IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2018] SMCDT 14

Between

Singapore Medical Council

And

Dr Foo Chee Boon Edward

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Professions — Medical profession and practice — Professional conduct — Professional misconduct under Section 53(1)(*d*) of the Medical Registration Act (Cap. 174) — Breach of Guideline 4.1.2 of the 2002 edition of the Singapore Medical Council's Ethical Code and Ethical Guidelines

Professions — Medical profession and practice — Professional conduct — Failure to keep clear and accurate medical records of the patient in respect of procedures performed — Failure to exercise due care in the management of the patient

Professions — Medical profession and practice — Professional conduct — Sentencing — Suspension

Contents

Singapore Medical Council
v
Dr Foo Chee Boon Edward

[2018] SMCDT 14

Disciplinary Tribunal — DT Inquiry No. 14 of 2018
Ms Molly Lim, *SC* (Chairman), Prof Tan Puay Hoon, Prof Tan Thiam Chye, and Prof Ho Khek-Yu Lawrence
4 December 2018

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6 May 2019

GROUNDS OF DECISION OF THE DISCIPLINARY TRIBUNAL

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

The Inquiry

1. This Disciplinary Tribunal ("**DT**") was appointed on 28 February 2018 to inquire into the three charges preferred by the Singapore Medical Council ("**SMC**") against Dr Foo Chee Boon Edward ("**the Respondent**").

2. The Respondent, a general surgeon, has been in practice since 1983, after attaining an MBBS qualification that year. He is also accredited with FRCS (Glasgow) (1989), Diplomate, American Board of Surgery (1995), and obtained recertification (2005).

3. At the material time in 2012, the Respondent, a registered medical practitioner under the Medical Registration Act (Cap. 174) ("**MRA**"), was practising at Hospital A.

4. The three charges preferred against the Respondent were as set out in the amended Notice of Inquiry re-dated 2 July 2018 ("**NOI**"), which was first served on the Respondent on 1 March 2018. A copy of the amended NOI is attached as **Annex 1**. The three charges related to the Respondent's care and management of his patient, one P ("**the Patient**"), who passed away on 4 February 2012 whilst in Hospital A from acute suppurative pericarditis with myocarditis.

5. The Respondent and DW 2 had performed a Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("**THBSO**") and a Lower Anterior Resection ("**LAR**") on the Patient on 31 January 2012 at Hospital A.

The Three Charges

6. As set out in the NOI, the Respondent was charged with having been guilty of professional misconduct under section 53(1)(*d*) of the MRA, in that:

   a) under the re-amended 1st charge – he had failed to keep clear and accurate medical records of the Patient in respect of the THBSO and LAR procedures performed on her on 31 January 2012, in breach of Guideline 4.1.2 of the 2002 edition of the SMC's Ethical Code and Ethical Guidelines ("**2002 ECEG**"), and that such conduct "*amounts to such*

serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner";

b) under the 2nd charge – he had failed to exercise due care in the management of the Patient, in that prior to the THBSO and LAR procedures which he performed on the Patient on 31 January 2012, he had provided inadequate instruction and care to the Patient during the delivery of the bowel preparation by prescribing a dosage of Oral Fleet that was inappropriate and excessive in all the circumstances, thereby exposing the Patient to severe and potentially life-threatening consequences, and that such conduct "*amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner*"; and

c) under the 3rd charge – he had failed to exercise due care in the management of the Patient, in that on 3 February 2012, he had failed to provide appropriate treatment to the Patient in light of her deteriorating condition in the ward, and that such conduct "*amounts to an intentional deliberate departure from standards observed or approved by members of the profession of good repute and competency*",

(collectively, "**the 3 charges**").

Respondent's Response

7. In his response to the 3 charges dated 1 June 2018, the Respondent informed the DT that he would be taking a certain course of action for the 1st charge, but would be claiming trial for the 2nd and 3rd charges.

Pre-Inquiry Conference ("PIC") and Applications

1st PIC on 2 April 2018

8. At the 1st PIC held on 2 April 2018, the following directions, amongst others, were given:

a) in relation to the Respondent's request for discovery of documents referred to by the SMC's four experts in their respective expert reports annexed to the NOI, the Respondent was to write to the SMC for those documents. Should there be a dispute between the parties as to the Respondent's entitlement to those documents, parties were to request an urgent PIC date for the DT to determine the dispute; and

b) timelines for the Respondent's answer or defence to the 3 charges, and hearing dates for the Inquiry.

2nd PIC on 27 April 2018 – Respondent's application for specific discovery

9. On the request of the Respondent, the DT held a 2nd PIC on 27 April 2018 to determine the parties' dispute as to whether the SMC should furnish the documents requested by the Respondent. At the conclusion of the 2nd PIC, the DT gave, amongst others, the following directions:

a) all documents requested for by the Respondent to be disclosed and given by the SMC by 2 May 2018;

b) in response to the Respondent's complaint that the 1st charge lacked particulars, the SMC was to clarify that the relevant time period for the charge was from the first consultation with the Respondent up to the procedures; and

c) various timelines for submission of documents.

3rd PIC on 5 June 2018

10. At the 3rd PIC, various timelines were given for the submission of documents to be used at the hearing commencing on 11 July 2018.

The Documents

11. For the purpose of the Inquiry, the parties had submitted the following documents, which were marked as follows:

a) Agreed Bundles of Documents (Volumes 1 to 3) ("**1AB to 3AB**");

b) Respondent's Bundles of Documents (Volumes 1 to 4) ("**1RBD to 4RBD**");

c) Index of Respondent's Bundles of Documents ("**5RBD**");

d) Agreed Statement of Facts ("**ASOF**");

e) SMC's Opening Statement ("**SMCOS**");

f) Respondent's Opening Statement ("**ROS**");

g) Statement of Evidence-In-Chief of Staff Nurse PW 1 ("**P-1**"); and

h) Various medical articles marked "**P-2**", "**PW-2A**", "**PW-5A**", "**R-1**" to "**R-21**".

The Hearing

12. The Inquiry was heard over two tranches:

a) 1st tranche: 11 to 13, and 19 July 2018; and

b) 2nd tranche: 24 and 31 July 2018.

The Respondent's plea

13. On the first day of the hearing, on 11 July 2018, the Respondent took the stand, during which the re-amended 1st charge was read out to him, and he pleaded guilty to the same. The 2nd and 3rd charges were also read out to the Respondent, and he pleaded not guilty to the same.

14. The ASOF was taken as read, and the Respondent agreed to its contents unconditionally.

15. Since the Respondent had pleaded guilty to the re-amended 1st charge, the DT found him guilty as charged, and deferred its decision on the appropriate sentence to be imposed until after it had made its decision on the 2nd and 3rd charges.

16. The hearing on the 2nd and 3rd charges continued during the rest of the 1st tranche and the 2nd tranche.

Witnesses

17. The witnesses for the SMC were:

    a) Staff Nurse PW 1; and

    b) four expert witnesses, namely:

        (i) PE 1, whose report dated 8 August 2017 was annexed to the NOI dated 1 March 2018 at Annex C (also at 3AB, pp. 244-345);

        (ii) PE 2, whose report dated 17 July 2014 was annexed to the NOI dated 1 March 2018 at Annex A (also at 3AB, pp. 191-194);

        (iii) PE 3, whose report dated 24 July 2014 was annexed to the NOI dated 1 March 2018 at Annex B (also at 3AB, pp. 210-213); and

        (iv) PE 4, whose report dated 4 September 2017 was annexed to the NOI dated 1 March 2018 at Annex D (also at 3AB, pp. 379-398).

18. The witnesses for the Respondent were:

    a) the Respondent (RW 1);

    b) DW 1;

    c) DW 2; and

    d) DE, the Respondent's expert witness, whose report dated 17 May 2018 was at 3AB, pp. 407-463.

19. At the conclusion of the 2nd tranche hearing on 31 July 2018, the DT gave the following directions:

a) parties were to submit their closing submissions by 15 October 2018, reply submissions by 29 October 2018, and mitigation and sentencing submissions by 16 November 2018; and

b) the 3rd tranche of the hearing be fixed on 4 December 2018, during which the DT would deliver its oral decision.

DT's Oral Decision

20. At the hearing on 4 December 2018, the DT informed the parties of its decision on the 3 charges. In respect of:

a) the re-amended 1st charge – as the Respondent had pleaded guilty to this charge, the DT found the Respondent guilty as charged – of professional misconduct under section 53(1)(*d*) of the MRA, in that his conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner;

b) the 2nd charge – the DT found that the 2nd charge had been made out against the Respondent beyond reasonable doubt, and that he was guilty of professional misconduct under section 53(1)(*d*) of the MRA, in that his conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner; and

c) the 3rd charge – the DT found that the 3rd charge had also been made out against the Respondent beyond reasonable doubt, and that he was guilty of professional misconduct under section 53(1)(*d*) of the MRA, in that his conduct amounted to an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

21. As for the sentence to be imposed, the DT made the following orders under section 53(2) of the MRA against the Respondent that:

a) he be suspended for a term of **12 months**, which was half the period of suspension the DT would otherwise have imposed, after taking into account the inordinate delay in the prosecution of the 3 charges against him;

b) he be censured;

c) he gives a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct; and

d) he pays to the SMC 90% of its costs and expenses of and incidental to these proceedings, including the costs of solicitors for the SMC, which costs were to be agreed or taxed.

GROUNDS OF DECISION

Background facts

22. Unless indicated otherwise, the background facts were not disputed. They were taken mainly from the ASOF (i.e. the Agreed Statement of Facts).

The Patient's referral to the Respondent

23. The Respondent first saw the Patient on 18 January 2012. She had been referred to him by DW 2, who was practising at Clinic B at the material time.

24. On 18 January 2012, the Respondent performed a colonoscopy on the Patient, and also ordered a CT abdominal-pelvis scan for her. A rectal biopsy subsequently revealed a large fungating friable tumour causing impending obstruction. The Respondent's diagnosis of the Patient was "*CA rectum, locally large but no evidence of metastasis*".

25. After discussing various treatment options with her, the Respondent discharged the Patient with medication on the same day, with advice for urgent admission to a restructured hospital via ER. The Respondent then informed DW 2 about the

Patient's diagnosis of "*CA Rectum with impending obstructio*n" on 19 January 2012.

26. On 26 January 2012, DW 2 reviewed the Patient's CT scans with her, and noted that the cancer was abutting the uterus, and local invasion could not be excluded. After discussing treatment options with her, DW 2 took the Patient's consent for a "*Total Hysterectomy and Anterior Resection*" in a consent form dated the same day.

27. DW 2 then prepared a memo to Hospital A dated 26 January 2012, admission assessment form, and consent form requesting to admit the Patient for "*Total Hysterectomy and Anterior Resection*". These procedures were to take place on 31 January 2012.

The Patient's admission to Hospital A for the THBSO and LAR procedures

28. On 30 January 2012, the Patient was admitted to Hospital A. Her diagnosis was documented on admission as "*CA rectum – for Anterior Resection & THBSO*". It was also documented that the height of the Patient was 151cm, and her weight was 31.7kg.

Events prior to the THBSO and LAR procedures

29. At around 3.20pm, the Respondent instructed that Oral Fleet be administered to the Patient "*as soon as possible, 45ml stat followed by another 45ml 1 hour later mixed with 300ml fruit juice*". The first dose of Oral Fleet was administered to the Patient at or around 4.50pm, and the second dose of Oral Fleet was administered to the Patient at or around 6.30pm. It was noted at 8pm that the Patient passed motion thrice with large amounts of watery brown stools.

30. At around 11.20pm, the Patient was seen by the Respondent, who noted that the Patient had passed motion four times with watery brown stools. The Respondent then instructed that a third and fourth dose of Oral Fleet were to be given to the Patient at 8am and 9am respectively the next day.

31. On 31 January 2012, the third dose of Oral Fleet was administered to the Patient at around 8am. The Respondent was informed that the Patient complained of chest pains after taking the third dose of Oral Fleet. The Respondent ordered that the fourth dose of Oral Fleet was not to be administered.

32. A renal panel and liver function test carried out at around 9.10am revealed that the Patient had a potassium level of 3.2mmol/L, and an albumin level of 18g/L. The Respondent was informed of these results at around 11.20am, and he ordered intravenous potassium replacement with 20mmol/L of potassium chloride in each pint of Dextrose/Saline solution to be given over six hours to the Patient. The total amount of fluids that the Patient received prior to the THBSO and LAR procedures was 3433ml.

33. The THBSO and LAR procedures started at about 7.45pm, and ended at about 10.45pm. The Respondent and DW 2 were the surgeons in charge of performing the THBSO and LAR procedures, and DW 1 was the anaesthetist. After the THBSO and LAR procedures were completed, the Patient was transferred to the general ward.

Events after the THBSO and LAR procedures

34. On 1 February 2012, the first post-procedure day, the Patient was seen by DW 2 at around 8am, and later in the day at around 3pm by the Respondent. At 10pm, the Patient was noted to be "*stable post-op*".

35. On 2 February 2012, the second post-procedure day, the Patient was seen by the Respondent at around 10am, and DW 2 at around 1.15pm. The Patient complained of epigastric pain when she saw DW 2. DW 2 made a diagnosis of gastritis, and prescribed Gaviscon to the Patient. At 10pm, the Patient was noted to be "*stable post-op*".

36. On 3 February 2012, the third post-procedure day, the Patient's temperature reached 39.1 degrees Celsius at around 3.30am. When the Respondent was informed of this, he instructed that the Patient should be encouraged to take more

sips of water and be given cooling measures. He added that anti-pyretic suppository was not suitable for the Patient.

Questions to consider

37. For this Inquiry, the DT had to consider two main questions:

a) whether the Respondent was guilty of professional misconduct as charged under each of the 3 charges; and

b) if so, what would be the appropriate sentence to be imposed.

Whether the Respondent was guilty as charged under the 3 charges

Re-amended 1st charge

38. Under the re-amended 1st charge, the Respondent was charged with having failed to keep clear and accurate medical records of the Patient in respect of the THSBO and LAR procedures as set out in the NOI.

39. Since the Respondent had pleaded guilty to the re-amended 1st charge, the only question for the DT to decide would be the sentence to be imposed as dealt with in paragraphs 85 to 111 below.

2nd charge

40. The 2nd charge against the Respondent read as follows:

"**SECOND CHARGE**

That you **DR FOO CHEE BOON EDWARD** are charged that whilst practicing as a registered medical practitioner at Hospital A, you failed to exercise due care in the management of your patient, one P ("the Patient"), in that prior to the Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("THBSO") and Lower Anterior Resection ("LAR") procedures which you performed on the Patient on 31 January 2012, you provided inadequate instruction and care to the Patient during the delivery of the bowel preparation, in that you had prescribed a dosage of

Oral Fleet that was inappropriate and excessive in all the circumstances, thereby exposing the Patient to severe and potentially life-threatening consequences.

PARTICULARS

(i) The Patient was admitted to Hospital A on 30 January 2012 at or around 1520 hrs;

(ii) You instructed that Oral Fleet be administered to the Patient "as soon as possible, 45 ml stat followed by another 45 ml 1 hour later mixed with 300 ml fruit juice";

(iii) The first dose of Oral Fleet was administered to the Patient at or around 1650 hrs, and the second dose of Oral Fleet was administered to the Patient at or around 1830 hrs;

(iv) You then instructed a third and fourth dose of Oral Fleet to be given on 31 January 2012 at 0800 hrs and 0900 hrs respectively;

(v) The third dose of Oral Fleet was administered to the Patient at or around 0800 hrs on 31 January 2012, but the fourth dose of Oral Fleet was not administered because the Patient had complained of chest pains at or around 0900 hrs on 31 January 2012;

(vi) A renal panel done at or around 0910 hrs on 31 January 2012 showed that the Patient had hypokalaemia, a common complication of Oral Fleet;

(vii) The administering of 3 dosages of Oral Fleet to the Patient from 30 January 2012 – 31 January 2012 was inappropriate and excessive, in that the recommended dose of Oral Fleet listed in the product insert is 2 doses of 45 ml at least 10 – 12 hours apart; and

(viii) The inappropriate and excessive dosage of Oral Fleet exposed the Patient to severe and potentially life-threatening consequences, including but not limited to severe dehydration as well as electrolyte abnormalities;

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

Respondent's defence

41. The Respondent did not dispute the particulars set out in the 2nd charge at (i) to (vi) namely that:

    a) he had initially ordered for four doses of Oral Fleet to be administered to the Patient; and

    b) of the four ordered doses of Oral Fleet, three were ultimately administered to the Patient. The fourth dose was not administered due to the Patient's complaints of chest pains after the third dose.

42. The Respondent however denied the charge that his prescription and the administration of the three doses of Oral Fleet to the Patient was inappropriate and excessive ("**the Three Doses**"). The Respondent contended that the Three Doses ordered were not inappropriate "*in a hospital setting with close monitoring*",[1] and that there were medical journals which supported the administration of the Three Doses.

SMC's case

43. In support of the 2nd charge, the SMC relied on the evidence of PE 1 and PE 4 as set out below.

44. On the question of whether the instruction and care provided to the Patient during the delivery of the bowel preparation was adequate, PE 1's evidence (as set out in his report dated 8 August 2017) was that:

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[1] See Respondent's Response to the Three Charges dated 1 June 2018 at [5]: 1AB, pp. 44-49 at 48-49.

"9. … The Health Sciences Authority of Singapore (HSA) had in 2009, issued a consumer guide on the use of oral sodium phosphates in view of the concerns of the risks associated with its use. When taken at purgative doses, it can potentially cause serious side effects such as acute phosphate nephropathy and electrolyte imbalance. HSA had also cautioned the use of these products in patients at risk, which included the following:

a. older individuals, especially those over 55 years of age;

b. individuals with a decreased circulating blood volume due to health conditions such as dehydration, congestive heart failure and liver impairment;

c. individuals with kidney impairment, bowel obstruction or active colitis;

d. individuals concurrently taking medications such as diuretics used to remove excessive body fluids, certain blood pressure medications and painkillers that may affect kidney function.

10. The recommended dose of oral fleet enema listed in the product insert for bowel preparation is 2 doses of 45 ml, at least 10-12 hours apart. However, the [Patient] was prescribed and administered 45 ml at 1650hrs on 30 January 2012 and 45 ml at 1830hrs on 30 January 2012. The [P]atient was prescribed another 2 doses of 45 ml to be given on 31 January 2012. However, only the first dose of 45 ml was administered at 0800hrs on 31 January 2012 and the second dose on the 31 January 2012 was cancelled as the [P]atient experienced chest pain after the dose at 0800hrs. This is an excessive dose and is an off-label dosage from the recommendation of the manufacturer."[2]

45. In cross-examination, PE 1 confirmed his evidence as follows:

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[2] See PE 1's report dated 8 August 2017 at [9]-[10]: 3AB, pp. 244-345 at 247-248.

> "Those will be off label use. So the registered indications and the registered doses is only two doses 10 to 12 hours apart. If -- and usually those two doses are more than sufficient to achieve the desired effect. The main reason why it is registered as two doses is because of the worry about the excessive phosphate load and the side effects from fleet, and really if after two doses are given and there's another additional desired effect for cleansing the bowel, then other formulations or other drugs could be considered."[3]

46. PE 1's further evidence was that the Respondent's prescription of four doses (of which three were administered) was already *"above and beyond … the maximum recommendation or the maximum registered dose with HSA, or even with the FDA*".[4] On the consequences of taking an excessive dose of Oral Fleet, PE 1 elaborated that:

> "… because of the patient's small weight and possibility of malnutrition, the electrolyte abnormalities are actually of great concerns. In addition, there is also a much higher risk for the patient to develop acute kidney injury, especially when the patient is already having chronic diarrhoea and this would then increase the risk of more life-threatening electrolyte abnormalities."[5]

47. PE 4 was likewise of the opinion that the dosage of Oral Fleet was inappropriately prescribed by the Respondent. His evidence (as set out in his report dated 4 September 2017) was that:

> "Given that the Patient is a very small size lady with a weight of 31.7kg on admission, coupled with a history of chronic diarrhoea, the latter can commonly result in electrolyte abnormalities like hyponatremia and hypokalaemia, in my opinion the Oral Fleet were inappropriately prescribed by [the Respondent], and the Patient was likely being prescribed and given an excessive doses of Oral Fleet which could have put her in serious fluid and electrolyte abnormalities that could be fatal.

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3 See PE 1's evidence: Notes of Evidence ("**NE**") 11/7/18, p. 71, lines 1-10.
4 See PE 1's evidence: NE 11/7/18, p. 71, lines 16-19.
5 See PE 1's evidence: NE 11/7/18, p. 72, lines 5-11.

> It was fortunate, in my opinion that the 4th dose of Oral Fleet was not served due to the Patient's symptom of chest pain after the 3rd dose."[6]

48. During examination-in-chief, when asked why he thought the Patient was given an excessive dose of Oral Fleet, PE 4's response was:

> "... the patient was given three dosage -- or in fact it was ordered four. So, in the product's ... warning and in the normal practice ... two is ... the maximums for all the patient ... for all we can actually give to our patients. Beyond that, I think there is no safe protocol to see how we monitor the patient. And that also means that they increase the risk of all the complications that associate with the higher dose."[7]

49. In view of the above evidence, which was accepted by the DT, the DT found that:

a) for bowel preparation prior to colonoscopy, the Oral Fleet prescribed should be a maximum of two doses as specified in the product insert;

b) as was PE 1's evidence at paragraph 44 above, the HSA had in 2009 issued an advisory for the public and health professionals, warning about the side effects of Oral Fleet, and cautioning against use in, amongst others, older individuals above 55 years of age, and individuals with a decreased circulating blood volume due to health conditions such as dehydration, congestive heart failure, and liver impairment;

c) dosage beyond the prescribed two doses, such as the Three Doses, would be inappropriate and excessive, and unnecessarily expose the Patient to life-threatening consequences, including acute phosphate nephropathy and electrolyte imbalance; and

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6 See PE 4's report dated 4 September 2017 at [16]: 3AB, pp. 379-398 at 382.
7 See PE 4's evidence: NE 13/7/18, p. 9, line 20 to p. 10, line 3.

d) in view of the Patient's low body weight and undernourished state, the Three Doses increased her risk of developing acute kidney injury and electrolyte disturbances.

50. The DT also found that none of the Respondent's witnesses had challenged the evidence of PE 1 and PE 4 that the recommended dose of Oral Fleet was usually two doses, and that three doses were "*off-label*".

51. DW 1, the anaesthetist who had assisted the Respondent in the THBSO and LAR procedures, admitted that she was aware that the recommended dosage for Oral Fleet was two doses, and she had agreed in cross-examination that three doses were an off-label dose:

> "Q. … Now you are aware that the recommended dose of oral fleet for bowel preparation is two doses, correct?
>
> A. Yes, correct.
>
> Q. So three doses is an off label dose, correct?
>
> A. Yes."[8]

52. In cross-examination, DW 2 had agreed that two doses of Oral Fleet for the Patient's colonoscopy on 18 January 2012 were sufficient:

> "Q. Two doses?
>
> A. Yes.
>
> Q. … And in your view, that was sufficient for this patient?
>
> A. That's right, for the colonoscopy, yes."[9]

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[8] See DW 1's evidence: NE 24/7/18, p. 11, lines 9-13.
[9] See DW 2's evidence: NE 24/7/18, p. 236, lines 12-16.

53. Even DE, the Respondent's expert, agreed that the maximum dosage of Oral Fleet should be two doses. In his expert report dated 17 May 2018, DE had stated that "*the maximum dosage of Oral Fleet which should be administered to a patient is 2 doses of 45ml each*".[10] In his evidence-in-chief, he said that "*I certainly won't give more than two*" and "*in a general case, we don't give more than two doses*",[11] when asked to elaborate on that part of his expert report. In cross-examination, DE also agreed that nothing in the product insert suggested that a patient could be given more than two doses of Oral Fleet.[12]

54. The Respondent had also conceded that he was aware of the recommendation in the product insert that only two doses of Oral Fleet should be given.[13] He was also aware that the dosage that he had ordered for the Patient was excessive:

a) in examination, when asked for the basis of his opinion regarding the appropriate dose of Oral Fleet to be administered, the Respondent had said that "*[he] would have liked not to give [her] three*";[14]

b) in examination, when asked to explain why he had ordered a total of four doses for the Patient, the Respondent had said that "*that would have been a limit, but [he] like not to give four*";[15]

c) in cross-examination, when asked if it was appropriate to order a non-standard dose of three doses of Oral Fleet, the Respondent had admitted that "*it was more than what [he] would usually give*";[16] and

d) when questioned by the DT as to whether he had used the three or four-dose regimen of Oral Fleet for other patients before, the Respondent had

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[10] See DE's report dated 17 May 2018 at [22(viii)]: 3AB, pp. 407-463 at 415.
[11] See DE's evidence: NE 31/7/18, p. 12, lines 2; 7-8.
[12] See DE's evidence: NE 31/7/18, p. 125, lines 22-24.
[13] See Respondent's evidence: NE 19/7/18, p. 249, line 11.
[14] See Respondent's evidence: NE 19/7/18, p. 38, line 3.
[15] See Respondent's evidence: NE 19/7/18, p. 39, lines 6-7.
[16] See Respondent's evidence: NE 19/7/18, p. 242, line 9.

conceded that it had been "*20, 30 years*" since he had done so, and agreed that it was a "*rare deviation*" from his usual regime for patients.[17]

Respondent's case

55. The DT noted that the Respondent's defence was that the Three Doses were not inappropriate as they were administered to the Patient in a hospital setting, where she could be closely monitored in an inpatient setting. The Respondent also contended that there were some medical articles which would support the administration of the Three Doses.

56. On the question of close monitoring, the Respondent's evidence was:

> "Well, the patient is in hospital, so that allows her to be under the eye of some medical personnel at all times, who can report on any adverse events. We can also get some clues of hydration status by just checking her physically as well as seeing how many times she goes to the toilet. And as well as, I guess, checking from blood tests as well."[18]

57. However, PE 1's evidence was that the Respondent had not provided any evidence to substantiate the "*close monitoring*" done on the Patient:

> "In that statement that the three doses, if it's intended as an off label use were ordered in a hospital setting with close monitoring, then I would expect that close monitoring would include not just the patient's vital signs and renal function but electrolytes abnormalities should be closely monitored, especially oral fleet has a high phosphate load and therefore, phosphate levels and calcium levels which will be affected by hyperphosphatemia which is a rise in phosphate levels in the blood, would have to be monitored, but this was not the case as I could not find any such results after the oral fleet was actually administered the next day."[19]

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[17] See Respondent's evidence: NE 19/7/18, p. 257, line 20 to p. 258, line 9.
[18] See Respondent's evidence: NE 19/7/18, p. 34, lines 9-15.
[19] See PE 1's evidence: NE 11/7/18, p. 75, lines 7-19.

58. The DT found that the Respondent did not produce any evidence to show that he had put in place the close monitoring regime. The Respondent was therefore not justified, even in a hospital setting, in exposing the Patient, by reason of the Three Doses, to unnecessary risks.

59. The DT accepted that it was not the case that all product inserts must be "*slavishly followed*"[20] as pointed out by the Respondent. Instead, in certain circumstances, doctors may depart from the product insert and prescribe a different dosage, if and only if, in the doctor's judgment, it would be in the interest of the patient to do so.

60. However, in cases of any departure from the product insert, the burden was on the doctor to justify the said departure. As such, the doctor should ensure that the patient had been so advised of the benefits and risks, and the patient's informed consent should be obtained and documented. In this case, none of that was done.

61. Even the Respondent's expert, DE, opined that, in case of such departure, it was incumbent on the doctor to justify the prescription:

> "… certainly, if a product insert says this, and you choose to do otherwise, you have to explain and justify why you do that…"[21]

No medical literature to support the Three Doses

62. The DT found that, contrary to his defence, the Respondent was unable to produce any medical literature that would support the Three Doses.

63. Instead, the medical literature adduced by the Respondent at the hearing supported the administration of two doses of Oral Fleet:

    a) the article, "*Safety, efficacy, and patient tolerance of a three-dose regimen of orally administered aqueous sodium phosphate for colonic cleansing before colonoscopy*"[22] – in cross-examination, the Respondent had agreed

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[20] See Respondent's Closing Submissions dated 15 October 2018 at [81]-[92].
[21] See DE's evidence: NE 31/7/18, p. 16, lines 11-13.
[22] See 3RBD, p. 220.

that the article showed that the standard treatment for bowel preparation was two doses of Oral Fleet;[23] and

b) the article, "*Bowel preparation for colonoscopy: Comparison of mannitol and sodium phosphate. Results of a prospective randomized study*"[24] – Counsel for the Respondent sought to show that it was not inappropriate to order four doses of Oral Fleet. However, PE 1 pointed out that the study was conducted in 1999, before reports of acute phosphate nephropathy and other serious side effects of electrolyte abnormalities were released.[25]

64. In cross-examination, the Respondent admitted that he had not produced any medical literature to support his position that three to four doses of Oral Fleet could be safely given to a patient.[26]

DT's findings

65. In light of the above evidence, the DT found that the 2nd charge of professional misconduct had been proven against the Respondent beyond reasonable doubt, and that such conduct amounted to "*such serious negligence that it objectively portray[ed] an abuse of the privileges which accompany registration of a medical practitioner*".

66. The Respondent should not have prescribed and administered the Three Doses. In doing so, the Respondent was guilty of "*serious negligence*", and had abused his privileges as medical practitioner, not least because he had disregarded the recommended dosage set out in the product insert and ignored the HSA's advisory of 2009. In so doing, the Respondent had disregarded the risks that the Three Doses would expose the Patient to, and unjustifiably increased those risks in view of the Patient's low body weight and malnourished state. The Respondent was not able to defend his decision in giving the Three Doses.

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[23] See Respondent's evidence: NE 19/7/18, p. 41, line 19 to p. 42, line 2.
[24] See exhibit R-1.
[25] See PE 1's evidence: NE 11/7/18, p. 97, lines 9-12.
[26] See Respondent's evidence: NE 19/7/18, p. 235, lines 1-21.

3rd charge

67. The 3rd charge against the Respondent read as follows:

"**THIRD CHARGE**

That you **DR FOO CHEE BOON EDWARD** are charged that whilst practicing as a registered medical practitioner at Hospital A, you failed to exercise due care in the management of your patient, one P ("the Patient"), in that on 3 February 2012, you failed to provide appropriate treatment in the light of the Patient's deteriorating condition in the ward.

PARTICULARS

(i) On 31 January 2012, you performed Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("THBSO") and Lower Anterior Resection ("LAR") procedures on the Patient;

(ii) On 3 February 2012, being the third post-operative day, the Patient developed a spike of fever in the early morning at or around 0400 hrs;

(iii) The Patient subsequently went on to show the following signs of clinical deterioration throughout the day, including but not limited to the following: recurrent hypotension; persistent hypothermia; persistent tachycardia; decreasing oxygen saturation; development of metabolic acidosis; and worsening shortness of breath;

(iv) Despite these signs of clinical deterioration, you refused at least five (5) suggestions to send the Patient to the Intensive Care Unit ("ICU") or High Dependency Unit ("HDU") for intensive monitoring;

(v) Your refusal to send the Patient to the ICU or HDU was influenced by the Patient's financial situation;

(vi) You knew or ought to have known that these signs of clinical deterioration required the Patient to be sent for intensive monitoring in either the ICU or HDU;

(vii) The Patient subsequently collapsed at 0215 hrs on 4 February 2012 and was pronounced dead at 0445 hrs, and the Patient's cause of death was eventually found to be "Acute Suppurative Pericarditis with Myocarditis"; and

(viii) Had the Patient been sent to either the ICU or HDU for intensive monitoring on 3 February 2012, her condition could have been better managed and she could have received timely treatment such that her chances of survival could have been increased;

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

SMC's case

68. The crux of the SMC's case under the 3rd charge was that on 3 February 2012:

a) which was the third day after her operation, the Patient's condition was deteriorating as she had exhibited signs of clinical deterioration, such as recurrent hypotension, persistent hypothermia, persistent tachycardia, decreasing oxygen saturation, development of metabolic acidosis, and worsening shortness of breath;

b) the Respondent knew or ought to have known that those signs of clinical deterioration required the Patient to be sent for intensive monitoring in either the ICU or HDU;

c) by reason of the said condition, either between the hours of 6pm and 7pm, or at the very latest by 11.50pm, the Respondent should have sent the Patient to either the ICU or HDU for intensive monitoring, but he did not;

d) the Patient subsequently collapsed at 2.15am on 4 February 2012 and was pronounced dead at 4.45am, and the Patient's cause of death was

eventually found to be "Acute Suppurative Pericarditis with Myocarditis"; and

e) had the Patient been sent to either the ICU or HDU for intensive monitoring on 3 February 2012, her condition could have been better managed, and she could have received timely treatment such that her chances of survival could have been increased.

69. In support of its case under the 3rd charge, the SMC relied on the evidence of its four experts, namely PE 1, PE 4, PE 2, and PE 3 (collectively "**the SMC's 4 Experts**") whose evidence were that, amongst others:

a) the undisputed applicable standard was that the Patient, who was indicated for sepsis or septic shock on 3 February 2012, should have been sent to the ICU;

b) the duty to send the Patient to the ICU crystallised between 6pm and 7pm on 3 February 2012, or at the very latest, 11.50pm, because of signs of clinical deterioration such as recurrent hypotension, persistent hypothermia, persistent tachycardia, decreasing oxygen saturation, development of metabolic acidosis, and worsening shortness of breath;

c) notwithstanding at least five requests by different nurses to send the Patient to the ICU, the Respondent had refused to do so; and

d) the Respondent had intentionally and deliberately departed from that standard when he had failed to send the Patient to the ICU.

70. It was the evidence of PE 3 that the basic criteria for ICU admission would be "*when the patient's vital signs are deteriorating and need vital organ support, particularly respirator and inotropic support*".[27]

[27] See PE 3's evidence: NE 12/7/18, p. 174, lines 18-20.

71. As was the evidence of the SMC's 4 Experts, which the Respondent and DE did not dispute in their respective oral testimonies, a patient who showed signs of sepsis or septic shock should be sent to the ICU for closer and more intensive monitoring.

72. PE 1's evidence (as set out in his report) was that:

> "… the [Patient] would have been a candidate for ICU care and monitoring for the following reasons:
>
> a. The possible diagnosis of sepsis and septic shock.
>
> b. The requirement for intensive monitoring. The [Patient] had required monitoring of her parameters on an hourly basis since 1400hrs on the 3 February 2012, with vital signs that were recurrently unstable.
>
> c. The controversial cause for her recurrent hypotension could be ascertained with invasive hemodynamic monitoring in the ICU, where the difference between hypovolemic shock and septic shock could be determined.
>
> d. Aggressive hemodynamic interventions with high volume of fluid resuscitation or inotropic support could be administered with closer monitoring and better expertise in the ICU.
>
> e. Decreasing oxygen saturation and increasing oxygen requirements would allow considerations for ventilatory support, both non-invasive and invasive, to be made in a speedier manner in the ICU."[28]

73. PE 4's evidence (as set out in his report) was that:

> "… it is my opinion that [the Respondent] has failed to provide the appropriate care and management of the Patient on the 3rd Post-op Day

[28] See PE 1's report at [22]: 3AB, pp. 244-345 at 251-252.

and this lead to the premature death of the Patient in the following aspects:

a. Failure to recognise the deteriorating condition of the Patient due to circulatory shock by ignoring the persistent low blood pressure, rapid heart rate and poor urine output

b. Failure to take appropriate and additional investigations to exclude possible serious post-op complications with an early septic workout when the Patient developed high fever

c. Failure to provide appropriate monitoring and treatment by sending the Patient to HDU or ICU for close monitoring, inotropic and ventilator support, other than repeatedly giving intravenous fluid infusion in the General Ward

d. Failure to make the Patient's safety and health his first consideration but rather, was largely concerned with the financial problems of the Patient. Such an irrelevant concern prevailed right from the beginning on admission till the time when the Patient's life was in grave danger".[29]

74. In cross-examination, the Respondent had agreed that the Patient had exhibited signs which would have indicated her for sepsis, which signs if persistent would have indicated her for septic shock, and which would therefore have made her a candidate for admission to the ICU:

"Q. … if MdmP had hypotension, hypothermia, tachycardia, leucocytosis, low urine output, which is oliguria, she would have fulfilled the definition of sepsis, wouldn't she? Or she would be indicated for sepsis, wouldn't she?

…

A. Yes, but you may be taking things out of context.

Q. And if these signs were persistent, then she will be indicated for septic shock, wouldn't she?

[29] See PE 4's report at [54]: 3AB, pp. 379-398 at 390.

...

Now would you agree that for someone who had just undergone a major surgical operation such as THBSO and LAR, and is indicated for sepsis or septic shock, she should be a candidate for ICU admission?

A. If a patient is in septic shock, yes, he will be a candidate for ICU admission.

Q. Right. Even without having gone through a surgical operation, correct?

A. That will be correct.

Q. And all the more if she has just gone through a major surgical operation, correct?

A. If they are in septic shock."[30]

75. In cross-examination, DE had also confirmed that a patient in septic shock should be sent to the ICU:

"... you need to send the patient in shock to ICU. I think there's no question about that..."[31]

"Because if it's sepsis, and you require like PE 4 pointed out, inotropes and so on, so forth, you go to ICU."[32]

76. The SMC thus submitted that the Respondent was aware that the applicable standard of conduct was that a patient who showed signs of sepsis or septic shock needed to be sent to the ICU.

77. As for when the applicable standard crystallised, the SMC's 4 Experts had testified that the Patient should have been sent to the ICU on 3 February 2012,

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[30] See Respondent's evidence: NE 24/7/18, p. 65, line 6 to p. 66, line 3.
[31] See DE's evidence: NE 31/7/18, p. 132, lines 4-5.
[32] See DE's evidence: NE 31/7/18, p. 155, lines 12-14.

and that had she been sent to the ICU, her chances of survival would have increased. The respective evidence of the SMC's 4 Experts as to when the Patient should have been sent to the ICU were as follows:

a) PE 1: "*…probably at after 4.00 pm on 3rd February…*";[33]

b) PE 2: "*… on 3rd February, I would have considered sending the patient down to ICU at 1600 hours…*";[34]

c) PE 3: "*… would definitely transfer the patient to ICU at 1900hrs on 3 Feb 2012*";[35] and

d) PE 4: "*… the definite point that I would send the patients to the high dependency or ICU … is when, at 1800 hours*"[36] on 3 February 2012.

78. All the SMC's 4 Experts had unanimously disagreed with the Respondent and DE's position that the Patient was indicated for ICU admission only on 4 February 2012. PE 1 had said that admitting the Patient to the ICU only on 4 February 2012 would amount to "*trouble-shooting when a problem has already occurred*";[37] PE 2 had completely disagreed with the Respondent and DE's position;[38] PE 3 described admitting the Patient to the ICU on 4 February 2012 as being "*just a premortem actually. It's just another transit before going to mortuary*";[39] and PE 4 had agreed that "*it will actually become quite futile*".[40]

79. The SMC thus submitted that, taking the various timings suggested by its experts, the duty to send the Patient to the ICU crystallised at 6pm to 7pm on 3 February 2012, and at the very latest, 11.50pm. That was because by that time, the Patient's signs of clinical deterioration could no longer be attributed to dehydration; she

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33 See PE 1's evidence: NE 11/7/18, p. 77, lines 14-15.
34 See PE 2's evidence: NE 12/7/18, p. 14, lines 15-16.
35 See PE 3's evidence: NE 12/7/18, p. 111, lines 14-17.
36 See PE 4's evidence: NE 13/7/18, p. 25, lines 6-9.
37 See PE 1's evidence: NE 11/7/18, p. 84, lines 3-4.
38 See PE 2's evidence: NE 12/7/18, p. 17, lines 7-10.
39 See PE 3's evidence: NE 12/7/18, p. 122, lines 16-19.
40 See PE 4's evidence: NE 13/7/18, p. 25, lines 16-17.

had hypothermia, persistent tachycardia, a drop in blood pressure, a decreasing trend in oxygen saturation, extremely low urine output despite significant fluid loading, leucocytosis, a reduced sodium bicarbonate level that was indicative of metabolic acidosis, and a spike in fever in the early morning. The SMC submitted that it would have been clear to any medical practitioner of good standing and repute that she was indicated for sepsis or septic shock, and should therefore be sent to the ICU for intensive monitoring.

Respondent's case

80. The Respondent's position in respect of the 3rd charge was that his post-operative management of the Patient was appropriate, as:

a) it was reasonable to attribute the Patient's hypotension to the inappropriate blood pressure cuff, as her blood pressure appeared to have improved after changing the blood pressure cuff to a paediatric one, and her mental status appeared to be well;

b) it was reasonable to attribute the Patient's poor urine output to dehydration, as her condition seemed to have improved after his fluid treatment; and

c) the Patient did not require ventilatory support, invasive physiologic monitoring, high dose inotropes, or renal replacement therapy, which were indications for ICU care, until 4 February 2012.

SMC's reply

81. The SMC's reply to the Respondent's position in respect of the 3rd charge is summarised as below:

a) the SMC submitted that the Respondent had no justification in ignoring the Patient's recurrent hypotension, which occurred in association with the other objective signs of clinical deterioration, like persistent tachycardia, decreasing oxygen saturation, leucocytosis, a reduced sodium bicarbonate level that was indicative of metabolic acidosis, oliguria, hypothermia, and her spike of fever, preferring instead to go all out in "getting" the Patient's

blood pressure reading back into an acceptable level through the use of a paediatric blood pressure cuff, and to make the medical decision based on his subjective assessment of the Patient's mental alertness. In PE 1's testimony, the Patient's objective signs should take precedence over a doctor's subjective assessment of mental alertness. The Respondent's refusal to consider the cluster of objective signs of clinical deterioration shows a deliberate and intentional departure from the applicable standards;

b) the SMC submitted that production of only 30ml of urine after eight hours of no urine and after receiving 1836ml of IV fluid should have alerted the Respondent that the Patient was suffering from something far more severe than dehydration. PE 1 explained that a patient who was merely in fluid deficit would not demonstrate other clinical signs of deterioration. PE 3 testified that any diagnosis of dehydration past 7pm was indefensible on the facts that, despite being loaded with so much fluid, the Patient's blood pressure showed an even lower reading, and her urine output was minimal. In failing to recognise that the Patient was suffering from something far more serious than dehydration, which any reasonable doctor would have done so, the Respondent intentionally and deliberately departed from the applicable standards; and

c) the SMC submitted that the Respondent's defence essentially rests on the Respondent's subjective view that the Patient did not need to be sent to the ICU because he felt she looked fine. It completely disregarded the objective signs of clinical deterioration, like recurrent hypotension, persistent tachycardia, decreasing oxygen saturation, leucocytosis, a reduced sodium bicarbonate level that was indicative of metabolic acidosis, oliguria, and hypothermia, which the SMC's experts would have relied on to send the Patient to the ICU. PE 3 was able to conclude that the Respondent fell below the applicable standard by not sending the Patient to the ICU by 7pm on 3 February 2012.

DT's findings

82. Based on the above evidence and the documents submitted, the DT noted that:

a) the Patient underwent the THBSO and LAR procedures on 31 January 2012. Her perioperative antibiotics were stopped on 2 February 2012;

b) on 3 February 2012:

(i) the Patient spiked a fever of up to 39.1 degrees Celsius at around 3.30am;

(ii) from 9am onwards, the Patient developed recurrent hypotension, persistent tachycardia, decreasing oxygen saturation, oliguria, with associated leucocytosis/neutrophilia, a reduced sodium bicarbonate level that was indicative of metabolic acidosis, and renal impairment, signs that were indicative of septic shock. The Patient was treated as per dehydration with fluid challenges;

(iii) from 6pm onwards, the Patient's temperature was documented to be 34.1 degrees Celsius, suggesting poor peripheral perfusion, which was another sign of progressive septic shock;

(iv) at 9pm, the Patient's blood pressure was documented to be 59/33 despite the use of a paediatric blood pressure cuff; and

(v) from 11.50pm onwards, the Patient became breathless and restless;

c) on 4 February 2012:

(i) at 2.15am, the Patient developed cardiopulmonary collapse; and

(ii) the Patient succumbed at 4.45am; and

d) the autopsy report showed pus in the pericardium consistent with acute suppurative pericarditis, which was in keeping with the diagnosis of a systemic sepsis.

83. By reason of the above, the DT found that:

a) on 3 February 2012, the Patient had exhibited signs of clinical deterioration such as recurrent hypotension; persistent hypothermia; persistent tachycardia; decreasing oxygen saturation; development of metabolic acidosis; and worsening shortness of breath;

b) by reason of the said clinical signs of deterioration, the Patient should have been sent to the ICU or HDU for intensive monitoring on 3 February 2012 at any time from 6pm to 11.50pm;

c) the signs of clinical deterioration suggested that the Patient was suffering from septic shock, which required intensive monitoring not available in a general ward;

d) the Respondent had failed or refused to send the Patient to the ICU or HDU, as he had wrongly judged the Patient to be suffering from dehydration, and continued to treat her for such condition in the ward;

e) the Respondent's diagnosis was wrong as per the evidence of SMC's 4 Experts as, based on the clinical signs exhibited by the Patient, she was undoubtedly suffering from septic shock;

f) by 4 February 2012, it was too late to send the Patient to the ICU, as at 2.15am on 4 February 2012, the Patient collapsed, and eventually died; and

g) had the Patient been sent to the ICU earlier on 3 February 2012, her condition could have been better managed, and she could have received timely treatment, and her chances of survival could have been increased.

84. In light of the above, the DT found that the 3rd charge of professional misconduct had been proven against the Respondent beyond reasonable doubt, and that such

conduct amounted to "*an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency*".

The appropriate sentence to be imposed

85. In considering the appropriate sentence to be imposed for the 3 charges, the DT has had regard to the sentencing principles as set out by the Court of Three Judges ("**C3J**") in ***Wong Meng Hang v Singapore Medical Council and other matters*** [2018] SGHC 253 ("**Wong's case**") at [23], [26], and [28].

86. Briefly, an appropriate sentence would be one which had taken into account, amongst other factors, the interests of the public in ensuring that the sentence imposed would "*uphold the standing and reputation of the [medical] profession, as well as to prevent an erosion of public confidence in the trustworthiness and competence of its members*", and which would serve as a general or specific deterrence.

87. Applying these principles, the DT was unable to accept the Respondent's sentencing submissions that only a fine be imposed on the Respondent for each of the 3 charges, as such fines would be woefully inadequate, and would not address the public interests or deterrence considerations.

88. Instead, having regard to the serious misconduct involved, the public interests and deterrence considerations, the DT was of the view that the minimum sentence would involve a period of suspension.

Under the re-amended 1st charge

89. Under the re-amended 1st charge, the Respondent was found guilty of having breached Guideline 4.1.2 of the 2002 ECEG, as he had failed to fully document discussion of treatment options and informed consent from the Patient in respect of the procedures. Guideline 4.1.2 of the 2002 ECEG provides that:

> "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."

("**Obligation to Document**").

90. It was common ground between the parties that all discussion of treatment options, informed consents, and treatment by drugs or procedures should be documented as provided for in Guideline 4.1.2 of the SMC's 2002 ECEG.

91. In ***In the Matter of Dr Chew Yew Meng Victor*** [2017] SMC DT 3,[41] the DT had (at [41]) taken the view that "*the failure to keep proper medical records cannot be seen as a minor or technical breach*".

92. For any surgery, proper counselling, advice, and consent taking are critical. It allows the patient to understand the process, risks, and alternatives, and to make an informed decision. Consent is an important process in the doctor-patient relationship to guide the patient to make an informed and right decision for herself. This builds trust and rapport in the doctor-patient relationship.

93. The Respondent first saw the Patient on 18 January 2012. From the first consultation, inpatient admission, and up till the surgery, the Respondent did not document the surgical risks and possible complications of the THBSO and LAR procedures, such as infection, sepsis, or the rare but serious mortality risk explained to the Patient. This was disconcerting, as the Patient was a high-risk patient due to her underweight status. The Respondent's failure to comply with his Obligation to Document was a serious breach.

94. In ***Yong Thiam Look Peter v Singapore Medical Council*** [2017] 4 SLR 66,[42] the C3J held (at [10]) that proper medical records "*form the basis of good*

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[41] See SMC's Bundle of Authorities ("**BOA**") dated 16 November 2018 at Tab 3.
[42] See SMC's BOA dated 16 November 2018 at Tab 6.

management of the patient and of sound communications pertaining to the care of the patient. By documenting such matters … 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. … There is also 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. … Hence, this too was a serious breach."

95. In view of the importance of requiring and ensuring that doctors comply with the Obligation to Document, and the fact that in recent cases there were many similar incidents of doctors having failed in their Obligation to Document, as a matter of public interest, and to serve as a general and specific deterrence against such failures in future, the sentence for a breach of the Obligation to Document should attract a suspension order and not a fine in lieu.

96. A suspension order should be similarly imposed for the Respondent's professional misconduct under the 2nd and the 3rd charges, as those misconduct were equally if not more serious than the professional misconduct under the re-amended 1st charge.

Why global net period of 12 months' suspension would be appropriate

97. Whilst the DT was of the view that a suspension order should be imposed, the DT was not able to agree with the SMC's sentencing submission that the suspension should be for three years for the 3 charges on a global basis. A three-year suspension was unduly harsh, and was unwarranted when compared to Wong's case, and the case of ***Singapore Medical Council v Kwan Kah Yee*** [2015] 5 SLR 201[43] ("**Kwan's case**").

98. In Wong's case, the DT had sentenced him to an 18-month suspension. The SMC had appealed against that sentence and asked for a three-year suspension. On appeal, the C3J ordered that Wong be struck off the register.

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[43] See SMC's BOA dated 16 November 2018 at Tab 5.

99. In Wong's case, the C3J had stated that that case was the "*most egregious cases of medical misconduct we have come across*". Wong and another doctor had administered a potent sedative to the patient during a liposuction procedure, despite not having had the necessary training or expertise to do so. They then failed to adequately monitor the patient during and after the procedure. That led to the patient's death. When they arranged for an ambulance to send the patient to the accident and emergency department, he was found to be without a pulse, and Wong made a false statement that the patient was given Pethidine, a pain medication, and local anaesthesia but not sedation.

100. In Kwan's case, Kwan was charged with two counts of improperly certifying the death of his patients and was sentenced to three months' suspension on each charge, to run concurrently. On appeal, the C3J sentenced Kwan to 18 months' suspension on each charge, to run consecutively, for a total of 36 months. The C3J held that the offences were grave:

> "(4) The improper issuance of a medical certificate based on non-existent medical records went against the very essence of professional medical standards and constituted a serious breach of the Applicant's 'Ethical Code and Ethical Guidelines'. This was seriously aggravated if the doctor fabricated records to justify the improper certification. This element of dishonesty was scarcely accounted for by the DT when it held that dishonesty led to the crossing of the threshold from a mere censure or fine to a suspension. It was wrong in principle and also wholly out of line with the approach taken with regards to dishonest lawyers: at [49]."

101. The DT was of the view that the Respondent's misconduct was not as egregious as that in Wong's case or in Kwan's case, such that it warranted a three-year suspension. Unlike in Wong's and Kwan's case, where both doctors were also found to be dishonest, there was no dishonesty involved in the Respondent's case. Also, unlike in Wong's case, the Respondent had conducted the THBSO and LAR procedures which were well within his competence. The Patient did not die as a result of the surgery.

102. Instead, the DT found that the Respondent's case was similar to the case of ***Gan Keng Seng Eric v Singapore Medical Council*** [2011] 1 SLR 745 ("**Eric Gan's case**") which was cited in Wong's case at [83]. The CJ had pointed out that, in Eric Gan's case, the patient had succumbed to a known complication of surgery: "*The surgeon did not cause the complication by his misconduct. Instead, the misconduct arose from the surgeon's failure to discover that the complication had set in.*"

103. Like in Eric Gan's case, the Patient did not die from the surgery, but septic shock, a known complication of surgery. The Respondent did not cause the complication by his misconduct. Instead, his misconduct arose from his failure to recognise that the Patient was suffering from septic shock.

104. In Eric Gan's case, he was suspended for a period of six months, and not the maximum of three years as allowed under the MRA. The DT was also of the view that, like Eric Gan's case, the period of suspension for the Respondent (after taking into account various factors) should not be for the maximum period of three years.

105. Applying the culpability/harm analysis as set out in Wong's case to determine the period of suspension, the DT was of the view that, as shown in the table below, having regard to the level of the Respondent's culpability and the harm caused, the Respondent should be suspended for a period of 24 months. The suspension period should be discounted by 50% and reduced to 12 months to take into account the inordinate delay by the SMC in prosecuting the Respondent.

Charge	**Culpability**	**Harm**	**Recommended sentencing guideline**	**DT's Decision**
1st charge	Medium	Slight	Suspension of 3 months to 1 year	Suspension of 6 months

2nd charge	Medium	Slight	Suspension of 3 months to 1 year	Suspension of 6 months
3rd charge	Medium	Moderate	Suspension of 1 to 2 years	Suspension of 12 months
			Total sentence	Suspension of 24 months
			After discount (Taking into account inordinate delay)	**Suspension of 12 months**

Delay in SMC's institution of the proceedings against the Respondent

106. In Wong's case, the C3J had also stated (at [26]):

> "Finally, considerations of fairness to the offender may, in appropriate cases, warrant the imposition of a lighter sentence. In cases such as Ang Peng Tiam where there had been inordinate delay in the SMC's prosecution of the disciplinary proceedings, we applied a sentencing discount in recognition of the prejudice that had been unfairly suffered by the offending doctor in the form of the mental anguish and anxiety that was caused by the pendency of the charge over a prolonged period of time. At the same time, we have previously emphasised that such considerations of fairness may be outweighed or even rendered substantially irrelevant by countervailing concerns in the public interest, especially in cases where the offence in question is particularly heinous: Ang Peng Tiam at [118]. Therefore, where important public interest considerations demand the imposition of a heavier penalty, the existence of prejudicial delay in the proceedings may have no mitigating effect at all in the sentencing of the offender."

107. The DT was of the view that there was inordinate delay in the SMC's prosecution of the 3 charges against the Respondent, which delay was not attributable to the Respondent:

a) on 17 April 2014, the Respondent was informed of the complaint against him, and he submitted his written explanation on 3 July 2014;

b) on 23 March 2015, the Respondent was notified that an inquiry would be held against him;

c) in September 2015, the SMC engaged legal counsel to act for them in the Inquiry. No reason was given as to why it took SMC about six months to do so. This was especially when the SMC had already engaged the services of PE 2 and PE 3 as their experts, and each had earlier furnished his expert report on 17 and 24 July 2014 respectively;

d) between September 2015 and September 2017 – the SMC had stated that it took a period of two years to contact another two experts, namely PE 1 and PE 4. However, PE 1's expert report dated 8 August 2017 stated that the SMC's solicitors had only written to him for such a report by their letter dated 26 May 2017;

e) no explanation was given as to why the SMC had to take up to two years to secure the services of PE 1 and PE 4; and

f) the net effect was that there was a delay of almost four years in the SMC's prosecution of the 3 charges against the Respondent.

108. In light of the mental anguish, anxiety, and distress suffered by the Respondent in having the charges hanging over his head during the period of delay, the DT was of the view that, in fairness to the Respondent, his period of suspension should be discounted by 50% (i.e. from 24 months to 12 months).

109. It was for this reason, and to avoid further sufferings by the Respondent, that the DT had decided at the 2nd PIC held on 27 April 2018 that it would first give its oral decision on the 3 charges after the parties' submissions. In this way, the Respondent would be able to know the outcome of the 3 charges sooner, rather

than having to await the DT's written grounds of decision which would usually take weeks to prepare.

110. The DT was also of the view that the net suspension period of 12 months would be more than sufficient to ensure that the objectives of sentencing were met (i.e. the public interests and deterrence considerations).

111. In the circumstances, the DT ordered that the Respondent be suspended from practice for 12 months, be censured, and that he gives a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct.

Order on costs

112. The DT ordered the Respondent to pay to the SMC 90% of its costs and expenses of and incidental to these proceedings, including the costs of solicitors for the SMC, which costs were to be agreed or taxed.

113. The DT had discounted 10% of the SMC's costs to take into account its unsuccessful objection to the Respondent's application for discovery. Those documents should have been provided without the need for a discovery application by the Respondent and a hearing of that application before the DT.

114. The DT should point out that it was only fair and right that the documents relied on by the SMC's experts in their respective reports should be made available to the Respondent to enable him and/or his experts to prepare his case in answer to the charges. Such discovery did not and would not have prejudiced the SMC, as those experts who would be giving evidence in support of the SMC's case for the 3 charges had already completed their respective reports in support of the charges, and would expect to be cross-examined or challenged on those documents.

Publication of Decision

115. The DT orders that the grounds of decision be published with the necessary redaction of identities and personal particulars of persons involved.

116. The Inquiry is hereby concluded.

Ms Molly Lim, *SC* — Chairman

Prof Tan Puay Hoon

Prof Tan Thiam Chye

Prof Ho Khek-Yu Lawrence

Mr Philip Fong and Mr Sui Yi Siong (M/s Eversheds Harry Elias LLP)
for Singapore Medical Council; and
Mr Charles Lin and Mr Gan Guo Wei (M/s Charles Lin LLC)
for the Respondent.

ANNEX 1

MEDICAL REGISTRATION ACT (CAP. 174)
MEDICAL REGISTRATION REGULATIONS 2010
REGULATION 27

NOTICE OF INQUIRY BY DISCIPLINARY TRIBUNAL

Re-Re-Dated: ~~1 March 2018~~ ~~9 May 2018~~ 2 July 2018

To : Dr Foo Chee Boon Edward

Dear Sir,

Notice is hereby given to you that in consequence of information received by the Singapore Medical Council, an Inquiry is to be held by the Disciplinary Tribunal into the following charges against you:

(RE-AMENDED) FIRST CHARGE

1. That you **DR FOO CHEE BOON EDWARD** are charged that whilst practicing as a registered medical practitioner at Hospital A), you failed to keep clear and accurate medical records of one P ("the Patient") in respect of the Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("THBSO") and Lower Anterior Resection ("LAR") procedures performed on her on 31 January 2012, in breach of Guideline 4.1.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines 2002 edition ("2002 ECEG"), to wit:-

PARTICULARS

(i) You first saw the Patient on 18 January 2012, and you thereafter performed the THBSO and LAR procedures on her on 31 January 2012;

(ii) From the time you first saw the Patient on 18 January 2012 to the time you performed the THBSO and LAR procedures on her on 31 January 2012, you

failed to fully document ~~any~~ discussion of treatment options and informed consent from the Patient in respect of the ~~THBSO and LAR~~ procedures, in that:-

(a) You did not document advising the Patient of the material risks and possible complications of the THBSO and LAR procedures, including but not limited to the possibility of anastomosis dehiscence and permanent stoma;

(b) You did not document advising the Patient of the added risks associated with operating on an underweight patient;

~~(c) You did not document informing the Patient of any alternatives to the THBSO and LAR procedures, such as non-surgical means to mitigate the risks of obstruction~~;

(c)~~(d)~~ You did not document the Patient's consent to undergo the THBSO and LAR procedures; and

(iii) All discussion of treatment options, informed consents and treatment by drugs or procedures should be documented pursuant to Guideline 4.1.2 of the 2002 ECEG;

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

SECOND CHARGE

2. That you **DR FOO CHEE BOON EDWARD** are charged that whilst practicing as a registered medical practitioner at Hospital A, you failed to exercise due care in the management of your patient, one P ("the Patient"), in that prior to the Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("THBSO") and Lower Anterior Resection ("LAR") procedures which you performed on the Patient on 31 January 2012, you provided inadequate instruction and care to the Patient during the delivery of the bowel preparation, in that you had prescribed a dosage of Oral Fleet that was inappropriate and excessive in all

the circumstances, thereby exposing the Patient to severe and potentially life-threatening consequences.

PARTICULARS

(i) The Patient was admitted to A I on 30 January 2012 at or around 1520 hrs;

(ii) You instructed that Oral Fleet be administered to the Patient "as soon as possible, 45 ml stat followed by another 45 ml 1 hour later mixed with 300 ml fruit juice";

(iii) The first dose of Oral Fleet was administered to the Patient at or around 1650 hrs, and the second dose of Oral Fleet was administered to the Patient and at or around 1830 hrs;

(iv) You then instructed a third and fourth dose of Oral Fleet to be given on 31 January 2012 at 0800 hrs and 0900 hrs respectively;

(v) The third dose of Oral Fleet was administered to the Patient at or around 0800 hrs on 31 January 2012, but the fourth dose of Oral Fleet was not administered because the Patient had complained of chest pains at or around 0900 hrs on 31 January 2012;

(vi) A renal panel done at 0910 at or around 0910 hrs on 31 January 2012 showed that the Patient had hypokalaemia, a common complication of Oral Fleet;

(vii) The administering of 3 dosages of Oral Fleet to the Patient from 30 January 2012 – 31 January 2012 was inappropriate and excessive, in that the recommended dose of Oral Fleet listed in the product insert is 2 doses of 45 ml at least 10 – 12 hours apart; and

(viii) The inappropriate and excessive dosage of Oral Fleet exposed the Patient to severe and potentially life-threatening consequences, including but not limited to severe dehydration as well as electrolyte abnormalities;

and that in relation to the facts alleged you have been guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174), in that your aforesaid

conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

THIRD CHARGE

3. That you **DR FOO CHEE BOON EDWARD** are charged that whilst practicing as a registered medical practitioner at Hospital A , you failed to exercise due care in the management of your patient, one P ("the Patient"), in that on 3 February 2012, you failed to provide appropriate treatment in the light of the Patient's deteriorating condition in the ward.

PARTICULARS

(i) On 31 January 2012, you performed Total Abdominal Hysterectomy with Bilateral Salpingo-oophorectomy ("THBSO") and Lower Anterior Resection ("LAR") procedures on the Patient;

(ii) On 3 February 2012, being the third post-operative day, the Patient developed at spike of fever in the early morning at or around 0400 hrs;

(iii) The Patient subsequently went on to show the following signs of clinical deterioration throughout the day, including but not limited to the following: recurrent hypotension; persistent hypothermia; persistent tachycardia; decreasing oxygen saturation; development of metabolic acidosis; and worsening shortness of breath;

(iv) Despite these signs of clinical deterioration, you refused at least five (5) suggestions to send the Patient to the Intensive Care Unit ("ICU") or High Dependency Unit ("HDU") for intensive monitoring;

(v) Your refusal to send the Patient to the ICU or HDU was influenced by the Patient's financial situation;

(vi) You knew or ought to have known that these signs of clinical deterioration required the Patient to be sent for intensive monitoring in either the ICU or HDU;

(vii) The Patient subsequently collapsed at 0215 hrs on 4 February 2012 and was pronounced dead at 0445 hrs, and the Patient's cause of death was eventually found to be "Acute Suppurative Pericarditis with Myocarditis"; and

(viii) Had the Patient been sent to either the ICU or HDU for intensive monitoring on 3 February 2012, her condition could have been better managed and she could have received timely treatment such that her chances of survival could have been increased;

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

NOTICE IS FURTHER GIVEN to you that **on 2 April 2018 at 5.30pm**, a Pre-Inquiry Conference will be held at **the Tribunal Room #01-01, Singapore Medical Council, 16 College Road, College of Medicine Building, Singapore 169854** to consider the above charges against you.

Copies of the following expert reports are enclosed: PE 2's expert report dated 17 July 2014 (**Annex A**); PE 3's expert report dated 24 July 2014 (**Annex B**); PE 1's expert report dated 8 August 2017 (**Annex C**); and PE 4's expert report dated 4 September 2017 (**Annex D**).

You are hereby invited to answer in writing the abovementioned charges and also to appear before the Disciplinary Tribunal at the time and place specified for the hearing of the Inquiry, for the purpose of answering them. You may appear in person or by counsel. The Disciplinary Tribunal has power, if you do not appear at the hearing of the Inquiry, to hear and decide upon the said charges in your absence. The Disciplinary Tribunal also has powers to proceed with and complete the inquiry in any manner, which is thinks fit if a warning against the hampering the progress of an Inquiry is disregarded and to order costs to be paid by you under section 53(5) of the Medical Registration Act.

If you intent to raise any defence at the Inquiry, you or your counsel shall, at least 10 days before the date fixed for the commencement of the Inquiry, send to the Council's solicitors the report of any expect witness whom you or your counsel intend to call at the Inquiry. You are also requested to co-operate with the Council's solicitors to prepare an agreed statement of facts, an agreed bundle of documents or exhibits to be used at the Inquiry or lists of witnesses to be called at the Inquiry.

If you desire to make any application that the Inquiry should be postponed, you should send a written application to the secretary of the Council at least 21 days before the date fixed for the commencement of the Inquiry, stating good reasons for such postponement.