IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2020] SMCDT 1

Between

Singapore Medical Council

And

Dr Kwan Kah Yee

… *Respondent*

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunal

Medical profession and practice – Professional misconduct – Erroneous certification of cause of death – Removal from Register

Singapore Medical Council

v

Dr Kwan Kah Yee

[2020] SMCDT 1

Disciplinary Tribunal — DT Inquiry No. 1 of 2020
A/Prof Chin Jing Jih (Chairman), Dr Tan Teow Hin Arthur and Mr Siva Shanmugam (Legal Service Officer)
13 December 2019; 29 January 2020

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Removal from Register

27 April 2020

GROUNDS OF DECISION

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

Introduction

1 These proceedings arose out of the demise of a patient on 17 March 2013 (the "**Deceased**"). The Respondent, Dr Kwan Kah Yee is the registered medical practitioner who attended at the Deceased's home on that day and certified the Certificate of Cause of Death ("**CCOD**") for the Deceased.

2 The Singapore Medical Council ("**SMC**") preferred two charges of professional misconduct pursuant to section 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("**MRA**") against the Respondent. The two charges are set out in the Notice of Inquiry dated 23 May 2019 (the "**NOI**"). At the hearing before the Disciplinary Tribunal ("**DT**") on 13 December 2019, the SMC sought leave to withdraw the second charge against the Respondent. The DT granted leave to SMC to withdraw the second charge pursuant to r34(5) of the Medical Registration Regulations.

Background

3 On 17 March 2013, the Deceased was found to be lying face down on the mattress on the floor of the master bedroom. As the Deceased was unresponsive, the ambulance was called in. The paramedics pronounced the Deceased dead at 1022 hours. The police was called in at 1025 hours to the Deceased's home.[1]

4 The Deceased's mother called the Respondent at around 1137 hours and the Respondent arrived at the Deceased's house at around 1208 hours.[2]

5 The Respondent examined the Deceased and certified in the CCOD that the "Cause of Death" of the Deceased was Ischaemic Heart Disease ("**IHD**"). The Respondent further certified "3 years" as the "Approximate interval between onset and death".[3]

6 The Respondent examined the Deceased and informed the police that he observed ecchymosis over neck, chest and upper limb of the Deceased. The Respondent also informed that such observation is consistent with the diagnosis of IHD.[4]

7 On 19 June 2013, the police wrote a report to the SMC informing the circumstances under which the Respondent made the certification.[5] On 20 November 2013, the SMC lodged a complaint to the Chairman of the Complaints Panel that the Respondent might have incorrectly certified the cause of death of the Deceased.[6]

8 On 23 May 2019, the NOI was served on the Respondent.[7] The present charge states that the Respondent wrongfully certified that the cause of death of the Deceased was IHD in the CCOD (the "**Charge**").

9 The Charge was framed in the main basis per the two limbs of professional misconduct in ***Low Cze Hong v Singapore Medical Council*** [2008] 3 SLR(R) 612 ("***Low Cze Hong***"), i.e. that the Respondent's conduct "*demonstrated an intentional, deliberate departure from standards observed or approved by the members of the profession of good repute and competency".*

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[1] Police report dated 19 June 2013, ABOD Tab 1
[2] Respondent's written explanation dated 8 May 2014, ABOD Tab 5
[3] CCOD, ABOD Tab 5, page 21, ASOF (Amendment No.1) at [8]
[4] ASOF (Amendment No. 1), at [11]
[5] Police report dated 19 June 2013, ABOD Tab 1
[6] Complaint by SMC, ABOD Tab 2
[7] Notice of Inquiry, ABOD Tab 11

Disciplinary Inquiry on 13 December 2019 (the "Hearing")

10 At the Hearing, the Respondent agreed to the Statement of Facts (Amendment No. 1) submitted by the SMC's Counsel and pleaded guilty to the Charge.

11 Even though the Respondent pleaded guilty to the Charge, it remains incumbent on the DT to closely scrutinise the facts and evidence and be satisfied that the Respondent's conviction is well founded; see ***SMC v Lim Lian Arn*** [2019] SGHC 172 ("***Lim Lian Arn***").

12 The test for professional misconduct in either limb of ***Low Cze Hong*** is a three-step inquiry. The DT needs to first establish the relevant benchmark that is applicable to the respondent doctor. The second stage requires that there has been a departure from the applicable standard by the respondent doctor. The third stage is to determine whether the departure was sufficiently egregious to amount to professional misconduct under the particular limb of ***Low Cze Hong;*** see ***Lim Lian Arn*** at [28]. The DT will now consider the evidence and whether the Charge against the Respondent has been made out.

The Charge

13 The Charge alleged that the Respondent wrongfully certified the CCOD of the Deceased. The Respondent certified that the cause of death of the Deceased was IHD.

The Deceased's "medical report" from NUH

14 The Respondent explained in his letter to the Investigation Unit ("**IU**") that he did his entries in the CCOD "according to the evidence from the medical report".[8] The Respondent claimed that the said "medical report" from the National University Hospital ("**NUH Medical Report**") was handed to him by one of the police-investigating officer.[9] Based on the NUH Medical Report, the Respondent claimed that the Deceased had abnormal ECG in 2010 and was treated for IHD.[10]

15 Investigations revealed that there was no such "NUH Medical Report" sighted or furnished to the IU. The NUH Medical Reports Section confirmed that they had no records of the Deceased.[11] The Respondent admitted subsequently that he was never presented with any medical records evidencing that the Deceased was suffering from

[8] Written Explanation dated 8 May 2014, [7], ABOD Tab 5, page 17, see also Written Explanation dated 10 March 2016, [5], ABOD Tab 7, page 36
[9] Written Explanation dated 8 May 2014, [5], ABOD Tab 5, page 17
[10] Written Explanation dated 8 May 2014, [7], ABOD Tab 5, page 20
[11] Letter from NUH dated 29 May 2014, Annex A, SMC's sentencing submissions

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IHD.[12] The Respondent had fabricated the NUH Medical Report to justify his certification and to exculpate himself. This Respondent made his certification without obtaining any proper medical evidence.

The information on the Deceased's medical condition from the Deceased's mother

16 In the Respondent's letter to the IU, he claimed that he had seen the Deceased in 2005, when he "*was doing locum practice"* in one of his "*doctor friend's clinic".*[13] The Respondent supported this claim with a letter from the police stating that the "*deceased's mother activated their own medical practitioner Dr Kwan Kah Yee to their unit".*[14] The Respondent also stated that the Deceased's mother informed him that he attended to the Deceased in 2005.[15]

17 The Respondent admitted before the DT that prior to his attendance at the home of the deceased upon his demise on 17 March 2013, he "*did not treat the deceased for any Ischaemic Heart Disease".*[16]

18 The Respondent also claimed that the Deceased's mother reported to him that the Deceased had symptoms of non-specific weakness, which the Respondent considered "*was consistent with chronic ischemic heart disease and not consistent with acute myocardial infarction*".[17]

19 We find that the Respondent did not rely on the Deceased's mother's information as the Respondent explained in his written explanation that he found the Deceased's mother to have "*incoherent speech and medical condition of vascular dementia*".[18]

20 In any event, as the certifying doctor, the Respondent had the responsibility to ensure that there were contemporaneous medical records to corroborate the Deceased's mother's statements, before he considered them for certifying the CCOD.

Whether the Respondent is guilty of professional misconduct for the Charge

21 It is trite that a doctor can only certify death if there is a valid clinical report (from the hospital or clinic the patient has been visiting or receiving treatments from) that could help the doctor identify if the cause of death was due to existing medical conditions.

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[12] ASOF (Amendment No.1), at [10]
[13] Letter to IU dated 8 May 2014, [4], ABOD tab 5, page 17
[14] Written Explanation dated 8 May 2014 at [4], ABOD Tab 5, page 17
[15] Written Explanation dated 8 May 2014, [4], ABOD Tab 5, page 19
[16] ASOF (Amendment No.1) at [9]
[17] Written Explanation dated 8 May 2014, [7], ABOD Tab 5, page 20
[18] Written Explanation dated 8 May 2014, [7], ABOD Tab 5, page 17

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22 In "Certification of death in Singapore" by Serene Ai Kiang, Siang Hui Lai, Proceedings of Singapore Healthcare, Vol 23, no.4 (2014)[19], it informs the medical practitioner that: -

> "The process involved in certification of the cause of death is analogous to making a clinical diagnosis in clinical practice. It requires **careful consideration of the patient's available clinical history and medical information**, through physical examination of the body and careful correlation with the circumstances of death**. Even if the cause of death is obviously due to medical cause or reasons, the doctor must still verify the circumstances of the patient's death to exclude foul play.**
> Procedure for death certification
> …
> (T)he doctor must **obtain** the **history and circumstances** leading to death; this can be obtained through the **Deceased's available medical records** and by interviewing family members in the case of death in the community."
> (Emphasis in bold)

23 The Respondent did not obtain the Deceased's clinical history and medical information before he certified the CCOD.

24 In the "Certification of death in Singapore" by Dr TC Chao, Singapore Medical Journal 1990, Vol 31:162-165[20], it also states that: -

> "… it is prudent for a general practitioner to obtain a **complete history of the circumstances surrounding the death of his patient before he decides to sign the certificate of cause of death.**
> Vague cause of death
> …
> (T)he cause of death should never be unknown. **If you do not know the cause of death, refer the case to the coroner**."
> (Emphasis in bold)

25 The relevant benchmark applicable to the Respondent (and any medical practitioner certifying the CCOD) would be to obtain the clinical and medical information of the Deceased to verify the history and circumstances leading up to the death. The Respondent failed to do so. In view of the insufficient information before the Respondent, the Respondent ought to have declined to certify the CCOD and refer the case to the coroner.

26 The Respondent departed from the applicable standard when he proceeded to certify the CCOD even though he did not have sufficient medical documents to arrive to his conclusion that the "Cause of Death" was IHD. This was an intentional and deliberate

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[19] Annex B of SMC's Expert Report, ABOD Tab 12
[20] Annex B of SMC's Expert Report, ABOD Tab 12

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departure from the applicable standard as the Respondent knew of the standards required of him in relation to the certification of death certificates[21], but nevertheless proceeded to do so without any basis to support his certification.

27 The departure from the applicable standard was sufficiently egregious to amount to professional misconduct. The issuance of false death certificate is a very grave breach of a doctor's ethical and professional duties; ***Singapore Medical Council v Kwan Kah Yee*** [2015] SGHC 227 at [52] ("***Kwan Kah Yee (2015)***"). The Ministry of Health had also issued a circular on proper death certification to remind practitioners that CCOD "*should only be issued when the cause of death is known AND the cause is natural. Unnatural causes of death should not be certified by the medical practitioner and must be reported to the Police who will then report it to the Coroner"*.[22]

28 Furthermore, certification of death by registered medical practitioners is a statutory duty imposed on them under the Registration of Births and Deaths Act. The Respondent had already been suspended on two separate occasions for charges relating to wrongful certification of CCOD and is fully aware of the responsibility as the certifying doctor[23].

29 In light of the above, the DT is of the view that the Charge against the Respondent has been made out.

Appropriate Sentence

30 We now turn to the issue of the appropriate sentence to be imposed on the Respondent for the Charge.

SMC's Submissions on Sentence

31 The SMC's Counsel, Mr Chiok, urged the DT to order the removal of the Respondent's name from the Register to uphold confidence in the medical profession and for public interest considerations.[24] The SMC's submissions in support for the sentence are summarily set out as follows:-

(a) Level of harm caused by the Respondent's misconduct is moderate to high;
(b) Public interest considerations weighed heavily in favour of imposing a stern sentence;
(c) There were 2 prior decisions where the DT and the Court dealt with the Respondent for the same misconduct of wrongly certifying causes of death;

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[21] ASOF (Amendment No.1) at [4]
[22] MOH Circular No. 14/2012, ABOD Tab 10, page 48
[23] ASOF (Amendment No.1) at [4]
[24] SMC Sentencing Submissions at [13]

(d) The Respondent could easily have avoided the misconduct by not issuing the CCOD and his culpability was high;
(e) The Respondent breached his undertaking given after conviction in his inquiry in 2011;
(f) The Respondent has a propensity to reoffend; and
(g) The Respondent was dishonest.

Respondent's Submissions on Sentencing

32 At the hearing, the Respondent (through his Counsel) informed that he does not object to the sentence sought by the SMC but urged the DT to not order any costs against him.

Sentencing precedents for wrongful certification of death

33 The SMC submitted two sentencing precedents for professional misconduct for wrongful certification of death. Both precedents cited involved the Respondent for his misconduct in 2011 and 2014. We note that the Court in ***Kwan Kah Yee*** (2015) commented that the sentences meted out for improper death certification in Singapore "*have thus far been exceedingly and inexplicably lenient considering the extensive negative consequences that may flow from an improperly certified death"*; [34].

34 In ***Kwan Kah Yee*** (2015), the Court referred to the sentencing precedent in England where heavier penalties for improper death certificates than what has traditionally been meted out by the DT in Singapore. The sentence for wrongful death certification in Singapore was then recalibrated in ***Kwan Kah Yee*** (2015). The Respondent in that case was suspended for 18 months for each charge of the two charges for issuing improper death certificate and the sentence was ordered to run consecutively for a total of 36 months.

DT's Considerations
Antecedents

35 The Respondent is a recalcitrant offender. This is the Respondent's third instance of facing disciplinary proceedings for wrongful certification of death certificates.

36 We set out below the chronology of the Respondent's antecedents:-

S/n	Date	Events
1.	16 October 2009	Date of wrongful certification of death in Respondent's first disciplinary inquiry, Disciplinary Committee Inquiry for Dr Kwan Kah Yee (2011)[25]

[25] Disciplinary Committee Inquiry for Dr Kwan Kah Yee (12 July 2011), at [1]

S/n	Date	Events
		(the "**1st Offending Act**")
2.	13 November 2009	Complaint made against the Respondent for 1st Offending Act[26]
3.	2 February 2010	Notice of complaint to the Respondent for 1st Offending Act[27]
4.	29 March 2010	Date of wrongful certification of patient A's death in Respondent's second disciplinary inquiry, In the matter of Dr Kwan Kah Yee [2014] SMCDT 10[28] (the "**2nd Offending Act**")
5.	18 November 2010	Complaint made against the Respondent for 2nd Offending Act[29]
6.	1 December 2010	MRA 2004 was repealed. MRA 2010 came into effect.[30]
7.	29 March 2011	Date of wrongful certification of patient B's death in Respondent's second disciplinary inquiry, In the matter of Dr Kwan Kah Yee [2014] SMCDT 10[31] (the "**3rd Offending Act**")
8.	4 July 2011	Complaint made against the Respondent for 3rd Offending Act[32]
9.	5-6 April, 1 June 2011	Inquiry proceedings for 1st Offending Act[33]
10.	12 July 2011	The Grounds of Decision for the 1st Offending Act was issued. The Respondent was convicted. The DT imposed 3 months suspension and a written undertaking to the Medical Council that the Respondent will not engage in the conduct complained of or any similar conduct.[34]
11.	21 September 2011	Notice of complaint to the Respondent for 2nd Offending Act[35]
12.	4 October 2011	Respondent's explanatory letter for 2nd Offending Act[36]

[26] Disciplinary Committee Inquiry for Dr Kwan Kah Yee (12 July 2011), at [3]
[27] ibid
[28] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [7]
[29] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [4]
[30] This date will be relevant for the issue of cost.
[31] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [12]
[32] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [11]
[33] Disciplinary Committee Inquiry for Dr Kwan Kah Yee (12 July 2011)
[34] Disciplinary Committee Inquiry for Dr Kwan Kah Yee (12 July 2011) at [43]
[35] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [8]
[36] ibid

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S/n	Date	Events
13.	28 November 2011	Notice of complaint to the Respondent for 3rd Offending Act[37]
14.	11 December 2011	Respondent's exculpatory statement for 3rd Offending Act[38]
15.	17 March 2013	Date of wrongful certification of death of the Deceased[39]
16.	19 June 2013	Letter from Police to SMC in relation to wrongful certification of death of the Deceased[40]
17.	1 August 2013	Health Science Authority issued a letter in relation to Respondent's 2nd and 3rd Offending Act [41]
18.	20 November 2013	Complaint against the Respondent for the Charge[42]
19.	22 April 2014	Notice of complaint to the Respondent for the Charge [43]
20.	8 May 2014	First Written Explanation by the Respondent for the Charge [44]
21.	29 May 2014	Letter from NUH confirming no medical records of the Deceased[45]
22.	2 June 2014	Notice of Inquiry for 2nd and 3rd Offending Act[46]
23.	8 December 2014	Second Written Explanation by the Respondent for the Charge [47]
24.	14 October 2014	Respondent was charged for 2nd and 3rd Offending Act[48]
25.	31 October 2014	Respondent pleaded guilty to 2nd and 3rd Offending Act Grounds of Decision issued by the DT – The Respondent was convicted and 3 months' suspension for 2nd and 3rd Offending Act, to run concurrently. The Respondent gave a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct.[49]
26.	31 July 2015	High Court Judgment for SMC's appeal on sentence for 2nd and 3rd Offending Act.

[37] Singapore Medical Council v Kwan Kah Yee [2015] SGHC 227 at [14]
[38] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [13]
[39] CCOD, ABOD Tab 5, page 21
[40] Letter from Singapore Police Force dated 19 June 2013, ABOD Tab 1, page 5-6
[41] Singapore Medical Council v Kwan Kah Yee [2015] SGHC 227 at [11] and [18]
[42] ABOD Tab 2, page 8
[43] ABOD Tab 3, page 12-13
[44] ABOD Tab 5
[45] Letter from NUH, SMC's sentencing submissions at Annex A
[46] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10 at [6] and [12]
[47] ABOD Tab 6
[48] Singapore Medical Council v Kwan Kah Yee [2015] SGHC 227 at [12], [19]
[49] In the matter of Dr Kwan Kah Yee [2014] SMCDT 10

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S/n	Date	Events
		The Respondent was suspended for 18 months for each charge, to run consecutively for 36 months.[50]
27.	10 March 2016	Third Written Explanation by the Respondent for the Charge[51]
28.	23 May 2019	Notice of Inquiry for the Charge[52]
29.	13 December 2019	Respondent pleaded guilty to the Charge

37 At the point in time when the Respondent committed the transgression specified in the Charge on 17 March 2013, he had already served three months' suspension for his first disciplinary inquiry in 2011. The Respondent was also put on notice for his second inquiry before the DT for similar misconduct. This meant that the Respondent committed the offence in the Charge with the knowledge of the past and pending disciplinary proceedings against him.

38 We are of the view that the Respondent's antecedents in 2011 *and* 2014 are relevant in determining the appropriate sentence notwithstanding that he was not sentenced for the 2nd and 3rd Offending Act at the time of commission of the present Charge. This Court in ***Kwan Kah Yee*** (2015), when the Court considered the Respondent's antecedent in 2011 even though he was not convicted at the time of commission of the 2nd and 3rd Offending Act:-

> "[67] Second, the DT erred in considering that the Respondent was not a repeat offender on the basis that he had not yet been sentenced for the Prior Charge when he committed the two acts of misconduct leading to the Charges. The DT reasoned that the sentence should not be stiffer than that imposed for the Prior Charge, which was primarily a three-month suspension. In our judgment, the DT was wrong. **It is important to note that while the Respondent had not yet been formally charged with the Prior Charge when he falsely certified Patients A and B's death certificates, he was on notice that he was under investigation for the prior offence. We considered this to be an aggravating factor and therefore took this into account when imposing the sentences** we have set out at [61] above. **In any event, it was not evident to us how the Respondent could not be regarded as a repeat offender since the plain facts were that he had repeatedly issued false death certificates. There was simply no ambiguity in this; Singapore Medical Council v Kwan Kah Yee** [2015] 5 SLR 201"
> (Emphasis added)

39 The Respondent was aware of his 1st, 2nd and 3rd Offending Act when he committed the act in the present Charge.

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[50] Singapore Medical Council v Kwan Kah Yee [2015] SGHC 227
[51] ABOD Tab 7
[52] ABOD Tab 11, page 67-70

40 Similar antecedents is an aggravating factor as they show a "*pattern of persistence in improper medical conduct"* and demonstrate a greater need for specific deterrence because the errant doctor had not only failed to mend his ways but had gone on to commit similar and more serious breaches of his duty; ***Yong Thiam Look Peter v Singapore Medical Council*** [2017] 4 SLR 66.

41 In the Respondent's first disciplinary inquiry in 2011, he faced a single charge of professional misconduct in that he had wrongly certified in the CCOD in respect of the patient's demise. The Respondent contested the charge but was found guilty by the Disciplinary Committee. The Disciplinary Committee found that there was no clinical ground and factual basis for the Respondent to certify that "Congestive Cardiac Failure" is a cause of death and the conclusion that the patient had IHD for six years prior to his demise. In particular, the Disciplinary Committee noted that the Respondent made up a "false" defence, that he had received a call from a "reliable source" from a polyclinic that informed him the patient developed IHD for six years prior to her demise ("**First Dishonest Act**"). The reference of a "reliable source" was omitted throughout the proceedings and was only mentioned just before the inquiry. The Respondent also did not call any witness to substantiate his claim. As such, the Committee found that the Respondent had misled in the course of the conducting his defence.

42 In the Respondent's second disciplinary inquiry in 2014, he faced two charges of professional misconduct in that he had wrongly certified in the CCOD in respect of two different patients. In relation to the first patient, the Respondent certified that bronchiectasis of approximately three days' duration led to the patient's demise. The Respondent relied on a chest x-ray of the Deceased from SATA, which purportedly showed radiological evidence of chronic obstructive airway disease ("**Second Dishonest Act**"). However, an investigation by Ministry of Health revealed, *inter alia,* that there was no record belonging to the patient from SATA. The Respondent admitted later that he erroneously certified the cause of death of the patient.

43 In relation to the second patient, the Respondent certified cause of death was IHD based on a complaint of chest pain and alleged medical information from various polyclinics that the patient was treated for IHD ("**Third Dishonest Act**"). Investigations transpired that there were in fact no medical records of the patient in the polyclinics and the patient's medical records in KK Hospital did not indicate that the patient suffered from IHD. The Respondent failed to adduce any copies of the medical reports allegedly referred to when making his certification. The Respondent admitted that he erroneously certified the cause of death of the patient.

44 The Respondent's antecedents in 2011 and 2014 were largely similar to the present Charge where he wrongly certified the CCOD, without any factual basis.

45 In assessing the extent of the Respondent's culpability, we note that the Respondent had breached his undertaking given to the SMC not to repeat similar conduct in his first

inquiry.[53] In the case of ***Dr AAN*** [2009] SMCDC 2, the errant doctor faced 20 charges of inappropriately prescribing hypnotic medications to various patients. In considering the appropriate sentence, the Committee noted that the errant doctor was previously struck off for over prescription of hypnotic drug and persisted in reoffending. The doctor had in his application for restoration assured the Council of better management and treatment of his patients. In spite of the assurance, the misconduct resulting in his present conviction had the same element as the previous conviction under which his name was removed from the Register. This indicated that the errant doctor was not truly remorseful for his actions. As such, the Disciplinary Committee ordered the doctor's name to be struck off.

46 In the present case, the Respondent failed to show any remorse and persisted in the same wrongful conduct of improper death certification. The repeated misconduct also showed the Respondent's lack of insight into the seriousness of wrongful certification of death and his dishonest conduct.

Dishonesty

47 The Respondent issued the death certificate without any contemporaneous documents to support his certification. In an attempt to substantiate his certification, he went as far as to claim the existence of the NUH Medical Report and essentially conjured the existence of evidence to avoid liability. The Respondent's dishonest conduct in an attempt to exculpate himself is a serious aggravating factor.

48 The SMC pointed out that in ***Kwan Kah Yee*** (2015), the Court was already inclined to strike off the Respondent's name from the Register, but did not do so as there was a question whether the usual penalty of striking off for dishonest lawyers should equally apply to medical professionals:-

> "[62]We would also add that the Respondent could well have been **struck off the medical register**. However, we declined to order that, because there were too many questions left unanswered at the conclusion of the investigation and the DT proceedings… Nevertheless, we should say here that even without the additional information and having regard only to the seriousness of the offence and **the patent dishonesty on the part of the Respondent, consideration could have been given to striking the Respondent off the medical register**. **We did not do so in this case as we would have wanted detailed submissions on the question of whether the usual penalty for dishonesty in professional dealings in the medical profession should be similar or different to that in the legal profession.** The Respondent was unrepresented and unreliable in the manner he made submissions; it was evident that we would not get much assistance from him. However, we flag this as an open issue that we will take up on an appropriate occasion in the future."

[53] [35(5)] SMC's Sentencing Submissions, See also S/n 10 of the Chronology at [39] above

49 In ***Wong Meng Hang v Singapore Medical Council and other matters*** [2018] SGHC 253 ("***Wong Meng Hang***"), the Court was of the view that the disparity in the treatment between dishonest lawyers and medical professionals is not well founded in principle. The Court explained that commitment of lawyers to the value of truth, honesty and ethics is shared with members of the medical profession and that there ought to be greater consistency in the way that each profession responds to grave breaches of such values. Therefore, as a general rule, misconduct involving dishonesty should almost invariably warrant an order for striking off where the dishonesty reveals a character defect rendering the errant doctor unsuitable for the profession. The overall consideration is whether the misconduct was so serious that it renders the doctor unfit to remain as a member of the medical profession: -

> "[67(e)] Striking off should be considered when the facts of the case disclose **an element of dishonesty….** Dishonesty on the part of a professional will generally be viewed with severity.
> …
> …(F)urther consideration which might suggest that the punishment of striking off is especially warranted, is where the errant doctor has shown a **persistent lack of insight into the seriousness and consequences of the misconduct**… in such cases, the lack of insight might suggest an impediment to reform or rehabilitation which warrants the sanction of striking off."

50 We stand guided by the principles set out in ***Wong Meng Hang.*** The Respondent failed to appreciate the seriousness of wrongful certification of death despite having served 3 months' suspension in 2011. It is undisputed that he was also aware of his 2nd and 3rd Offending Act when he committed the Charge. The Respondent attempted to exculpate himself by fabricating evidence that he was handed the Deceased's medical report. This is also not the first time the Respondent attempted to deceive the tribunal by making up evidence to exculpate himself. The Court in ***Kwan Kah Yee*** (2015) had observed as follows:-

> "(I)mproper issuance of a false death certificate based on non-existent medical records goes against the very essence of these standards and constitutes a very serious breach of the Code. **This is seriously aggravated if the doctor then fabricates or conjures up records in an attempt to justify the false certification**… Additionally, the **Respondent displayed his lack of contrition and repentance before us at the oral hearing, when he continued to justify his improper certification of Patient A and B's death despite the overwhelming evidence against him**"; [49]
> (Emphasis in bold)

51 Based on the Respondent's dishonest conduct and lack of insight as is evident from his antecedents, we are of the view that striking off the Respondent's name off the Register is the appropriate sanction. The other relevant factors set out below only fortify our view that striking off is the appropriate sentence to be imposed.

Public Interest

52 It is trite that the common sentencing objectives for sentencing are general and specific deterrence, the protection of public and the maintenance of public confidence in the profession.[54]

53 There are extensive negative consequences that may flow from an improperly certified death. It is important to set out what the Court explained in ***Kwan Kah Yee*** (2015) regarding the public interest considerations for wrongful certification of CCOD:-

> "[52] …The issuance of a false death certificate is a very grave breach of a doctor's ethical and professional duties. The Coroners Act (Cap 63A, 2012 Rev Ed) requires that certain types of unexplained deaths be inquired into by the Coroner. This requirement serves several important functions. From a legal standpoint, it is a vital safeguard against the possibility of homicides being covered up. It may also be important in determining liability in civil lawsuits – in cases of malpractice, for instance – or for the settlement of certain kinds of insurance claims. From a public health standpoint, it serves a critical function. When an otherwise healthy person dies, it is important that society understands why that has happened so that mistakes may be avoided, lessons may be learnt, and possible sources of disease and infection may be discovered and guarded against. From a personal standpoint, not knowing the true cause of the death of a loved one can cause great anguish and confusion for the bereaved family."

54 Wrongful certification of death could lead to the erosion of public trust in the medical profession and also serious complications and consequences for the deceased's family. An accurate certification of death is needed to ensure that it does not impact criminal investigations when homicides may be covered up or investigations hampered.

55 We note that the same aggravating considerations observed by the Court in ***Kwan Kah Yee*** (2015) applies with equal force in the present case:-

> "[59]…
>
> (a) The offences committed by the Respondent were serious ones with potentially damaging consequences;
> (b) The Respondent was brazen and his acts of dishonesty were indefensible;
> (c) He attempted to cover up his wrongdoing;
> (d) He persisted in this conduct despite already facing the Prior Charge;
> (e) He displayed a lack of remorse that was evident in the position that he took before us.
>
> Considering his lack of insight into the wrongfulness of his actions, public confidence in and the reputation of the medical profession would not have been adequately protected if the Respondent were given a

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[54] ***Wong Meng Hang*** at [54]

> lighter sentence on the basis of the mitigating circumstances raised, even if we were to accept these as true."

56 The Respondent's unrepentant conduct indicates that it will be a risk to the public if the Respondent is allowed to continue practice. There is high regard and trust vested in the medical profession and hence the need to ensure that the highest standards of professional practice and conduct be maintained, that failures to adhere to the standards must then be visited with sanctions of sufficient gravity; ***Peter Yong*** at [19].

Deterrence

57 The considerations of general and specific deterrence in sentencing are trite and are set out clearly in ***Tan Kay Beng v PP*** [2006] 4 SLR(R) 10:-

> "It is premised upon the upholding of certain statutory or public policy concerns or alternatively, upon judicial concern or disquiet about the prevalence of particular offences and the attendant need to prevent such offences being contagious. Deterrence, as a general sentencing principle, is also intended to create an awareness in the public and more particularly among potential offenders that punishment will be certain and unrelenting for certain offences and offenders.
>
> Specific deterrence is directed at persuading a particular offender from contemplating further mischief. This assumes that a potential offender can balance and weigh consequences before committing an offence…."

58 The principles of general and specific deterrence are applicable in considering the appropriate sentence for the Respondent. As for general deterrence, there is a need to ensure that certifying doctors do the necessary verifications and reviews to ensure that the CCOD is accurate. As for specific deterrence, the Respondent's attitude was cavalier and he clearly failed to appreciate the seriousness of his misconduct given that he continued to commit the same misconduct repeatedly. The Respondent also showed a fundamental lack of integrity as he continued to engage in dishonest conduct in an attempt to evade culpability.

Costs

59 The Respondent submitted that Costs should not be ordered against him having regard to the SMC's delay in prosecution of the Respondent. It was also argued that the present Charge could have been consolidated with the 2nd and 3rd Offending Act and dealt with together during the disciplinary proceedings in 2014. The Respondent was not represented in the disciplinary proceedings in 2014 and did not apply for consolidation of the charges at that stage. The DT noted that complaint for the present Charge was made on 20 November 2013. The Respondent received the Notice of Complaint on 22 May 2014 and provided his written explanations on 8 May 2014, 8 December 2014 and 10 March 2016

60 The SMC's response was that there was no inordinate delay since Counsel was appointed as the SMC needed time to find an expert to assist with investigations. With respect to the issue of consolidating the Charge with the proceedings in 2014, the SMC explained that the complaints were presented to SMC at different dates and each complaint took its own inquiry process.

Our decision on Costs

61 In **SMC v BXR** [2019] SGHC 206 ("**BXR**"), the Court made the following observations on the relevance of the amount of time that is taken for prosecution to the issue of costs ;

> "47 The respondent submitted that another reason for ordering costs against the SMC is that there was an inordinate delay in carrying out the prosecution. The respondent suggested that the principles set out in *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("*Ang Peng Tiam*") (at [109]–[117]), in relation to when a *sentencing discount* may be given due to an inordinate delay in prosecution, would be equally applicable to determining when costs may be ordered against the SMC if there is a delay in the prosecution of the medical practitioner.
>
> 48 We agree with the respondent that an inordinate delay in the prosecution of a medical practitioner's case should be a relevant consideration in favour of ordering costs against the SMC….
>
> 49 Further, we agree that the principles set out in *Ang Peng Tiam* provide a useful starting point for determining when the *time taken* to carry out a prosecution may be a relevant factor in awarding costs against the SMC. In *Ang Peng Tiam* at [109], this court set out a list of three cumulative conditions that have to be satisfied before a sentencing discount will be given:
>
> (a) there has been a significant delay in prosecution;
> (b) the delay has not been contributed to in any way by the offender; and
> (c) the delay has resulted in real injustice or prejudice to the offender.
>
> In our judgment, these same three cumulative requirements should be satisfied before the court can consider the time taken for the prosecution in determining whether costs should be ordered against the SMC. However, one modification we make is to replace the term "offender" with the term "medical practitioner", because an "offender", *ie*, a medical practitioner who is convicted of the charges preferred against him or her, would *not* be entitled to costs in any event.
>
> …
>
> 51 As for the third requirement at [49(c)], we consider that:
>
> (a) the mental anguish, anxiety and distress suffered by the medical practitioner in having the charge(s) hanging over him during the period of delay;

(b) any tarnishing of the medical professional's reputation; and/or
(c) the loss of income or career opportunities suffered by the medical professional would constitute material prejudice: see *Ang Peng Tiam* at [115]. We emphasise, once again, that this is not an exhaustive list."

62 The DT is of the view that it is not inappropriate for the SMC to obtain an expert report in support of the NOI. On the issue of consolidating the current Charge with the earlier 2014 matter, we accept the SMC's explanation that as the complaints were presented to SMC at different dates, each complaint will take its own inquiry process with investigations taking a distinctly different timeline. The DT further noted that the Respondent had knowingly engaged in the present misconduct with total disregard to the disciplinary proceedings relating to his antecedents. Even if the facts were to disclose a delay on the part of the SMC, clearly such delay would not have resulted in any real injustice or prejudice to the Respondent in the circumstances. The DT accordingly saw no reason not to order costs against the Respondent.

Sentence imposed

63 Taking into account the nature of the complaint together with the Respondent's conduct, the DT orders that:-

(a) The Respondent's name be removed from the appropriate register; and
(b) The Respondent to pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

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

A/Prof Chin Jing Jih
Chairman

Dr Tan Teow Hin Arthur

Mr Siva Shanmugam
Legal Service Officer

Andy Chiok and Margaret Lee (Michael Khoo & Partners)
for Singapore Medical Council; and
Diana Ngiam (Quahe Woo & Palmer LLC)
for the Respondent.