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6. BIOMEDICAL LAW AND ETHICS

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I. Introduction

6.1 There were three cases involving medical negligence and two disciplinary cases of note in the year under review. The former considered the treatment of close relations with potentially addictive medication, the causation of loss in negligent medical advice and the need for informed consent in withdrawing medication. The disciplinary cases addressed conduct bringing disrepute to the medical profession by reason of misuse of patient information and the applicability of the usual rules of evidence law pursuant to the Evidence Act 1872[1] ("EA") in the context of disciplinary proceedings under the Medical Registration Act 1997[2] ("MRA").

II. Medical negligence

A. Negligence in treating close relations with prescription psychiatric medication

6.2 In *Tiong Sze Yin Serene v Chan Herng Nieng*[3] ("*Serene Tiong*"), the claimant alleged that the defendant psychiatrist, with whom she was in an intimate relationship, had negligently prescribed her Xanax tablets (a drug used to treat anxiety and panic disorders) that caused her to suffer side effects and become addicted to Xanax. The parties conceded that a *de facto* doctor–patient relationship arose in the context of their intimate relationship. The relevant dispute was whether the defendant had breached his professional duty of care in the way that he prescribed, advised and monitored her Xanax use. The claimant alleged that the defendant failed to properly assess her medical condition, ascertain the

1 2020 Rev Ed.
2 2020 Rev Ed.
3 [2022] SGHC 170.

suitability of Xanax for her condition and prescribed excessive quantities of Xanax, resulting in her addiction to the drug. She also claimed that the defendant had not properly managed her condition by failing to arrange alternative psychiatric care after their relationship ended. As a result, she suffered from Xanax addiction and the associated side effects of excessive Xanax prescription. The claimant also brought a claim under the rule in *Wilkinson v Downton*[4] against the defendant for intentionally inflicted psychiatric injury, namely adjustment disorder with anxiety.[5]

6.3 The allegations of breach were resolved principally on a factual basis: the court did not believe that the claimant was prescribed Xanax in the region of 280 to 330 tablets and preferred the defendant's evidence of only 14 Xanax tablets being prescribed. At this low level of prescription, the joint expert appointed by the parties opined that the risk of dependency was very low.[6] Accordingly, a reasonable psychiatrist would not have foreseen such a risk and could not be expected to take the precautionary measures claimed. Even on the claimant's own inconsistent evidence on consuming (at its highest) 100 Xanax tablets a month, the risk of dependency was still low and well within the recommended maximum daily dosage for the drug. Finally, the claimant was also prescribed the same amount of Xanax by another psychiatrist that she saw after her relationship with the defendant ended. It was incongruous that she did not allege that this subsequent prescription was excessive or in breach of a duty of care.

6.4 Secondly, the court was also not persuaded that the claimant in fact suffered damage. In the joint expert's opinion, the risk of side effects complained of was in the region of 20%. It was also not possible for Xanax to give rise to suicidal thoughts. The lack of any objective evidence that she did suffer side effects, coupled with the significant delay between consumption and the onset of alleged symptoms, meant that her claims of loss were disbelieved. If indeed the claimant suffered side effects, this was contradicted by the subsequent continued prescription of Xanax by another psychiatrist without further complaint. In respect of her alleged withdrawal symptoms, this was contradicted by the circumstantial evidence indicating she had considerable control over the amount of Xanax she consumed over a 15-month period, even though she claimed to have a substantial number of extra tablets on hand. The allegation that she suffered from an adjustment disorder with anxiety was also not substantiated by the evidence adduced. The plaintiff's claims in medical negligence were therefore dismissed.

4 [1897] 2 QB 57.
5 This claim will not be reviewed given the subject matter of this chapter.
6 *Tiong Sze Yin Serene v Chan Herng Nieng* [2022] SGHC 170 at [109].

6.5 In its reasoning, the court also made several pertinent observations on the professional obligations under the Singapore Medical Council's Ethical Code and Ethical Guidelines[7] ("SMC ECEG"). First, the SMC ECEG is only a general guide to professional conduct, and a breach of any of the guidelines is not *ipso facto* medical negligence. Medical practitioners may justify non-compliance with good reasons for conduct that departs from these guidelines. In this case, the court found that the defendant had in fact complied with the requirements of the SMC ECEG. There was no blanket prohibition against doctors treating their loved ones under Guideline B1.1, provided they could eschew any personal prejudices or bias in their professional care of such a relation.

6.6 Nevertheless, Guideline B1.4 proscribes doctors from treating "those close" to them where this involves, *inter alia*, controlled drugs or drugs with a significant potential for dependence. However, the quantity of Xanax prescribed in this case did not give rise to such a significant potential. In addition, Guideline B1.5 allows physicians to care for persons close to them where it involves a "minor condition". The joint expert called by the parties agreed that the claimant had a "self-limiting minor episode" of anxiety, which would fairly constitute a minor condition within the exception to Guideline B1.5. The court also accepted the joint expert's opinion that the doctor has a discretion to determine whether their loved one's condition is within the realm of minor conditions under Guideline B1.5. However, it is worth bearing in mind that when the conduct is being evaluated for breach of a professional duty of care in negligence, and not professional misconduct, this exercise of discretion must nevertheless be subject to the *Bolam/Bolitho* requirement of logicality.

B. Informed consent and causation of loss

6.7 In *Sheng Ling Huo v Orthosports@Novena*,[8] the claimant alleged negligent medical advice against two orthopaedic surgeons practising as "Orthosports@Novena". The claimant underwent a knee replacement procedure using a Genesis II implant. After post-surgical physiotherapy, ten follow-up consultations with the defendants and seven physiotherapy sessions, no adverse side effects or pain were recorded in his medical notes and rehabilitation was uneventful.

6.8 The claimant, however, alleged that he was in severe pain all this while. A year and five months after the knee replacement procedure, the polyethylene liner of the replacement knee implant dislocated. One of the defendant surgeons advised that he should undergo a revision

7 2016 Ed.
8 [2022] SGHC 163.

knee replacement surgery, but the claimant declined as he was averse to further surgery. Instead, he brought a negligence claim against the defendants, alleging that they had failed to properly advise him of the risk of dislodgement of the polyethylene liner. Pursuant to this claim, the defendant also relied on *Chester v Afshar*[9] to argue that materialisation of the risk of dislodgement that he should have been warned of was sufficient to establish the action. The District Court found that the claimant was adequately informed of the risk of dislodgement and dismissed the claim.

6.9 On appeal to the General Division of the High Court ("High Court (General Division)"), the judge upheld the lower court's finding that the claimant had been adequately informed of the risks of implant failure. The claimant himself could not remember what was told to him; there was consequently nothing to challenge the defendants' testimony, which was corroborated by the medical record and consent form.

6.10 On the question of causation of loss and the exceptional rule established in *Chester v Afshar*, the High Court (General Division) noted that prior decisions of the High Court had rejected the exception that materialisation of the risk alone was sufficient to establish causation in negligent advice cases. Medical procedures are fraught with risks, and it cannot be in the interests of justice to hold that liability arises simply when that risk, however small or low, materialises. Causation of damage should depend on whether the claimant would not, objectively assessed, have been willing to run the risk. In this case, the risk of implant failure by reason of dislodgement was about 1.2% and was independent of any surgical negligence. The patient at the relevant time was suffering from a bad knee that would have been remediated by the total knee replacement, while the risk of dislodgement was small and non-life threatening. He was also offered the surgery free of charge as a charity had agreed to underwrite the procedure. Causation of the damage would not have been established on traditional principles. The result in *Chester v Afshar* was driven by the importance placed in the UK on the exercise of patient autonomy.[10] That policy imperative has not, thus far, been well received in the Singapore courts in relation to displacing the traditional rules on causation in professional negligence. The appeal was accordingly dismissed as without merit.

9 [2005] AC 134.

10 See *ACB v Thomson Medical Pte Ltd* [2017] 1 SLR 918 at [113]–[114].

C. Informed consent to withdraw medication?

6.11 Finally, the patient in *Chia Soo Kiang v Tan Tock Seng Hospital Pte Ltd*[11] presented at the first defendant's Emergency Department with a persistent fever. She was fully alert and informed the attending physician that she did not have shortness of breath or palpitations. However, she had a history of various ailments, including ischaemic heart disease, type 2 diabetes and stage 4 chronic kidney disease, amongst others. The doctor diagnosed her with infection due to sepsis of unknown origin and prescribed a broad-spectrum antibiotic. She was then transferred to the general ward, where a series of medical officers and a senior consultant confirmed the initial diagnosis. However, they also thought that her sepsis was complicated by coagulopathy, a type 2 myocardial infarction, acute kidney injury and chronic kidney disease. They substituted the original antibiotic for another, and temporarily stopped prior chronic medications for her heart and hypertension as these were assessed to complicate treatment of her current condition. The senior consultant thought that referral to a cardiologist was not necessary as the management of type 2 myocardial infarction required the treatment of the underlying sepsis, which the Department of General Medicine was competent to do.

6.12 Later the next day after admission, the patient was changing after a shower with the assistance of a nursing intern. She collapsed suddenly and was moved to her bed where resuscitation was carried out. Unfortunately, she never regained consciousness and passed away three weeks later. The court accepted the defendant's expert opinion that the patient suffered a cardiac arrest during her shower, but it was unclear what the cause was. This could have been due to a myocardial infarction or pulmonary embolism but was not ascertained as the patient's family declined an autopsy. Her son, acting as her personal representative, instituted proceedings on behalf of her estate, claiming clinical negligence by the attending physicians in (a) incorrectly diagnosing her condition on admission; (b) allowing her to shower and not promptly attempting resuscitation upon her collapse; and (c) failing to obtain her informed consent in stopping her chronic medication upon admission to the general ward. The defendant hospital was alleged to be vicariously liable for the actions of its employee doctors.

6.13 In respect of the first claim, it was argued that the attending physicians failed to diagnose the patient with type 1 myocardial infarction. However, the court agreed with the defendant's experts that the patient did not have the requisite symptoms at the time of admission; nor was it necessary to undertake further tests and investigations which would have

11 [2022] SGHC 259.

brought additional risks. Instead, her symptoms were consistent with type 2 myocardial infarction. The defendants' expert witnesses all agreed that admission to the intensive care unit ("ICU") or high dependency unit ("HDU") was not indicated, and the general ward was suitably competent to deal with the type 2 myocardial infarction's underlying cause – the sepsis. The claimant's medical expert testimony on a type 1 myocardial infarction diagnosis was also found to be unreliable.

6.14 Quite apart from these contraindicatory symptoms, a cardiac arrest was also highly unpredictable, and the defendant doctors could not be faulted for failing to predict its onset. Interestingly, the court also observed that given the patient's fraught medical history, an abundance of caution might have led private hospital doctors to admit her to the ICU or HDU – provided the relevant charges were paid for. However, in the public sector where healthcare is subsidised, doctors must balance the needs of the patient against the proper allocation of healthcare resources in ICU/HDU care. This observation indicates that the allocation of healthcare resources is at the least a relevant consideration in determining the requisite standard of care,[12] and the private or public context in which healthcare is provided is accordingly important. However, it remains to be seen if the local courts will defer in breach determinations to healthcare institutional or doctors' judgments on resource allocation[13] and allow the calibration of the standard of care to be driven by those allocation decisions.[14]

6.15 In respect of the second claim, the court found that the patient readily agreed to the offer to have a shower, and the nursing intern was competent in assisting her in doing so. Likewise, the claim that the defendant hospital was slow to respond to the patient's collapse was not borne out by the evidence. The response by the nursing intern was immediate and the various steps taken were reasonable given the patient's condition after her collapse. These were common-sense evaluations without the court needing to refer to expert evidence in support.

6.16 Finally, in respect of the third claim, there was no evidence adduced by the claimant to support a causal connection between the stoppage of the patient's chronic medications and her eventual collapse; it could plausibly have been caused by a pulmonary embolism instead. The alternative argument – that the doctors failed to obtain the patient's informed consent before stopping the medications – also did not hold

12 See also *Knight v Home Office* [1990] 3 All ER 237.

13 *Cf R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898 at 906.

14 For further discussion, see *Principles of Medical Law* (Andrew Grubb, Judith Laing & Jean McHale eds) (Oxford University Press, 3rd Ed, 2010) at paras 7.51–7.57.

water. The court held that cessation of medication is a clinical decision that does not require the patient's consent, even if it is a matter of professional courtesy to "advise the patient that he should stop using it".[15] This is presumably on the ground that after initial administration, the treatment has since become contraindicated, or the adverse effects of the medication have since outweighed its anticipated clinical benefits. It is a logical extension of the rule that the patient cannot generally demand treatment which the doctor "considers is adverse to the patient's clinical needs".[16] The claimant representative therefore failed in respect of all his claims of clinical negligence.

6.17 The court went on to observe that:[17]

> … [i]t is inconceivable to expect a doctor, for example, to ask a patient if he would like a Panadol. He may have to check if the patient has any relevant allergies but does not have a duty to ask if the patient consents to a pain killer, an anti-inflammatory, an antihistamine, or such other drugs, though he might still tell the patient to stop taking the medication once he feels better.

It is doubtful if this pronouncement is intended to apply to all drug prescriptions. For example, there are some drugs with a low risk of serious side effects, such as an increased risk of suicidality associated with anti-depressant use in adolescents, which should be disclosed for the patient or parent to properly consent to their prescription. Perhaps the better explanation for the obviation of consent to the types of drugs mentioned is that they are routinely administered without any material side effects that patients need to know of before agreeing to take them. Otherwise, the overall tenor of this paragraph of the judgment is more consistent with the obviation of patient consent before drugs can be withdrawn pursuant to a clinical judgment that they are contraindicated.

III. Disciplinary proceedings

A. Improper conduct bringing disrepute to the profession

6.18 The claimant in *Serene Tiong*[18] also lodged a complaint against the defendant (Dr Chan) and his friend Dr Julian Ong with the Singapore Medical Council ("SMC") in respect of the salacious WhatsApp messages that were exchanged between the accused doctors. Disciplinary proceedings were instituted against each of the doctors on a single charge

15 *Chia Soo Kiang v Tan Tock Seng Hospital Pte Ltd* [2022] SGHC 259 at [30].
16 *R (Burke) v General Medical Council* [2006] QB 273 at [55].
17 *Chia Soo Kiang v Tan Tock Seng Hospital Pte Ltd* [2022] SGHC 259 at [30].
18 See para 6.2 above.

of improper conduct which brought disrepute to the medical profession under s 53(1)(*c*) of the MRA.[19] The improper conduct charge related to a particular exchange of messages concerning K, a former patient of Dr Ong's who was a property agent. Dr Ong obtained consent from K to share her contact details with Dr Chan, on the pretext that Dr Chan was interested in purchasing an investment property. The messages, however, revealed that the true purpose was to enable Dr Chan to attempt to engage in a sexual encounter with K. The rest of the WhatsApp messages that were uncovered by Serene Tiong were not the subject of the respective charges against the doctors but were nonetheless relevant to interpreting those that were. The disciplinary tribunal ("DT") rejected Dr Ong's explanation that the introduction of K was solely because Dr Chan was a prospective property investment client. They thought that the messages revealed that the doctors were colluding to allow Dr Chan to attempt to engage in sexual activity with K. As a result, Dr Ong failed to treat K with due courtesy, consideration and respect required by Guideline C1 of the SMC ECEG. The DT suspended him for eight months. As for Dr Chan, although K was not his patient, he colluded with Dr Ong in contacting K on false pretences. This objectively amounted to improper conduct bringing disrepute to the profession, and the DT thus suspended Dr Chan for five months.

6.19 Both doctors appealed against their conviction and sentences, while the SMC cross-appealed on the ground that their sentences were manifestly inadequate. As a matter of principle, the Court of Three Judges in *Ong Kian Peng Julian v Singapore Medical Council*[20] agreed with the DT that a doctor need not have been in breach of any of the guidelines in the SMC ECEG to bring disrepute to profession.[21] Rather, the test is whether the conduct complained of would objectively damage the reputation of the profession. This is determined from the perspective of an objective layperson, without any special deference to what other members of the medical profession might think.[22]

6.20 Looking at the messages in an "integrated and contextual manner", it was quite clear to the court that the conversation was not about property but a "potential sexual venture".[23] This meaning was reinforced when the surrounding conduct of the one of the accused doctors was considered. Dr Chan was already in contact with another property agent, but never asked her about property investment opportunities. Nor was it

19 Cap 174, 2014 Rev Ed; now s 59D(1)(*b*) of the Medical Registration Act 1997 (2020 Rev Ed).
20 [2022] SGHC 302.
21 See also *Pang Ah San v Singapore Medical Council* [2014] 5 SLR 681 at [42].
22 *Low Chai Ling v Singapore Medical Council* [2013] 1 SLR 83 at [72].
23 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [35].

significant that Dr Chan never actually met K or engaged in any sexual activity with her, as the gravamen of the charge was the misuse of K's contact information for an improper purpose.

6.21 Consequently, the court considered that a reasonable person, having been apprised of their exchange of a patient's contact information for an improper purpose, would "without hesitation" consider it improper conduct.[24] K was Dr Ong's patient at the relevant time, and the latter obtained her consent to share contact details with Dr Chan under false pretences, in collusion with Dr Chan. This was a betrayal of her trust and in breach of Guideline C1 of the SMC ECEG. The reasonable layperson would also conclude that Dr Chan ought not to have voluntarily colluded with Dr Ong in such a manner, even though K was not his patient and the offer to share K's contact information was unsolicited. Knowing that the contact information was handed to him in breach of a professional duty, Dr Chan also intended to act on the information shared for an improper purpose. Both doctors were therefore guilty of improper conduct which brought disrepute to the profession.

B. Evidential issues relating to a finding of guilt

6.22 In assessing the guilt of the two doctors, the court also considered the admissibility of several other WhatsApp messages that were exchanged between Dr Ong and Dr Chan, which related to their sexual escapades and the contact information of women for either doctor to attempt to engage in sexual relations with them ("the Remaining Messages"). Principally, the court held that the Remaining Messages could clearly be admitted not as similar fact evidence, but as background evidence for the limited purpose of elucidating the nature of the relationship and dealings between the two doctors. These were helpful in shedding light on the nature and meaning of the main messages exchanged that formed the basis of each of the doctor's charge. In particular, the court noted that evidence may be admitted for such a purpose under s 9 of the EA. This appears to be consistent with the position that has been taken in criminal cases.[25] The court further suggested, in *obiter*, that as is the case in civil and criminal cases, similar fact evidence is generally inadmissible in DT cases under the MRA unless it can be shown that the probative value of the evidence outweighs its prejudicial effect.[26] That said, it may be relevant

24 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [49].

25 See *Michael Anak Garing v Public Prosecutor* [2017] 1 SLR 748 at [6]–[10] and *Public Prosecutor v Ranjit Singh Gill Menjeet Singh* [2017] 3 SLR 66 at [12]–[22]. See generally Jeffrey Pinsler SC, *Evidence and the Litigation Process* (Singapore: LexisNexis, 7th Ed, 2020) at paras 3.048–3.049.

26 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [40]–[48].

to point out that in this case, the court had not considered the potential implication(s) of s 51(4) of the MRA (which, among other things, states that a DT is not bound by the provisions of the EA but may inform itself on any matter in such manner as it thinks fit)[27] as well as *Wee Teong Boo v Singapore Medical Council*,[28] which will be discussed next.

6.23 In *Wee Teong Boo v Singapore Medical Council*, Dr Wee was charged for rape in the criminal courts. At the close of the Prosecution's case at the trial, the High Court (General Division) convicted Dr Wee on an amended charge of sexual assault by penetration and one count of outrage of modesty.[29] On appeal, the Court of Appeal acquitted Dr Wee on both charges.[30] The SMC then commenced disciplinary proceedings against Dr Wee on three charges of professional misconduct. As part of the Prosecution's case, the Prosecution sought to admit as evidence certain statements given by Dr Wee to the police as well as his testimony at his criminal trial ("the Evidence"). The DT held that the Evidence was admissible. Before the DT reached a decision on whether Dr Wee was guilty of professional misconduct, Dr Wee applied to the High Court (General Division) for, among other things, an order quashing the DT's decision to admit the Evidence. Dr Wee contended that the Evidence was hearsay and thus should not have been admitted by the DT. Preliminarily, the High Court (General Division) briefly considered whether Dr Wee's application was premature as the DT had yet to reach a decision on Dr Wee's guilt. However, as the parties had not engaged substantially with this issue before the High Court, it declined to pronounce on the matter.[31]

6.24 The crux of the case was then whether the DT had erred in admitting the evidence. This engaged s 51(4) of the MRA, which states that:

> A Disciplinary Tribunal is not bound to act in a formal manner and is not bound by the provisions of the Evidence Act 1893 or by any other law relating to evidence but may inform itself on any matter in such manner as it thinks fit.

6.25 To assist the court in the interpretation of s 51(4), the High Court (General Division) first considered the nature and character of disciplinary proceedings. In that regard, it held that:[32]

> (a) The procedure of disciplinary proceedings substantially mirrors the criminal trial process.

27 Now s 59A(4) of the Medical Registration Act 1997 (2020 Rev Ed).
28 [2022] SGHC 169.
29 *Public Prosecutor v Wee Teong Boo* [2019] SGHC 198.
30 *Public Prosecutor v Wee Teong Boo* [2020] 2 SLR 533.
31 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [22]–[37].
32 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [38]–[47].

(b) The SMC *qua* Prosecution must establish the charge(s) against the medical practitioner beyond reasonable doubt.

(c) An important feature of DTs is the presence of strong public interest considerations which underpin their inception, processes and outcomes. These inform the sentencing of a medical practitioner following the affirmative finding of a DT on professional misconduct charges, as well as the consideration of the nature and purpose of a DT at an earlier stage of the inquiry.

6.26 The High Court then held that the Evidence did constitute hearsay.[33] Additionally, s 147(3) of the EA cannot be used to admit evidence ahead of the cross-examination of the medical practitioner during the inquiry.[34]

6.27 Returning to the interpretation of s 51(4) of the MRA, the High Court (General Division) held that:[35]

(a) It is incontrovertibly clear that s 51(4) confers on the DT a discretion to admit evidence in DT proceedings, without being confined by the usual rules of evidence (such as when the evidence may be excluded by the usual rules of evidence).

(b) The prerequisite to the admissibility of evidence in DT proceedings is whether the evidence is logically probative or relevant to the proceedings.

(c) Notwithstanding s 51(4), the DT is required to comply with the rules of natural justice.

(d) Any evidence is admissible if relevant to the DT proceedings, including hearsay evidence. That said, it is contingent on the DT's compliance with the rules of natural justice and, in particular, the right to a fair hearing. Such a right to a fair hearing is usually secured by offering the defendant doctor an opportunity to comment on and contradict the evidence. In certain situations where the hearsay evidence is a statement given by the accused, it may be that fairness requires that the opportunity to cross-examine the maker of the hearsay evidence be made available to the defendant to test the evidence, unless good and cogent reasons can be given for the witness's non-attendance.

33 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [48]–[52].
34 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [53]–[59].
35 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [60]–[132].

6.28 Given that the Evidence was relevant to the case and that the DT did not appear to have breached any rules of natural justice, the High Court (General Division) concluded that the DT had not erred in admitting the Evidence.[36] Finally, the High Court (General Division) clarified that s 259(1) of the Criminal Procedure Code 2010[37] ("CPC") did not render Dr Wee's statements to the police inadmissible in the DT proceedings, while s 258 of the CPC does not apply in the context of non-criminal proceedings such as DT proceedings.[38]

C. Sentencing

6.29 In terms of sentencing in disciplinary cases, the only relevant case in the year of review is *Ong Kian Peng Julian v Singapore Medical Council*.[39] The facts as well as issues relating to a finding of guilt in this case have already been discussed above.[40] On sentencing, the court first noted that parties had not disputed the applicability of the four-step sentencing framework that the court had set out in the previous case of *Wong Meng Hang v Singapore Medical Council*[41] ("*Wong Meng Hang*"). That framework was designed specifically for cases where deficiencies in a doctor's clinical care caused harm to a patient.[42] Nevertheless, in 2020, the Sentencing Guidelines Committee appointed by the SMC published certain sentencing guidelines which extended the applicability of the *Wong Meng Hang* framework to both clinical and non-clinical offences.[43] The court recognised the logic of the committee's suggestion to extend the applicability of the framework, but emphasised "the importance of bearing in mind the nuances of each case".[44]

6.30 In this case, the DT had sentenced Dr Ong to a term of suspension of eight months and Dr Chan to a term of suspension of five months. Applying the *Wong Meng Hang* framework:

> (a) In relation to Dr Ong, the court concluded that the harm caused to be on the higher end of the moderate range. In particular, the court explained that it was all the more aggravating that the victim was Dr Ong's patient. It added that if actual physical harm

36 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [133].
37 2020 Rev Ed.
38 *Wee Teong Boo v Singapore Medical Council* [2022] SGHC 169 at [134]–[149].
39 See para 6.19 above.
40 See paras 6.18–6.22 above.
41 [2019] 3 SLR 526. This framework was first reviewed and discussed in (2018) 19 SAL Ann Rev 82 at 93–104, paras 6.26–6.47.
42 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [60].
43 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [61].
44 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [62].

had been caused to the victim, the sanction called for would likely have been a striking-out order. The court then held that the culpability of Dr Ong was on the high end of the medium range. It also stated that the circumstances surrounding Dr Ong's misconduct were "novel" in that they involved an attempt by a doctor to procure a sexual benefit for another member of the profession.[45] Further, based on Dr Ong's oral testimony, the court inferred that Dr Ong was not truly remorseful for his actions. The fact that Dr Ong was a senior doctor of more than 20 years' standing also amplified the negative impact his misconduct would have had on the public confidence in the medical profession. All factors considered, the court increased the term of suspension for Dr Ong to two years.[46]

(b) In relation to Dr Chan, the court noted that the relevant facts were largely similar to those of Dr Ong, except that Dr Chan was the recipient of the contact information of the victim, and accordingly played a more "passive" role than Dr Ong. The victim was also not Dr Chan's patient. The court concluded that the level of harm caused by Dr Chan was similar to that occasioned by Dr Ong, though Dr Chan's culpability was somewhat lower than that of Dr Ong. The court also considered Dr Chan's seniority in the profession. In the end, the court increased the term of suspension for Dr Chan to 18 months.[47]

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45 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [78].
46 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [64]–[83].
47 *Ong Kian Peng Julian v Singapore Medical Council* [2022] SGHC 302 at [84]–[91].