Rajah J (as he then was), in allowing an appeal against conviction, explained that the prosecution's burden to prove its case beyond reasonable doubt embodies two important social values—the presumption of innocence as a central and fundamental moral assumption in criminal law, and that gravity and weightiness that society equates with punishment (at [58]-[60]). In respect of the presumption of innocence, Rajah J stated as follows (at [59]):

> It cannot be assumed that an individual is guilty by mere dint of the fact that he has been accused of an offence, **unless and until the Prosecution adduces sufficient evidence to displace this presumption of innocence**. That threshold below which society will not condone a conviction or allow for the presumption of innocence to be displaced is the line between reasonable doubt and mere doubt. **Adherence to this presumption also means that the trial judge should not supplement gaps in the Prosecution's case.** If indeed gaps in the evidence should prevail so that the trial judge feels it is necessary to fill them to satisfy himself that the Prosecution's burden of proof has been met, then the accused simply cannot be found legally guilty. In short, the presumption of innocence has not been displaced. [emphasis added]

348 Of the gravity that society connotes with punishment, Rajah J stated (at [60]):

> It would be wrong to visit the indignity and pain of punishment upon a person (and his family) unless and until the Prosecution is able to dispel all reasonable doubts that the evidence (or lack thereof) may throw up. Therefore, it is critical that trial judges appreciate that inasmuch as

> fanciful conspiracy theories, often pleaded by the Defence, will not suffice to establish reasonable doubt, **the Prosecution's theory of guilt must be supportable by reference to the evidence alone and not mere conjecture that seeks to explain away gaps in the evidence.** Suspicion and conjecture can never replace proof. [emphasis added]

349 Rajah J added that reasonable doubt might arise "by virtue of the lack of evidence submitted, when such evidence is necessary to support the Prosecution's theory of guilt" (at [61]). In such cases, Rajah J reminded the court that "it is not so much that the accused should be given the benefit of the doubt as much as the Prosecution's case simply not being proved" (at [61]).

350 Similarly, in *Jayasekara Arachchilage Hemantha Neranjan Gamini v Public Prosecutor* [2011] 3 SLR 689, Steven Chong J (as he then was) affirmed the principles iterated by VK Rajah J in *Jagatheesan* (at [1]), and reminded the prosecution that its burden was not merely on a balance of probabilities (at [2]):

> This case serves as a reminder that the Prosecution's burden of proof cannot be discharged simply by persuading the trial judge to accept that the Prosecution's version of the events is more *probable* than the version offered by the accused without addressing the critical question whether the evidence adduced by the Prosecution has proved the charge beyond reasonable doubt. When this occurs, it may lead to an egregious error in conflating and confusing the crucial difference in the treatment of the burden of proof in a criminal case with that of a civil trial. [emphasis in original]

351 The SMC has to prove the elements of Charge 3 brought against Dr R as it had outlined in its Opening Statement at the start of the Inquiry[277]. However, even at the highest, Counsel for the SMC rested its case entirely on Dr R's recollection of the conferences that he had allegedly presented the Patient's case at[278]. When Dr R confirmed through his former lawyers to the Patient's lawyers that the pictures in the Four Emails represented the slides that he had used, Counsel for the SMC argued that this strongly indicated that Dr R had used her unanonymised photographs in the Four Emails during his presentations[279]. However, Counsel for Dr R was right to argue that, given Dr R's clarification that he would not have used all the Patient's photographs, the precise photographs used, or the precise presentations in 2008 and 2009 could not be proved[280].

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[277] Prosecution's Opening Statement, at para 23.
[278] PCS, [140].
[279] PCS, [143].
[280] RRS, [4], [5].

Our findings

352 The Tribunal found that Dr R had obtained the Patient's consent to use her unanonymised photographs to describe her case in one or more medical or scientific publications and in presentations at medical or scientific conferences. Accordingly, this Tribunal finds that Dr R had not been in breach of any duty as charged, and had not been guilty of professional misconduct that amounted to serious negligence.

Charge 5 – Whether Dr R failed to obtain informed consent to use the Patient's medical information in at least 2 medical presentations in 2010 and 2013, and if so, whether that amounted to serious negligence

353 The SMC's case for Charge 5 faced similar obstacles as those it faced in relation to Charge 3. First, this Tribunal disagrees with Counsel for the SMC's submission that it ought to exercise its discretion to amend Charge 5 to state the dates of the medical presentations. Even if the dates in Charge 5 were amended, this Tribunal had found that Dr R had obtained the Patient's informed consent to use her medical information in accordance with the applicable standard in 2008 at [352] above.

354 The remaining issues to be addressed were whether and when Dr R had presented the Patient's medical information. In these as well, the SMC failed to surmount similar difficulties to those it faced in relation to Charge 3 in relation to discharging its burden of proof.

Case for the SMC

355 Counsel for the SMC provided two reasons in support of its case that Dr R had used the Patient's Unrelated Medical Information in his presentations.

356 First, through a letter by his former lawyers, Dr R confirmed that he had used the 15 photographs in his Four E-mails in his presentations[281]. Given that these photographs included those of the Patient in 2003 and 2004, the SMC argued that it is a logical inference that he had mentioned the Patient's past procedures in the course of his presentations[282]. This is further supported by the fact that the first photograph is captioned "25.10.03 before any ops".

[281] PCS, [143].
[282] PCS, [142].

357 Second, given that Dr R insisted on mentioning the Patient's past cosmetic procedures in his Book Chapter, in order to allow other doctors could come to their own conclusions[283] (at [333] above), it would have been logical to infer that he took the same approach during his presentations.

358 The SMC argued that Dr R's explanation and account should not be believed due to inconsistencies in his evidence[284]. First, it was only during cross-examination that Dr R denied for the first time that he had mentioned presenting the Patient's case at a conference in South America in 2013, even though the Patient had mentioned the same in her Complaint[285]. Second, while Dr R had initially said that he "may not have" referred to the Patient's past cosmetic procedures during his presentations, but later strongly disagreed that he had done so[286].

Case for Dr R

359 On the other hand, Counsel for Dr R's first objection was that the SMC had no evidence that Dr R had presented at medical presentations in 2010 and 2013 as charged, or even in 2008 or 2009. He testified that he would "usually [take] less than 5 minutes" to give an oral description of her case, and would not have time to explain her past procedures[287].

360 Dr R explained that he would have gone into greater detail in the Book Chapter than in a presentation made in a very limited time, where he "would have just shown the big parotid" and "resolved parotid"[288].

361 In any event, Dr R explained that, there was never any discussion with the Patient that, moving forward, these would be the only photographs that he would show. He explained that he had sent her the Four Emails to show her the manner and style in which she would be presented. In any event, Dr R highlighted that the Patient knew that her case was a work in progress.

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[283] PCS, [146].
[284] PCS, [142].
[285] PCS, [166]-[167].
[286] PCS, [141].
[287] PCS, [148].
[288] Transcript dated 23 March 2018, 56:22-25.

Our findings

362 Having considered the above evidence, this Tribunal finds that the SMC had not proved beyond reasonable doubt that Dr R had used "her medical information on her condition of enlarged parotid glands and/or medical information unrelated to her condition of enlarged parotid glands ("Medical Information") in at least two medical presentations in 2010 and 2013".

363 Even if Charge 5 were to be amended in the terms sought by the SMC, this Tribunal finds that the SMC did not prove beyond reasonable doubt that Dr R had used "her medical information on her condition of enlarged parotid glands and/or medical information unrelated to her condition of enlarged parotid glands ("Medical Information") in at least two medical presentations from 2008 to 2013.

364 Accordingly, this Tribunal finds that Dr R had not been in breach of any duty as charged duty, and had not been guilty of professional misconduct that amounted to serious negligence.

Charge 1 – Whether Dr R documented insufficient detail of consent and intentionally departed from applicable standards

365 It is not disputed that the Written Consent comprised the only documentation prepared by Dr R to record that the Patient had given her consent to use her photographs and medical information. The disputed issues were: (a) the applicable standard for documenting a patient's consent for publishing a patient's photographs and information at the material time in 2008, (b) whether Dr R had met that standard, and (c) if he failed to meet that standard, whether he had done so intentionally or deliberately.

(a) Applicable standard of conduct in documenting informed consent for medical publications and presentations

366 The parties disputed whether Guideline 4.1.2 of the 2002 ECEG governed the documentation of informed consent for using a patient's photographs and medical information for medical presentations. Alternatively, Counsel for the SMC argued that there existed an implied ethical obligation to document the same.

Whether Guideline 4.1.2 of the 2002 ECEG governed the applicable standard of conduct

CASE FOR THE SMC

367 Counsel for the SMC first argued that Guideline 4.1.2 of the 2002 ECEG governed the present situation on both a literal and purposive interpretation. Guideline 4.1.2 provides:

> 4.1.2 Medical records
>
> 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 the management of a case. All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented.

368 Counsel for the SMC argued that Guideline 4.1.2 applied on the basis of Guideline 3 of the 2002 ECEG, which states that the principles of the 2002 ECEG are "applicable to a wide variety of circumstances and situations", including to "[k]eep confidential all medical information about patients". In support of this, it was further noted that a restrictive approach towards interpreting the 2002 ECEG had been rejected in the Disciplinary Inquiry for Dr ABU dated 7 March 2011, (at [53] – [61]). In that case, "management plans or remedies" in Guideline 4.1.4 was found to be expansive enough to include treatments offered for prevention and wellbeing, and not just for particular medical conditions.

369 In identifying Guideline 4.1.2 as applying generally in medical ethics, the SMC distinguished medical ethics from publication ethics and research ethics, with the latter two being inapplicable in the present case. In respect of publication ethics, Counsel for the SMC pointed out that Dr PE and Dr DE2 agreed that, as a doctor may be subject to more stringent ethical requirements than a publisher, a publisher's acceptance of the Written Consent was not sufficient evidence that it complied with medical ethics[289]. In respect of research ethics, it was clear that ethical requirements such as those in the BAC's Report on Personal Information in Biomedical Research dated 7 May 2007 ("BAC Report") did not apply to the present case where the Patient had not been a clinical research subject[290].

[289] PCS, [253].
[290] PCS, [260].

370 Turning to the content of the applicable standard, Counsel for the SMC relied on Dr PE's evidence and argued that Dr R had a duty to do the following[291]:

(a) Clearly and accurately define the terms "photos", "describe [the Patient's] case" and "medical/scientific publications"; and

(b) Document:

(i) The contents of any discussions in relation to the Patient's consent that took place between the Patient and him prior to signing the Written Statement on 4 August 2008;

(ii) What the Patient understood from signing the Written Statement;

(iii) The scope and duration of any consent given by the Patient;

(iv) The contents of any discussions in relation to the Patient's consent that took place subsequent to the signing of the Written Statement;

(v) Any changes or modifications to the scope of the Written Statement.

371 Dr PE opined that the present case centred on medical confidentiality, which was enshrined by Guideline 4.2.3.1 of the 2002 ECEG, as follows:

> 4.2.3.1 Responsibility to maintain medical confidentiality
>
> A doctor shall respect the principle of medical confidentiality and not disclose without a patient's consent, information obtained in confidence or in the course of attending to the patient. However, confidentiality is not absolute. It may be over-ridden by legislation, court orders or when the public interest demands disclosure of such information. An example is national disease registries which operate under a strict framework which safeguards medical confidentiality.
>
> There may be other circumstances in which a doctor decides to disclose confidential information without a patient's consent. When he does this, he must be prepared to explain and justify his decision if asked to do so...

372 Further, Dr PE argued that Guideline 4.2.4.1 provided for a patient's right to information, as follows:

> 4.2.4.1 Right to information

[291] PCS, [249].

> A doctor shall provide adequate information to a patient so that he can make informed choices about his further medical management. A doctor shall provide information to the best of his ability, communicate clearly and in a language that is understood by the patient.
>
> A doctor shall respect a patient's choice of accepting or rejecting advice/ treatment that is offered, after steps have been taken to ensure that there is no language barrier and the patient understands the consequences of his choice. He shall also facilitate a patient obtaining a second opinion if he desires it.
>
> If a doctor wishes to enter a patient into a clinical trial, adequate information must be given to the patient and informed consent must be obtained. The doctor needs to familiarise himself with the relevant sections of the current Guidelines on Good Clinical Practice and inform the patient accordingly before he or she joins the trial.

373 In the light of those provisions, Dr PE opined that Guideline 4.2.2 governed the taking of informed consent in the present case:

> 4.2.2 Informed consent
>
> 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…

374 Dr PE argued that, as Guidelines 4.2.2 and 4.2.4.1 of the 2002 ECEG are in the context of providing beneficial treatment to a patient, it logically followed that the present case required a higher standard, because consent was sought for a purpose that is not beneficial to a patient, such as for medical educational purposes[292]. Dr PE's evidence was that this was in line with the teaching standard of the Centre for Medical Ethics and Professionalism[293].

375 Applying these guidelines, Dr PE opined that a doctor "should explicitly inform" the patient of the exact photographs to be used[294]. Where the forum for publishing the photographs has not been established, a doctor "must" inform the patient of the same, and "must obtain explicit consent for the 'blanket use'"[295]. Further, Dr PE opined that a patient "must" be informed that she has the right to withdraw consent at any point of time. In Dr R's case, Dr PE opined that, if the full extent of how Dr R would use the photographs and information had not been agreed upon, Dr R should have obtained informed consent "as

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[292] Dr PE's Report, 1 BSR, Tab 3, at para 17.
[293] Dr PE's Report, 1 BSR, Tab 3, at para 18.
[294] Dr PE's Report, 1 BSR, Tab 3, at para 22.
[295] Dr PE's Report, 1 BSR, Tab 3, at para 23.

proximally as possible" prior to each occasion where he used the same[296]. Dr R should have at least informed the Patient of her right to withdraw consent when he first obtained her consent on 4 August 2008[297]. Dr PE opined that it was possible that Dr R had taken consent in this way, but did not document the same.

376 In cross-examination, Dr PE conceded that his opinion on what a doctor "must" do in connection with obtaining consent was not based on any authority, and only on what he claimed to be general principles[298]. Even so, when Dr PE was given a chance to change his view, Dr PE stood by his view that a doctor "must" (and not only "should") inform a patient that she could withdraw consent based on his ethical duty[299]. At the same time, he had to concede that the standard forms used by hospitals did not contain a provision informing the patient that she could withdraw consent, and that this requirement is nowhere found in the 2002 ECEG or other ethical requirements[300].

CASE FOR DR R

377 Counsel for Dr R urged this Tribunal, on the basis of the totality of evidence, to reconsider their preliminary objection that Charges 1 and 1A were fundamentally defective, because Guideline 4.1.2 only applied in the context of medical care and treatment, and did not regulate a doctor's documentation of a patient's consent for medical publications and presentations.

378 Counsel for Dr R argued that, on a purposive interpretation, the obligation to document informed consent under Guideline 4.1.2 of the 2002 ECEG only relates to consent for the purpose of medical care and treatment[301]. Applying the *ejusdem generis* principle of interpretation, the phrase "informed consent" in that guideline should be interpreted to mean informed consent from a patient for the purpose of medical care and treatment only. No authority was cited to extend the phrase "informed consent" to consent for the use of the patient's photographs and medical information in medical publications and presentations. That it did not so extend, is supported by the subsequent introduction of guidelines on consent-taking for using a patient's photographs in the latest 2016 edition

[296] Dr PE's Report, 1 BSR, Tab 3, at para 27.
[297] Dr PE's Report, 1 BSR, Tab 3, at para 28.
[298] Transcript dated 7 March 2018, 99:12-100:3.
[299] Transcript dated 7 March 2018, 101:19-102:19.
[300] Transcript dated 7 March 2018, 117:25-118:2, 119:22-120:7.
[301] RCS, [177].

of the ECEG. In any event, any doubt as to the proper scope of the phrase "informed consent" under Guideline 4.1.2 should be resolved in favour of Dr R pursuant to the principle against doubtful penalisation, or the principle of strict construction.

379 There was broad agreement among the experts that Guideline 4.1.2, on a plain reading, only applied in a therapeutic context. Dr DE2 opined that "informed consents" in Guideline 4.1.2 related to consent for therapeutic procedures, and not for non-therapeutic matters, because the guideline was concerned with ensuring a "sustained practice" that would allow other clinicians to continue to treat the patient[302]. In fact, Counsel for the SMC accepted Dr DE2's opinion there was no "legal or regulatory requirement on the part of the clinician concerned to document the consent" for publication of a case commentary[303].

380 While Dr PE initially opined in his Supplemental Report 1 that he disagreed with Dr DE2's view of the limited application of Guideline 4.1.2, Dr PE conceded repeatedly during cross-examination that, on applying a "strict reading", Guideline 4.1.2 only applied to medical records in the context of treatment[304]. Dr PE further conceded that Guideline 4.1.2 did not specifically deal with the standard for recording consent for using medical information for educational purposes[305].

381 Dr DE2's opinion that the purpose of documenting informed consent in a patient's medical record was to ensure continuity of care finds support in *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66. In that case, the C3J dismissed the doctor's appeal against a six-month suspension ordered by the disciplinary tribunal in respect of two charges of professional misconduct for failing to obtain informed consent, and for failing to keep clear and accurate medical records, and a third charge for failing to provide professional services of a reasonably expected quality. In respect of Guideline 4.1.2 of the 2002 ECEG, the C3J expressed that the underlying purpose of the guideline was to keep clear and accurate medical records as follows, at [10]:

> It is important that medical professionals properly document the management of patients under their care. Properly kept medical records form the basis of good management of the patient and of sound

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302 RCS, [179].
303 PCS, [267].
304 RCS, [182]-[184].
305 RCS, [182].

> communications pertaining to the care of the patient. By documenting such matters as patients' symptoms, history of illnesses, findings of clinical examinations, relevant investigative data, diagnosis and treatment plans, doctors not only set out the basis upon which they have acted but also ensure that the care of patients can be safely taken over by another doctor should the need arise. In this case, the DT also noted that the need for detailed medical notes was "imperative" because Dr Yong practises in a group practice with several other doctors any of whom might be called upon to take over any given case. There is also a significant public health consideration in that detailed records enable effective reviews of cases where problems have ensued and this helps ensure that remedial or preventive measures can be developed. Dr Yong's scant notes were illegible and there was inadequate documentation in respect of virtually every visit by the Patient. Hence, this too was a serious breach.

382 As regards Counsel for the SMC's argument in favour of a broad interpretation of the 2002 ECEG, Counsel for Dr R pointed out the decision in the Disciplinary Inquiry for Dr ABU dated 7 March 2011 did not stand for a general proposition against a restrictive interpretation of the 2002 ECEG.

383 While Professor DE1 had suggested that it should be documented that (a) the patient had been informed of the right to withdraw consent, (b) the patient's name would not be disclosed by the doctor (a confidentiality clause), and (c) the patient assigned all rights to the doctor to publish the photographs or medical information in any form the doctor deemed necessary, he clarified that this constituted his own personal practice and such details are "not commonly executed or used" in practice in Singapore in 2008[306]. Of the applicable standard in 2008, Professor DE1 opined that "the bar was very low", and it was "widely acceptable" to take a "broad and generic" written consent as sufficient documentation for use of a patient's photographs and medical information for educational and academic purposes[307].

384 Professor Tan DE1 evidence that the Singapore General Hospital used a standard consent form that was similar to the Written Consent, and which stated[308]:

> I, so-and-so, of IC so-and-so have agreed for photographs to be taken for academic and medical purpose

385 Apart from Professor DE1's evidence, Counsel for Dr R also referred to the "typical photographic consent form" set out in the Article at [299] above. Faced with this,

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[306] RCS, [224].
[307] RCS, [216].
[308] RCS, [217].

Dr PE conceded that the Article provided the "minimum standard" that applied in Singapore in 2008. He also had to concede that he could not refer to any authority to contradict the proposition in the Article[309].

Whether there existed an ethical obligation that governed the applicable standard of conduct

386 Putting aside the 2002 ECEG, Counsel for the SMC argued that there nevertheless existed an implied ethical obligation to document informed consent for using photographs and medical information for educational purposes in 2008. On the other hand, Counsel for Dr R argued that, if Guideline 4.1.2 was found not to apply, Charges 1 and 1A should be dismissed in their entirety[310].

CASE FOR THE SMC

387 The SMC argued that an inherent ethical obligation existed in 2008 on the basis of the evidence given by Professor DE1, and Dr PE[311]. Dr PE opined that, in the light of *Eu Kong Weng v Singapore Medical Council* [2011] SGHC 68, case notes should record discussion of treatment options, benefits, risks, complications, questions addressed and other information[312]. The SMC also pointed to Professor DE1's acknowledgement that Dr R would have breached medical ethics if he had failed to reflect the Patient's concerns *if those had been actually expressed*[313].

388 However, Counsel for the SMC clarified that it was not their case that this duty is an inherent obligation in the same sense that the C3J in *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 found that the duty to charge a fair and reasonable fee for services rendered was inherent in all professions[314]. In that case, the C3J stated that while the medical profession occupies "a unique societal position of both great privilege and commensurate responsibility"[315], the obligation to charge a fair and reasonable fee for services rendered is an "inherent one in all professions, and that any express statutory provisions or regulations merely state in explicit terms an obligation

[309] Transcript dated 7 March 2018, 172:21-24; RCS, [223].
[310] RRS, [80].
[311] Transcript dated 12 June 2018, 234:8-235:10.
[312] Dr PE's Statement, 1 BSR, Tab 3, at para 32.
[313] PCS, [278], note 517.
[314] Transcript dated 12 June 2018, 228:2-230:21.
[315] PCS, [272].

which has existed all along" (at [65]). It was on that basis that the C3J went on to find that the 2002 ECEG supported the finding of such an inherent ethical obligation (at [68]).

389 However, Dr PE had to concede that Dr R may have had the relevant discussions with the Patient although they were not documented[316]. Dr PE had to further concede that it is not disputed that the Patient had signed the Written Consent, and that, barring her evidence of posing oral questions and objections to Dr R, the Patient had given blanket consent[317]. Dr PE admitted that the Written Consent would have been sufficient if it had been provided by the Patient "with the full understanding that Dr R was being given permission to use any or all her photographs in an un-anonymised fashion in educational and other material that covered a book chapter and various medical presentations, and that he would do so at any point in the future"[318]. He conceded that the Patient understood the written consent that she signed[319], and that it was "not an unreasonable expectation" that "to describe my case" referred to necessary medical and personal information[320].

CASE FOR DR R

390 Counsel for Dr R argued that, if Guideline 4.1.2 of the 2002 ECEG is found not to apply, Charges 1 and 1A are fundamentally defective and should be dismissed.

391 Counsel for Dr R pointed to Dr DE2 and Dr PE's evidence in cross-examination that there was no ethical duty to reduce a patient's consent for the purposes of publication to writing in 2008.

392 Counsel for Dr R distinguished Counsel for the SMC's reliance on *Gan Keng Seng Eric* (see [342] above). In that case, the doctor appealed against his suspension on the basis that the disciplinary committee's finding that he breached his duties by failing to attend to the patient personally on the night of 6 December 2005 did not fall within the scope of the charge (at [28]). However, the C3J held that the doctor had not been misled in any way as to the case that he had to meet. While that conduct had not been particularised in the charge or its particulars, the doctor's entire conduct relating to caring

[316] Dr PE's Statement, 1 BSR, Tab 3, at para 35.
[317] Transcript dated 7 March 2018, 102:20-103:15.
[318] Dr PE's Statement, 1 BSR, Tab 3, at para 60.
[319] Transcript dated 7 March 2018, 81:19-82:1.
[320] Dr PE's Statement, 1 BSR, Tab 3, at para 45.

for the patient had been put in issue when he was charged with wilful neglect of his duties and gross mismanagement in the post-operative treatment for the entire period of 6 to 8 December 2005 (at [29]).

393 Counsel for Dr R also distinguished the decision in the Disciplinary Committee in the Inquiry for Dr Eric Chong Yu dated 17 August 2012 ("*Dr Eric Chong Yu*"), where the disciplinary committee made a similar finding that the respondent doctors had tackled each and every particular, and were not misled or prejudiced by the case they had to meet. Further, they had been given the opportunity to present evidence after the charges had been amended, and they confirmed that no further evidence would be presented (at [62]). It was in those circumstances that the disciplinary committee concluded that it is sufficient to make out professional misconduct on the part of the respondent doctors when certain and not all particulars of the charges had been proven (at [63]).

394 However, Charge 1 alleges that the duty to document informed consent is premised on Guideline 4.1.2 of the 2002 ECEG, and on no other basis. Moreover, Counsel for the SMC had framed Charge 1 and 1A on the basis of Guideline 4.1.2, and maintained that basis even after Counsel for Dr R had raised a preliminary objection at the start of the Inquiry Hearing. In the result, this Tribunal agrees with Counsel for Dr R that the present situation is distinguishable from the cases concerning *Eric Chong Yu* and *Gan Keng Seng Eric*.

Our findings

395 Having given careful consideration to the experts' evidence, this Tribunal finds that Guideline 4.1.2 did not give rise to a duty for a doctor to record a patient's consent to use photographs or medical information *for medical publications or presentations*.

396 This Tribunal also finds that no inherent ethical obligation arose in the manner in which the C3J had found an obligation to charge a reasonable fee in *Lim Mey Lee Susan*.

397 For completeness, this Tribunal noted the C3J's observations on the sufficiency of doctors' record-keeping in cases concerning taking informed consent for medical treatment. The Tribunal noted that the C3J has remarked in *Leslie Lam* that it did not find the doctor's record-keeping satisfactory, but that he had been charged with failing to take

informed consent, and not with a failure to maintain proper documentation (at [46]). Similarly, in *Low Cze Hong*, the C3J has opined that, while the charge was not for failure to keep proper records, the doctor's lack of proper records did not assist him (at [80]). These observations suggested that the C3J may not have found the doctors' record-keeping sufficient to have met the applicable standard if such charges had been brought. However, in the present case where Dr R had been charged with a failure to sufficiently document taking a patient's consent, this Tribunal has had the benefit of expert evidence to reach its finding that the applicable standard of documenting consent for medical presentations and publications in 2008 was not as the SMC had argued.

(b) Whether Dr R met the standard

398 On the basis of this Tribunal's above finding that the applicable standard of documenting informed consent for using a patient's photographs and medical information for educational purposes in 2008 did not require documentation of the scope of the consent as Counsel for the SMC alleged, this Tribunal finds that Dr R had met the applicable standard of documentation in 2008.

399 Even if documentation was required in 2008, this Tribunal agrees with Counsel for Dr R that Dr R's documentation in the Written Consent satisfies the applicable norms for documentation on a comparison of the guideline in the Article, Professor DE1's evidence of the consent used by Hospital A, and the Written Consent, as follows:

Source	**Year of publication / documentation**	**Wording**
Guidelines for Standard Photography in Plastic Surgery	2001	I, [patient's name], give permission to [doctor's or practice' name] for my picture to be used for teaching, for presentation to other doctors, or for publication.
Hospital A (as per Professor DE1's evidence)	2008	I, so-and-so, of IC so-and-so have agreed for photographs to be taken for academic and medical purpose.
Dr R	2008	I, [the Patient's name], hereby allow Dr R to use my photos in medical/ scientific publications & to describe my case.

400 Importantly, given this Tribunal's finding at [239] above that the Patient had not qualified or modified her consent at any time from 2008 until her e-mail of 22 September 2013, there was no reason for Dr R to have amended the Written Consent.

401 In the present case, given this Tribunal's above finding that Dr R had met the applicable standard of conduct, this Tribunal finds that Dr R had not been in breach of a duty to document the Patient's consent, and had not committed any deliberate or intentional departure from the applicable standard that amounts to professional misconduct.

Charge 1A – Alternatively, whether Dr R documented insufficient detail of consent, and if so, whether it amounted to serious negligence

402 This Tribunal next considers the alternative charge that Dr R's conduct amounted to serious negligence that objectively constituted an abuse of the privileges of being registered as a medical practitioner under the second limb of *Low Cze Hong*.

403 However, this Tribunal finds that this Charge was not made out for the same reasons that Charge 1 was not made out.

(a) First, like Charge 1, Charge 1A was based on a breach of Guideline 4.1.2 of the 2002 ECEG. Having found at [395] above that Guideline 4.1.2 did not apply to obtaining informed consent for use of photographs and medical information for educational purposes, Charge 1A must therefore be dismissed.

(b) Second, in any event, it was also clear to this Tribunal that no ethical obligation to document such informed consent arose in the nature of that found by the C3J in *Lim Mey Lee Susan.*

(c) Third, all three experts did not dispute that the Written Consent met the minimum standard of documentation of consent for the purpose of medical publications and presentations.

404 Counsel for the SMC urged this Tribunal to find that Dr R had taken a cavalier approach to documenting the Patient's consent by failing to document her concerns about

the Handwritten Consent, and by presenting her case despite her objections[321]. However, these crucial facts on which Charge 1A rested have failed to be proven beyond reasonable doubt.

405 In the result, this Tribunal finds that Dr R did not by his conduct demonstrate any serious negligence that would have been caught under Charge 1A.

OBSERVATIONS ON DR R'S AND THE PATIENT'S CREDIBILITY

406 In the Inquiry, the Tribunal made the following observations on the credibility of Dr R and the Patient.

Dr R's credibility

407 Counsel for the SMC challenged Dr R's credibility in respect of his failure to raise various facts in his Written Explanation, and his inconsistent evidence during the Inquiry Hearing.

408 In making our findings of fact, we had discussed above (at [120(a)], [126], [175], [184], [211]), that we were unable to agree with the challenges brought by Counsel for the SMC on the consistency of Dr R's evidence, including on the following challenges:

(a) Dr R varied in his recollections as to whether he had a chaperone present for all cases, including male patients;

(b) Dr R appeared to have moved furniture in his consultation room to make it appear larger in photographs, in response to the Patient's allegation that the room had been too small to accommodate a chaperone;

(c) Dr R varied in his recollections as to whether the Patient's husband had been present in the consultation room with the Patient at all times;

(d) Dr R varied in his recollections as to whether he invoiced and charged patients before treatment; and

[321] PCS, [317].

(e) Dr R varied in his recollections as to the sequence of events on 4 August 2008.

409 These were not significant discrepancies in the light of the *undisputed* facts that the Patient signed the Handwritten Consent, that she received the Four Emails, that she received a copy of the Book Chapter, and that she only objected in writing by her email of 22 September 2013. Accordingly, the Tribunal does not find that the inconsistencies amounted to any significant error in his evidence or any dishonesty that would give reason to discredit his evidence.

The Patient's credibility

410 On the other hand, we are not impressed at all with how the Patient sought to portray herself as an unsophisticated and submissive person who had been oppressed and tricked by Dr R into consenting to the use her photographs and medical information.

411 She tried to explain away her objective inaction over a period of five years by saying that she was very grateful to Dr R for treating her, and that she "felt a mixed sense of obligation and gratitude", and that she felt that she should trust him, because "he is a doctor, which is a highly regarded and respected profession" [322]. However, her management of her own medical affairs demonstrated that she had always been a discerning and prudent patient.

412 Moreover, the Patient's alleged "unreserved trust" in Dr R was inconsistent with her conduct following the occasions that she claimed to have discovered being tricked. The Tribunal took the view that the Patient's portrayal was calculated to explain away her behaviour in taking no action to stop Dr R from using her photographs and information from 2008 to 2013, and her conduct in continuing to consult with Dr R during that period.

413 To make matters worse, the Patient made various allegations on insignificant issues that appeared calculated to taint Dr R's reputation in the eyes of this Tribunal. The Patient denied that she had asked Dr R for a more Caucasian look, and insisted that it was Dr R who had first mentioned her condition of enlarged parotid glands, and insisted that

[322] RRS, [40].

it was Dr R who had first proposed a win-win arrangement. The Patient alleged that Dr R had made a show of sending her the Four Emails in her presence, but that he had not actually done so, even though there is no dispute that she did receive the emails that same day.

414 The Patient also claimed that she attended at Dr R's Clinic on 23 February 2010, 20 March 2010, 8 January 2011, and 26 March 2011, solely to let him photograph her, and that she had been charged and had paid consultation fees on each visit. However, it was hard to believe that she would have repeatedly paid a not insignificant amount of consultation fees if there had in fact been no consultation.

415 Accordingly, this Tribunal found that there had been absolutely no merit in making these spurious allegations against Dr R.

416 In *Leslie Lam*, the patient gave evidence that there had been no discussion with the doctor on the benefits, risks, complications or alternatives of the procedure at all, which was diametrically opposed to the doctor's evidence (at [48]). However, the C3J took cognisance of the fact that the patient had been well-informed, was forthcoming in his discussions with the doctor about his condition, and had undergone a similar procedure previously (at [53]), but sought to portray himself as the "unwitting patient, wholly reliant on his doctor, who had in fact been taken advantage of" (at [51]). When considering the patient's credibility as a whole, the C3J found it improbable that the patient's account was true—that he had undergone the procedure without any discussion with the doctor (at [51]). For completeness, we note that the C3J in *Leslie Lam* took the view that the form that the patient had signed had been documentary evidence that the doctor had discussed the treatment with the patient, and expressed in *obiter dicta* that the charge had not been for failure to document the taking of the patient's consent (*Leslie Lam* at [61]).

417 In a similar vein, in the present case, this Tribunal concludes that the Patient had deliberately crafted an impression of herself as a vulnerable patient who had been taken advantage of by Dr R, which was discovered to be completely at odds with the Patient's highly educated background, her capabilities, and her conduct. In the circumstances, this

Tribunal felt a need to express its strongest condemnation for the Patient's conduct in bringing the Complaint, and in giving her evidence against Dr R.

418 Finally, this Tribunal observes that the Patient's delay in taking action in respect of her allegations subsequently occasioned further delays in instituting and prosecuting these proceedings. The delay in bringing her allegations in respect of matters that happened in a period that was over five to ten years ago made it extremely difficult for Dr R and the witnesses to recollect events. It was fortunate that there remained some documentary evidence that assisted the parties and this Tribunal to shed light on the material events.

OUR DECISION ON THE CHARGES

419 Having carefully considered the evidence and submissions put forward by the parties, this Tribunal finds that all the Charges had not been made out against Dr R, and accordingly, dismiss the Charges against him.

COSTS

420 In *Ang Pek San Lawrence v Singapore Medical Council* [2015] 2 SLR 1179, the C3J observed that its power to order costs in disciplinary proceedings served an important function (at [27]):

> [W]e consider that the power to order costs is an important salutary power for courts and tribunals. The power should be exercised to incentivise appropriate conduct in litigation and, to that extent, to discourage behaviour that impedes the administration of justice. More importantly, it serves as a safeguard against unnecessary financial prejudice being inflicted on a party to the proceedings by the prosecution of unwarranted litigation. This is equally true in the context of disciplinary proceedings instituted pursuant to the MRA.

421 In that case, the C3J dismissed counsel for the SMC's arguments that the SMC ought to be immune from an adverse costs order since the Complaints Committee had initially dismissed the complaint, and the complaint only proceeded upon the Minister's decision to allow the complainant's appeal against dismissal (at [28]).

422 Counsel for the SMC had also submitted that an adverse cost order could not be made against it because the Disciplinary Committee itself was not permitted to make such

an order under the MRA, and that its participation in the appeal and the inquiry was necessitated by the carrying out of its public regulatory function.

423 The C3J found that the Disciplinary Committee had an implied ancillary power under the MRA to order costs against the SMC if it dismissed the charges brought by the SMC (at [30]):

> For all these reasons, we are satisfied that the power of a Disciplinary Committee to order costs against both parties, and not just the medical practitioner alone, is one that is well-founded and serves a useful purpose. Such a power is within the implied ancillary powers of a tribunal such as the Disciplinary Committee and it cannot easily be displaced or limited save by express provision. That power in relation to the making of an adverse cost order against the respondent was certainly not excluded here, and indeed it could not be just because the MRA is silent on the matter. We therefore find that the Disciplinary Committee does have an implied ancillary power under the MRA to order costs against the respondent if it dismisses the charges brought by the respondent.

424 All the more, the principles applied in the present case where the Complaints Committee ordered that an inquiry be held by a disciplinary tribunal, and there was no reason to depart from the trite principle that costs ought to follow the event.

425 In the circumstances, Dr R should be entitled to costs and we so order.

OBSERVATIONS ON CONDUCT OF PATIENT-COMPLAINANT

426 In the light of the findings made above on the Patient's behaviour in bringing her Complaint and in her evidence, this Tribunal makes the following observations.

427 There is a need for a safeguard either in the MRA or in its subsidiary legislation against vexatious and baseless complaints. In the present situation, a complainant faces no consequences in the event that her complaint is dismissed, even if a Disciplinary Tribunal makes an express finding that her complaint was vexatious or completely baseless. In such a situation, by the time that the evidence is before the Disciplinary Tribunal, public resources in the form of the SMC's time and funds would have been spent investigating and prosecuting a complaint. The respondent doctor would also have had to spend a substantial amount of time and money, and suffer anxiety and distress in defending against the charges.

428 Presently, the MRA contains no remedy even if the charges were ultimately dismissed, and even if the complaint was expressly found to have been vexatious or completely baseless. While the MRA provides a procedure for complaints to be investigated, for findings to be reported to the Complaints Committee, and for the Complaints Committee to make findings on whether to convene a formal inquiry or take such other action, the investigator and the Complaints Committee would not have the benefit of all facts and evidence that would subsequently come before a disciplinary tribunal, and be subject to testing in cross-examination. In the circumstances, it would be important that there should be a safeguard against any abuse of the complaints procedure, in order to uphold the authority of the SMC as the governing body that upholds the standards of the medical profession.

429 Moving forward, this Tribunal urges the consideration of giving disciplinary tribunals the power to sanction complainants perhaps by a cost order should the disciplinary tribunal find the complaint to be baseless or the complainant to have acted improperly in bringing a complaint. Having such a mechanism in place would help weed out unmeritorious complaints to the SMC and prevent waste of public resources. It will also help safeguard the reputation of the SMC and the public trust and confidence of the medical profession in society.

PUBLICATION OF DECISION

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

431 The hearing is hereby concluded.

Dr A/Prof Roy Joseph	Dr Wu Dar Ching	Mr Bala Reddy
Chairman		Legal Service Officer

Chia Voon Jiet, Koh Choon Min (Drew & Napier LLC)
for Singapore Medical Council; and

Lek Siang Pheng, Melvin See, Mark Shan, Toh Cher Han
(Dentons Rodyk & Davidson LLP)
for the Respondent.

Annex A – Charges

1ST CHARGE

1. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to maintain clear and accurate medical records of your patient, one Ms P (the "**Patient**"), as would be expected from a reasonable and competent doctor in your position, in that you documented insufficient detail of the Patient's consent given for the use of her photographs and medical information during a consultation on 4 August 2008 and in subsequent consultations from 27 April 2009 to 24 August 2013 in breach of Guideline 4.1.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition):

Particulars

(a) the Patient commenced Botox treatment for her condition of enlarged parotid glands with you on 5 January 2008;

(b) the Patient had a consultation with you on 4 August 2008;

(c) during the consultation on 4 August 2008, the following statement was written and signed in the Patient's medical records ("**Written Statement**"):

"I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(d) the Written Statement and the Patient's medical records did not clearly and/or accurately set out or define the following terms in the Written Statement:

(i) the Patient's "photos";

(ii) "to describe [the Patient's] case"; and

(iii) the "medical /scientific publications";

(e) the following details were not documented in the Patient's medical records:

(i) the contents of any discussions in relation to the Patient's consent that took place between the Patient and you prior to the signing of the Written Statement on 4 August 2008;

(ii) what the Patient understood from signing the Written Statement;

(iii) the scope and duration of any consent given by the Patient;

(iv) the contents of any discussions in relation to the Patient's consent that took place between the Patient and you subsequent to the signing of the Written Statement on 4 August 2008 in relation to the Written Statement; and/or

(v) any changes or modifications to the scope of the Written Statement;

(f) a reasonable and competent doctor in your position would have documented the information stated at paragraphs 1(d) and/or 1(e) above in the Patient's medical records;

and that in relation to the facts alleged, your aforesaid conduct amounts to an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency, and that you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

ALTERNATIVE FIRST CHARGE

1A. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to maintain clear and accurate medical records of your patient, one Ms P (the "**Patient**"), as would be expected from a reasonable and competent doctor in your position, in that you documented insufficient detail of the Patient's consent given for the use of her photographs and medical information during a consultation on 4 August 2008 and in subsequent consultations from 27 April 2009 to 24 August 2013 in breach of Guideline 4.1.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition):

Particulars

(a) the Patient commenced Botox treatment for her condition of enlarged parotid glands with you on 5 January 2008;

(b) the Patient had a consultation with you on 4 August 2008;

(c) during the consultation on 4 August 2008, the following statement was written and signed in the Patient's medical records ("**Written Statement**"):

> "I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(d) the Written Statement and the Patient's medical records did not clearly and/or accurately set out or define the following terms in the Written Statement:

(i) the Patient's "photos";

(ii) "to describe [the Patient's] case"; and

(iii) the "medical /scientific publications";

(e) the following details were not documented in the Patient's medical records:

(i) the contents of any discussions in relation to the Patient's consent that took place between the Patient and you prior to the signing of the Written Statement on 4 August 2008;

(ii) what the Patient understood from signing the Written Statement;

(iii) the scope and duration of any consent given by the Patient;

(iv) the contents of any discussions in relation to the Patient's consent that took place between the Patient and you subsequent to the signing of the Written Statement on 4 August 2008 in relation to the Written Statement; and/or

(v) any changes or modifications to the scope of the Written Statement;

(f) a reasonable and competent doctor in your position would have documented the information stated at paragraphs 1A(d) and/or 1A(e) above in the Patient's medical records;

and that in relation to the facts alleged, 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 you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

SECOND CHARGE

2. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to obtain informed consent from your patient, one Ms P (the "Patient"), from 4 August 2008 to 2011 as would be expected from a reasonable and competent doctor in your position, before using unanonymised full frontal and

side photographs of her face ("Unanonymised Photographs") in your book chapter, R "Facial and Lower Limb Contouring". Botulinum Toxins in Clinical Aesthetic Practice. 2nd ed. Informa UK Ltd, 2011. 206 to 222 ("Book Chapter"), thereby resulting in a breach of the Patient's confidentiality and privacy:

Particulars

(a) on 5 January 2008, the Patient consulted you on the use of Botox to treat her condition of enlarged parotid glands and commenced Botox treatment for her condition of enlarged parotid glands;

(b) from 5 January 2008 to 24 August 2013, you began each treatment consultation with the Patient by taking photographs of her face;

(c) on 4 August 2008, the Patient had a consultation with you, during which:

(i) the Patient requested a set of before and after photographs from you as she experienced visible improvements in her condition, and you provided the Patient with 15 Unanonymised Photographs by way of Four Emails dated 4 August 2008;

(ii) the following signed and written statement was found in the Patient's medical records ("**Written Statement**"):

> "I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(iii) you did not specify the photographs that you intended to use, and the Patient's understanding was that you would consult her and seek her approval once you had selected the photographs to be used;

(iv) you informed the Patient that you would only use her photographs in one particular paper or article, but did not specify the details of the said paper or article;

(v) when the Patient informed you that she was not comfortable with the idea of her photographs being shown in public as she did not want to be identifiable, you assured the Patient that you would either blank out her eyes or show her face from the nose downwards in the photographs; and

(vi) you reassured the Patient that she could "trust" you when she mentioned, amongst others, that the Written Statement did not state that you would blank out her eyes in the

photographs or use photographs that show her face from the nose downwards;

(d) when the Patient learnt that you used the Unanonymised Photographs in a plastic surgery conference during a consultation sometime in mid-2010, she reminded you that she did not consent to you using the Unanonymised Photographs in medical presentations, and that you promised to either blank out her eyes or show the face from the nose downwards before using her photographs;

(e) subsequently, you informed the Patient of your intention to use the Unanonymised Photographs in the Book Chapter during a consultation sometime in or around late-2011, and the Patient reminded you not to use the Unanonymised Photographs;

(f) the following Unanonymised Photographs of the Patient were reproduced at pages 212, 213 and 214 of the Book Chapter:

(i) photograph of the Patient labelled as "Fig 7.7 Case 3: (A) Before parotid enlargement";

(ii) photograph of the Patient labelled as "Fig 7.7 Case 3: (B) After enlargement";

(iii) photograph of the Patient labelled as "Fig 7.7 Case 3: (C) After first onabotulinumtoxinA treatment";

(iv) photograph of the Patient labelled as "Fig 7.7 Case 3: (D) After second onabotulinumtoxinA treatment";

(v) photograph of the Patient labelled as "Fig 7.7 Case 3: (E) After third onabotulinumtoxinA treatment";

(vi) photograph of the Patient labelled as "Fig 7.7 Case 3: (F) January 2010";

(vii) photograph of the Patient labelled as "Fig 7.8 Case 3: (A) Before parotid enlargement";

(viii) photograph of the Patient labelled as "Fig 7.8 Case 3: (B) After enlargement";

(ix) photograph of the Patient labelled as "Fig 7.8 Case 3: (C) After first onabotulinumtoxinA treatment, as seen from below";

(x) photograph of the Patient labelled as "Fig 7.8 Case 3: (D) After second onabotulinumtoxinA treatment";

(xi) photograph of the Patient labelled as "Fig 7.8 Case 3: (E) After third onabotulinumtoxinA treatment";

(xii) photograph of the Patient labelled as "Fig 7.8 Case 3: (F) Parotid January 2010, as seen from below";

(xiii) photograph of the Patient labelled as "Fig 7.9 Case 3: (A) Parotid enlargement";

(xiv) photograph of the Patient labelled as "Fig 7.9 Case 3: (B) After second onabotulinumtoxinA treatment";

(xv) photograph of the Patient labelled as "Fig 7.9 Case 3: (C) After three doses of onabotulinumtoxinA"; and

(xvi) photograph of the Patient labelled as "Fig 7.9 Case 3: (D) January 2010";

(g) you did not blank out the Patient's eyes or show the Patient's face from the nose downwards in the Unanonymised Photographs used in your Book Chapter at pages 212, 213 and 214 listed at paragraph 2(f) above;

(h) you were aware at all relevant times that the Patient did not want the Unanonymised Photographs to be used;

(i) you were also aware at all relevant times that the Patient did not want to be identifiable;

(j) a reasonable and competent doctor in your position would have:

(i) informed the Patient of his intention to use the Unanonymised Photographs in the Book Chapter either at the time of the signing of the Written Statement or in subsequent consultations before such use;

(ii) obtained the Patient's consent to use the Unanonymised Photographs in the Book Chapter;

(iii) informed the Patient of her right to withdraw her consent to use the Unanonymised Photographs in the Book Chapter at any reasonable point; and

(iv) not used the Unanonymised Photographs in the Book Chapter in the event that the said consent was withdrawn;

and that in relation to the facts alleged, 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

you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

THIRD CHARGE

3. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to obtain informed consent from your patient, one Ms P (the "Patient"), from 4 August 2008 to 2013 as would be expected from a reasonable and competent doctor in your position, before using unanonymised full frontal and side photographs of her face ("Unanonymised Photographs") in at least two medical presentations in 2010 and 2013, thereby resulting in a breach of the Patient's confidentiality and privacy:

Particulars

(a) on 5 January 2008, the Patient consulted you on the use of Botox to treat her condition of enlarged parotid glands and commenced Botox treatment for her condition of enlarged parotid glands;

(b) from 5 January 2008 to 24 August 2013, you began each treatment consultation with the Patient by taking photographs of her face;

(c) on 4 August 2008, the Patient had a consultation with you, during which:

(i) the Patient requested a set of before and after photographs from you as she experienced visible improvements in her condition, and you provided the Patient with 15 Unanonymised Photographs by way of Four Emails dated 4 August 2008;

(ii) the following signed and written statement was found in the Patient's medical records ("**Written Statement**"):

> "I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(iii) you did not specify the photographs that you intended to use, and the Patient's understanding was that you would consult her and seek her approval once you had selected the photographs to be used;

(iv) you informed the Patient that you would only use her photographs in one particular paper or article, but did not specify the details of the said paper or article;

(v) when the Patient informed you that she was not comfortable with the idea of her photographs being shown in public as she did not want to be identifiable, you assured the Patient that you would either blank out her eyes or show her face from the nose downwards in the photographs; and

(vi) you reassured the Patient that she could "trust" you when she mentioned, amongst others, that the Written Statement did not state that you would blank out her eyes in the photographs or use photographs that show her face from the nose downwards;

(d) you used the Unanonymised Photographs when you presented the Patient's case at a plastic surgery conference sometime in mid-2010;

(e) when the Patient learnt that you used the Unanonymised Photographs in a plastic surgery conference during a consultation sometime in mid-2010, she reminded you that she did not consent to you using the Unanonymised Photographs in medical presentations, and that you promised to either blank out her eyes or show the face from the nose downwards before using her photographs;

(f) you subsequently informed the Patient of your intention to use the Unanonymised Photographs in in your book chapter, R "Facial and Lower Limb Contouring". *Botulinum Toxins in Clinical Aesthetic Practice*. 2nd ed. Informa UK Ltd, 2011. 206 to 222 during a consultation in sometime in or around late-2011, and the Patient reminded you not to use the Unanonymised Photographs;

(g) you used the Unanonymised Photographs when you presented the Patient's case to medical practitioners and/or other patients during your trip to South America sometime in the second half of 2013;

(h) you did not blank out the Patient's eyes or show the Patient's face from the nose downwards in the Unanonymised Photographs used during the presentations mentioned at paragraphs 3(d) and 3(g) above;

(i) you were aware at all relevant times that the Patient did not want the Unanonymised Photographs to be used;

(j) you were also aware at all relevant times that the Patient did not want to be identifiable;

(k) a reasonable and competent doctor in your position would have:

(i) informed the Patient of his intention to use the Unanonymised Photographs in medical presentations

either at the time of the signing of the Written Statement or in subsequent consultations before such use;

(ii) obtained the Patient's consent to use the Unanonymised Photographs in medical presentations;

(iii) informed the Patient of her right to withdraw her consent to use her Unanonymised Photographs in medical presentations at any reasonable point; and

(iv) not used the Unanonymised Photographs in medical presentations in the event that the said consent was withdrawn;

and that in relation to the facts alleged, 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 you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

FOURTH CHARGE

4. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to obtain informed consent from your patient, one Ms P (the "Patient"), from 4 August 2008 to 2011 as would be expected from a reasonable and competent doctor in your position, before using her medical information that were unrelated to her condition of enlarged parotid glands ("Unrelated Medical Information") in your book chapter, R "Facial and Lower Limb Contouring". Botulinum Toxins in Clinical Aesthetic Practice. 2nd ed. Informa UK Ltd, 2011. 206 to 222 ("Book Chapter"), thereby resulting in a breach of the Patient's confidentiality and privacy:

Particulars

(a) on 5 January 2008, the Patient consulted you on the use of Botox to treat her condition of enlarged parotid glands and commenced Botox treatment for her condition of enlarged parotid glands;

(b) on 4 August 2008, the Patient had a consultation with you, during which:

(i) the following signed and written statement was found in the Patient's medical records ("**Written Statement**"):

"I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(ii) you informed the Patient that you would only use her medical information on her condition of enlarged parotid glands ("**Related Medical Information**") in one particular paper or article, but did not specify the details of the said paper or article;

(iii) you reassured the Patient that she could "trust" you when she mentioned, amongst others, that the Written Statement did not state that you were to only use the Related Medical Information in the said paper or article; and

(iv) there was no discussion between you and the Patient on the use of the Unrelated Medical Information;

(c) you told the Patient during a consultation in sometime in or around late-2011 that you intended to use the Related Medical Information in the Book Chapter;

(d) you used the Unrelated Medical Information in the Book Chapter, namely:

(i) the following sentences and/or part thereof under the section entitled "Case 3" at page 210 of the Book Chapter:

a. "This 38-year-old woman previously had an augmentation rhinoplasty, chin augmentation, blepharoplasty, and correction of prominent ears between the years 2002 and 2004 (Fig. 7.7A)";

b. "she complained of a "fat" face and was puzzled as to why her face looked so broad and "egg-like" when her body remained thin and her weight constant";

c. "Not wishing to undergo any additional surgery…"; and

d. "she felt she looked more normal";

(e) you were aware at all relevant times that the Patient did not want the Unrelated Medical Information to be used;

(f) a reasonable and competent doctor in your position would have:

(i) informed the Patient of his intention to use the Unrelated Medical Information in the Book Chapter either at the time

of the signing of the Written Statement or in subsequent consultations before such use;

(ii) obtained the Patient's consent to use the Unrelated Medical Information in the Book Chapter;

(iii) informed the Patient of her right to withdraw her consent to use the Unrelated Medical Information in the Book Chapter at any reasonable point; and

(iv) not used the Unrelated Medical Information in the Book Chapter in the event that the said consent was withdrawn;

and that in relation to the facts alleged, 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 you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed).

FIFTH CHARGE

5. That you, Dr R, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that whilst practising at the Clinic, you failed to obtain informed consent from your patient, one Ms P (the "Patient"), from 4 August 2008 to 2013 as would be expected from a reasonable and competent doctor in your position, before using her medical information on her condition of enlarged parotid glands and/or medical information unrelated to her condition of enlarged parotid glands ("Medical Information") in at least two medical presentations in 2010 and 2013, thereby resulting in a breach of the Patient's confidentiality and privacy:

Particulars

(a) on 5 January 2008, the Patient consulted you on the use of Botox to treat her condition of enlarged parotid glands and commenced Botox treatment for her condition of enlarged parotid glands;

(b) on 4 August 2008, the Patient had a consultation with you, during which:

(i) the following signed and written statement was found in the Patient's medical records ("**Written Statement**"):

> "I (name of Patient), hereby allow Dr R to use my photos in medical/scientific publications & to describe my case";

(ii) you informed the Patient that you would only use her Medical Information in one particular paper or article, but did not specify the details of the said paper or article; and

(iii) you reassured the Patient that she could "trust" you when she mentioned, amongst others, that the Written Statement did not state that you were to only use the Medical Information in the said paper or article;

(c) you used the Medical Information when you presented the Patient's case at a plastic surgery conference sometime in mid-2010;

(d) when the Patient learnt that you used the Medical Information in a plastic surgery conference during a consultation sometime in mid-2010, she reminded you that she did not consent to you using the Medical Information in medical presentations;

(e) you used the Medical Information when you presented the Patient's case to medical practitioners and/or other patients during your trip to South America sometime in the second half of 2013;

(f) you were aware at all relevant times that the Patient only agreed to the use of the Medical Information in one particular paper or article as stated at paragraph 5(b)(ii) above;

(g) a reasonable and competent doctor in your position would have:

(i) informed the Patient of his intention to use the Medical Information in medical presentations either at the time of the signing of the Written Statement or in subsequent consultations before such use;

(ii) obtained the Patient's consent to use the Medical Information in medical presentations;

(iii) informed the Patient of her right to withdraw her consent to use the Medical Information in medical presentations at any reasonable point; and

(iv) not used the Medical Information in medical presentations in the event that the said consent was withdrawn;

and that in relation to the facts alleged, 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 you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed)."

Annex B - AGREED STATEMENT OF FACTS

A. INTRODUCTION

1. The Respondent, Dr R, is a specialist in plastic surgery with a registration number of MXXXXX. Dr R practises at the Clinic.

2. The Complainant is Ms P, a Singaporean female bearing NRIC No. SXXXXXXXX. Ms P was Dr R's patient and received treatment from Dr R for her condition of enlarged parotid glands ("**Condition**") by way of botulinum toxin (Botox) injections at the Clinic from 5 January 2008 to 24 August 2013 ("**Treatment Period**").

3. By way of a statutory declaration dated 7 April 2014, Ms P filed her complaint against Dr R regarding his alleged use of her confidential medical information (including un-anonymised photographs) in his book chapter R "Facial and Lower Limb Contouring". *Botulinum Toxins in Clinical Aesthetic Practice.* 2nd ed. Informa UK Ltd, 2011. 206 to 222. ("**Book Chapter**") and in two medical presentations without her consent.

4. On 11 December 2014, Dr R provided a written explanation to Ms P's complaint.

B. MS P'S TREATMENT WITH DR R

5. Between 25 October 2003 and 20 November 2004, Ms P consulted Dr R at the Clinic and underwent five cosmetic surgeries and procedures. Dr R took photographs of Ms P's face during these consultations for the purposes of documenting her progress and kept them in her medical records.

6. On 19 December 2007, Ms P consulted Dr R. During this consultation, Ms P learnt from Dr R that her parotid glands were enlarged.

7. On 5 January 2008, Ms P agreed to receive treatment by botulinum toxin injections for the Condition. Ms P received botulinum toxin treatment from Dr R for the Condition at the Clinic on the following 15 occasions over the course of the Treatment Period:

   (a) 5 January 2008;

   (b) 2 February 2008;

   (c) 1 March 2008;

   (d) 29 May 2008;

   (e) 4 August 2008;

   (f) 27 April 2009;

(g) 25 July 2009;

(h) 23 January 2010;

(i) 3 July 2010;

(j) 1 December 2010;

(k) 9 July 2011;

(l) 29 October 2011;

(m) 8 September 2012;

(n) 2 March 2013; and

(o) 24 August 2013.

8. Ms P also consulted Dr R at the Clinic on 23 February 2010, 20 March 2010, 6 August 2010, 8 January 2011 and 26 March 2011 but did not receive botulinum toxin injections from Dr R following the consultation.

C. DR R'S USE OF MS P'S MEDICAL INFORMATION (INCLUDING PHOTOGRAPHS)

9. During the consultation on 4 August 2008, Ms P and Dr R both signed underneath a written statement in Ms P's patient medical records as follows ("**Written Statement**"):
"I (name of Patient) hereby allow Dr R to use my photos in medical/scientific publications and to describe my case."

10. Dr R sent four emails to Ms P dated 4 August 2008 at 10.51am, 10.52am, 10.59am and 11.00am respectively.

11. Sometime in January 2011, Dr R used Ms P's un-anonymised full frontal and side photographs of her face at pages 212 to 214 of the Book Chapter as follows:

(a) photograph labelled as "Fig 7.7 Case 3: (A) Before parotid enlargement";

(b) photograph labelled as "Fig 7.7 Case 3: (B) After enlargement";

(c) photograph labelled as "Fig 7.7 Case 3: (C) After first onabotulinumtoxinA treatment";

(d) photograph labelled as "Fig 7.7 Case 3: (D) After second onabotulinumtoxinA treatment";

(e) photograph labelled as “Fig 7.7 Case 3: (E) After third onabotulinumtoxinA treatment”;

(f) photograph labelled as “Fig 7.7 Case 3: (F) January 2010”;

(g) photograph labelled as “Fig 7.8 Case 3: (A) Before parotid enlargement”;

(h) photograph labelled as “Fig 7.8 Case 3: (B) After enlargement”;

(i) photograph labelled as “Fig 7.8 Case 3: (C) After first onabotulinumtoxinA treatment, as seen from below”;

(j) photograph labelled as “Fig 7.8 Case 3: (D) After second onabotulinumtoxinA treatment”;

(k) photograph labelled as “Fig 7.8 Case 3: (E) After third onabotulinumtoxinA treatment”;

(l) photograph labelled as “Fig 7.8 Case 3: (F) Parotid January 2010, as seen from below”;

(m) photograph labelled as “Fig 7.9 Case 3: (A) Parotid enlargement”;

(n) photograph labelled as “Fig 7.9 Case 3: (B) After second onabotulinumtoxinA treatment”;

(o) photograph labelled as “Fig 7.9 Case 3: (C) After three doses of onabotulinumtoxinA”; and

(p) photograph labelled as “Fig 7.9 Case 3: (D) January 2010”.

12. The photographs of Ms P set out at the paragraph immediately above were photographs taken by Dr R during his consultations with her from 2003 to 2010.

13. In the section entitled “Case 3” at page 210 of the Book Chapter, Dr R also referred to the following medical information obtained from Ms P over the course of his consultations with her from 2003 to 2010:

(a) “This 38-year-old woman previously had an augmentation rhinoplasty, chin augmentation, blepharoplasty, and correction of prominent ears between the years 2002 and 2004 (Fig. 7.7A)”;

(b) “she complained of a “fat” face and was puzzled as to why her face looked so broad and “egg-like” when her body remained thin and her weight constant”;

(c) “Not wishing to undergo any additional surgery…”; and

(d) “she felt she looked more normal”.

D. CESSATION OF USE BY DR R

14. On 22 September 2013, Ms P sent an email to Dr R expressing her "deep unhappiness" with the way he used her medical information in the Book Chapter. Ms P also requested that Dr R "immediately stop any further publication of [her] case, and also immediately cease use of [her] case in [his] presentations or any future articles" and propose how he "intend[ed] to remedy the situation with regards to the article already in the public domain". Ms P further informed Dr R that she would "in due course revert to [Dr R] on [her] proposal for mitigating the current situation".

15. On 24 September 2013, Dr R responded to Ms P by way of a letter to express his surprise at her email. Dr R stated that during the consultation on 4 August 2008, Ms P had allegedly asked to see how her photos would be presented. He allegedly showed her the proposed PowerPoint presentation slides with her full face un-anonymised photographs that he allegedly intended to present at presentations and in any future medical/scientific publications and she was allegedly agreeable. Dr R also stated in his letter that he sent the Powerpoint slides containing the photographs to her in 4 emails. Dr R also explained in his letter that there was no alleged unethical use of her medical information.

16. By way of two letters from Law Firm B to Law Firm A dated 7 and 26 November 2013, Dr R confirmed that there was no further use of Ms P's medical information (including her photographs) following her request of 22 September 2013 and that he would inform his publishers as such but that her revocation of consent does not operate retrospectively.