IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2023] SMCDT 1

Between

Singapore Medical Council

And

Dr Ho Tze Woon

... Respondent

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Breach of section 53(1)(*e*) of the Medical Registration Act – Suspension

Table of Contents

INTRODUCTION 3

BACKGROUND FACTS 4

ISSUES 6

WHETHER A PATIENT SHOULD GENERALLY BE REPOSITIONED TO A SUPINE POSITION BEFORE CPR IS ADMINISTERED 8

WHETHER THE RESPONDENT'S FAILURE TO REPOSITION THE PATIENT TO A SUPINE POSITION BEFORE ADMINISTERING CPR IS JUSTIFIABLE IN THE CIRCUMSTANCES OF THIS CASE 12

SUBMISSIONS ON SENTENCING 29

PROSECUTION'S SUBMISSIONS ON SENTENCE 31

RESPONDENT'S SUBMISSIONS ON SENTENCE 38

DT'S DECISION ON THE APPROPRIATE SENTENCE 39

CONCLUSION 46

This judgment is subject to final editorial corrections approved by the Disciplinary Tribunal and/or redaction pursuant to the publisher's duty in compliance with the law, for publication in LawNet and/or the Singapore Law Reports.

Singapore Medical Council
v
Dr Ho Tze Woon

[2023] SMCDT 1

Disciplinary Tribunal – DT Inquiry No. 1 of 2023
Prof Sonny Wang Yee Tang (Chairman), Dr Yii Hee Seng, Ms Chong Chin Chin (Judicial Service Officer)
6, 9, 20 May, 10 June, 4 July, 1 December 2022, 10 and 17 February 2023

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Breach of section 53(1)(*e*) of the Medical Registration Act – Suspension

21 February 2023

GROUNDS OF DECISION

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

Introduction

1. Dr Ho Tze Woon (the "**Respondent**") is a registered medical practitioner who faced a single charge under section 53(1)(*e*) of the Medical Registration Act 1997 (Cap 174, 2014 Rev Ed) (the "**MRA**") for failing to provide professional services of the quality that is reasonable to expect of him. The charge reads:

> "That you, Dr Ho Tze Woon, are charged that on 14 January 2017, whilst practising at Central 24-Hr Clinic (Yishun) ("the **Clinic**") at Blk 701A Yishun Avenue 5, #01-04, Singapore 761701, you had acted in breach of Guidelines A1(1) and/or A1/(4) of the 2016 edition of the Singapore Medical Council Ethical Code and Ethical Guidelines ("**2016 ECEG**") in that you failed to

provide your patient, the late Mr P ("the **Patient**"), with competent and appropriate care and/or a standard of medical care that is based on a balance of evidence and accepted good clinical practice as would be expected of a reasonable and competent doctor in your position when you failed to correctly administer Cardiopulmonary Resuscitation ("**CPR**") on the Patient by performing CPR while the Patient was still in a sitting position.

Particulars

(a) In the evening of 14 January 2017, you attended to the Patient when he visited the Clinic;
(b) the Patient became unconscious in the procedure room of the Clinic;
(c) after assessing the Patient, you performed CPR on the Patient while the Patient was still in a sitting position;
(d) you did not attempt the lay the Patient into a supine position before performing CPR on the Patient;
(e) a reasonable and competent doctor in your position would have placed the Patient into supine position before performing CPR as that is the accepted standard of care;

and that in relation to the facts alleged, you have failed to provide professional services of the quality which is reasonable to expect of you under s 53(1)(*e*) of the Medical Registration Act (Cap. 174)."

Background facts

2. The Patient was accompanied by his friend Ms PW ("**Ms PW**") when he visited the Clinic on 14 January 2017 at about 8.05pm. At that time, the Patient complained of breathlessness. The Patient had a long history of severe asthma and was 45 years old at the material time.

3. The Respondent was the locum doctor on duty in the Clinic. At the material time, the Respondent held a valid Basic Cardiac Life Support ("**BCLS**") certification for two years from 27 August 2015 to 27 August 2017 and he was qualified to administer CPR. The Respondent had prior experience with collapse cases and had attended to a number of them during the course of his hospital postings, including his prior postings as a medical officer in the Khoo Teck Puat Hospital ("**KTPH**").

4. The Respondent assessed the Patient to be having an asthma attack and he proceeded to prescribe six tablets of prednisolone (5mg each) to the Patient. He further instructed a clinic assistant, Mr PW2 ("**Mr PW2**") to administer nebulization treatment to the Patient. Nebulization commenced at about 8.08pm in a treatment room adjacent to the Respondent's consultation room (the "**treatment room**").

5. The Patient was seated on a chair next to the nebulizer machine while Mr PW2 assisted to put on and hold the nebulizer mask to the Patient's face. While the nebulization treatment was being administered, the Patient's face turned purple (i.e. cyanosed) and he began to lose consciousness. Mr PW2 immediately shouted for the Respondent who was in the adjacent consultation room at that time.

6. The Respondent assessed that the Patient was in cardiac arrest upon determining that the latter was pulseless and unconscious. The Respondent immediately began performing CPR on the Patient who remained in a sitting position at around 8.13pm. It is not in dispute that the Respondent started CPR without lying the Patient in supine position and did not attempt to do so.

7. Mr PW2 continued to hold the nebulizer mask for the Patient as the Respondent performed CPR on the Patient. The Respondent instructed another clinic assistant, Ms PW3 ("**Ms PW3**") to call the Singapore Civil Defence Force ("**SCDF**") and she went to the reception counter to make the first call at around 8.14pm. Ms PW3 made at least three calls to the SCDF before the ambulance arrived.

8. The Respondent did not seek assistance from Mr PW2, Ms PW3 or Ms PW to move the Patient to the floor. He also did not give instructions to any of them to clear the room or to make space so that he could lie the Patient down onto the floor.

9. While the Respondent was performing CPR on the Patient, Ms PW3 asked the Respondent if he wanted to administer adrenalin to the Patient to which the Respondent replied that he could not locate the Patient's vein to insert a cannula.

10. The Respondent continued to perform CPR on the Patient while he was seated on the chair until the paramedics arrived sometime between 8.23pm and 8.25pm. When the paramedics arrived, they found the Patient seated on the chair with a nebulizer mask on and the Respondent was still performing chest compressions on the Patient.

11. The paramedics examined the Patient and assessed that he had no pulse and was not breathing. Three paramedics then brought the Patient down from the chair, laid him onto the floor. Manual CPR was administered before switching to a LUCAS mechanical chest compression machine ("**LUCAS machine**"). The Patient was fitted with a laryngeal mask airway to keep his airway open. The paramedics also administered adrenalin intravenously to the Patient at the Clinic.

12. At or around 8.37pm, the paramedics transported the Patient to KTPH and continued with the resuscitation process throughout the journey. At or around 8.41pm, the ambulance arrived at KTPH. The Patient remained unconscious and bradycardic with no spontaneous breathing on arrival. The Patient was subsequently intubated and there was a return of spontaneous circulation shortly after. The Patient required dopamine inotropic support throughout. He was assessed to have suffered from a severe near fatal asthma attack.

13. The Patient was subsequently transferred to the medical intensive care unit of KTPH for further management and he required mechanical ventilation for his status asthamaticus. It was also assessed that the Patient presented the following issues: (a) hypoxic brain injury secondary to prolonged downtime; (b) pneumonia; and (c) pneumomediastinum. On 21 January 2017 at 10.48am, the Patient was declared brain dead and passed away while still on life support. His cause of death was status asthmaticus.

14. On 10 March 2017, the Patient's sister (the "**complainant**") filed a complaint with the Singapore Medical Council ("**SMC**") against the Respondent alleging that he had failed to correctly administer CPR on her brother. The Notice of Complaint dated 8 September 2017 was sent to the Respondent. The Respondent provided a written explanation in response to the complaint on 15 September 2017 (the "**Written Explanation**"). The Notice of Inquiry dated 16 March 2020 was served on the Respondent on 18 March 2020. The Respondent claimed trial on the charge.

Issues

15. The Respondent faced a charge under section 53(1)(*e*) of the MRA for having "failed to provide professional services of the quality which is reasonable to expect of him". The relevant test is set out in *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 ("***Peter Yong***") at [11] which is extracted below:

> "In our judgment, the charge under s 53(1)(*e*) involves an objective assessment of standards of medical care which can be reasonably expected of medical practitioners. This calls for a consideration of what reasonable medical practitioners would expect of their peers in delivering medical care. These may be regarded as minimum standards of acceptable care derived from the expectations of reasonable medical practitioners. In the case before us, Dr Yong has accepted that he failed to meet these standards in relation to the third charge and this is unsurprising given that the DT found his conduct in this regard fell short of *elementary* clinical standards."

16. The primary issue before us is whether the Respondent's method of administering CPR while the Patient is in a seated position without lying the patient supine on the floor met the "minimum standards of acceptable care derived from the expectations of reasonable medical practitioners". The SMC submitted that the Respondent should have repositioned the Patient from a seated position to a supine position before performing CPR. The circumstances in which a patient cannot be repositioned from a seated to a supine position are extremely limited and that they are not applicable in the present case.

17. The Respondent contended that there was no requirement to reposition the Patient into a supine position before performing CPR as this was not specifically taught in the BCLS course. Even if this is the minimum acceptable standard expected of a reasonable and competent doctor to attempt to reposition the Patient, the Respondent's actions were justifiable for a number of reasons: (a) there was insufficient space to transfer the Patient to the floor in the treatment area; (b) neither he nor the persons in the Clinic were trained to effect the transfer; (c) an indeterminate amount of time would be required to reposition the Patient; and (d) the possibility of injury to the Patient and/or persons transferring the Patient. In view of these circumstances, it was not unreasonable for the Respondent to administer CPR immediately without attempting to make a transfer.[1]

[1] Paragraph 9 of the Respondent's Reply Submissions dated 16 August 2022.

18. To assist the DT in the inquiry, each party adduced expert opinions. The SMC called the following two experts:

(a) Professor PE1 ("**Prof PE1**") who is a senior consultant at the Emergency Department at Institution A. He is an instructor of the BCLS course accredited by the Singapore Resuscitation and First Aid Council.

(b) Dr PE2 ("**Dr PE2**") who is a family physician practicing at Institution B.

19. The Respondent called Dr DE ("**Dr DE**") who is Senior Consultant at the Department of Emergency Medicine at Institution C. Dr DE was asked by the SMC to provide an expert opinion for purposes of the inquiry and he provided a report on 11 March 2020. Subsequently, the SMC decided that it would not be calling Dr DE as its expert witness for the inquiry. The Respondent then decided to call Dr DE to give expert evidence and Dr DE provided a further report on 14 September 2021.

Whether a patient should generally be repositioned to a supine position before CPR is administered

20. A key issue in contention is whether a patient should be repositioned to a supine position before administering CPR if he had suffered cardiac arrest while in a seated position. As a starting point, we examined what the Respondent would have been trained to do in the BCLS course and in this regard, Prof PE1's evidence was instructive as he is the chief instructor for the course. According to Prof PE1, the Respondent's certification in 2015 would have been based on the curriculum found in the 2011 version of the BCLS manual. According to Prof PE1, the main differences between the 2011 version and the others relate to the compression depth and the rate of compression. The 2011 version required a compression depth of at least 5 cm at a rate of at least 100 per minute. The later iterations required a compression depth of at least 4-6 cm at a rate of 100-120 per minute. For the purposes of this inquiry, these differences are not material. Prof PE1 explained that he could not locate the actual manual that was used for BCLS training in 2011 but the *SingHealth's Basic Cardiac Life Support Course*

electronic book (25 September 2012) ("**BCLS manual**") would be the version that is closest to the manual that would have been used for 2011.[2]

21. The BCLS manual provides for a number of preliminary steps to be taken before performing chest compressions. After ascertaining that the patient's responsiveness and activating emergency medical service (including the calling of an ambulance), the next crucial step to be taken is found in Step 4 of the BCLS manual and it states:

> "Step 4: Position the victim
>
> For CPR to be effective, the victim must be lying on his/her back on a firm, flat surface. If the victim is lying face down, or on his/her side, the rescuer will need to roll the victim over onto his/her back. Do take care that the head, neck and body are supported and turned simultaneously during repositioning, to avoid aggravating any potential cervical spine injury."

22. According to Prof PE1, it was emphasised during BCLS training that the patient should be lying on a firm flat surface for effective CPR. He explained that such a surface would offer counterforce during compression and would enable the blood to be squeezed out of the heart's chambers. The rescuer's shoulders should be directly over the patient, with his elbows locked in extension and with his weight directly over his clasped hands placed on the lower sternum. Prof PE1's evidence was that even under optimal conditions, CPR only provides 30% of normal cardiac output, which is the bare minimum needed to keep the brain and other vital organs alive before normal circulation is restored by advance resuscitation interventions.[3]

23. Dr PE2 gave expert evidence from his perspective as a family physician. In his opinion, a person undergoing resuscitation for cardiac / respiratory arrest must be treated in the correct position. The person may not be in an optimal position for the resuscitation and will need to be moved rapidly but safely into the correct position. He agreed that a hard surface is required under the patient to provide uniform force and sternal counter pressure. Chest compression at inadequate rate and depth with insufficient recoil leads to unfavourable clinical outcomes. He also observed that there are situations when patients are in prone or lateral positions, under general anesthesia in operating rooms,

---

[2] Singhealth's Basic Cardiac Life Support Course electronic book (25 September 2012) was found at Tab 4 of Prosecution's Bundle of Documents.

[3] Paragraph 13 of Prof PE1's report dated 27 December 2021.

undergoing surgeries and suffer cardiac arrest. The preferred position is to turn the patient supine to perform CPR.[4]

24. The general rule that CPR should be performed with patients lying on their back on a firm flat surface was also accepted by the Respondent's expert, Dr DE. In his report[5], he explained that during chest compressions, compression of the sternum squeezes the heart between the sternum and the spine which causes blood to flow from the heart to the aorta and to the various parts of the body (including the brain). As much effort is required to perform chest compressions, performing chest compressions with patients in the supine position enables the rescuer to keep the shoulders directly over the patient's sternum. The rescuer can use the body weight to compress the sternum and hence reduce fatigue.

25. The experts further gave their views on the effectiveness of administering CPR on the Patient who was in a seated position. Dr DE explained that more effort would be required to perform chest compressions on a patient in a seated position. In addition, performing CPR in the sitting position poses a mechanical disadvantage compared to the supine position as the blood from the heart will have to flow against gravity to reach the brain[6].

26. Prof PE1 was of the view that the manner in which the Respondent had administered CPR was not consistent with the BCLS guidelines. This is because it was impossible to provide effective compression as the Patient's back was not against a firm surface. Any blood pumped out into the arteries had to work against gravity to reach the brain.[7] Prof PE1 acknowledged that it was not specifically taught in the BCLS course that the rescuer should reposition a victim from the sitting position to a supine position as it was not possible to cover all scenarios and locations in which cardiac arrest may occur. However, the principles of effective CPR were taught and persons who are trained and certified in BCLS should be able to reposition the victim appropriately. Further, all the diagrams illustrating CPR showed chest compressions being performed with the patient

[4] Paragraph 13 of Dr PE2's report dated 30 October 2021
[5] Paragraph 19-20 of Dr DE's first report dated 11 March 2020 ("**Dr DE's first report**").
[6] Paragraph 21 of Dr DE's first report.
[7] Paragraph 17 of Prof PE1's report.

lying supine on the floor. It was not taught in BCLS that it is acceptable to perform CPR on a patient in a sitting position.[8] Dr PE2 also opined that a patient suffering from cardiorespiratory arrest in a seated position must be lowered to the floor to achieve effective chest compression.[9]

27. In our view, the Respondent was certified to administer CPR in accordance with the training he had received at BCLS course and he ought to know that administering CPR while the Patient was in a seated position is not an effective way to resuscitate him. We accept Prof PE1's evidence that the Respondent would have been taught to administer CPR with the patient being in a supine position and that the principles of effective CPR would have been explained to the Respondent. This is why Step 4 of the BCLS manual contained specific instructions to reposition a patient so that he is lying with his back on a firm flat surface for CPR to be effectively administered. As explained by all the experts, compressions should generally be done with a patient lying on a firm flat surface. This is necessary to achieve the desired depth of compression needed for effective CPR with the firm flat surface acting as a counterforce. The key objective of such chest compressions is to pump blood from the heart to other parts of the body especially the brain. Administering CPR while a patient is in a seated position makes it difficult (or almost impossible) for a rescuer to achieve the necessary depth of chest compression and it is also counterproductive because the rescuer has to work against gravity to pump the blood up to the brain.

28. Counsel for the Respondent argued that the Respondent should not be expected to know that there was a need to reposition the Patient from a seated position to a supine position since it was not specifically taught in the BCLS course. This contention is, in our view, untenable. He was trained to administer CPR with the patient in a supine position. He was never taught that it would be acceptable to administer CPR while a patient is in a seated position. As the principles of effective CPR were taught, it would be reasonable to expect a medical practitioner to be able to apply these principles and react accordingly in the given circumstances even in the absence of prescriptive instructions in the BCLS course. In particular, Step 4 of the BCLS manual clearly illustrated the

[8] Paragraph 22 of Prof PE1's report.
[9] Paragraph 13(c) of Dr PE2's report.

importance of repositioning a patient to the supine position. Moreover, the Respondent was no stranger to collapse cases and he had experience dealing with such emergency situations in his previous postings in the hospital. Therefore, given his experience and training, he would know that CPR is not normally performed with a patient in a seated position. In this connection, we note that the Respondent admitted during cross examination that he had never performed CPR or witness CPR being performed on a patient in a seated position. He was also never taught to administer CPR with the patient in a seated position.[10]

29. For completeness, we now turn to the Respondent's contention that Dr PE2's expert opinion on BCLS should be disregarded because Dr PE2 could not show that he was BCLS-certified at the time of the incident even though he was BCLS-certified from November 2018 to November 2020. Given that the key differences between the different iterations of the BCLS manuals lie in the depth and rate of chest compression and not how the patient should be positioned for CPR, we do not agree that Dr PE2's evidence should be disregarded just because he could not produce proof that he was BCLS-certified as at 2017. In any event, we note that Counsel for the Respondent accepted that Dr PE2 can give his opinion on how a family physician would react in such an emergency situation. Therefore, Dr PE2's opinion on what he would have done if he were in the Respondent's position remains relevant.

Whether the Respondent's failure to reposition the Patient to a supine position before administering CPR is justifiable in the circumstances of this case

30. Much of the evidence adduced during the inquiry revolved around the question of whether the Respondent's conduct was reasonable in the circumstances of this case such that he could not be said to have fallen below the minimum standards of acceptable care.

31. While it is the general position that CPR should be conducted on a person in a supine position, the experts also acknowledged that there are exceptional circumstances where this could not be done.

[10] Transcripts on 9 May 2022 at page 178.

32. Dr DE opined that there may be exceptional circumstances where laying a patient into supine position before performing CPR is not possible. For example, it may not be possible to do so due to spatial constraints (eg in the small elevator) or where there are manpower constraints (where there is insufficient manpower to reposition the patient from a chair or bed to the floor). In such exceptional circumstances, CPR may be performed without laying the patient in a supine position.[11]

33. Prof PE1 gave two illustrations in his report where he stated that if a patient was trapped in his seat in a car crash or was in a confined space such as a diving bell, the paramedics would have to try their best to achieve chest compression in whatever way they can before the patient can be evacuated. He added that such exceptions are very limited and where there is an option to lay the patient supine on the floor, that should always be done. Even in the narrow confines of a commercial aeroplane, it is possible to lay the patient down on the floor of the aisle while the rescuer modifies his position by straddling the patient's legs or performs over-the-head compressions.[12] In his view, manpower and spatial constraints are not exceptions to the general rule to administer CPR while the patient is in a supine position on a firm and flat surface.[13]

34. Dr PE2 gave evidence that the act of transferring an unconscious patient from a seat on to the floor would place the rescuer(s) at high risk of injury. The optimal number of persons needed to perform this transfer is three. It would be a less-than-optimal transfer if fewer than three persons is attempting it. In many clinical settings, additional rescuers may be expected to arrive at the scene within a very short time and in such circumstances, it may be more appropriate to wait for help rather than risk personal injury. Any risk of injury must be balanced against the risk of delaying CPR and thereby reducing the chance of a successful outcome. This is especially relevant if the Respondent was alone and had no one to assist him.[14]

[11] Paragraph 22 of Dr DE's first report.
[12] Paragraphs 18 to 19 of Prof PE1's report.
[13] Paragraph 22 of Prof PE1's report.
[14] Paragraphs 14 to 15 of Dr DE's report.

35. The issue before us is whether exceptional circumstances exist in this case that would justify the administration of CPR on the Patient who had collapsed in a seated position without attempting to transfer him to the floor, while waiting for paramedics to arrive.

36. The Respondent was given an opportunity to respond to the complaint and he provided a Written Explanation on 15 September 2017 about 9 months after the incident. In the Written Explanation, he gave three reasons for not laying the Patient in a supine position: (a) there was a lack of space to lie the patient down at the narrow space of the walkway corridor; (b) he was in a "very chaotic situation" with Ms PW3 walking in and out to look for ambulance and Ms PW was there looking at the Patient's progress; (c) Ms PW, Ms PW3 and Mr PW2 were standing behind and blocking him from laying the patient down into supine position. During cross examination, the Respondent clarified that for (a), he was referring the treatment room.[15] In the Respondent's subsequent written statement for the inquiry dated 27 December 2021, he gave additional reasons for his actions including the lack of training or experience, difficulties in transferring the Patient and the additional time needed to transfer which would result in delay in commencement of CPR. We will now deal with the Respondent's contentions summarised in the closing submissions as outlined in paragraph 17 above.

(a) Insufficient space in the treatment room

37. A key plank of the Respondent's defence is that there was insufficient space to transfer the Patient to the floor before administering CPR.

38. For the purposes of the inquiry, the parties tendered a series of photographs of the treatment room and the Clinic. These photographs were taken during Dr DE's site visit at the Clinic on 18 October 2019. Dr DE took measurements of the treatment room and he recorded the measurements as 240 cm in length and 177 cm in width. On one side of the treatment room, there was a table with a nebulizer and two plastic foldable chairs. The treatment room was also used to store objects such as boxes, foldable trolleys and a wheelchair. The Respondent contended that there were renovations made to the

[15] Transcripts on 9 May 2022 at page 159.

treatment room after the incident in 2017 and that the actual size was approximately only 177 cm in width and 80 cm in length.

39. Based on the evidence before us, we find that the layout of the treatment room in 2017 is represented by the photographs taken during the 2019 site visit. Ms PW3 has worked as a clinic assistant at the Clinic since 1999 and became the group supervisor in 2011. Mr PW2, who is Ms PW3's son, has worked part-time at the Clinic since 2014 and would typically work there three times a week. Both had worked at the Clinic for a long time. They confirmed that there was no change to the layout of the treatment room and that no renovations were carried out to the treatment room that altered its size. This was also confirmed by Dr PW4, who is the clinic manager for the Clinic. As the clinic manager, it would not be possible for renovations to take place without his knowledge. We found the evidence given by these witnesses to be credible and reliable. The paramedics who attended to the Patient also confirmed that the treatment room was of the same size.

40. By way of contrast, the Respondent's recollection of the layout of the treatment room had been proven to be inaccurate and full of inconsistencies. Even though he made inquiries with other colleagues who had worked as a locum doctor in the Clinic, just like him, they were unable to corroborate his assertion that the treatment room was much smaller than shown in the photographs. His assertion that the length of the treatment room was only 80 cm in length was also contradicted by his own evidence given during cross examination. He was invited to provide an estimate of the length of the room using the furniture in the DT hearing room as a reference and measurements were taken after that. Based on his own estimate, the length of the treatment room was 288 cm (which was much closer to the measured length of 240 cm) and more importantly, significantly longer than 80 cm as he had claimed.[16] When queried by this tribunal as to why he did not make any mention of this in his Written Explanation since he had visited the Clinic in September 2017 before he provided his Written Explanation, he could not give a satisfactory response.[17] It is indeed puzzling to us why there was no

[16] Transcripts on 9 May 2022 at page 139.
[17] Transcripts on 20 May 2022 at pages 181 and 182.

mention of this especially since this would clearly be material to his defence if the room had a different layout compared to the time of the incident.

41. Below are photographs to show the interior layout of the treatment room and the area of the Clinic just outside the treatment room.[18]

42. During the site visit, Dr DE laid on the floor of the treatment room with Mr PW2 kneeling next to him to show the amount of space in the treatment room. The following photographs were taken with Dr DE lying in different positions – one where he was completely within the treatment room and one where part of the upper torso was outside the doorway to the treatment room.[19] According to Mr PW2, after the paramedics

[18] These are photographs found in the Agreed Bundle of Documents ("**AB**") at AB 27, AB 32, AB 30 and AB 28 respectively.
[19] These are photographs found in AB 37 and AB 41 respectively.

transferred the Patient to the floor, the head of the Patient was just outside the doorway of the treatment room with the rest of the body inside the treatment room. In other words, the second picture below would be representative of the position of the Patient was in when the paramedics were attempting to resuscitate him. Ms PW3 corroborated Mr PW2 evidence on this.

43. There were four paramedics from the SCDF who attended to the Patient: Mr PM1 ("**Paramedic 1**"); Mr PM2 ("**Paramedic 2**"); Mr PM3 ("**Paramedic 3**") and Mr PM4 ('**Paramedic 4**"). Paramedic 1, Paramedic 2 and Paramedic 3 were involved in transferring the Patient to the floor and performing CPR. Paramedic 4 was the Emergency Medical Technician driver who dropped off the other paramedics at the Clinic. He returned to the Clinic after parking the vehicle and he laid a canvas on the floor for the Patient but was not involved in the transfer of the Patient or the administration of the CPR. Paramedic 3 did not give evidence at the inquiry.

44. The paramedics commenced manual CPR before they proceeded to use the LUCAS machine for machine aided CPR. They also fitted the Patient with a laryngeal mask airway for the Patient to keep his airway open. Paramedic 1, Paramedic 2 and Paramedic 4 each had differing recollections regarding the position of the Patient after he was transferred to the floor. Paramedic 1 could not remember exactly whether the Patient's upper or lower body was positioned inside the treatment room after the transfer.[20] According to Paramedic 2, the upper body of the Patient was outside the

[20] Paramedic 1's written statement dated 25 May 2022 at [29] and [30].

treatment room.[21] Paramedic 4's evidence was that the Patient was laying fully outside the treatment room along the corridor of the Clinic.[22]

45. Given the different roles played by the paramedics, we are inclined to believe that Paramedic 2's recollection of the position of the Patient would be more accurate compared to that of Paramedic 4's. Further, Paramedic 2's evidence was also more consistent with that of Ms PW3 and Mr PW2 even though there is some discrepancy as to whether it is just the head or part of the upper body was laid outside the treatment room. In our view, this difference is not material which we will explain below.

46. The evidence shows that the Patient need not be moved entirely out of the treatment room for manual CPR to be administered by the paramedics. There were specific reasons why the paramedics had to move the Patient's upper body further outside the treatment room. As explained by Paramedic 1, the paramedics required more space for them to perform the machine aided CPR using the LUCAS machine. Paramedic 1 explained that more space around the Patient's upper torso was needed for the paramedics to slide the backplate of the LUCAS machine under the Patient's body before commencing machine aided CPR. This backplate measured approximately 43 cm by 17 cm.[23] In addition, Paramedic 2 also explained that the Patient's head and upper body was positioned outside the treatment room where there was more space for one of the paramedics to position himself at the Patient's head to insert the laryngeal mask airway.[24] In our view, the fact that the paramedics chose to place the Patient partially outside the treatment room did not prove that there was insufficient space in the treatment room for CPR. The paramedics had to do so to in order to use their equipment. These are not considerations which would be relevant to the Respondent who would only be doing manual CPR.

47. Prof PE1 and Dr PE2 both gave their opinion on whether there were spatial constraints which stopped the Respondent from transferring the Patient to the floor. Prof PE1 was of the view that even though the space in the treatment room was small and it may be

---

[21] Paramedic 2's written statement dated 27 May 2022 at [27].
[22] Paramedic 4's written statement dated 27 May 2022 at [15].
[23] Transcripts on 10 June 2022 at page 33.
[24] Paramedic 2's written statement dated 27 May 2022 at [27].

uncomfortable for the Respondent, CPR could have been administered there with the Patient lying supine on the floor and the Respondent kneeling next to him. Dr PE2 was of the same view. Even though the space was small, it was not impossible to lie the Patient supine as was demonstrated by the paramedics' ability to do so when they did the transfer.

48. Dr DE also acknowledged that it was possible to perform CPR with the Patient lying fully within the treatment room even though the positioning of the Respondent would not have been optimal.[25] However, when probed further by Counsel for the SMC, Dr DE refused to give an opinion on whether it would have been preferable to perform CPR with the Patient lying supine in the tight space compared to performing CPR with the Patient in a seated position. However, Dr DE confirmed during cross examination that administering CPR in a tight space compared to administering CPR on a patient in a seated position would have two advantages: (a) there is greater counterforce than if the Patient was in a seated position; and (b) any blood flow from squeezing the heart would not have to work against gravity.[26] Notwithstanding these concessions, Dr DE refused to comment on whether CPR done with the Patient in supine position would be more effective.

49. In our view, while the treatment room was not spacious, it was big enough for the Patient to be laid in a supine position on the floor as shown in the photographs taken with Dr DE and Mr PW2. In terms of build, Dr DE is taller than the Patient and Mr PW2 is bigger in size compared to the Respondent:

    (a) At the time the photographs were taken, Mr PW2 was approximately 175 cm tall and weighed 78 kg. Dr DE was 180 cm tall and weighed 90 kg.
    (b) At the time of the incident, the Respondent was 164cm tall and weighed 50kg. The Patient was 174 cm tall and weighed 72 kg.

50. If there was sufficient space for Dr DE and Mr PW2 (who were both of a bigger build) to be positioned side by side in the treatment room, the Respondent should have sufficient space to kneel next to the Patient to perform CPR. While the Respondent's

[25] Transcripts on 20 May 2022 at page 81.
[26] Transcripts on 20 May 2022 at page 85.

position may not be optimal for chess compression due to the tight space, the administration of CPR on the Patient lying supine from this position would still be more effective than the administration of CPR with the Patient in a seated position. As explained earlier, the counterforce provided by the firm flat surface is essential to help the rescuer achieve the required depth of compression. This would have improved the Patient's chances of survival.

51. The fact remains that the paramedics were able to lay the Patient on the floor before administering CPR. Based on Paramedic 2's recollection, they did not shift any furniture in the treatment room or move any furniture out of the treatment room before transferring the Patient to the floor. This on its own shows that the Respondent's contention of a lack of space is untenable. He made a subjective assessment which turned out to be erroneous. In our view, it did not matter whether the Patient laid entirely within the treatment room or only partially so. It was not in dispute that there was no door leading to the treatment room. Instead, there was just a doorway that led to another open space in the corridor of the Clinic. There is no particular reason why the Patient had to be placed squarely within the treatment room before administering CPR. What was critical is for the Patient to lie down on a firm flat surface so that effective CPR can be administered. It was open to the Respondent to create more space (if necessary) by moving part of the Patient's body out of the doorway, as the paramedics did. He could also have created more space within the treatment room by instructing the clinic assistants or Ms PW to push the movable objects such as the wheelchair or the trolleys out of the treatment room.

(b) Not trained to transfer the Patient

52. The paramedics gave evidence on how a 3-man transfer was done for the Patient. Paramedic 3 and Paramedic 2 each stood on the Patient's left and right side and they lifted the Patient off the chair by supporting his armpits. They rotated the Patient in a clockwise direction such that his back was facing the doorway. Paramedic 1 supported his head and back. The Patient was moved backwards before he was lowered onto the ground in a supine position. According to Paramedic 1, they had to use their strength to lift the Patient out of the chair but they minimised the use of force and avoid lifting against gravity.

53. The Respondent contended he was not trained in the BCLS course to transfer a patient from a sitting to a supine position. He also did not have prior experience of such transfers in the various cases cardiac arrest cases he attended to in KTPH. None of the clinical assistants in the Clinic were trained on patient transfer. Therefore, his conduct in not attempting to transfer the Patient did not fall below the minimum acceptable standard of care.

54. As a preliminary observation, we note that this issue of lack of training was not raised by the Respondent in his Written Explanation given in 2017. He stated "The patient moved while I was doing the CPR. When I thought to lie the patient to supine position to continue CPR. The ambulance and paramedics arrived and took over the patient and sent him to the hospital". There was no indication that he thought that manpower constraints would be an issue. This manpower issue was raised after the Respondent had sight of Dr DE's observations in his first report given in 2020 that the Respondent may not have known or have been trained in the best technique to carry an unconscious patient sitting on a chair to lie flat on the floor. For the purposes of the inquiry, we will give the Respondent the benefit of the doubt and proceed on the basis that this was a consideration which was operating on the Respondent's mind at the material time.

55. Prof PE1 and Dr PE2 were both of the view that the patient transfer could be safely done by three persons or even two persons. Both provided similar illustrations in their respective reports on how such transfers could have been effected and they agreed that the Respondent could have obtained assistance from the clinic assistants and Ms PW for the transfer.

56. At [29] and [30] of Prof PE1's report, he explained two possible methods of transfer:

(a) <u>Method 1</u>: The chair, with the Patient still sitting on it, is rotated such that he is aligned with the long axis of the room. Then with one person supporting and protecting his head, the helper pulls the Patient in a controlled slide off the chair. Once the Patient's buttocks are on the ground, the chair is removed, and the Patient's torso and head lowered into a full supine position.

(b) Method 2: Without moving the chair, with one person standing at the Patient's side supporting and protecting the head, the helper slides the Patient off the chair in a controlled manner. The Patient's knees will most likely have to be flexed due to the narrow breadth of the room. Once the Patient's buttocks are on the floor, he is then rotated to align with the long axis of the room before being laid on the ground.

Prof PE1 further explained during cross-examination that the natural tendency would be for the Patient to collapse and the transfer was, in essence, a "controlled topple". The Respondent could have gotten his assistants to control the head while he tips the patient over and brings him to the ground.[27]

57. Dr PE2 further expressed the view that it should have been instinctive for the Respondent to assign Mr PW2 (being the strongest person) to do the heavy lifting and the Respondent would focus on neck stabilization during the transfer. Ms PW3 and Ms PW could have also assisted Mr PW2 with the shifting of the Patient while the Respondent stabilised the head.[28]

58. Prof PE1's opinion was that patient transfer need not be explicitly taught in the BCLS course and that it would be reasonable to expect the rescuer to be able to mobilise help to lower someone safely onto the floor. It is also not necessary for the persons assisting with the transfer to be trained or experienced in patient transfer.[29] Dr PE2 was of the same view. While it would have been safer and more expedient to make the transfer if all persons at the scene are trained in such patient transfer, the lack of specific training on patient transfer would not justify or excuse the Respondent from attempting to coordinate a transfer in a manner best possible under the circumstances. An inaction will mean no chance of initiating effective CPR and no chance of improved survival for the Patient.[30]

[27] Transcripts on 9 May 2022 at page 29.
[28] Transcripts on 9 May 2022 at pages 95 to 97.
[29] Prof PE1's report at [31].
[30] Dr PE2's report at [13f] and [13g].

59. On the question of whether the paramedics would seek assistance from untrained bystanders, Paramedic 1 gave evidence that he would normally rely on trained personnel to assist. However, if he were alone and the paramedics crew were not around, he would enlist the help of an untrained bystander due to the urgency of the situation.[31] Paramedic 2 gave evidence that typically three persons of medium build trained in patient transfer would be required for an optimum transfer. If there are only two persons, a transfer should still be made to give the patient the best possible chance of survival. He also testified that an untrained bystander may be enlisted to assist and the paramedics would be responsible for issuing commands to the assisting bystanders.[32]

60. Dr DE took a different view. His evidence was that the Respondent faced manpower constraints that prevented the Respondent from transferring the Patient to a supine position. He explained that the Respondent was not trained in the mechanics of patient transfer. Without the BCLS training, the clinic assistants would also have been even less able to assist the Respondent on an attempted transfer. Even if the Respondent had the requisite knowledge and available manpower to safely attempt the transfer, the Respondent and the clinic assistants are all of small build and therefore they are unlikely to have enough strength to transfer the Patient. He was of the view that patient transfer would not be an easy task. Whether a transfer can be made would depend on the varying capabilities of the doctor and bystander. If the Respondent had thought through the situation and assessed that a transfer was not feasible, he should continue to do chest compression in a sitting position and not attempt to make a transfer.

61. The evidence before us is that 3-man transfer is optimal and a 2-man transfer can still be safely executed. While it would be ideal for the transfer to be effected by trained personnel, the evidence show that it is not a necessary requirement. We are satisfied on the evidence that the Respondent could and should have called upon Mr PW2, Ms PW3 and Ms PW to assist with the transfer and there was sufficient manpower to make an attempt at transferring the Patient to the floor instead of continuing with ineffective CPR with the Patient in a seated position. Mr PW2 (who was of bigger build than the

[31] Transcripts on 10 June 2022 at page 28.
[32] Transcripts on 10 June 2022 at page 54.

Patient) was with him in the treatment room and he could have helped with the heavy lifting since the Respondent was of a significantly smaller build. Ms PW3 was available to assist if she had been called upon. Ms PW was also standing in the vicinity.

62. We do not agree with Dr DE's opinion that as long as the Respondent makes a subjective assessment that it would not be feasible to attempt a transfer, the Respondent cannot be faulted for continuing with the CPR with the Patient in a sitting position. Whether the Respondent has met the minimum standards of acceptable care cannot be subjectively determined by the Respondent. As stated in *Peter Yong*, the charge under section 53(1)(*a*) involves an objective assessment of standards of medical care which can be reasonably expected of medical practitioners. This calls for a consideration of what reasonable medical practitioners would expect of their peers in delivering medical care.

63. For completeness, we need not make a determination on whether the Respondent should have attempted to transfer the Patient on his own in a 1-man transfer as this issue is moot given the manpower that the Respondent had at his disposal.

64. In our view, the fact that the Respondent was not given specific instructions at the BCLS course on how to transfer a patient from a seated position is not a valid justification for not even attempting to transfer the Patient to the floor before administering CPR. Having gone through the BCLS training, the Respondent ought to know what position the Patient should be placed in for the purposes of CPR. It is pertinent to note that Step 4 of the BCLS manual contained instructions on how to mitigate the risk of injuring the patient during repositioning. It required the rescuer to take care that the head, neck and body of the patient are supported and turned simultaneously when repositioning the patient by turning him/her over onto his/her back. These general principles would equally apply to a transfer of the Patient from a chair to the floor and as a trained medical practitioner. Using these principles, the Respondent should be able to give instructions to provide proper support for the Patient's head during the controlled descent to the floor. On the Respondent's own evidence given during cross-examination, he would attempt a transfer if there was

sufficient space in the treatment room and he would have done so notwithstanding that he did not have formal training on patient transfer.[33]

(c) Attempted transfer of the patient would cause delay in administering CPR

65. Counsel for the Respondent submitted that the Respondent was right to commence CPR immediately instead of attempting to transfer the Patient to the floor as any attempt to transfer may cause significant delay. In Dr DE's report, he emphasized the importance of continuous or uninterrupted chest compressions. His view is that the transfer of a patient from a sitting to a supine position requires time, especially with untrained personnel, as it is a process that should be handled with care. During this period of time, CPR could not be administered to the Patient.[34] Dr DE agreed that a delay of 10 to 12 minutes for effective CPR to be performed would reduce a victim's chances of survival but whether the reduction would be significant would depend on the underlying condition of the victim.[35] Further, the Respondent submitted that the SMC had not adduced any evidence of how fast it would take to make the transfer.

66. SMC's experts disagreed with this analysis. Dr PE2 explained that there is no evidence that an ineffective CPR from the start is superior to quickly repositioning the Patient supine and starting effective CPR as soon as possible. Dr PE2 also referred to a study which showed that the chances of survival would be reduced if there is a longer delay in CPR initiation.[36] He disagreed with Dr DE that the risk in delaying CPR outweighed the importance of repositioning the Patient into supine position before performing CPR.[37] In his view, ineffective CPR is as good as no CPR.[38] In his view, the preparation to move the patient may have taken one to two minutes as everyone needs to be in position and instructions need to be given. Thereafter, the actual transfer should only take a few seconds.[39]

[33] Transcripts on 9 May 2022 at page 191.
[34] Dr DE's second report dated 14 September 2021 ("**Dr DE's second report**") at paragraphs 36 and 37.
[35] Transcripts dated 20 May 2022 at page 21.
[36] Dr PE2's report at page 16.
[37] Dr PE2's report at paragraph 29.
[38] Transcripts on 9 May 2022 at page 89.
[39] Transcripts on 9 May 2022 at page 97.

67. In Prof PE1's opinion, performing CPR while the Patient was in a seated position would be ineffective because the Patient's back was not against a firm surface. Prof PE1 indicated in his report that ineffective CPR for the estimated 9 minutes that it took for the ambulance to arrive, would have decreased the Patient's chances of survival by 90%. In support, he referred to the *SFRAC's Basic Cardiac Life Support + Automated External Defibrillator Manual (2018)* where it was stated that at the start of a cardiac arrest, the oxygen level in the blood decreases, causing brain damage. If this situation is reversed immediately, survival chance could be as high as 90%. With a 6 minutes delay, this drops to 40-50% and at 9 minutes, it is at 10%.[40] During cross-examination, he clarified that the extract did not show that there would be a drop in the chance of survival by 90%. His position remained that a short delay in starting CPR to transfer the Patient to the floor is not expected to affect the survivability as it then allows effective CPR to be administered thereafter. In his view, the transfer would not take more than 30 seconds.[41] Even if longer than 30 seconds was needed, it would still be better than doing ineffective CPR for the whole duration of time while waiting for the paramedics to arrive.[42]

68. In response, Dr DE explained during cross examination that the excerpt referred to by Prof PE1 would be applicable to a patient with a sudden cardiac arrest due to ventricular fibrillation and the most common cause is heart attack. However, the Patient was in cardiac arrest due to a fatal asthmatic attack and the Patient was not breathing in enough oxygen. In such a case, the prognosis would be worse. His chances of survival would have been 10% even with an optimal set-up. He also stated in his report that out of 11,061 out-of-hospital cardiac arrests between 2011 and 2016 in Singapore, only 440 survived, being a low survival rate of 4%.[43] At this juncture, we note that the study which Dr DE relied on dealt with out-of-hospital cardiac arrest cases in general and it was not a study on out-of-hospital cardiac arrest cases that happened in a clinical setting. We will explain the significance of this in the later part of the judgment.

---

[40] Prosecution's Bundle of Documents at page 19.
[41] Prof PE1's report at [24].
[42] Transcripts on 9 May 2022 at page 28.
[43] See Dr DE's second report at paragraph 22.

69. The crux of the Respondent's argument is that it is better to immediately commence and to continue with ineffective CPR rather than to spend some time trying to put the Patient in a supine position for more effective CPR. We have difficulties accepting this argument. Even though the experts did not fully agree on the *extent* to which the survivability of the Patient would have been affected by delay in commencing CPR, what is clear to us is that the sooner effective CPR is administered on the Patient, the better the chances he would have in surviving. This was not disputed by all the experts. Based on the evidence, the transfer could take between 30 seconds or up to a few short minutes, depending on how well coordinated the effort was. If the Respondent had transferred the patient, he would still be able to administer more effective CPR before the paramedics' arrival.

70. In our view, any delay in commencing effective CPR would still give the Patient a better chance of surviving compared to futile and ineffective CPR with the Patient in a seated position. In this case, the Patient had ineffective CPR for almost 10 to 12 minutes. The failure to provide any effective CPR during this period would have reduced the Respondent's chances of survival substantially. As Dr PE2 put it, ineffective CPR is as good as no CPR. The failure to move the Patient to the correct position meant no chance of initiating effective CPR and no chance of improved survival for the Patient. We agree with these observations. This is the case even if we accept Dr DE's evidence and assume that the Patient may only have had 10% chance of survival under an optimal set up for CPR. The fact remained that his chances of survival were diminished by the actions of the Respondent. Just because he may have had a lower chance of survival at the outset did not mean that this reduction would not be significant. In such circumstances, it would be even more critical that effective CPR was provided as soon as possible to give him a fighting chance of survival.

(d) Possibility of injury to the Patient and the Respondent or persons assisting with the transfer

71. The Respondent raised the argument that there was a risk of aggravating or causing injury to the Patient if the transfer was not properly done. In addition, there would be a risk of injury to him and the assistants as they are of smaller build compared to the

Patient. Dr DE also opined in his report that the Patient is of a relatively large build compared to the Respondent and his clinic assistants. This would have increased the safety risk of making a transfer.[44]

72. In our view, the risk of injury to the Respondent, persons assisting with the transfer or the Patient is overstated. To begin with, the evidence is that a safe transfer can be made by three persons and we know for a fact that the treatment room was big enough for three persons to enter, which was what the paramedics did. The Respondent had the requisite manpower to perform a similar 3-persons transfer. While the Respondent was of a smaller build compared to the Patient, this factor on its own is not determinative. We are not dealing with a situation where the Respondent had to do the transfer on his own. Mr PW2, who was in the treatment room with the Respondent, would be able to assist with the heavy lifting since he was relatively young (at 20 years of age) and was of a bigger build than the Patient. Together with the assistance of one other person (whether it is Ms PW3 or Ms PW), the Respondent and Mr PW2 should be able to safely move the Patient to the floor without causing further injury to the Patient or to themselves.

73. We would add that, as far as the Patient is concerned, we are of the view that the benefit of administering potentially life-saving CPR on the Patient would outweigh any risk of injury to the Patient that may result in the course of transferring the Patient. The Patient was already in cardiac arrest. If no effective CPR is done, the Patient would not survive. The immediate task that the Respondent was faced with was to resuscitate the Patient. This paramount consideration would outweigh other considerations such as the possibility of injury to the Patient.

74. For the reasons given above, we find that the SMC has proved the charge under section 53(1)(*e*) of the MRA beyond a reasonable doubt that the Respondent had failed to provide professional services of the quality which is reasonable to expect of him by administering CPR while the Patient was still in a seated position. In our view, the Respondent ought to have made an attempt to move the Patient to the floor instead of doing CPR with the Patient in a seated position for 10 to 12 minutes. The Respondent

[44] See Dr DE's 2nd report at paragraph 35.

had sufficient manpower to assist him with a safe transfer. The Respondent's failure to undertake the elementary step of placing the Patient in a supine position before administering CPR, as he was trained in BCLS course to do, had denied the Patient his best possible chance of survival. Based on his training, he should know that performing CPR in the manner he did was ineffective. It did not matter that the Respondent was not taught specifically on how to transfer a collapsed patient from a seated position to the floor. He had been taught the fundamental principles of effective CPR; how CPR ought to be done with a victim lying on a firm hard surface; and the need to reposition a victim who is lying face down or on his/her side and how this can be done safely by supporting the head, neck and body. It is reasonable to expect a BCLS-trained medical practitioner to be able to apply these principles in the given emergency situation he may face and improvise accordingly.

75. We agree with the SMC that members of the public are entitled to expect that a BCLS-trained doctor working in a family clinic would perform and execute the minimum standards expected of him in resuscitation efforts to save the patient. We accordingly convict the Respondent of the charge.

Submissions on sentencing

76. The SMC submitted that the sentencing framework in *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526 ("***Wong Meng Hang***") and the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals dated 15 July 2020* ("**Sentencing Guidelines**") would be applicable in this case.

77. Counsel for the Respondent raised a preliminary issue as to whether the DT should apply these principles for a charge under section 53(1)(*e*) of the MRA. It was argued that the framework is not applicable because the doctor in *Wong Meng Hang* faced a charge of professional misconduct under section 53(1)(*d*) of the MRA which is not the charge the Respondent faced. Since the Respondent did not face a professional misconduct charge, the sentence should be lower than what is set out in the sentencing framework in *Wong Meng Hang*.

78. We agree with the SMC that the sentencing framework in *Wong Meng Hang* and the Sentencing Guidelines are applicable to this case. Even though the charge considered in *Wong Meng Hang* related to section 53(1)(*d*) of the MRA, the court in pronouncing the sentencing framework to calibrate the range of sentences had intended it to apply to cases where there were deficiencies in doctor's clinical care causing harm to a patient (see [36]). This would be broad enough to cover disciplinary offences under section 53(1)(*e*).

79. It was made clear at [45] of the Sentencing Guidelines that the sentencing framework would apply not only to professional misconduct (section 53(1)(*d*) of MRA) but also to all five limbs under section 53 of the MRA. In a recent decision of the Court of Three Judges in *Ong Kian Peng Julian v SMC and other matters* [2022] SGHC 302, the court endorsed the position taken in the Sentencing Guidelines and held that the sentencing framework was applicable to non-clinical offences. The court went on to determine the appropriate sentence to be given to two doctors for their improper acts or conduct which brought disrepute to the medical profession under section 53(1)(*c*) of the MRA. In our view, the application of the sentencing framework under *Wong Meng Hang* is not confined to only cases under section 53(1)(*d*) of the MRA exclusively and the general factors laid out in the framework would remain relevant for offences under other limbs of section 53 of the MRA.

80. The four steps of the *Wong Meng Hang* sentencing framework are summarised below:

(a) Step 1: The first step is to evaluate the seriousness of the offence with reference to harm and the culpability of the doctor. In this regard, harm encompasses bodily harm, emotional and psychological harm, economic harm, harm to society including harm to public confidence in the medical profession, as well as potential harm that could have resulted but did not materialise.

(b) Step 2: Identify the applicable indicative sentencing range using the following sentencing matrix:

Harm / Culpability	Slight	Moderate	Severe
Low	Fine or other punishment not amounting to suspension	Suspension of 3 months to 1 year	Suspension of 1 to 2 years
Medium	Suspension of 3 months to 1 year	Suspension of 1 to 2 years	Suspension of 2 to 3 years
High	Suspension of 1 to 2 years	Suspension of 2 to 3 years	Suspension of 3 years or striking off

(c) Step 3: Identify the appropriate starting point within the indicative sentencing range.

(d) Step 4: Adjust the starting point by taking into account offender-specific aggravating and mitigating factors.

Prosecution's Submissions on Sentence

81. The SMC submitted that the DT should exercise its powers under section 53 of the MRA to impose the following sentence:

(a) that the Respondent's registration in the Register of Medical Practitioners be suspended for nine (9) months;

(b) that the Respondent be censured;

(c) that the Respondent provides a written undertaking to the SMC that he will not engage in the conduct complained of and any similar conduct in the future; and

(d) that the Respondent pays the costs and expenses of and incidental to these proceedings, including the costs of the SMC's solicitors.

82. Applying the sentencing framework in *Wong Meng Hang* and *the Sentencing Guidelines*, the SMC submitted that the harm caused falls within the higher end of the "moderate" range because:

(a) The Respondent's actions significantly decreased the Patient's chances of survival which led to his demise. The very purpose of providing effective CPR is to keep the vital organs alive by providing oxygen and blood flow to the brain and heart while waiting for additional help to arrive. The failure to provide effective CPR in this case has a clear connection to the harm eventually caused to the Patient.

(b) There is a strong likelihood that the Respondent's actions resulted in a permanent and irreversible harm to the Patient. The longer the delay in administering effective CPR, the more likely permanent and irreversible damage to the brain would occur due to the lack of circulation of blood and oxygen to the brain. According to *SingHealth's Basic Cardiac Life Support Course electronic book (2 April 2017)*, the most sensitive organ is the brain and if circulation to the brain is not restarted within 4 to 6 minutes, permanent and irreversible damage can occur.[45]

83. The SMC submitted that the Respondent's culpability falls within the middle of the "low" range because:

(a) The Respondent had acted negligently in failing to reposition the Patient into a supine position.

(b) The Respondent had failed to adhere to the basic steps taught in BCLS and this is a clear departure from the standard of care reasonably expected of a medical practitioner. This is a factor that increases his culpability.

---

[45] Prosecution's Bundle of Documents at page 114.

(c) The fact that the incident occurred in an emergency setting would render him less culpable compared to a situation where the negligent conduct had been committed in relation to a non-emergency procedure. However, it must be acknowledged that all cases requiring the administration of CPR would take place in an emergency setting.

(d) The SMC had earlier submitted that this was a one-off offence and not an instance where the same act had been repeated over an extended period of time. At the hearing on 10 February 2023, the SMC submitted that this factor would have a neutral effect on culpability because it would be uncommon for a family physician to have to deal with cardiac arrest cases since it is not a common event.

84. The SMC submitted that the starting point for an appropriate punishment would be eight months suspension. Given the Respondent's lack of remorse and his conduct in the proceedings, the SMC asked for a one-month uplift of the suspension period. This would result in a global sentence of nine-month suspension term. The SMC submitted that the Respondent exhibited a clear lack of remorse and insight into his misconduct. Under [69(c)] of the Sentencing Guidelines, if the offender attempts to pin blame on others for his or her own improper conduct or continues to justify his improper conduct despite overwhelming evidence against him, that would amount to an aggravating factor. This was demonstrated by:

(a) The Respondent's insistence that the treatment room was of a different size in 2017 even though there was overwhelming evidence to the contrary from various witnesses (including the witnesses he summoned). His own witness statement was contradicted by his own assessment of the size of the treatment room during the inquiry. Notwithstanding this, he refused to accept that his assessment or recollection was erroneous.

(b) He even resorted to levelling allegations against Ms PW3, Mr PW2 by repeatedly asserting that they were telling lies to protect the Clinic and

insinuated that the renovations were made to the treatment room to increase its size after the incident. He provided no proof to back up his assertions.

85. The SMC submitted that there was no inordinate delay that would warrant the giving of a sentencing discount. Notwithstanding that there was around 2.5 years between the time the Respondent received the Notice of Complaint and the service of the Notice of Inquiry, this period was shorter than in other cases where the court found that there was inordinate delay (*Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("***Jen Shek Wei***") and *Yip Man Hing Kevin v Singapore Medical Council* [2019] 5 SLR 320 ("***Kevin Yip***")). In *Singapore Medical Council v BXR* [2019] 5 SLR 904 ("***BXR***"), the court found that there was inordinate delay as the SMC took 2.5 years to issue the Notice of Inquiry after the respondent provided his written explanation. The court held that the period of delay must be assessed with reference to the complexity of the case at hand. The issues in the proceedings below related to consent-taking and the documentation of this consent and the court found that these are not matters of great medical or legal complexity. That case can be distinguished from the present case where sufficient time was required by the SMC to prepare the relevant expert reports to deal with the novel issues for this case as this is the first case dealing with the issue of the standard of care expected of a BCLS-trained family practitioner administering CPR.

86. The SMC further submitted that in the lead up to the commencement of the inquiry by this DT, the Respondent was responsible for some delay arising from the time taken to confirm the list of witnesses, to prepare Dr DE's second report and to obtain the evidence of the SCDF paramedics. There was no evidence of injustice or prejudice as the Respondent could carry on with his practice as a locum doctor.

87. Following the hearing on 10 February 2023, the SMC provided a detailed chronology of events to the DT on 14 February 2023. We outline the key events below:

(a) The Notice of Complaint was sent to the Respondent on 8 September 2017.

(b) The Respondent provided his Written Explanation on 15 September 2017.

(c) On 11 July 2018, the Respondent was notified of the Complaints Committee's decision to refer the matter for a formal inquiry by a Disciplinary Tribunal.

(d) Between November 2018 and January 2019, the SMC corresponded with Dr DE to be engaged as an expert. After Dr DE expressed concerns in April 2019 that he may not be able to comment on the standard of care expected of a family physician, the SMC reached out other family physicians for an expert opinion. Dr PE3 ("**Dr PE3**") was subsequently engaged on 7 May 2019.

(e) Site visits were arranged for both Dr DE and Dr PE3 in October 2019.

(f) On 18 March 2020, the Notice of Inquiry was served on the Respondent together with the expert reports from Dr DE and Dr PE3.

(g) Parties were informed that the first DT was constituted on 27 July 2020.

(h) When the Respondent indicated that he wished to claim trial to the present charge and plead guilty to the other charges, the first DT directed on 6 November 2020 that another DT be convened. The first DT dealt with the other charges on 21 January 2021 in *Singapore Medical Council v Dr Ho Tze Woon* [2021] SMCDT 2.

(i) The present DT was constituted on 26 April 2021. We were only informed of the existence of the first DT during the hearing on 10 February 2023.

(j) The first Pre-Inquiry Conference ("**PIC**") was held on 2 June 2021 where parties were given directions to finalise the list of witnesses (including the Respondent's expert). The Respondent indicated on 16 June 2021 that he intended to issue subpoena to obtain information from SCDF on the names of the paramedics involved in this matter.

(k) On 20 August 2021, the Respondent objected to the SMC calling Dr PE3 as an expert. This is almost 1.5 years after having sight of Dr PE3's report.

(l) The Respondent sought a few extensions of time to submit Dr DE's reply report and it was eventually submitted on 14 September 2021.

(m) The SMC engaged Dr PE2 on 19 September 2021.

(n) The second PIC was held on 20 September 2021 after the Respondent sought guidance from the DT concerning the issuance of subpoenas in the General Division of the High Court. The SMC informed the DT that the Respondent would be challenging the independence of Dr PE3 as an expert witness and the SMC will be calling an additional expert. The Respondent's Counsel informed the DT that he would need to take further instructions on whether the SMC should be calling two experts.

(o) Another PIC was held on 13 October 2021 to deal with the objections to Dr PE3 being called as an expert. The DT directed that Dr PE3 should be replaced to err on the side of caution as there was a possible appearance of apparent bias. At that time, the SMC informed that Dr PE2 would be ready to provide an expert opinion so as not to delay the proceedings.

(p) Subpoena to be served on SCDF was approved by the General Division of the High Court on 27 October 2021.

(q) Dr PE2 submitted the expert report on 1 November 2021.

(r) The Respondent informed on 26 November 2021 that more time was required to interview the paramedics and to prepare the witness statements.

(s) On 24 December 2021, the SMC informed DT that it would be adducing a further expert report from Prof PE1. A PIC was convened on 30 December 2021 to deal with the issue of whether the SMC should be permitted to call Prof PE1 as an expert.

(t) On 28 December 2021, SCDF informed that it was agreeable to having the parties jointly interview the paramedics on certain conditions.

(u) The inquiry was scheduled to commence on 17 January 2022. However, the hearing had to be vacated on 11 January 2022 due to medical reasons concerning a member of the DT. The hearing was rescheduled to 6, 9, 13, 17 and 20 May 2022 which was the earliest dates where parties and the members of the DT were available.

(v) On 11 March 2022, the parties conducted a joint interview with the paramedics.

(w) The DT was notified of parties' disagreement on the witness statements of the paramedics on 11 April 2022. The DT directed that it was for the paramedics to decide what evidence they wished to adduce and parties were to address the DT at the inquiry itself if they had objections to the contents of the evidence. If parties were unable to agree the contents of the joint statements, each party would be at liberty to call the paramedics as their own witnesses after obtaining the requisite subpoenas.

(x) On 4 May 2022, the Respondent wrote to the DT to seek directions in relation to the paramedics' being called as witnesses. The Respondent sought an extension of time to finalise the paramedics' witness statements and sought an adjournment of the hearing in the meantime. The SMC informed the DT on 5 May 2022 that it was no longer practicable to submit jointly prepared statements for the paramedics. The SMC then reserved the right to cross-examine the paramedics should they be called as witnesses. The DT directed that the hearing was to proceed on 6 May 2022.

(y) Two days of the May tranche had to be vacated as a member of the DT was diagnosed with COVID-19. Based on the availability of witnesses, counsel and the DT members, the inquiry continued on 10 June and 4 July 2022. The DT ordered submissions as well as reply submissions to be filed by August 2022 for a further hearing on 5 September 2022. The September 2022 hearing was refixed to 1 December 2022 as a member of the DT was on long medical leave. The DT delivered the verdict to convict after hearing oral submissions on 1

December 2022 and gave further directions for the filing of sentencing submissions by 16 January 2023 for a further hearing on 10 February 2023.

Respondent's Submissions on Sentence

88. Counsel for the Respondent submitted that the harm caused would be "slight" and the culpability would be "low" under the sentencing framework in *Wong Meng Hang*. The Patient was already experiencing breathlessness at the time he visited the Clinic and he went into cardiac arrest due to reasons unrelated to the Respondent. His failure to shift the Patient to a supine position only resulted in a loss of chance of survival at best and this loss of chance was minimal. Dr DE had testified that the survival rate of out-of-hospital cardiac arrest patients was only 4%. Given the Patient's poor track record of compliance with treatment and symptoms, there was already a high risk of an adverse outcome. Even in an optimal CPR set up, the Patient would only have had a 10% survival rate given the nature of his medical condition.

89. The Respondent's decision to perform CPR with the Patient in a seated position was made in a stressful emergency situation under severe time constraints. There was no deliberate and/or intentional departure from best medical practices.

90. The Respondent also relied on the following mitigating factors:

(a) The Respondent gave an unreserved apology in the Written Explanation.

(b) There would be hardship to the Respondent as he is the sole breadwinner supporting his parents and grandmothers.

(c) The proceedings had taken a toll on his mental health.

(d) The Respondent had no related antecedents.

91. Counsel for the Respondent submitted that a sentencing discount should be given in view of the inordinate delay given that there was a 3-year delay from the time the SMC received the complaint and the issuance of the Notice of Inquiry.

92. Counsel for the Respondent submitted that a fine not exceeding $2,000 would be appropriate.

DT's Decision on the Appropriate Sentence

Applying the Wong Meng Hang sentencing framework

93. Applying the *Wong Meng Hang* sentencing framework and the Sentencing Guidelines, we agree with the SMC that the harm caused in this case is on the higher side of "moderate". It would not be appropriate to classify this "slight harm" as submitted by the Respondent as this would mean that the offence did not cause actual personal injury or that the offence did not undermine public confidence in the medical profession.

94. There was no evidence before us to show that if effective CPR had been performed, the Patient *would* have survived. However, if CPR had been effectively performed, it could have improved the Patient's chances of being successfully resuscitated. Therefore, the Respondent's failure to provide effective CPR had a direct adverse effect on the chances of survival for the Patient and we also agreed with the SMC that permanent and irreversible harm was done to the Patient.

95. We reject the Respondent's argument that the harm done to the Patient was minimal in view of the medical condition of the Patient and the generally low survival rate for patients with out-of-hospital cardiac arrest. Even if we take the Respondent's case at its highest and that the Patient only had a 10% of survival under an optimal CPR set up due to his medical condition, this does not mean that the Respondent can exercise less care or that the minimum standards we would expect from him would be lower.

96. By administering ineffective CPR, it is equivalent to not providing any CPR at all. In this regard, the observations of the DT in *Singapore Medical Council v Dr Islam Md Towfique* [2022] SMCDT 5 ("***Dr Islam***") are instructive. In that case, Dr Islam was the attending anaesthetist for the patient's surgery. He left the operating theatre on a number of occasions while the operation was ongoing. As a result of his absence, he failed to detect the changes in the patient's vital signs and failed to initiate early

supportive and resuscitative treatments when the patient suffered from intraoperative acute pulmonary embolism. The DT observed at [41]:

> "The low prospects of surviving a pulmonary embolism cannot negate the potential harm that may have been caused by the Respondent's multiple departures from the Operating Theatre. We are unable to accept the Respondent's argument that because of the low prospects of surviving a pulmonary embolism, the harm caused by the Respondent's misconduct was minimal. This would lead to an illogical outcome where a doctor treating a patient whose condition makes the prospects of survival low, is able to take less care, because the chances of survival were small in any event. Although a doctor who is treating such a patient should not be subject to a higher standard, conversely, the standard should not be lowered simply because the patient had poor prospects of survival to begin with."

97. In our view, the low survival rate figure cited for out-of-hospital cardiac arrest ("**OHCA**") cases must be understood in its proper context. This information was extracted from a research paper published in the Journal of the American Heart Association entitled "*Incidence and Outcomes of Out-of-Hospital Cardiac Arrest in Singapore and Victoria: A Collaborative Study*". Based on a review of a total of 11061 OHCA incidents that were attended to by emergency medical services ("**EMS**") in Singapore between 2011 and 2016, the study found that 7.3% of the patients had sustained return of spontaneous circulation on arrival at the emergency department and 4% of the patients survived for discharge. The following observations were also made in the study:[46]

(a) The odds of survival increased significantly with public location of arrest, initial shockable rhythm, witnessed arrest, bystander CPR and bystander defibrillation but decreased significantly with EMS response time and age.

(b) The odds of survival could be raised by more than 2 times with witnessed OHCA. The odds were also increased with bystander CPR by 1.75 times in Singapore.

(c) The report also considered why the survival outcomes appear better in Victoria compared to Singapore. One reason given was that all patients experiencing OHCA in Singapore received treatment at scene and almost all were transported

[46] Pages 277 to 280 of the Bundle of Statements and Reports.

after a brief period of resuscitation. In contrast, Ambulance Victoria paramedics resuscitated less than half of EMS-attended cases and transported only half of these EMS-treated cases after a longer period of resuscitation. Compared to Victoria, the SCDF had a lower threshold for initiating resuscitation and no termination of resuscitation protocol at time of study. This may explain why only 7.3% of transported patients in Singapore had a pulse on arrival at hospital despite transporting almost all patients with OHCA treated by EMS. It is conceivable that many of these futile transports could be avoided in Singapore had there been a termination of resuscitation protocol in place.

98. It is pertinent to note that the report dealt with all types of OHCA incidents including those that occurred in public places. Therefore, not all the cases had or could have had timely CPR intervention. Here, we are dealing with a collapse within a medical clinic with a BCLS-trained doctor on duty where CPR could have been administered on the spot shortly after the collapse. As shown in the report itself, the odds of survival would increase significantly with effective CPR. Therefore, while the figure of 4% may be representative of the overall survival rates of OHCA incidents in general, it is unlikely to be representative of the survival rates of OHCA incidents within a clinic where CPR could have been administered by the doctor.

99. Although the resuscitative measures taken at KTPH managed to restore the heartbeat and blood circulation, the Patient's brain had already been damaged as he was found to have suffered "hypoxic brain injury secondary to prolonged downtime".[47] Therefore, in our view, it is not open to the Respondent to contend that harm done to the Patient was minimal. To be clear, we are not making a finding that the Patient would definitely have survived if the Respondent had administered CPR properly. All we are saying is that the failure to administer CPR properly at the outset had affected the Patient's chances of survival as the first few minutes after collapse were squandered doing ineffective CPR.

100. In addition, we find that the Respondent's failure to deliver elementary clinical care by providing CPR in a proper manner would also undermine public confidence in the

[47] Report from KTPH dated 13 September 2017 at AB 16 and Agreed Statement of Facts at [24].

medical profession. The members of the public would reasonably expect the doctor attending to patients in the clinic to be able to perform CPR in a proper manner.

101. As for culpability, we agree with the SMC's assessment of the various factors which would impact on the Respondent's culpability. In our view, the level of culpability would fall slightly above the middle of the "low" range. We note from that [54(d)] of the Sentencing Guidelines states that a doctor would be more culpable if what he failed to uphold was the most basic and elementary professional standards. That said, we do acknowledge that it is rare for a family physician to encounter cardiac arrest cases based on the evidence given by the SMC's experts. The Respondent had to act quickly in an emergency and he had administered the other treatments for the Patient appropriately save for the lapse in the administration of CPR. The lapse arose from a misjudgment that there was no space to lay the Patient on the floor and that there was insufficient manpower to effect the patient transfer. In accordance with [54(n)] of the Sentencing Guidelines, a doctor who committed the offence in an emergency situation may be less culpable than one who did not. While we are prepared to give some weight to this factor, the Respondent cannot *significantly* lower his culpability by simply relying on the urgency of the situation. After all, the need to administer CPR would only arise in an emergency situation and the Respondent was specifically trained to deal with this situation through the administration of CPR.

102. Having regard to the factors above, we are of the view that a period of eight months suspension would be a suitable starting point.

Lack of remorse

103. In our view, the Respondent had demonstrated a lack of remorse or insight and this is an aggravating factor identified in the Sentencing Guidelines. In his sentencing submissions, the Respondent maintained his contention that the BCLS course failed to equip him with the requisite expertise and / or knowledge to deal with the incident. He also submitted that there are shortcomings in the current BCLS training, during which the Respondent was taught to only stop CPR when the patient wakes up or regain consciousness, when the automated external defibrillator arrives and analyses heart

rhythm or when the emergency team takes over the CPR.[48] The Respondent's complete lack of insight into his wrongdoing is apparent to us. He continued to blame the lack of specific training and had not shown any genuine remorse for what he had done. We agree with the SMC that it would be appropriate to increase the suspension period to nine months in view of this aggravating factor.

No inordinate delay in institution or prosecution of proceedings

104. For the delay in the institution or prosecution of proceedings to be taken into account as a mitigating factor, (a) the delay must have been significant; (b) the delay must not have been contributed to in any way by the offender; and (c) the delay must have resulted in real injustice or prejudice to the offender (*Kevin Yip* at [100]).

105. Having carefully reviewed the chronology of events, we do not find that there is any inordinate delay that would warrant the giving of any discount to the sentencing. The period between the time the Respondent was given the Notice of Complaint to the time he was served with the Notice of Inquiry was 2.5 years. This period is shorter than the other cases referred to by parties where inordinate delayed was found:

(a) *Jen Shek Wei* – The court that there was a delay in prosecuting the case. The Notice of Complaint was sent on 17 July 2012 and Dr Jen gave his response on 2 August 2012. The SMC waited nearly three years thereafter to issue the Notice of Inquiry on 8 July 2015. The court also found that the delay was overly lengthy by any reasonable measure.

(b) *Kevin Yip* – The complaint was lodged on 24 October 2011. Dr Yip was notified of the complaint on 22 May 2012 and he issued his explanation on 29 June 2012. Almost three years later, Dr Yip was notified on 2 April 2015 that a formal inquiry would be convened and the Notice of Inquiry was issued on 3 November 2015. The court found that there was inordinate delay.

[48] Paragraphs 24 to 32 of the Mitigation Plea and Sentencing Submissions.

(c) *BXR* – The complaint was lodged on 7 April 2014. The doctor was asked to provide an explanation on 9 October 2014 and the explanation was provided on 11 December 2014. The SMC obtained its initial expert report only on 8 May 2017 and the Notice of Inquiry was served on 25 May 2017 (more than 2.5 years from the time he was first notified of the complaint). The court found that this was not a particularly complex matter and the delay was not justifiable.

(d) *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("***Ang Peng Tiam***") – Dr Ang was first notified of the complaint on 27 June 2011 and he provided the explanation on 19 July 2011. He was informed on 2 May 2012 that the matter would be referred for a formal inquiry and he waited almost three years before he was served the Notice of Inquiry on 22 April 2015. The court found that the SMC had not sufficiently explained why such a long time was taken to issue the Notice of Inquiry and why a long time was taken to conduct the investigations and to obtain the various expert reports (see [121]). The court held that there was inordinate delay on the facts of the case.

(e) *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] 5 SLR 1168 ("***Leslie Lam***") – The Respondent relied on this case to show that there would be inordinate delay if the matter took more than six years for the patient's complaint to reach the court. The court observed at [84] "[o]n the face of it, *and without having examined the reasons for this*, it seems to us that this is an inordinately long time to dispose of such a matter" [*emphasis added*]. We are of the view that the court is not laying down a general principle as to what length of time would amount to an inordinate delay. Each case would have to be examined on the facts. More importantly, the court need not go into a detailed examination of the facts on delay because this issue was not engaged as Dr Lam's conviction was set aside. On the facts of that case, the complaint was lodged on 17 August 2011. Dr Lam was notified of the complaint on 12 April 2012 and he provided an explanation on 28 April 2012. More than 17 months later, a formal inquiry was ordered. On 25 September 2015, the Notice of Inquiry was served. Therefore, this case involved a delay of over three years between the time Dr Lam was notified of the complaint to the time the Notice

of Inquiry was issued. This case is distinguishable as the time taken in our case was much shorter.

106. Apart from looking at the past precedents for the duration of time that would be indicative of any inordinate delay, the issue of whether there is any inordinate delay in prosecution should also be assessed on the facts of each case. In this regard, we accept the SMC's explanation that time was needed to prepare the various expert reports and to arrange for site visits before issuing the Notice of Inquiry to deal with the Respondent's defence that there was insufficient space to lay the Patient supine. We do not find that the SMC had delayed matters.

107. We are also of the view that there was no inordinate delay in the proceedings in relation to the events that took place after the service of the Notice of Inquiry Even though the first DT was appointed in July 2020 which was about four months after the service of the Notice of Inquiry, the first DT only dealt with the charges which the Respondent pleaded guilty to and directed on 6 November 2020 that a new DT be convened to deal with the present charge which the Respondent was claiming trial on to avoid any bias or perception of bias. The present DT was constituted on 26 April 2021. Any delay in the proceedings that arose from the need to constitute another DT cannot be said to be caused by the prosecution. After this DT gave directions for the preparation of documents for the inquiry, we note that the Respondent also took some time to finalise Dr DE's second report as well as to obtain the evidence of the SCDF paramedics. Even though the DT had to postpone the inquiry from January 2022 to May 2022 as one of the DT members was unwell, we note that the inquiry could not have been completed in January in any event as the evidence of the paramedics was not ready. The additional time taken to prepare the case for the Respondent should not count towards delay in prosecution. Once the hearing commenced in May 2022, the DT had proceeded as expeditiously as possible and the need to refix any inquiry dates was due to factors beyond our control.

108. In our view, there are no mitigating factors in this case that would justify reducing the sentence. Any personal and financial hardship faced by the Respondent would not have

mitigating value. We take guidance from the following observations of the court in *Singapore Medical Council v Chua Shunjie* [2020] 5 SLR 1099 at [67]:

> "We think that the majority was wrong to place any weight on the personal and financial hardships encountered by Dr Chua, which included the fact that he was divorced and had lost the support of his family and that he faced substantial financial liabilities in the form of having to repay the MOH should he fail to fulfil his bond. In the context of criminal proceedings, it is clear that personal hardships faced by accused persons will rarely have any mitigating value (see *Public Prosecutor v BDB* [2018] 1 SLR 127 at [75]). In so far as medical disciplinary proceedings are concerned, the same principles ought to apply in light of the overarching concerns of protecting the public and upholding public confidence in the integrity of the medical profession. While we sympathise with the difficult circumstances faced by Dr Chua, we do not think that this is such an exceptional case as to justify according any mitigating weight to such matters."

Conclusion

109. Accordingly, this DT orders that:

(a) the Respondent's registration in the Register of Medical Practitioners be suspended for **nine (9) months**;

(b) the Respondent be censured;

(c) the Respondent provides a written undertaking to the SMC that he will not engage in the conduct complained of and any similar conduct in the future; an

(d) the Respondent pay the costs and expenses of and incidental to these proceedings, including the costs of the solicitors to the SMC.

110. At the end of the hearing, the SMC requested that the suspension commence 40 days after the date of the order, to take into consideration the time frame for appeal. As the Respondent consented to the request, we make the further order that the period of suspension is to commence 40 days after 17 February 2023.

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

112. The hearing is hereby concluded.

Prof Sonny Wang Yee Tang Chairman	Dr Yii Hee Seng	Ms Chong Chin Chin Judicial Service Officer

Mr Chia Voon Jiet and Ms Charlene Wong (M/s Drew & Napier LLC)
for Singapore Medical Council; and

Mr Amos Cai, Mr Yip Jian Yang and Mr Kieran Pillai (M/s Yuen Law LLC)
For Dr Ho Tze Woon