IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2016] SGHC 145

Originating Summons No 2 of 2015

In the matter of section 55(1) of the Medical Registration Act (Cap 174)

And

In the matter of the Inquiry by the Disciplinary Tribunal of the Singapore Medical Council for Dr Wong Him Choon, a registered medical practitioner

Between

SINGAPORE MEDICAL COUNCIL

… *Applicant*

And

DR WONG HIM CHOON

… *Respondent*

GROUNDS OF DECISION

[Professions] — [Medical profession and practice] — [Professional conduct]

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v
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10 May 2016

25 July 2016

Andrew Phang Boon Leong JA (delivering the grounds of decision of the court):

Introduction

1 It is an understatement of the highest order to state that doctors are part of the bedrock of our society. This is so not least because they care for people by helping to heal them, *regardless of* their situation or station in life. And even in the direst of circumstances, for example, when physical death is at the patient's doorstep, their kindness and assistance is no less (and may be even more) important. That is why all of us look up to doctors and respect them for the high calling that is rightfully theirs to claim. And that calling is of course embodied in the Hippocratic Oath. As this court observed in *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 ("*Lim Mey Lee Susan*") (at [39]−[40]):

39 Turning to *the medical profession*, the idea that the practice of medicine is, above all, a calling of the highest order is a historical cornerstone of the medical profession. It can be traced through the millennia – through countless doctors who have taken, in one form or another, a version of what has oft been hailed as one of the world's first *ethical* codes, the Hippocratic Oath (and see also, in this regard, the *general* definition of a "profession" in the [*Oxford English Dictionary*] ([30] *supra*) referred to above at [30]). In Singapore, this oath currently takes the form of the Singapore Medical Council Physician's Pledge (presently found in the Second Schedule to, read with reg 16(2) of, the Medical Registration Regulations 2010 (S 733/2010)), which is taken by every doctor upon being admitted as a fully registered medical practitioner and which reads as follows:

> I ***solemnly pledge to dedicate my life to the service of humanity***; give due respect and gratitude to my teachers; ***practise my profession with conscience and dignity; make the health of my patient my first consideration***; respect the secrets which are confided in me; ***uphold the honour and noble traditions of the medical profession***; respect my colleagues as my professional brothers and sisters; not allow the considerations of race, religion, nationality or social standing to intervene between my duty and my patient; maintain due respect for human life; ***use my medical knowledge in accordance with the laws of humanity***; comply with the provisions of the Singapore Medical Council's Ethical Code and Ethical Guidelines; and constantly strive to add to my knowledge and skill.
>
> I make these promises solemnly, freely and upon my honour.
>
> [emphasis added in bold italics]

40 This pledge is *even more explicit* in its reference to *ethical* obligations and values than the corresponding declaration taken by lawyers (pursuant to r 30 of, read with the First Schedule to, the Legal Profession (Admission) Rules (reproduced above at [32])). In our view, this pledge constitutes no mere rhetoric. Instead, it embodies – as the summary with regard to the *legal* profession set out above (at [38]) underscores – a calling that seeks, amongst other obligations, to be *helpful to others in an important way* (here, by curing the sick) and goes *beyond* mere money-making and the advancement of self-serving interests.

[emphasis in original]

2 Indeed, the court in *Lim Mey Lee Susan* proceeded to elaborate upon the above observations thus (at [41]−[42]):

> 41 Indeed, the proposition that the spirit of public service and the existence of *ethical* obligations underpin all professional practice applies with equal (and, arguably, even greater) force to medical practitioners, whom we collectively entrust with our health, our well-being and, in certain instances, our lives. In this respect, the medical profession occupies a unique societal position of both great privilege and commensurate responsibility. In this regard, the following observations by the then Governor of the Straits Settlements, Sir John Anderson, in his speech on the occasion of the formal opening of the very first medical school in Singapore on 28 September 1905 are particularly apposite (published in *The Straits Times* of 29 September 1905 (available at <http://newspapers.nl.sg/Digitised/Article/straitstimes19050929-1.2.47.aspx> (accessed 24 June 2013)), also quoted (in part) in *Transforming Lives: NUS Celebrates 100 Years of University Education in Singapore* (Singapore University Press Pte Ltd, 2005) at p 11):
>
> > … What I want you to remember is that the course of study you are about to enter upon is ***not merely*** *a course of study which is* ***intended to enable you to earn a living***, but … a passport to *membership of* ***a very great profession****, a profession* ***in many instances*** *of* ***unselfish devotion and splendid achievement****, a profession with very* ***lofty ideals*** *and one which calls for* ***all the best qualities****, mental* ***and moral****, which a man can give*. It demands not only freshness and vigour of body, but steadiness and skill in hand and eye. *It wants infinite patience* ***and keenest sympathy****, and to all these qualities there has to be added* ***unfaltering courage***. …
>
> [emphasis added in italics and bold italics]
>
> As also articulated by this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [36]:
>
> > … The importance of maintaining the highest level of professionalism and ethical conduct has been duly acknowledged by the [Singapore Medical Council] in the Introduction section of the [Singapore Medical Council] Ethical Code (at p 1):

> The medical profession has always been held in the highest esteem by the public, who look to their doctors for the relief of suffering and ailments. In modern medical practice, ***patients and society at large expect doctors to be responsible both to individual patients' needs as well as to the needs of the larger community. Much trust is therefore endowed upon doctors to do their best by both.*** *This trust is contingent on the profession maintaining the highest standards of professional practice and conduct.*
>
> …
>
> [High Court's emphasis in *Low Cze Hong* in italics; emphasis added in bold italics]
>
> 42 We would like to emphasise, in the circumstances, that fostering a culture of ethics and striving to achieve the ideals embodied within the practice of medicine as a whole represent the only meaningful way to approach the questions that matter in this profession. It is with this in mind that we now turn to Issue 1 proper, namely, whether there exists, on the part of all doctors who practise medicine in Singapore, an ethical obligation to charge a fair and reasonable fee for their services. In our view, any engagement with this issue must take place in the full context of the professional status of doctors and the unique situation which they occupy in society, coupled with the ethical considerations which necessarily attach to both these weighty positions (and which are embodied in the pledge reproduced above at [39]).
>
> [emphasis in original]

3 It is important to emphasise right at the outset what the nature – as well as ideals – of the medical profession are simply because of their woeful neglect in the context of the present case. In fairness to the doctor concerned, we note that there was neither an allegation nor a finding of dishonesty as such. However, as we shall elaborate upon below, his conduct in the entire case fell far short of the ideals set out above and is (simultaneously) a reminder to all concerned that doctors ought never to lose sight of them.

4 This case also – as we shall also elaborate upon below – concerns the important issue of *perspective*. In particular, the doctor must also be cognisant of *the patient's position and welfare*. And this entails placing himself or herself in the shoes of the patient, so to speak. In this regard, the following oft-cited advice from a father to his daughter in a famous novel ought to be noted (see Harper Lee, *To Kill A Mockingbird* (William Heinemann Ltd, 1960; reprinted in the New Windmill Series, 1966) at p 35):

> First of all, … if you can learn a simple trick, Scout, you'll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view – … until you climb into his skin and walk around in it.

5 In many ways, the wisdom contained in the above quotation is, in point of fact, an integral part of *the doctor's* duty which we have set out above. The underlying thread is one of care and common humanity.

6 With these broad principles in mind, we now turn to the specific facts and issues of the present case, which is an appeal by the Singapore Medical Council ("the SMC") against the decision of the Disciplinary Tribunal ("the DT") appointed by it for the disciplinary inquiry in relation to the respondent, Dr Wong Him Choon ("Dr Wong"). The DT found that Dr Wong was not guilty of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("MRA"). We allowed the appeal and now give the detailed grounds for our decision.

Background facts

7 On 3 September 2011, at or about 10.35pm, Mr Fan Mao Bing ("the Patient"), a Chinese national and construction worker, visited the Accident and Emergency Department ("A&E") of Raffles Hospital ("RH") after having

fallen off "monkey stairs" from a height of about three metres at a construction site managed by a construction company called Kajima Overseas Asia Pte Ltd ("Kajima"). The Patient was an employee of Tai Ping Yang Jian Gong Pte Ltd ("TPY"), a sub-contractor of Kajima. The Patient fell on his right (master) hand. He was brought to RH by a safety supervisor of TPY and safety officer from Kajima.

8 Dr Wong was at the material time a consultant orthopaedic surgeon at Raffles Orthopaedic Centre, RH. He attended to the Patient. Before treating the Patient, he asked to view the Patient's Work Permit where he learned that the Patient's Work Permit would expire in November 2011. The relevance of this piece of information is discussed below at [107]. At about 1am on 4 September 2011, Dr Wong performed surgery involving the immediate closed reduction and percutaneous "K-wire" fixation of the right distal radius on the Patient's right hand. For the avoidance of doubt, this surgery involved, broadly speaking, the driving/drilling of the "K-wire" through the right hand of the Patient and bending the exposed portions of the said wire outside the Patient's skin.

9 After the surgery, Dr Wong certified the Patient to be fit for discharge on the same day, and the Patient was discharged at around 1pm on 4 September 2011. The Patient therefore spent 15 hours at RH. Dr Wong issued a medical certificate ("MC") to cover the Patient's stay at the hospital on 3 and 4 September 2011 and certified the Patient *fit for light duties* for one month from 5 September 2011 (the first post-operative day) to 5 October 2011. The Patient was given an appointment for a post-operative review on 7 September 2011, the third day after he was supposed to return work and perform light duties. The Patient was not given any post-operative or post-

discharge medical leave. According to Dr Wong, the Patient did not communicate that he had any pain in his right hand at the time of discharge.

10 On 7 September 2011, the Patient was reviewed by Dr Wong, who scheduled another follow-up on 5 October 2011. In the former visit, the Patient was recorded to have complained of "itchiness" in his right hand. The Patient visited RH, earlier than his scheduled appointment, on 21 September 2011, where he was attended to by Dr Andrew Dutton ("Dr Dutton"), as Dr Wong was away. Dr Dutton noted that the Patient "presented stating [*sic*] discomfort over the K-wire sites".

11 The Patient visited Changi General Hospital ("CGH") on 11 September 2011 and 23 September 2011. During these two visits, the Patient received medical leave of 14 days from 11 to 24 September 2011 and for eight days from 23 to 30 September 2011, respectively. As will be seen below, notwithstanding the receipt of medical leave from CGH, the Patient was not receiving his salary from his employer, TPY.

12 The Patient's situation was brought to the attention of one Mr Jolovan Wham ("Mr Wham"), the Executive Director of the Humanitarian Organisation for Migration Economics. Mr Wham swore a complaint that was authorised by the Patient to the SMC on 3 October 2011. In his complaint, he alleged that the Patient had been informed by a nurse at RH that the Patient was only issued two days' worth of medical leave "because [that was] the arrangement that the company [had] with the doctor". Mr Wham suggested that the reason for the "collusion" might be to circumvent a legal requirement for the employer to report work injuries to the Ministry of Manpower

("MOM") if three or more days of sick leave are granted to the employee or the employee is hospitalised for more than 24 hours.

13 When the Patient returned to see Dr Wong on 5 October 2011, he told Dr Wong that he had not been paid a salary because he was unable to work on the construction site and was not granted a MC by Dr Wong. Dr Wong issued the Patient with a MC that backdated the coverage of medical leave given to the Patient, covering his absence from work from 6 September 2011 to 20 November 2011.

14 The Patient returned to see Dr Wong on 11 October 2011 for the removal of the pins (*ie*, the exposed portions of the "K-wire"). The pins were removed, and the Patient came back again on 25 October 2011 for the removal of sutures. The Patient's Work Permit expired on 14 November 2011, and he went back to China on 17 November 2011.

15 The SMC issued Dr Wong a Notice of Complaint on 27 January 2012. After reviewing Dr Wong's explanatory statements that were tendered on 13 February 2012 and 25 February 2013 in response to the Notice of Complaint and conducting its own investigations, the SMC informed Dr Wong on 7 August 2013 that the Complaints Committee had, after having reviewed the relevant material, ordered that a formal inquiry be held by a DT. On 4 November 2014, the SMC sent Dr Wong a Notice of Inquiry, which set out the charge against him ("the Charge"). The Charge reads as follows:

Charges

> 1. That you [Dr Wong] are charged that on 4 September, 2011, whilst practising as an Orthopaedic Surgeon at Raffles Orthopaedic Centre, [RH] … , you failed to exercise due care in the management of … [the Patient], a construction worker, in that you had:-

Particulars

i. *inappropriately certified the patient to be unfit for work* for 2 days namely from 3 September 2011 to 4 September 2011 (both dates inclusive) after the patient was admitted to [RH] for 15 hours from 10pm on 3 September 2011 to 1pm on 4 September 2011 and *after he underwent surgery on 4 September 2011 at 1am, a duration of hospitalisation leave which was insufficient for a patient who was at the material time recovering from a distal radius fracture for which surgery was necessary and a metacarpal fracture that was being treated conservatively*; and

ii. *inappropriately certified the patient to be fit to perform light duties at work* for a period of 1 month from 5 September 2011 to 5 October 2011 (both dates inclusive), *which certification is inappropriate for a patient who was at the material time recovering from a distal radius fracture for which surgery was necessary and a metacarpal fracture that was being treated conservatively*; [*sic*]

That the patient had thereafter, in relation to the same complaint, received hospitalisation leave from one Dr Yea Kok Chin of the [A&E] Department of [CGH] on 11 September 2011 for a period of 14 days from 11 September 2011 to 24 September 2011 (both dates inclusive) and further hospitalisation leave from one Dr Looi Chong Heng Peter of the [A&E] Department of [CGH] on 23 September 2011 for a period of 8 days from 23 September 2011 to 30 September 2011 (both dates inclusive). [*sic*]

and that in relation to the facts alleged you have been guilty of professional misconduct under section 53(1)(d) of the [MRA].

[emphasis added]

16 By way of summary, the essence of the Charge was that Dr Wong "inappropriately" (1) gave the Patient "a duration of hospitalisation leave that was insufficient for a patient who was recovering from a distal fracture for which surgery was necessary and a metacarpal fracture that was being treated conservatively"; and (2) "certified [the Patient] to be fit to perform light duties … [when] he was at the material time" recovering from the aforementioned.

17 To give context on the way the case was advanced before the DT, we highlight at the outset that this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") (at [37]) accepted that "professional misconduct", which the MRA sanctions against, "can be made out in at least two situations":

> (a) where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency ("the first limb"); or
>
> (b) where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner ("the second limb").

18 Before the DT, the SMC narrowed the issue of professional misconduct to the first limb, *viz*, there *was* ***an intentional, deliberate departure by Dr Wong from standards observed or approved by members of the profession of good repute and competency***.

19 The DT conducted the inquiry on 15 and 22–25 June 2015 and delivered its written decision ("the DT's Decision") on 15 September 2015.

20 The SMC called four factual witnesses, *viz*, Mr Wham; Dr Yea Kok Chin and Dr Peter Looi, the two doctors from CGH who had issued medical leave to the Patient (see above at [11]); and Mr Victor Teo Xi Lung, an investigator appointed by the SMC to carry out investigation under Part VII of the MRA. The SMC also called Assoc Prof Aymeric Lim ("A/P Lim") as its expert witness.

21 The defence called two factual witnesses, Dr Wong and Dr Prem Kumar Nair, the Chief Corporate Officer of RH. It also called Dr Kamal Bose ("Dr Bose") as its expert witness.

The DT's Decision

22 The DT was of the view that the test in relation to the first limb of *Low Cze Hong* involved the following interlocking strands of inquiry: (1) what was the applicable standard of conduct; (2) whether the Respondent fell below the applicable standard of conduct; and (3) whether the Respondent's conduct was an intentional and deliberate departure from that standard (DT's Decision at [70]).

23 The DT preferred A/P Lim's expert evidence over Dr Bose's evidence on the applicable standard. In this regard, the DT found A/P Lim's opinion to be backed by the academic literature. This was not the case with Dr Bose's evidence (see the DT's Decision at [79]–[80]). The DT found the applicable standard of conduct in respect of the post-surgery discharge of the Patient to be as follows:

> (a) A doctor had to take into account the following primary factors before deciding on the "type or duration" of medical leave: (i) the nature of the illness, injury or disability; (ii) the method of treatment used; (iii) the amount of recovery time needed post-treatment; (iv) whether the patient needed hospitalisation; (v) the nature of the patient's occupation; and (vi) the patient's medical needs and personal circumstances (see the DT's Decision at [72]).
>
> (b) ***It was for the doctor to establish that there were adequate conditions for rest and rehabilitation if medical leave for two days***

after the surgery followed by light duty was to be given. The basic principle would be that a doctor would have to obtain a detailed history from the patient, especially in relation to the nature of his work before issuing a medical certificate for light duty, and ***a reasonable doctor dealing with a person in the Patient's position should take proactive steps to make inquiry from the said patient*** (see the DT's Decision at [74] and [77]).

(c) Two days of hospitalisation leave was insufficient for a patient with a distal radius fracture that had been fixed and a metacarpal fracture that had been treated conservatively, and the patient should not go back to work on the second post-operation day even if light duties were available. In this regard, it was not appropriate to provide light duty instead of the standard two weeks' medical leave, as during the immediate postoperative period the patient would have required immobilisation of his affected limb. ***It was not the practice among members of the medical profession of good standing and repute to certify a worker fit for light duties instead of two weeks' medical leave immediately after the surgery for a distal radius fracture*** (see the DT's Decision at [78]–[79]).

24 The DT opined that Dr Wong was in breach of the applicable standard of conduct. Its findings were as follows:

(a) Dr Wong "***did not follow the very basic principle*** of obtaining a detailed history from the Patient, especially in relation to the nature of his work, before issuing a medical certificate for light duty. … These are the ***basics of medical care which we found wanting*** in this case" [emphasis added] (see the DT's Decision at [74]).

(b) Dr Wong was "in breach of the applicable standards of conduct" because "he failed to discharge the onus on him to discuss with the Patient and to establish whether there were adequate conditions for rest and rehabilitation post operation or the availability of light duty before issuing the medical leave and certifying the Patient fit for light duties" (see the DT's Decision at [75]).

(c) Dr Wong's argument that the Patient's post-surgery pain score of zero entitled him to conclude that the Patient could return to work to do light duty was to be rejected. The "pain score reading could be attributed to the Patient being under the effects of analgesics administered post-operation and thus he could not feel the pain" (see the DT's Decision at [76]).

(d) Dr Wong had "departed from the standard of care" by awarding only two days of hospitalisation leave for a patient with a distal radius fracture that had been fixed and metacarpal fracture that had been treated conservatively (see the DT's Decision at [78]).

(e) Dr Wong "had failed to comply with the applicable standards of conduct in the management of the Patient by giving only two days' medical leave to cover the period when the Patient was in the hospital and certifying that the Patient was fit for light duties from the first post-operation day from 5 September 2011 to 5 October 2011" (see the DT's Decision at [81]).

25 The DT, however, took the view that Dr Wong's conduct was not an "intentional and deliberate departure from the applicable standard of conduct". Its findings in this regard were as follows:

(a) "[T]here was no conclusive evidence to show that Dr Wong proceeded to certify the Patient fit for light duty with full personal knowledge or after having been told that there was no light duty available or provided by the employer for the Patient" (see the DT's Decision at [86]).

(b) "[T]here was no conclusive evidence to show that Dr Wong issued the light duty certification in accordance with any agreement between the hospital and Kajima" (see the DT's Decision at [87]).

(c) The DT also did not think that the fact that an inappropriate number of days of medical leave was given by Dr Wong was sufficient to suggest that Dr Wong was guilty of "intentional deliberate [*sic*] departure from the applicable standard of conduct" (see the DT's Decision at [88]).

26 In the circumstances, the DT decided that the SMC had not proved the Charge (as read together with the criteria set out by the first limb of *Low Cze Hong*) beyond a reasonable doubt, and, accordingly, held that Dr Wong was not guilty of the Charge.

The appeal

27 The SMC's appeal was brought under s 55(1) of the MRA. It appealed against the decision of the DT on the following grounds:

(a) the DT erred in finding that Dr Wong's actions were not intentional and deliberate;

(b) the DT "misapplied its mind to the question of whether there was an intentional and deliberate departure from the applicable standard of conduct" by Dr Wong; and

(c) the DT "made an error of law in that it misapplied the applicable test for professional misconduct".

28 The central question before this court, as noted in s 55(11) of the MRA, was whether the findings of the DT were "unsafe, unreasonable or contrary to the evidence" such that Dr Wong should be convicted of the Charge.

29 Viewed within the context of how the case was advanced below pursuant to the first limb in *Low Cze Hong*, the *sole issue* that arose for determination is appropriately framed as follows: whether the finding of the DT that Dr Wong's conduct was not an intentional and deliberate departure from the applicable standard of conduct is "unsafe, unreasonable or contrary to the evidence".

30 Counsel for the SMC, Mr Philip Fong ("Mr Fong"), sought to pursue an alternative argument in both written submissions and his oral arguments (albeit briefly in the case of the latter) on whether Dr Wong was guilty of professional misconduct by reason of gross negligence, *ie*, the second limb in *Low Cze Hong*. For reasons that will become apparent, we were not minded to allow this issue to be ventilated or make findings in relation to the same in the appeal, as the SMC never advanced its case on this limb before the DT. However, we set out the *provisional observations* we made during the hearing of the appeal in relation to the applicability of the second limb of *Low Cze*

Hong on the facts and on how the SMC could have – ***on these particular facts*** – advanced its case under *both* limbs of *Low Cze Hong*.

The parties' submissions

The SMC's submissions

31 The SMC submitted that the DT had misinterpreted the charge against Dr Wong as one of certifying the Patient fit for light duties despite knowing that no light duties were available. The Charge, however, was for not giving the Patient any post-operative medical leave for rest and recovery. Since Dr Wong *intended* to give the Patient two days of medical leave and one month of light duties, the Charge against him was made out. The gravamen of the Charge concerned Dr Wong's conduct in "consciously not giving the Patient any post-surgery medical leave". Therefore, what the SMC had to prove (and had indeed proven) was that two days of medical leave was insufficient for a patient who had just undergone surgery for a distal radius fracture and whose metacarpal fracture was being treated conservatively.

32 During oral arguments before this court, Mr Fong suggested that there was no need for the SMC to prove that Dr Wong had an intention to breach the applicable standard. Mr Fong also argued that the backdating of the MC by Dr Wong demonstrated that Dr Wong was aware that he had departed from the relevant standard at the time he chose to certify the Patient fit for light duties. Mr Fong submitted that Dr Wong's awareness of the practice in other "Government restructured hospitals" of giving two weeks' medical leave demonstrated that he knew of (and had intentionally departed from) the applicable standard at the time he certified the Patient fit for light duties. Towards the end of his arguments, Mr Fong – in response to questions from

the court – was able to crystallise the SMC's case as follows: the DT found that, under the applicable standard, it was incumbent on Dr Wong to ascertain the availability of adequate conditions for rest and rehabilitation before he certified the Patient fit for light duties. Because Dr Wong certified the Patient fit for light duties without ascertaining this, there was an intentional, deliberate departure from the applicable standard on his part. The subsequent backdating of the MC buttresses the inference that he knew the applicable standard would require him to grant the Patient medical leave for two weeks after the surgery.

33 We note, for completeness, that in relation to the second limb of *Low Cze Hong*, the SMC argued in its written submissions that Dr Wong was guilty of gross negligence, and the DT should have convicted him on this alternative basis. In this regard, since the DT found that Dr Wong did not follow a *very basic principle* of medical care and found that the *basics of medical care were wanting* in Dr Wong's treatment of the Patient, it was clear that Dr Wong was grossly negligent in the treatment of the Patient.

Dr Wong's submissions

34 Dr Wong pointed out that the SMC had chosen to run its case before the DT based on the first limb of *Low Cze Hong*; however, the SMC had not highlighted how the requisite mental element (*ie*, that the act that constitutes the misconduct was done intentionally or deliberately) was satisfied on the evidence adduced before the DT; it simply assumed that the mental element flowed from a finding that Dr Wong had fallen below the applicable standard. In this regard, he argued that the SMC had effectively lowered the standard of professional misconduct by using the phrase "consciously depart" interchangeably with "intentional and deliberate departure".

35 In oral arguments before this court, counsel for Dr Wong, Mr S Selvaraj ("Mr Selvaraj"), argued that it was incumbent on the Patient to have asked Dr Wong for medical leave during his review of the Patient on 7 September 2011. In this regard, he pointed out that Dr Wong had allegedly asked the Patient if he had any "problems". Mr Selvaraj also vigorously argued that there was no need for the issuance of a MC in this case, as it was not a major surgery and involved "just two wires".

36 Mr Selvaraj then pursued arguments relating to the notion of "supervised rest" (which we elaborate on and address below at [103]–[104]). He argued that because Dr Wong had "***dealt with foreign workers, he had some knowledge about them***". The point he sought to make was that Dr Wong had good reason to suspect that the Patient, by reason of him being a foreign construction worker, would not be adequately rested if he was not supervised. We pause to highlight that (as we expressed in the hearing before us), in our judgment, this was an *illegitimate and outrageous submission* that should never have been made before this court.

37 Mr Selvaraj then pointed out that not much could be inferred from Dr Wong's backdating of the MC on 5 October 2011, as such backdating was done so that the Patient could get the wages that were not paid to him. All in all, Mr Selvaraj submitted that the Charge was not made out by the SMC.

38 We also note for completeness that, in relation to the second limb of *Low Cze Hong*, Dr Wong pointed out in his written submissions that there was no allegation of "serious negligence" in the Charge. He therefore argued that the second limb of gross negligence in *Low Cze Hong* should neither be raised by the SMC nor be considered by the court for this reason.

The law

The scope of review by the High Court

39 As noted by Sundaresh Menon CJ in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San Lawrence*") (at [32], referring to *Low Cze Hong* (at [39]–[40])), under s 55(11) of the MRA (previously s 46(8) of the Medical Registration Act (Cap 174, 2004 Rev Ed)), the High Court would have to make the following findings before it can intervene in the decision of a DT:

(a) there is something clearly wrong either:

(i) in the conduct of the disciplinary proceedings; and/or

(ii) in the legal principles applied; and/or

(b) the findings of the DT are sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence has been misread.

40 As we noted in *Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 ("*Gobinathan*") (at [29]), in assessing the decision of a DT, the court should be mindful that a DT has had the benefit of hearing oral evidence and is "a specialist tribunal with its own professional expertise and understands what the medical profession expects of its members". For this reason, the court should accord an appropriate degree of respect to a DT's decision and be slow to overturn its findings. However, a DT's decision would, nevertheless, have to be reached reasonably and in accordance with the law and the facts, which are established in each case based on the relevant evidence. To that extent, the High Court should not give undue deference to

the views of a DT and thereby render its own powers nugatory (see *Low Cze Hong* (at [42]) recently approved in *Ang Pek San Lawrence* (at [33])).

Professional misconduct

41 Prior to 1998, the MRA sanctioned "infamous conduct in a professional respect" by medical practitioners. The MRA was amended in 1998 (by Act 5 of 1997) where that phrase was replaced with "professional misconduct". In this regard, Parliament had noted that the standard of "infamous conduct in a professional respect" was too restrictive of the offences for which disciplinary action could be taken, and hence proposed in its place the phrase "professional misconduct", which was to "*discipline doctors who have been guilty of any* ***improper act or conduct which brings disrepute to his profession***" (*Singapore Parliamentary Debates*, *Official Report* (25 August 1997) vol 67 at col 1566 (Mr Yeo Cheow Tong, Minister for Health)) [emphasis added in italics and bold italics].

42 In interpreting the ambit of the term "professional misconduct" in s 53(1)(*d*) of the MRA, the court would have to bear in mind the intention of Parliament in adopting this formulation. This court surveyed the Commonwealth authorities to ascertain the criteria for assessing whether there has been "professional misconduct" by a medical practitioner in *Low Cze Hong* (at [20]–[37]). It is therefore apposite to discuss the principles expounded in that decision.

43 Before we do so, however, we highlight, parenthetically, that in the SMC's submissions, it urged this court to review the law on professional misconduct and expound on other instances that might fall within the scope of professional misconduct and/or a single test for professional misconduct. It

appeared to suggest that there was a lack of clarity in the law (putatively arising from the two limbs in *Low Cze Hong*) because the correct test for professional misconduct was wider and encompassed any serious departure from standards of good medical practice. As we highlighted to Mr Fong during the hearing and as will be seen below, in so far as the charge brought against a doctor relates to intentional conduct and/or gross negligence *vis-à-vis* his diagnosis and treatment of and advice to the patient (as was the case in the present appeal), the requisite elements that need to be satisfied to bring a charge within the definition of "professional misconduct" as set out in s 53(1)(*d*) of the MRA have been set out clearly in both *Low Cze Hong* and *Ang Pek San Lawrence* and that therefore no further review of the law in this particular regard is necessary. Mr Fong rightly conceded that this was the case.

44 In *Low Cze Hong*, this court sought to unpack the meaning of "professional misconduct" as set out in the then s 45(1)(*d*) of the MRA (which is *in pari materia* with the present s 53(1)(*d*) of the MRA). An important decision that sheds light on the approach to assessing professional misconduct by medical practitioners, which was analysed by the court in *Low Cze Hong* (at [28] and [34]), is that of the Judicial Committee of the Privy Council (on appeal from the Professional Conduct Committee of the General Medical Council) in *John Roylance v General Medical Council (No 2)* [2000] 1 AC 311 ("*Roylance*"). That decision makes clear the importance of *identifying a link between clinical misconduct and the profession of medicine* in order to establish professional misconduct. We highlight below the observations made by the Privy Council in *Roylance* (at 332, *per* Lord Clyde):

> In the present case the critical issue is whether, if there was misconduct, the misconduct was "professional misconduct." As counsel for the General Medical Council pointed out it is *not simply clinical misconduct which is in issue*. Professional

> misconduct extends further than that. ***So it is not simply misconduct in the carrying out of medical work which may qualify as professional misconduct. But there must be a link with the profession of medicine***. Precisely what that link may be and how it may occur is a matter of circumstances. The closest link is where the practitioner is actually engaged on his practice with a patient. Cases here may occur of *a serious failure to meet the necessary standards of practice, such as gross neglect of patients or culpable carelessness in their treatment*, or the taking advantage of a professional relationship for personal gratification. [emphasis added in italics and bold italics].

45 The court in *Low Cze Hong* also observed (at [29]) that Lord Denning MR's observations (at 873) in *In re A Solicitor* [1972] 1 WLR 869 that negligence "may amount to a professional misconduct if it is inexcusable and is such as to be regarded as deplorable by his fellows in the profession" was applicable in relation to professional misconduct in the MRA.

46 Also of relevance is the decision of the New South Wales Court of Appeal in *Pillai v Messiter* (No 2) (1989) 16 NSWLR 197 ("*Pillai*") where the court considered the statutory test of "misconduct in a professional respect" under the Medical Practitioners Act 1938 (NSW). Kirby J in *Pillai* poignantly expressed that departures from accepted standards could constitute professional misconduct as follows (at 200):

> The words used in the statutory test ("misconduct in a professional respect") plainly go beyond that negligence which would found a claim against a medical practitioner for damages …. On the other hand *gross negligence might amount to relevant misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient … Departures from elementary and generally accepted standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to such professional misconduct: ibid.* But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a *deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray*

> *indifference and an abuse of the privileges which accompany registration as a medical practitioner* … [emphasis added]

47 It is after pulling together these analytical strands in the Commonwealth authorities that the court in *Low Cze Hong* (at [37]) accepted that professional misconduct "can be made out in ***at least*** two situations", *viz*, the first limb and second limb [emphasis added].

48 We highlight that, in relation to each of the two limbs in *Low Cze Hong*, the burden of proof is on the SMC, and the DT had to satisfy itself that this burden had been discharged beyond a reasonable doubt (see also *Lee Kim Kwong v Singapore Medical Council* [2014] 4 SLR 113 ("*Lee Kim Kwong*") (at [12] and [42]) as well as *Gobinathan* (at [61]–[62])).

49 As emphasised by this court in *Ang Pek San Lawrence* (at [39]), the DT had to make the following findings before it can hold that the SMC has proven the charge against the allegedly errant doctor:

(a) In relation to the first limb of *Low Cze Hong*:

(i) what the applicable standard of conduct was among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct relates to;

(ii) if the applicable standard of conduct required the said doctor to do something and at what point in time such duty crystallised; and

(iii) whether the said doctor's conduct constituted an intentional and deliberate departure from the applicable standard of conduct.

(b) In relation to the second limb of *Low Cze Hong*:

(i) whether there was serious negligence on the part of the doctor; and

(ii) whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

50 As noted in *Ang Pek San Lawrence* (at [40]) the limbs in *Low Cze Hong* set out high thresholds that have to be crossed before a conviction can be sustained. It bears repeating that these requirements are different from, and are also more exacting than, those applicable to establishing civil liability, both in terms of the standard of misconduct that must be shown as well as the standard of proof that must be discharged.

51 Finally, to address squarely the SMC's contention that this court needed to pronounce that the categories in *Low Cze Hong* are not closed, we highlight that in *Lim Mey Lee Susan* (at [44]), we had already expressed the view that professional misconduct would extend ***to the breach of other ethical obligations***, such as the doctor's breach of the ethical obligation to charge a fair and reasonable fee for the services rendered to his or her patient. It is therefore axiomatic from our finding of professional misconduct in the form of overcharging in *Lim Mey Lee Susan* that the situations that fall within the ambit of "professional misconduct" within s 53(1)(*d*) of the MRA are not limited to the situations espoused in *Low Cze Hong* (at [37]). However, we

should also reiterate a point made above (at [43]) that in so far as the charge brought against the doctor relates to intentional conduct and/or gross negligence *vis-à-vis* his diagnosis and treatment of and advice to the patient, the principles laid down in *Low Cze Hong* are themselves clear and need not be changed.

Our decision on conviction

52 As noted above at [31], the SMC argued that all it had to prove before the DT (which it had done) was that two days of medical leave was insufficient for a patient who had just undergone surgery for a distal radius fracture and whose metacarpal fracture was being treated conservatively. This was because the gravamen of the Charge concerned Dr Wong "consciously not giving the Patient any post-surgery medical leave".

53 As we observed in *Lee Kim Kwong* (at [13]), the first limb of *Low Cze Hong* can only be satisfied *when the doctor consciously departs from the applicable standard*. However, as we pointed out to Mr Fong at the start of the hearing, apart from establishing that Dr Wong's conduct fell below the applicable standard, it was incumbent on the SMC to also demonstrate that Dr Wong was *conscious of the applicable standard* such that he might be said to have intentionally and deliberately departed from it. This was the principal point that we had to satisfy ourselves of in this appeal.

54 For ease of discussion, we adopt the framework set out in *Ang Pek San Lawrence* (see above at [49(a)]) in setting out the reasons for our decision as regards the satisfaction of the first limb of *Low Cze Hong* on the present facts.

The applicable standard and the time at which the duty crystallised

55 Of relevance to the present analysis are the following findings of the DT in relation to the applicable standard (see above at [23] for a more extensive summary of the DT's findings in this regard):

> (a) It was ***for the doctor to establish*** that there were adequate conditions for rest and rehabilitation if medical leave for two days after the surgery followed by light duty was to be given. A reasonable doctor dealing with a person in the Patient's position should ***take proactive steps to make inquiry*** from the said patient (see the DT's Decision at [74] and [77]).
>
> (b) ***It was not the practice among members of the medical profession of good standing and repute to certify a worker fit for light duties instead of two weeks' medical leave immediately after the surgery for a distal radius fracture*** (see the DT's Decision at [78]–[79]).

56 Both the above findings were the subject of and derived from A/P Lim's expert evidence, which the DT preferred. By way of background, A/P Lim is the Chairman of the Medical Board of the National University Hospital ("NUH"). He is a Senior Consultant of the Department of Hand & Reconstructive Microsurgery in NUH. The central strand that ran through A/P Lim's evidence was that it was incumbent on Dr Wong to ensure that there were adequate conditions for the Patient's rest and rehabilitation when issuing light duties to the Patient (see the DT's Decision at [17] and [21]). His ultimate point, however, was that light duties should have never

been issued in the present case and was in favour of prescribing at least two weeks of medical leave.

57 Dr Bose is a Consultant Orthopaedic Surgeon at the Mount Elizabeth Medical Centre and a Visiting Consultant (Department of Orthopaedic Surgery) at the Singapore General Hospital. As noted by the DT, Dr Bose had not – at the time he gave evidence before the DT – published on hand surgery and was "not exactly a hand specialist" (see the DT's Decision at [63]). Dr Bose's evidence was that he did not "find the management of the case by [Dr Wong to be] wanting in any way". In this regard, as noted by the DT, he was of the view that it was not the normal practice to give medical leave to a patient who had gone for surgery for a distal radius fracture (see the DT's Decision at [66]). Nevertheless, it must be noted that even Dr Bose agreed with the point noted above at [55(a)], *viz*, that "the onus was on the doctor to discuss with the patient whether light duty or medical leave is suitable" (see the DT's Decision at [69]).

58 The DT, like both A/P Lim and Dr Bose, accepted without difficulty the proposition that the applicable standard required Dr Wong to establish that there were adequate conditions for rest and rehabilitation before light duties were given. On our part, we had no difficulty in accepting this finding of the DT, which was based on unanimous expert opinion, on the applicable standard.

59 In relation to the appropriateness of certifying a patient fit for light duties ***immediately after the surgery for a distal radius fracture instead of two weeks of medical leave,*** the DT preferred A/P Lim's evidence over that of Dr Bose. A/P Lim's evidence was preferred as it was supported by academic

literature that states that during the immediate postoperative period, the patient would have required immobilisation of his affected limb (see generally Steven Z Glickel *et al*, "Long-Term Outcomes of Closed Reduction and Percutaneous Pinning for the Treatment of Distal Radius Fractures" (2008) 33A *Journal of Hand Surgery* 1700, which was referenced in A/P Lim's expert report, and the DT's Decision (at [79]) where this view is accepted). Apart from the fact that Dr Bose was not an expert in hand surgery, a factor which goes towards the weight that should be given to his opinion, we agree with the DT that his opinion that it was appropriate to certify the Patient fit for light duties was not supported by the relevant medical literature.

60 While we have observed that the High Court should not give undue deference to the views of a DT and thereby render its own powers nugatory (see *Low Cze Hong* at [42]), we point out that from our analysis of the evidence (see above at [56]–[59]), the DT was entirely correct in arriving at its view on the applicable standard in light of the expert evidence that was before it. In particular, we found A/P Lim's evidence to be cogent and well-reasoned. We therefore accept the DT's findings on the applicable standard.

61 As a consequence, we rejected Mr Selvaraj's submissions that there was no need for MC in this case as it was not a major surgery which had involved "just two wires". We also rejected Mr Selvaraj's submission that it was incumbent on the Patient to inform Dr Wong that he needed medical leave. This was not supported even by the evidence of Dr Bose, who gave evidence for Dr Wong.

62 Although it is axiomatic, we highlight for completeness that it was the unanimous opinion of A/P Lim and Dr Bose that the duty of the doctor to

discuss with the patient whether there were adequate conditions for rest and rehabilitation *crystallised and was to be discharged before the doctor decides* on the type and duration of medical leave to be administered on the patient (see the DT's Decision at [72]–[73]).

Dr Wong's conduct constituted an intentional, deliberate departure from the applicable standard of conduct

63 We turn to address the arguments raised by Mr Fong on Dr Wong's conduct. We highlighted to Mr Fong that the backdating of the MC by Dr Wong on 5 October 2011 did *not*, *without more*, demonstrate that he (Dr Wong) was aware of the applicable standard at the time he certified the Patient fit for light duties. In a similar vein, Dr Wong's alleged awareness of the practice of awarding two weeks' medical leave in "Government restructured hospitals" was not sufficient, in and of itself, to suggest that he was aware of the applicable standard, which is, by definition, an objective standard he is bound to as a member of the profession (as opposed to the practice of a certain group of hospitals).

64 As just noted, the SMC's case, as initially framed in its submissions, did not, with respect, quite get to the nub of the issue, which is whether the DT had veered off-course and erred in concluding that there was no intentional, deliberate departure from the applicable standard. In particular, the DT had, in fact, noted as follows (see the DT's Decision at [86]):

> We find that there was no conclusive evidence to show that *Dr Wong proceeded to certify the Patient fit for light duty with full personal knowledge* or after having been told that there was no light duty available or provided by the employer for the Patient… [emphasis added]

65 In our judgment, the DT's above finding (at [86] of its decision, and to which we have just referred), had, with respect, fundamentally contradicted its own findings on the evidence on, *broadly speaking*, (1) the applicable standard requiring the ***doctor to establish*** that there were adequate conditions for rest and rehabilitation before issuing light duties; (2) Dr Wong's breach of this applicable standard; and (3) Dr Wong's reason for backdating the MC and the inference that might be drawn from the same (see also above at [67] where we focus on specific findings of the DT which fall within these broad categories). Put simply (and with respect), there is, in our view, a fundamental disconnect between DT's finding at [86] of its decision on the one hand and the actual (as well as objective) evidence which it took into account in holding that Dr Wong fell below the applicable standard. In our view, the DT made all the findings that were necessary to establish an intentional, deliberate departure from the applicable standard by Dr Wong and thereby convict him of the Charge but then decided not to convict him of the same by focusing on an issue that was entirely irrelevant to the Charge at [86] of its decision. We proceed to elaborate on this.

66 In this regard, it is apposite to first consider the actual (as well as objective) findings of the DT in relation to Dr Wong's conduct. The DT found that Dr Wong "***had not established the availability of light duties***" [emphasis added]. We reproduce the DT's analysis of the evidence (at [55]):

> It was conceded by Dr Wong that in his letter to the SMC dated 1 February 2012, at tab 4, page 18–19 of PIB1, he did not say that he had checked with the Patient's supervisor that light duties were available. Similarly, in his second letter dated 25 February 2013 to the SMC, he also did not state that he had established that light duties were available. He explained that he would have put in these details if he had the benefit of a legal counsel [*sic*]. But during cross-examination, he asserted that he was told by the Patient's employer that light

> duties were available. But this was not stated in his statements to the SMC. Neither did he call Mr Veerapandyan to corroborate him. This was also not supported by Mr Veerapandyan in his statement at tab 11 of P1B1. In his clinical notes, there was no note to state that he asked the Patient regarding the availability of light duties. ***Having reviewed the evidence, we found that Dr Wong had not established the availability of light duties. It was subsequently after much questioning on this issue that Dr Wong admitted that he assumed that there were light duties*** *and maintained it was the Patient's responsibility to tell him if no light duties are available*. But he agreed that by virtue of the SMC Ethical Code and Ethical Guidelines clause 4.1.1.1, it was his responsibility to check whether light duties are available. ***He conceded that if no light duties were available[,] he would have issued a full MC***. In fact, on 5 October 2011, this was what he did by issuing a full MC and backdated it for the Patient to be paid as he as informed by the Patient that there were no light duties**. *We are of the view that the backdating was an attempt to cover the mistake made initially for not issuing a full MC***. [emphasis added in italics and bold italics]

67 It is apparent from the passage cited in the preceding paragraph that the DT had made the following findings:

(a) Dr Wong had not established the availability of light duties;

(b) Dr Wong would have issued a full MC if no light duties were available; and

(c) the backdating of the MC on 5 October 2011 was an attempt to cover up the mistake for initially not issuing full MC.

68 The DT's findings noted above at [67], which were reached correctly on the evidence before it, were sufficient for it to have convicted Dr Wong of the Charge. In this regard, we highlight that the *applicable standard would have required Dr Wong to establish* that there were adequate conditions for

rest and rehabilitation if medical leave for two days after the surgery followed by light duty was to be given (see above at [55(a)]).

The existence of light duties was not verified by Dr Wong

69 In our judgment, as rightly noted by the DT, Dr Wong did *not* ascertain the existence of light duties during his initial consultation with the Patient on 4 September 2011. In our view, he had relied on his previous experience with Kajima and had assumed that such duties would be available. Because the applicable standard would require him to establish adequate conditions for rest and rehabilitation *vis-à-vis* the Patient, we found that these were *assumptions* that Dr Wong was *not* entitled to make.

70 In this regard, we note, for example, that Dr Wong *candidly* pointed out during his evidence-in-chief that he had assumed that there would be light duties available for the Patient by reason of his dealings with Kajima. We briefly highlight his evidence:

> Q. Yes, I see. *So you gave light duties because it was your understanding [that] there would be light duties.*
>
> A. ***You see, I didn't realise at that time, because I know Kajima***. Because they are the main [contractor], they have several other people, but I'm not sure how many sub-[contractors] they have, whether they stick to the what you call that –
>
> Q. The data centre.
>
> A. Whether they comply with the ruling or not, at that time I wasn't -- to my mind, ***I'm just dealing with Kajima***.
>
> Q. Yes, of course.
>
> A. And they have given -- ***they have in the past been giving patients light duty, proper light duty***. They go to the office. This guy all he need to do is just report

> to office and talk to his boss, have a chit-chat, drink coffee or something like that, you know?
>
> [emphasis added in italics and bold italics]

71 Parts of his evidence in cross-examination appeared to also suggest that ***he was prepared to operate on his assumptions*** and did not ascertain that each patient before him had adequate conditions for rest and rehabilitation:

> A. … They tell me that sometimes the light duty means just going back to the office and reporting, that's all, all right. And that was what they had told me beforehand. *And so you have to go by experience*. Kajima, we have treated patients from Kajima beforehand. He says light duty means light duty. ***I cannot repeat time and again and says [sic] got light duty or not***. Right.
>
> …
>
> A. Kajima may be just one of them. And usually, most of the companies, all right, to broaden the picture, those companies that come to us, they when they say they have light duties means they have light duties. ***We cannot work and every time the new construction worker come in, and ask all over again whether you have light duty or not***. You see, if you want to give him light duty, you must tell -- these companies will tell us, yes, there is light duty.
>
> [emphasis added in italics and bold italics]

72 In fact, it became quite clear towards the end of cross-examination that Dr Wong ***did not make any adequate inquiries of the Patient's conditions of work or rest***. We reproduce his evidence below as follows:

> Q. And you didn't establish at that point in time what mode of transportation he took if he was normal on a normal working day? To go to the construction site, you didn't do that? Now, and you didn't do that because you didn't think it was relevant?
>
> A. I --
>
> Q. You assumed that --
>
> A. *I thought they* --

> Q. -- they would know what to do?
>
> A. -- *would have adequate, safe and adequate transportation because, you know, I have seen them going in vans, lorries, buses and so you know …*
>
> [emphasis added]

73 Having analysed the relevant evidence, we highlight that the finding by the DT that Dr Wong had not established the availability of light duties (see above at [67(a)]) was *entirely consistent with the relevant evidence*. It was therefore surprising, to say the least, that Mr Selvaraj sought to impress upon the court in oral arguments without any evidential basis that Dr Wong had checked with the safety coordinator from Kajima, one Subbaiah Veerapandyan ("Mr Pandyan"), who had accompanied the patient to RH on 3 September 2011, on the existence of light duties. Mr Selvaraj then shifted his position. He stated that Dr Wong knew of the existence of light duties "because he was treating patients from Kajima". In our judgment, Mr Selvaraj's submissions were *entirely unmeritorious*. Pursuant to the applicable standard, the existence of light duties and adequate conditions for rest and rehabilitation were *not* matters to simply be *assumed* by Dr Wong.

Dr Wong would have issued a full MC if no light duties were available and backdated the MC to cover up his mistake of not giving MC

74 Dr Wong's own evidence was that he had to give the Patient medical leave on 5 October 2011 as he found out that light duties were not available. Dr Wong's conduct in backdating the MC therefore clearly demonstrated that he ***had not ascertained*** (***in accordance with the applicable standard***) the existence of light duties before issuing the same on 4 September 2011. While Dr Wong shaped his evidence on the stand in order to suggest that he had

backdated the Patient's MC in order that the Patient could be paid his salary, his concessions have not escaped our notice:

> Q. Well, in fact you told the tribunal yesterday that you have the patient MC coverage that was more than medically necessary.
>
> A. You see, look –
>
> Q. Correct you told the tribunal that yesterday.
>
> A. You see, the thing is medical leave [was] necessary because, you know, the criteria. *The criteria is this[:]* ***If there is no light duty available, then you have to cover him with MC*** *because he cannot return back to the full job*. I did say that, if there is no light duty available, then I will have to cover him with MC because he cannot return to the full job. …
>
> [emphasis added in italics and bold italics]

75 He stated this most categorically in other parts of his evidence during cross-examination as follows:

> Q. Now and you also said that if you knew that no light duties were available for [the Patient], you would have given him medical leave.
>
> A. Yes.
>
> …
>
> Q. Yes. Now but what you told the tribunal was that the reason why you gave this leave all the way was to cover him so that he will be paid all the way until the time he left Singapore.
>
> A. *Yah, because there is no light duty, he cannot go back to his full work*. You know, with his hand still with pins inside, he can do light duties, no problem; but he cannot do his full work, full original work. …
>
> [emphasis added]

76 It was revealed towards the end of cross-examination that Dr Wong had backdated the MC because there were no light duties. If it were indeed the case that Dr Wong, in accordance with the applicable standard, had

ascertained the existence of light duties on 4 September 2011, then it would indeed be curious that he had only realised that there were no light duties provided for the Patient on 5 October 2011. In this regard, Dr Wong's case was not that Mr Pandyan was lying. The backdating of the MC therefore supports the view that Dr Wong was attempting to cover up his mistake of failing to ensure that there were adequate conditions for rest and rehabilitation for the Patient before certifying him fit for light duties on 4 September 2011. We reproduce his evidence:

> Q. And I put it to you that you realised on 5th October that the patient was completely not fit for light duties at all from 5th September 2011.
>
> A. *I disagree.* ***I already certified that he's fit for light duties. MC was given because no light duties was available****. … That he was not given the opportunity to rest, have a supervised rest, in the place of work. …*
>
> [emphasis added in italics and bold italics]

77 Based on our review of the evidence, which we have set out above at [74]–[76], we have found that the DT was completely entitled to find that Dr Wong would have issued a full MC if no light duties were available and had backdated the MC to cover up his mistake (see above at [67(b)]–[67(c)]).

Dr Wong intentionally and deliberately departed from the applicable standard

78 There is, of course, a further question of whether Dr Wong's conduct amounted to an intentional, deliberate departure from the applicable standard. In this regard, we had to satisfy ourselves that Dr Wong knew on 4 September 2011 when he certified the patient fit for light duties that it was *incumbent on him to first establish if there were adequate conditions for rest and rehabilitation*.

79 In the context of the present facts, Dr Wong had not established the availability of light duties before he certified the Patient of the same. The DT's finding that Dr Wong was "***covering up" his mistake*** by backdating the MC on 5 October 2011, in our judgment, led to the very ***strong inference*** that Dr Wong knew that it was incumbent on him to check with the Patient on the existence of light duties. However, we found that the evidence before the DT ***squarely supported a finding*** that Dr Wong knew of the applicable standard without a need for such an inference to be drawn.

80 In this regard, it is clear on the evidence that Dr Wong *knew* of the applicable standard at the relevant time:

> Q. -- nowhere there did you say that you had checked that – with the supervisors, that [the Patient] was able – that light duties were available.
>
> A. *Like I said, the principle of issuing MC and light duty, have to check first, I mean, you know,* ***we do that all the time. I thought it was obvious*** …
>
> [emphasis added in italics and bold italics]

81 Dr Wong even highlighted that establishing the existence of light duties before certifying a patient fit of the same was part of the "usual [procedure]". We highlight, in any case, that pursuant to para 4.1.1.1 of the SMC's Ethical Code and Ethical Guidelines ("the Code and Guidelines"), it would be incumbent on a doctor to ensure that he conducts an adequate assessment of his patient's condition. The said paragraph provides as follows:

> *A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.*
>
> If treatment is suggested or offered to a patient without such personal evaluation, the doctor must satisfy himself that he has sufficient information available and that the patient's best

> interest is being served. Such information could be transmitted by voice, electronic or other means by a referring doctor. Only in exceptional or emergency circumstances should a diagnosis or treatment be offered without personal contact and without the intermediation of a referring doctor.
>
> [emphasis added]

82 The Code and Guidelines represent "the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore" and "the minimum standards required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore" (see para 1 of the Code and Guidelines). As the Code and Guidelines represent so fundamentally ***the most basic aspects of clinical practice***, we emphasise that an errant practising doctor would be hard put to argue that he has no knowledge of matters which are covered by the said Code and Guidelines. On the contrary, there would be a strong presumption that he has knowledge of the matters contained therein. It would otherwise be all too convenient for an errant doctor to allege that he did not depart from the applicable standard intentionally on the basis that he did not know of the applicable standard at the relevant time. To the extent outlined, we would have additionally been prepared to find that Dr Wong knew of the applicable standard by virtue of it being broadly encapsulated in para 4.1.1.1 of the Code and Guidelines.

83 There was therefore an intentional, deliberate departure from the applicable standard by Dr Wong; he had certified the Patient fit for light duties without first establishing the availability of such duties *and* with the knowledge that he was required to establish the same.

84 With respect, therefore, the DT had *slipped into error* when it focused its mind (see the DT's Decision at [86], and reproduced above at [64]) on whether Dr Wong had certified the Patient fit for light duties *with the*

knowledge that such duties were not available. It should, instead, have considered whether Dr Wong had certified the Patient fit for light duties (1) without first establishing the existence of such duties; and (2) with the knowledge that it was incumbent on him (*ie*, Dr Wong) to ascertain the existence of such duties from the Patient.

85 We therefore accepted Mr Fong's crystallisation of the SMC's case which ran as follows: the DT had found that, under the applicable standard, it was incumbent on Dr Wong to ascertain the availability of adequate conditions for rest and rehabilitation before he certified the Patient fit for light duties. Because Dr Wong certified the Patient fit for light duties without ascertaining this, there was an intentional, deliberate departure from the applicable standard on his part. Consequently, we allowed the appeal and held that Dr Wong was guilty of the Charge.

***Observations with regard to the second limb of* Low Cze Hong**

86 Before we turn to discuss our decision on sentence, we make some observations on the applicability of the second limb of *Low Cze Hong*. We are of the provisional view that, ***based on the findings of the DT***, Dr Wong would, *in any case*, have been liable for gross negligence under the *second limb* of *Low Cze Hong*. As noted above at [49(b)], in relation to the second limb of *Low Cze Hong*, it has to be shown that (i) there was serious negligence on the part of the doctor; and that (ii) such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

87 In so far as point (ii) referred to in the preceding paragraph is concerned, as noted in *Pillai* (at 200) "*serious negligence [that] portray[s] indifference"* to the welfare of the patient would also fall under the label of

gross negligence. Similarly, it was noted in *Lee Kim Kwong* (at [44]) that "serious negligence may demonstrate precisely a lack of such concern for the patient's interest". The DT in the present case took the view that there was serious negligence on the part of Dr Wong as he "did not follow the ***very basic principle*** of obtaining a detailed history from the Patient, especially in relation to the nature of his work, before issuing a medical certificate for light duty" (see the DT's Decision at [74]; emphasis added). The DT also found the ***basics of medical care*** wanting in this case (see *ibid*). The finding that Dr Wong fell short of the *basics of medical care* shows that Dr Wong was grossly negligent.

88 In the hearing before us, Mr Fong submitted that the SMC did not pursue an alternative argument based on the second limb of *Low Cze Hong* because, in his view, the decision of this court in *Ang Pek San Lawrence* required the SMC to elect which limb it was proceeding under. This is however, not apparent from a close reading that case. We there observed (at [40]) as follows:

> … In our judgment, those prosecuting disciplinary proceedings against medical practitioners should assist future Disciplinary Committees by: (a) specifying in the charge the precise allegation that is being made against the medical practitioner concerned; and (b) *specifically setting out or indicating which limb of Low Cze Hong is being invoked,* ***so that there is clarity as to the case that the medical practitioner must meet as well as the issues and the relevant evidence that the Disciplinary Committee should consider***. [emphasis added in italics and bold italics]

89 In the present case, where the SMC could have relied on the same set of facts (and evidence) to establish professional misconduct under both the first limb and the second limb of *Low Cze Hong*, it would have been open to it to have pursued both arguments in the *alternative* without any prejudice to Dr Wong. However, given that only the first limb of *Low Cze Hong* was

pursued in the court below, we were not inclined to hear arguments, much less make a conclusive finding, on the applicability of the second limb on the facts in the context of this particular case.

90 We wish to go further and observe that although the fact that the doctor was not aware of the applicable standard *might* result in a charge based on the first limb of *Low Cze Hong* not being made out against him, such lack of awareness of the applicable standard on the part of the doctor may itself constitute gross negligence and result in an alternative charge based on the second limb of *Low Cze Hong* being established against him. In this regard, we highlight that it would be open to the SMC to make this argument in appropriate cases. Indeed, it might be ***essential*** that such an argument is made by the SMC in appropriate cases; it might be all too easy for a doctor to allege his subjective ignorance of the applicable standard when the charge brought against him is based on the first limb of *Low Cze Hong*. An (alternative) argument based on the second limb of *Low Cze Hong* would invariably bring within its fold circumstances where the doctor's *subjective ignorance* of the applicable standard is *objectively and wholly unacceptable*.

Our decision on sentence

91 After the court convicted Dr Wong of the Charge, we invited the parties to submit on the sentence to be imposed on Dr Wong.

The parties' submissions

92 Mr Fong submitted that there were several aggravating factors in the present case. These factors were summarised as follows:

(a) Dr Wong's main concern was not the patient's welfare and interest – he was advancing the interests of the employer and wanted the Patient to return to work as soon as possible.

(b) Dr Wong alluded to irrelevant considerations when asked why the Patient was only granted two days of medical leave.

(c) Dr Wong was unremorseful and sought to pin the blame on the Patient for his own failure to adequately manage his post-operative recovery.

(d) The professional misconduct influenced the proper care of the Patient and caused harm to the Patient – he suffered pain (as noted from Dr Dutton's case notes).

93 The SMC prepared a table setting out precedents that it had gathered. As we highlighted in the hearing, those precedents could be grouped as follows: those that related to (i) general practitioners who had issued medical leave certificates to patients without examination or medical justification; and (ii) specialist doctors who had failed to properly treat and manage their patient's condition post-operatively. It was apparent to us that the first category of cases was not relevant on the present facts. We therefore asked Mr Fong to focus on the second category of cases. We highlight these cases.

94 The first was a case involving Dr K ("*Dr K* case"), which was heard in September 2004. In that case, the doctor failed to make an adequate evaluation of the patient's medical condition and properly manage the hepatitis-B infection that the patient developed during the course of the treatment. He pleaded guilty of two charges brought against him by the SMC for his

misconduct. He was sentenced by the Disciplinary Committee ("the DC") to three months' suspension. He was also censured, required to give a written undertaking not to repeat the professional misconduct and ordered to pay the SMC's costs and expenses of the proceedings.

95 The second case that the SMC relied on was that involving Dr L ("*Dr L* case"), which was heard between May 2009 and January 2010. In that case, the doctor failed to personally assess the patient after the operation even though he was aware that the patient was unwell after the unsuccessful procedure. The patient died subsequently from complications due to sepsis. The doctor contested two charges brought against him for (i) practising beyond the scope of his duties; and (2) wilful neglect and gross mismanagement of the patient. He was convicted of the second charge by the DC. He was sentenced to six months' suspension. He was also censured, required to give a written undertaking not to repeat the professional misconduct and ordered to pay 70% of the SMC's costs and expenses of the proceedings. We note that the doctor's appeal of the DC's decision was dismissed by this court.

96 The last case the SMC relied was that involving Dr Amaldass S/O Narayana Dass ("*Dr Amaldass* case"). In that case, which was heard between August 2012 and May 2014, the doctor (1) failed to adequately explain the risk and complications of the procedure to the patient prior to the procedure; (2) failed to ensure the patient was effectively sedated before commencing the procedure; (3) failed to inform the patient of a dressing; (4) left threads in the patient's glabella region; and (5) subsequently performed a second open rhinoplasty but failed to remove the implant in the patient notwithstanding overwhelming evidence of infection. The doctor

pleaded guilty to one charge for misconduct. He was fined $5,000 and sentenced to four months' suspension by the DC. He was also censured, required to give a written undertaking not to repeat the professional misconduct and ordered to pay the SMC's costs and expenses of the proceedings. We also note that the doctor's appeal of the DC's decision was dismissed by this court.

97 Having referred to these precedent cases and highlighted the aggravating factors in the present case, the SMC submitted that Dr Wong should be suspended for a period of four months, censured and required to furnish a written undertaking that he will not repeat such conduct.

98 Mr Selvaraj, after setting out Dr Wong's experience in the medical profession, made two points: (1) the propriety of the medical treatment was not an issue in the present case; and (2) Dr Wong was a first-time offender. On the back of these two points, he submitted that Dr Wong should be fined, censured and required to furnish a written undertaking that he would not repeat such professional misconduct. Mr Selvaraj did not address us on the precedents referred to by the SMC noted above at [94]–[96].

The aggravating factors in the present case

99 As apparent from our analysis in *Lee Kim Kwong*, the reason for an intentional departure from the requisite standard, while not directly relevant to conviction, is relevant to sentencing. We turn to analyse Dr Wong's reasons for intentionally and deliberately departing from the applicable standard and highlight a few aspects of Dr Wong's conduct that stand out in the present case.

100 When asked why the normal and accepted practice of giving medical leave of "at least a week" was not followed, Dr Wong disagreed that this was a standard practice. He explained that only "Government restructured hospital[s]" would have to do that as they did not have "the luxury of seeing [a patient] in two or three days" for a follow-up. They therefore "covered" the patient with medical leave until the post-operative follow-up appointment. However, even on this analysis there are problems with Dr Wong's evidence. The Patient was discharged on 4 September 2011. His follow-up appointment was scheduled on 7 September 2011. Therefore, Dr Wong should have at the very least provided the Patient with medical leave from 5 to 7 September 2011. When asked why this was not done, Dr Wong suggested (incredibly, in our view) that this was because he wanted to give the Patient the chance to try whether there was anything he could do at work and not give the Patient the impression that his condition was serious.

101 In our judgment, Dr Wong's failure to provide a MC to cover the Patient for even the period between 5 to 7 September 2011 demonstrated a wilful disregard for the patient's welfare and interests, and in particular, his need for proper rest and rehabilitation.

102 The other parts of Dr Wong's evidence, which the DT did not analyse in its decision, reveal the reasons why Dr Wong departed from the requisite standard by not awarding medical leave and certifying the patient suitable for light duties after surgery for a distal radius fracture. The evidence demonstrated that Dr Wong had, in fact, regard to various unfounded and ultimately irrelevant criteria.

103 Firstly, Dr Wong gave evidence that he did not give the Patient medical leave as he wanted the Patient to have "supervised rest". We reproduce Dr Wong's evidence, where he stated as follows:

> … The crux of the matter is he does not really need to go and rest at home. So he can do something. ***What's the difference of him going to office and him hanging around Geylang***, ***which he obviously has gone several time*** … If when [*sic*] you put the [P]atient in the dormitory there is no supervised rest, right … ***And probably he will be doing something with his hands, maybe play mah-jong or something like that, I don't know***. I cannot supervise him, you see.
>
> So when you go to a company place, it is supervised rest. I would still emphasise that it's a supervised rest and not actual work.
>
> [emphasis added in bold italics]

104 The notion of "supervised rest" did not, in our judgment, stand up to scrutiny. Analysing the evidence noted above at [103], it was clear to us that Dr Wong knew that the Patient needed rest; but he appeared to be concerned that ***he*** would not be able to supervise the Patient to ensure that the Patient was not abusing the medical leave if he were to grant the MC. If this was truly his reasoning, then it would seem to suggest that he thought foreign construction workers were somehow to be treated differently from other patients. Indeed, this appeared to emerge also from Mr Selvaraj's submissions (see above at [36]). ***We wish to emphasise in no uncertain terms that this is utterly wrong***. The doctor's first priority is to ensure the patient's care and welfare.

105 Dr Wong's evidence also exhibits *an indifference to the welfare of the Patient*. In this regard, he was content with giving the Patient, a foreign construction worker, light duties and ***letting the employer decide the extent to which the Patient should rest.*** He appeared to also be keen in maximising the

value that the employer could extract from the construction worker. We reproduce his evidence as follows:

> … But light duty is actually supervised rest. … by common sense, a person on light duty is not doing the full work. He is a reduced [*sic*] amount of work, but in fact it is resting at the work place, *depending on what type of light duties he has been given*. … For example … chat with your supervisor… look through this inventory … ***The boss is at liberty to let the patient go home and rest after reporting to the office***. This is what light duty is all about. …
>
> …
>
> … ***So I am having light duties … I am doing something useful for the company or I am doing something useful for myself also***. Instead of looking around and some people, when they are on MC, they say okay, I am quite good, I can do something else, ***I can earn extra money***. So there is no supervised rest in this case. …
>
> [emphasis added in italics and bold italics]

106 We therefore agreed with the SMC's submission that Dr Wong's main concern was not the patient's welfare and interest – he was, instead, advancing the interests of the employer and wanted the Patient to return to work as soon as possible.

107 The evidence also demonstrated that Dr Wong possibly did not give the Patient medical leave, as he was suspicious of the circumstances surrounding his accident. As noted above at [8], Dr Wong checked the expiry of the Patient's Work Permit upon seeing him. Dr Wong was cross-examined on why this was done. He responded that this was because, *inter alia*, he observed an "increased frequency" in foreign workers getting injured before their Work Permits expired. He later changed his evidence to suggest that he looked at the Work Permit expiry date to decide on the type of treatment that

should be pursued according to the length of time the Patient had left till the expiry of his Work Permit.

108 We note also that Dr Wong was unremorseful and sought to pin the blame on the Patient for his own failure to adequately manage his post-operative recovery. In this regard, both his written submissions and Mr Selvaraj's oral submission *incessantly alluded* to the *misconceived view* that it was incumbent on the Patient to inform him that he needed MC when he was asked by him if he had any "problem" on 7 September 2011.

109 We were also of the view that the professional misconduct by Dr Wong influenced the proper care of the Patient and caused harm to the Patient. In this regard, as highlighted by the SMC, the Patient complained of pain in his injured hand on 21 September 2011 when he visited Dr Dutton. He was also in pain when he presented himself at CGH on 11 September 2011 and 23 September 2011.

110 It should not be the case that a patient has to "kneel and beg" (as the Patient in fact did, according to Dr Wong) for medical leave that he was in any case entitled to on proper clinical grounds. This was what happened to the Patient. All in all, in our judgment, the evidence revealed that Dr Wong chose not to give the Patient medical leave for a ***multitude of extraneous, less than proper, as well as non-medical considerations***.

Recalibration in sentencing benchmarks

111 In at least two previous decisions of this court, we have discussed the need to recalibrate sentences in relation to professional misconduct concerning doctors. We refer first to our decision in *Lee Kim Kwong*. In that case, the

appellant doctor, a specialist in obstetrics and gynaecology, was charged for professional misconduct for allegedly commencing a Caesarean section on his patient by making an incision on her abdomen without having first tested if the anaesthetic, *ie*, epidural anaesthesia ("EA"), administered earlier to her had taken full effect, thereby causing her to scream in pain. The charge further alleged that he continued with the procedure despite his patient's scream of pain. The SMC argued before the DC that the appellant was liable for professional misconduct under the first limb of *Low Cze Hong*; however, the DC convicted the appellant under both limbs of *Low Cze Hong* and suspended him from practice for nine months and ordered that he pay a financial penalty of $10,000 as well as costs. On appeal, this court upheld the appellant's conviction. We then turned to consider the sentence that should be imposed on the appellant.

112 The DC in that case imposed a sentence of, *inter alia*, nine months' suspension of practice on the appellant. We noted (at [39]) that the sentencing precedents relevant to the facts of that case would have suggested a starting point in the region of three months' suspension from practice. Having considered those precedents, we reduced the period of suspension imposed by the DC to five months. However, as we made clear in our decision (at [45]), the reduction in the period of suspension imposed on the appellant was to "achieve a measure of consistency with the sentencing precedents". It is apposite to reproduce our views therein (at [45]–[47]) at some length for context:

> 45 The second broad point we would make is this. In the present case, it was to achieve a measure of consistency with the sentencing precedents that we reduced the period of suspension imposed on the Appellant to five months from the nine months handed down by the DC. *But we would emphasise that fidelity to precedent ought not to lead to*

> *ossification of the law. For circumstances change: the way medicine is practised now may be different in many respects from the way it was practised, say, a decade ago, and it may well be rather different from the way it will be practised a decade from today. A corollary of this is that, given two similar cases separated in time by a substantial number of years, the sentence that was appropriate in the earlier case may not necessarily be appropriate in the later.*
>
> 46 All we would say is that it is open to the [SMC] in future cases to persuade the DC or this court that ***relevant sentencing precedents are no longer a helpful guide to the appropriate sanction that ought to be imposed because prevailing circumstances are materially different from those at the time when those precedents were decided***. For example, from a cursory examination of the published grounds of decision of DC cases available on the [SMC's] website, we note that it is very rare for periods of suspension to exceed six months. There are two cases in which three years' suspension was imposed, one involving gross overcharging of a patient and the other involving a sexual relationship lasting more than a decade between a medical professional and a patient who had psychiatric problems, but it would seem that these are exceptional.
>
> 47 Indeed, the [SMC] itself, in its written submissions, referred at least twice to the fact that the precedent concerned was dated, observing that the case of Dr S (discussed above at [31]) "took place almost 15 years ago and would not [be] reflective of the needs of the profession and the public today", as well as observing that as two other cases "are very old precedents from almost 20 years ago, the DC is entitled to take the view that the benchmark should be moved in light of the prevailing circumstances today". But it is not enough to state that sentencing precedents should not be followed simply because they are from another era; some ***more concrete difference between the circumstances then and the circumstances now that calls for correspondingly different approaches or benchmarks should be demonstrated***. Should the Respondent on some future occasion take the view that the sentencing tariffs have up to that point in time been set too low, whether generally or in respect of a particular type of case, this is something it should bear in mind when it makes the argument before the relevant adjudicatory body.
>
> [emphasis added in italics and bold italics]

113 We pause briefly to highlight that, as observed in *Lee Kim Kwong*, for the purposes of sentencing, the relative seriousness of a conviction under the first and second limb of *Low Cze Hong* respectively must depend on the precise fact situation. We reproduce the court's analysis (at [44]), as follows:

> However, that is not to say that cases under the first limb, *ie*, those that involve an intentional or deliberate departure from medically-accepted standards, will *invariably* attract *heavier* sanctions than cases under the second limb, which involve serious negligence. For instance, an intentional departure from medically-approved standards may be motivated by a genuine but mistaken concern for a patient's interests … . On the other hand, ***serious negligence may demonstrate precisely a lack of such concern for the patient's interests. Where this is so, negligent wrongdoing may be deserving of greater punishment than intentional wrongdoing***. Put simply, the precise fact situation would be of the first importance. [emphasis in bold italics added; emphasis in italics in original].

114 This court had the occasion to reconsider the "inexplicably lenient" sentencing precedents in relation to one aspect of professional misconduct, *viz*, improper certification of death, in *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201 ("*Kwan Kah Yee*"). In that case, the SMC appealed against the sentence imposed on the respondent, a doctor who had certified the death of two of his patients allegedly on the back of an X-ray and clinical records respectively. Both the X-ray and clinical records were found to not exist. The respondent pleaded guilty to charges of improperly certifying the death of his patients. The respondent was sentenced to three months' suspension for each charge. In the appeal, this court observed as follows (at [34]):

> *The precedents revealed that the sentences meted out for improper death certification have thus far been exceedingly and inexplicably lenient considering the extensive negative consequences that may flow from an improperly certified death.* While the facts in the cases of Dr X and Dr Y were not before

> us, the facts on which the Respondent was sentenced for the Prior Charge were, and we observed that the sentence imposed by the DC there was unduly lenient. The Respondent had in the Prior Charge falsely certified the death of the patient, who had passed away on 16 October 2009. It was only when the patient's family dealt with an insurance claim that they realised that the Respondent had certified the patient as having IHD for the last six years, which was untrue as far as they had been aware. When the family confronted the Respondent, he was reportedly unhelpful. And when the Respondent was charged, he contested it. [emphasis added]

115 As observed by the court in *Kwan Kah Yee* (at [29]–[30]), the legislative changes to the MRA in 2010, which, by way of background, *inter alia*, made provision for the SMC to bring appeals against sentences imposed by a DT, underscore the court's role to review a DT's decision on sentence. This might require the court "from time to time to recalibrate the sort of sentence that should be considered for certain types of misconduct" (see *Kwan Kah Yee* at [30], citing *Lee Kim Kwong* at [45]–[47]).

116 On the facts on that case, and having regard to general and specific deterrence, the court sentenced the respondent to a suspension of 18 months' on each charge and held (at [61]) that they should run consecutively.

117 As can be seen from *Lee Kim Kwong* and *Kwan Kah Yee*, we have on at least one previous occasion referred to and, on another, exercised our discretion to depart from precedents that do not reflect the prevailing circumstances and state of medical practice. In our judgment, public interest considerations weigh heavily in *imposing deterrent sentences on errant doctors* who are found guilty of professional misconduct. In this regard, we expressed at the hearing that we found the sentences imposed in the *Dr K* case, *Dr L* case and *Dr Amaldoss* case ("the Relevant Precedents") to be lenient. *We observed without reservation that these sentences should have in fact been*

longer. We highlighted to the parties that this court has given fair notice of its intention to recalibrate sentences across professional misconduct cases, and would do so in the present case.

118 To the extent that the Relevant Precedents imposed a sentence of between three to six months, we considered in the present case that Dr Wong should be suspended for a period of six months. In this regard, while the harm to the patients in the Relevant Precedents was far greater, in our judgment, the recalibration of the sentences across cases for professional misconduct by medical practitioners coupled with the several aggravating factors that we have noted above at [99]–[110] makes this a suitable period of suspension. In sentencing Dr Wong, we ordered that he be (1) suspended for a term of six months with effect from the delivery of our judgment; (2) censured; and (3) required to furnish a written undertaking not to repeat such professional misconduct. Dr Wong was to bear the costs of the inquiry before the DT and the appeal. These costs were to be taxed if not agreed.

Conclusion

119 For the reasons set out above, we allowed the appeal with costs and convicted and sentenced Dr Wong in respect of the Charge accordingly.

Sundaresh Menon Chief Justice	Chao Hick Tin Judge of Appeal	Andrew Phang Boon Leong Judge of Appeal

Philip Fong, Shazana Anuar and Sui Yi Siong (Harry Elias Partnership LLP) for the applicant;
S Selvaraj, Myint Soe and Edward Leong (MyintSoe & Selvaraj) for the respondent.
