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6. BIOMEDICAL LAW AND ETHICS

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I. Introduction

6.1 In the year under review, the Court of Three Judges revisited the question of deficient professional performance under s 53(1)(*e*) of the Medical Registration Act[1] ("MRA") and considered the applicability of the *Wong Meng Hang v Singapore Medical Council*[2] ("*Wong Meng Hang*") sentencing framework for disciplinary offences to this section. Another medical disciplinary decision applied the same framework to professional misconduct in the over prescription of opioids, resulting in a striking-off order. The General Division of the High Court ("General Division") considered the duty of hospitals to prevent falls in the only reported medical negligence decision for the year. Finally, a couple of cases applied the new rules for the extension of time for inquiries in disciplinary proceedings introduced by the Medical Registration (Amendment) Act 2020[3] ("MRAA 2020").

II. Medical negligence

6.2 In *Pappa w/o Veeramuthu v National University Health Services Group Pte Ltd*,[4] the claimant was an elderly patient admitted to hospital for surgical fixation of her right femur after it was fractured in a fall at her home. Post-surgery, she was assessed as a fall risk and underwent rehabilitative care at a community hospital. She was placed in a single-bed isolation room, the interior of which was not visible to nursing staff outside. The only means by which the patient could call for help was

1 Cap 174, 2014 Rev Ed. Now renumbered as s 59D(1)(*d*) of the Medical Registration Act 1997 (2020 Rev Ed) since the repeal and re-enactment of Pt VII of the Medical Registration Act (Cap 174, 2014 Rev Ed), with effect 1 July 2022.
2 [2019] 3 SLR 526. This case was reviewed in TE Chan & PR Prabakaran, "Biomedical Law and Ethics" (2018) 19 SAL Ann Rev 82 at paras 6.26–6.57.
3 Act 34 of 2020.
4 [2023] SGHC 70.

via an emergency call bell. On the fateful day, the patient was seated in a visitor's chair while eating her breakfast. After a nurse administered her medication and left, the patient claimed that she developed an intense pain in her back but could not reach the emergency bell. She therefore attempted to move out of her chair unassisted and fell, fracturing her left femur – which required a second surgery and further rehabilitation.

6.3 She sued the community hospital's owner and manager for breach of an undisputed duty of care to take reasonable steps to minimise her fall risk while under the care of the community hospital and its staff. As the patient was not able to self-ambulate, this duty required the patient to be seated in a proper geriatric chair, and not a visitor's chair. The emergency bell needed to be placed within her reach especially when she was left alone in the isolation room. The district judge held, *inter alia*, that the hospital was not in breach of its duty when the nurse left the patient in the visitor's chair. The patient did not indicate any problems with being left there nor request to be moved back to her bed. The bell, which she was very familiar with using, was within her reach.

6.4 On appeal, the General Division overturned the findings of due care on the part of the respondent hospital. The weight of the objective evidence indicated on a balance of probabilities that the patient was already suffering from back pain prior to sitting in the visitor's chair. The court also doubted the credibility of some of the hospital's witnesses in relation to their account of the events on the fateful day and the placement of the emergency bell. In contrast, the court found the patient's narrative sufficiently corroborated by her contemporaneous account of her fall to a doctor at the hospital less than two hours after the incident and the hospital's own records of her care. Accordingly, the court also found that the emergency bell was not placed within her reach, which is why she attempted to move to her bed without assistance and fell. These failures were in breach of the hospital's duty of care and caused her to fall. The respondent hospital was thus held liable for damages in negligence, subject to any defence of contributory negligence that remained to be determined.

III. Disciplinary proceedings

A. Failure to provide professional services of reasonable quality

6.5 Reported medical disciplinary cases under s 53(1)(*e*) of MRA are relatively rare since the provision was introduced by the Medical

Registration (Amendment) Act 2010[5] ("MRAA 2010"). There had previously only been two reported decisions, one by the Court of Three Judges[6] and another by the Disciplinary Tribunal[7] ("DT") until the decision in *Ho Tze Woon v Singapore Medical Council*[8] ("*Ho Tze Woon*"). The appellant was a locum general practitioner who saw a patient with a history of severe asthma. After being prescribed nebulisation treatment, the patient collapsed while seated in the clinic's treatment room and lost consciousness. The appellant rushed into the room and assessed that the patient was in cardiac arrest. He proceeded to perform cardiopulmonary resuscitation ("CPR") on the patient while the latter remained seated in the treatment room and asked his clinic assistant to summon the paramedics. When the paramedics arrived, they found the patient seated in the same chair, pulseless and not breathing. They moved him to the floor and proceeded to administer manual CPR, followed by use of a mechanical chest compression machine. The patient was then transported to hospital while efforts to resuscitate him continued. Upon arrival at Khoo Teck Puat Hospital, the patient was intubated and spontaneous circulation returned. The patient was assessed to have suffered from a severe asthma attack and was subsequently declared brain dead in the intensive care unit. He then passed away.

6.6 The patient's sister filed a complaint with the Singapore Medical Council ("SMC") on the basis that the appellant had not performed CPR correctly by leaving the patient in a seated position throughout the administration of CPR. The SMC brought a charge under s 53(1)(*e*) of the MRA for failing to place the patient in a supine position on a flat, hard surface, in accordance with the basic principles of CPR. This amounted to a failure to meet the minimum standards of acceptable care derived from the expectations of reasonable medical practitioners, and therefore a breach of s 53(1)(*e*). The DT agreed that it would be reasonable to expect a medical practitioner, as a general rule, to first place a patient on a firm, flat surface before administering CPR. Performing CPR while a patient was seated was ineffectual.

6.7 The appellant's own expert witness accepted this principle. The only real issue was whether exceptional circumstances prevented the appellant from doing so. The DT considered that it was objectively feasible to reposition the patient in the treatment room despite its small area, and there were other clinic staff present who could have assisted him to do so even if they were not trained in CPR. Any delay in commencing

5 Act 1 of 2010.
6 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66.
7 *In the Matter of Dr Fernandes Mark Lee* [2017] SMCDT 2.
8 [2024] 3 SLR 1245.

CPR by repositioning the patient, or risk of harm by moving him, was outweighed by the ineffectiveness of administering CPR while seated. The appellant was not excused even if he subjectively assessed the feasibility of repositioning the patient and made a decision against it: the standards expected of him were objectively assessed.

6.8 On appeal, the Court of Three Judges first reiterated that the appropriate test for the standard of reasonable professional services was clearly indicated by the plain language of the subsection (and as articulated earlier in *Yong Thiam Look Peter v Singapore Medical Council*[9] ("*Peter Yong*")): an objective assessment of the minimum standards of acceptable care derived from the expectations of reasonable medical practitioners.[10] The court rejected the appellant's argument that a breach would only occur if there was a serious disregard of or persistent failure to meet minimum or elementary clinical standards. This argument was inconsistent with the plain language of s 53(1)(*e*), which indicated no such qualification. The decision in *Lim Lian Arn v Singapore Medical Council*,[11] which stipulated a serious disregard of or persistent failure to meet professional standards, related to the requirements for establishing the more serious and culpable offence of professional misconduct under s 53(1)(*d*) – not deficient professional performance under s 53(1)(*e*).[12] Secondly, the suggestion that the reference to "elementary" standards in *Peter Yong*[13] contemplated standards below those which were reasonably expected was also rejected as being inconsistent with the plain language of s 53(1)(*e*). A breach of elementary standards would certainly fall below minimum standards, but did not exhaust the plain scope of the subsection.

6.9 Next, the court agreed with the findings of the DT. There was an expert consensus that effective CPR required a patient to be placed supine on a firm, flat surface. This was also explicitly stated in step four of the Basic Cardiac Life Support ("BCLS") course, which the appellant had been certified in. There was also nothing in the BCLS manual to suggest that moving a patient in cardiac arrest was dangerous. It therefore followed that the appellant would be in breach of minimum standards for performing CPR unless there were exceptional circumstances that prevented him from properly positioning his patient. The court *objectively* assessed the factual circumstances and disagreed with the appellant's expert witness that there was insufficient space within the treatment room to lay the patient in a supine position. The paramedics

9 [2017] 4 SLR 66.
10 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [30].
11 [2019] 5 SLR 739.
12 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [68].
13 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [11].

were subsequently able to do so by extending the patient's body partially outside the treatment room. There were also no appreciable manpower constraints on the appellant in repositioning the patient. All situations requiring CPR were emergency situations and there was nothing onerous about repositioning the patient in the particular circumstances. Crucially, the appellant did not even attempt to do so. Therefore, the court found that he was in breach of reasonably expected professional standards under s 53(1)(*e*).

6.10 The DT accepted the SMC's submission that the sentencing framework developed in *Wong Meng Hang* in relation to professional misconduct under s 53(1)(*d*), and the *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals*,[14] could be applied to disciplinary offences under s 53(1)(*e*). Applying that framework, they suspended the appellant for nine months.

6.11 In terms of sentencing, a preliminary but important issue the Court of Three Judges had to address was whether the sentencing matrix framework that it had issued in *Wong Meng Hang* applied in the appellant's case. The court held that that framework was developed to deal with clinical cases of professional misconduct under s 53(1)(*d*) of the MRA, which was the particular disciplinary offence that the two defendant doctors in *Wong Meng Hang* were convicted for.[15] It was a framework designed to help ascertain the appropriate sanction in cases where a medical practitioner's misconduct had caused harm to a patient.[16] The appellant here was convicted for a different disciplinary offence, which was for failing to provide professional services of the quality reasonably expected of him under s 53(1)(*e*) of the MRA.

6.12 The court observed that considering the inherent overlap in the different disciplinary offences, the *Wong Meng Hang* framework could theoretically be applied in the appellant's case. That said, care must be taken to "properly examine the factual matrix of [each case] in order to determine whether the framework should be applied in sentencing [in the given case]".[17]

6.13 In this regard, the court noted there is a degree of overlap in the various limbs of s 53(1) of the MRA. In particular, in all cases involving professional misconduct by a medical practitioner (an offence

14 Singapore Medical Council, *Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* (15 July 2020).
15 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [62].
16 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [56].
17 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [3].

under s 53(1)(*d*)), the medical practitioner would necessarily be guilty of failing to provide professional services of the quality reasonably expected of him (an offence under s 53(1)(*e*)). Nevertheless, there will be many cases where a medical practitioner fails to provide professional services of a quality reasonably expected of him but such failure would not rise to the level of professional misconduct. The court referred to its earlier decision of *Low Cze Hong v Singapore Medical Council*,[18] where it had defined professional misconduct to include at least the following two situations: (a) where there was an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; and (b) where there had been such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner.

6.14 The court held that it could be useful to apply the *Wong Meng Hang* framework to cases where a medical practitioner is convicted of an offence under the various other limbs of s 53(1) (that is, other than s 53(1)(*d*)), *provided that there is professional misconduct involved in the case*. This is because the culpability of the medical practitioner in such cases would likely fit within the minimum culpability contemplated when the framework was developed. However, in cases where a medical practitioner is convicted of an offence under the various other limbs of s 53(1) and there is no professional misconduct involved, the level of culpability involved would be lower and accordingly it would be inappropriate to apply the *Wong Meng Hang* framework. Speaking generally, the court also underscored that "[u]ltimately, in the same way that a sentence must always fit the crime, the suspension of a medical practitioner must fit the nature of the disciplinary offence".[19]

6.15 On the facts of the appellant's case, there was no professional misconduct involved. The court therefore concluded that it was not appropriate to apply the *Wong Meng Hang* framework in the appellant's case.[20] Instead, the court arrived at the condign sentence in the appellant's case by taking reference from two precedent cases.[21] In the end, it reduced the sentence of nine-month suspension which was imposed by the DT to three-month suspension.

6.16 In particular, the court was careful not to ascribe too much weight to the fact that the patient eventually passed away.[22] This is

18 [2008] 3 SLR(R) 612 at [37].
19 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [3].
20 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [71].
21 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 and *In the Matter of Dr Fernandes Mark Lee* [2017] SMCDT 2.
22 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [76].

because the appellant's failure to properly administer CPR on the patient could not be said to have caused the patient's death. Instead, the failure was "an omission to provide care which could potentially have saved the patient's life, or at the very least increased his chances of survival".[23] The court reiterated that in assessing the level of harm involved in a given case, it is salient to bear in mind that "harm is a function of both the injury to the patient and the degree of connection between the doctor's conduct and that injury".[24] In the appellant's case, there was little evidence to inform the extent of adverse effect of the appellant's failure to properly administer CPR on the patient's chances of survival.[25]

B. Commentary

6.17 It is surprising how little attention was paid in the parliamentary process to the introduction of s 53(1)(*e*) as part of a performance assessment framework under the MRAA 2010. For the first time, s 2A(*b*) enacted an explicit legislative objective of protecting the health and safety of the public by "uphold[ing] standards of practice within the medical profession". Performance assessments of registered medical practitioners pursuant to a complaint that the professional services provided are not of a quality which is reasonable to expect were introduced, where medical practitioners agree to this at the invitation of a complaints committee ("Complaints Committee").[26] Although one member of the house noted the vague nature of the standard prescribed under s 53(1)(*e*),[27] the Health Minister moving the Bill for its second reading did not explore the basis of or regulatory expectations underlying the newly introduced premise for investigations and disciplinary proceedings.[28]

6.18 There is some evidence that inspiration was drawn from the Australian regulatory regime for healthcare professionals in devising the amendments introduced by the MRAA 2010.[29] The Australian Health Practitioner Regulation National Law Act (Qld) ("AHPRNL") is a legislative scheme that was adopted by all states and territories except for New South Wales to harmonise regulatory and disciplinary matters

23 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [79].
24 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [80].
25 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [81].
26 Sections 39(1)(*c*), 44(3)(*a*) and 45 of the Medical Registration Act (Cap 174, 2014 Rev Ed).
27 Singapore Parl Debates; Vol 86, Sitting No 14; Col 1928; [11 January 2010] (Assoc Prof Paulin Tay Straughan, Nominated Member).
28 Singapore Parl Debates; Vol 86, Sitting No 14; Cols 1948–1960; [11 January 2010] (Khaw Boon Wan, Minister for Health).
29 See Ministry of Health, *Public Consultation Paper on the Proposed Amendments to the Medical Registration Act* (14 January 2009) at para 9(a).

in relation to health professionals.[30] This model law envisages three disciplinary categories, namely professional misconduct, unprofessional conduct, and unsatisfactory professional performance. The last category bears the closest resemblance to s 53(1)(*e*), for s 5 of the AHPRNL defines unsatisfactory professional performance as follows:

> **5 Definitions**
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> …
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> ***unsatisfactory professional performance***, of a registered health practitioner, means the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is *below the standard reasonably expected of a health practitioner* of an equivalent level of training or experience.
>
> [emphasis in original in bold italics; emphasis added in italics]

6.19 There is an overlapping ground of complaint under the Australian framework, namely unprofessional conduct. This is defined as "professional conduct that is of a lesser standard than that which may be reasonably expected of the health practitioner by the public or the practitioner's professional peers".[31] Whether the conduct falls short of the reasonable expectations of the doctor's peers or the public calls for an objective determination in the light of the particular circumstances.[32] The definition of unprofessional conduct includes specifically enumerated matters such as contravention by the practitioner of provisions of the AHPRNL.[33] Unsatisfactory professional performance, which is a subset of unprofessional conduct, is focused on the capacity of the practitioner in the practice of the relevant health profession delivering health services rather than in administrative, regulatory or other matters,[34] while unprofessional conduct encompasses the professional's character or conduct more generally.[35] Unsatisfactory performance looks at factors that may preclude the ability to perform adequately, including the care provided, but not necessarily negligence in performance.[36] The

30 See I Freckelton, "Regulation of Health Practitioners: National Reform in Australia" (2010) 18 *Journal of Law & Medicine* 207.
31 See, *eg*, Health Practitioner Regulation National Law (Qld) s 5.
32 *Medical Board of Queensland v Whittaker* [2010] QCAT 312 at [21].
33 See Health Practitioner Regulation National Law (Qld) s 5.
34 See *Solomon v Australian Health Practitioner Regulation Agency* [2015] QCAT 94 at [126].
35 *Medical Board of Australia v Hocking* [2015] ACAT 44 at [20]. See also Australian Health Practitioner Regulatory Agency, *Regulatory Guide April 2021* at p 60.
36 I Freckelton, "Regulation of Health Practitioners: National Reform in Australia" (2010) 18 *Journal of Law & Medicine* 207 at 217.

same professional disciplinary sanctions follow for both unsatisfactory professional performance and unprofessional conduct.[37]

6.20 In respect of unsatisfactory professional performance, a Western Australian Administrative Tribunal has opined that it is:[38]

> … suggestive of a generalised deficiency in the way in which the practitioner handles his or her professional affairs … it is likely that a finding of unsatisfactory professional performance will occur where the performance of the practitioner concerned has consistently fallen below the expected standard as a medical practitioner, or where the practitioner has never attained that standard.

However, other disciplinary decisions in respect of unsatisfactory professional performance have not confined themselves to systematic lapses on the part of medical practitioners. Individual incidents have also given rise to findings of unsatisfactory professional performance, such as where a clinician failed to appropriately manage and treat a patient pre- and post-surgery, who subsequently died,[39] or failed to report an error in drug administration that contributed to the death of a patient.[40] Ultimately, the seriousness of the departure from reasonably expected standards depends on the facts of each case, and attempts to define unsatisfactory professional performance beyond the statutory definition should be avoided.[41] Thus, Australian disciplinary tribunals also do not insist on persistent breaches of reasonable professional standards in order to establish unsatisfactory professional performance.[42] However, they do recognise implicitly that there must be some degree of seriousness in episodic breaches to warrant professional discipline.[43] They also emphasise the protection of the public as the paramount consideration

37 Health Practitioner Regulation National Law (Qld) s 191(3).

38 *Medical Board of Australia v Roberts* [2014] WASAT 76 at [182]. See also *Jemielita v Medical Board of Australia* [2015] QCAT 86, where, under the repealed Medical Act 1894, competency was considered to suggest a more generalised deficiency in the way in which a practitioner handles his professional affairs, as opposed to carelessness which may be limited to individual, perhaps sporadic, incidents; *Sadler v General Medical Council* [2003] 1 WLR 2259 and *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), although the relevant regulatory concept under the UK Medical (Professional Performance) Act 1965 (c 51) is "seriously deficient performance".

39 *Medical Board of Australia v Bourke* [2015] QCAT 400.

40 *Medical Board of Australia v Davies*, State Administrative Tribunal, VR 152/2016.

41 *Medical Board of Australia v NG Davies* [2018] QCAT 215 at [33] and [35].

42 See also *Sadler v General Medical Council* [2003] 1 WLR 2259, where the Privy Council observed (at [62]): "It would plainly be contrary to the public interest if a sub-standard surgeon could not be dealt with by the [Committee on Professional Performance] unless and until he had repeatedly made the same error in the course of similar operations".

43 *Cf* Health Practitioner Regulation National Law (NSW) s 139B, which modifies the definition of unsatisfactory professional performance in the model law to

(cont'd on the next page)

in deciding what disciplinary action to take, rather than a punitive objective.[44]

6.21 Another point of difference from the Singapore position is that unsatisfactory professional performance does not warrant a striking off or suspension from practice; rather, if the performance and professional standards panel finds that a health practitioner has behaved in a way that constitutes unsatisfactory professional performance, it may: (a) impose conditions on the practitioner's registration; (b) caution; or (c) reprimand him.[45] Conditions may include further education or training within the specified period of conditional registration, and these must be reviewed by the panel within a specified review period. Such conditions are more focused on rehabilitation and the maintenance or raising of professional standards, rather than deterrence.

6.22 The equivalent of all these options are available to the Complaints Committee under the MRA 1997,[46] save that conditions may only be imposed on a health practitioner's registration with his consent, or by a DT.[47] Conduct under s 53(1)(*e*) also attracts the more draconian sanctions of suspension, striking off from the medical register or a financial penalty if the matter is referred to a formal inquiry before the DT.[48] The Complaints Committee can only impose a suspension or striking off with the agreement of the relevant registered medical practitioner.[49]

6.23 Notwithstanding the court's ruling that a breach of s 53(1)(*e*) does not require there to be a serious disregard of or persistent failure to observe minimum clinical standards, distinctions based on the seriousness of the breach under s 53(1)(*e*) are required as a matter of both substance (the appropriate regulatory response) and procedure (whether the matter may be dealt with formally or informally). In moving the

denote conduct that "is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience".

44 See Australian Health Practitioner Regulation Agency & National Board, *Regulatory Guide* (April 2021), Pt 10 at pp 75–76.

45 See Health Practitioner Regulation National Law (Qld) s 191. Reprimands are recorded on a practitioner's registration: s 225(j).

46 Medical Registration Act (Cap 174, 2014 Rev Ed) ss 49(1)(*a*), 49(1)(*b*), 49(1)(*d*) and 49(1)(*e*); current version: Medical Registration Act 1997 (2020 Rev Ed) s 46(1).

47 Medical Registration Act (Cap 174, 2014 Rev Ed) s 49(1)(*g*)(iv); current version: Medical Registration Act 1997 (2020 Rev Ed) s 46(1)(*g*)(iv).

48 Medical Registration Act (Cap 174, 2014 Rev Ed) ss 53(2)(*a*), 53(2)(*b*) and 53(2)(*e*) respectively; current version: Medical Registration Act 1997 (2020 Rev Ed) ss 59D(2)(*a*), 59D(2)(*b*) and 59D(2)(*e*).

49 Medical Registration Act (Cap 174, 2014 Rev Ed) s 49(1)(*g*); current version: Medical Registration Act 1997 (2020 Rev Ed), s 46(1)(*g*).

MRAA 2010 for its second reading, the Health Minister acknowledged that there would be different degrees of seriousness in the deficient performance of a medical practitioner, and only the more serious cases would be referred to the DT:[50]

> We propose to widen the range of orders available to the Complaints Committees so that *less serious complaints can be concluded expeditiously without the heavy legal involvement and time required for Disciplinary Tribunals*. When the Complaints Committee deems that no formal inquiry is necessary, the new section 49 will allow the Committee to: … (b) order that the registered medical practitioner undergo further training, or seek and take advice in relation to the management of his practice; … These changes also allow the SMC *to deal with correctable behaviours more constructively*. [emphasis added]

6.24 This distinction was made clear by the different powers afforded to the Complaints Committee and the DT. The more draconian sanctions are only available to the latter.[51] Thus, determinations by the Complaints Committee within the scope of its powers would be focused on rehabilitation, while more serious cases brought before the DT would include the need for deterrence.[52] After the most recent amendments in 2022, the language of s 46(2) of the Medical Registration Act 1997[53] ("MRA 1997") now more specifically directs a Complaints Committee to refer a complaint for a formal DT inquiry where "cause of sufficient gravity for a formal inquiry exists".[54] In addition, s 40(7)(*b*) of the current version also now provides that:

> … the Medical Council may immediately refer a complaint or any information directly to the President of the Disciplinary Commission for the appointment of a Disciplinary Tribunal where it relates to any of the following:
>
> …
>
> (*b*) any other matter that, in the opinion of the Medical Council, *involves a serious threat to the health and safety of any patient*.
>
> [emphasis added]

6.25 The decision in *Ho Tze Woon* should therefore also be seen as an example of when a single episode of deficient professional performance is of sufficient gravity or seriousness to warrant a formal inquiry. The facts in this case are envisaged by the current s 40(7)(*b*) of the MRA 1997 in

50 Singapore Parl Debates; Vol 86, Sitting No 14; Cols 1899–1900; [11 January 2010] (Khaw Boon Wan, Minister for Health).

51 See para 6.22 above.

52 See I Freckelton, "Regulation of Health Practitioners: National Reform in Australia" (2010) 18 *Journal of Law & Medicine* 207 at 217–218.

53 2020 Rev Ed.

54 *Cf* Medical Registration Act 1997 (2020 Rev Ed) s 46(2).

its reference to a serious threat to patient health and safety. The failure to administer effective CPR compromised the health and safety of the patient as the DT found that it "directly affected the patient's chances of survival". Although the patient subsequently died, the evidence indicated that his chances of survival were not high to begin with.[55] In the case of *In the Matter of Dr Fernandes Mark Lee*,[56] the doctor's failure to accurately communicate the results of his patient's cancer screening results deprived the latter of an opportunity to take earlier follow-up action, resulting in a delay of about 20 months before seeing a specialist.[57] The patient was subsequently diagnosed with colorectal cancer, but there was no finding that the delay prejudiced the chances of success of the subsequent surgical and oncology treatment. The DT issued a censure and only imposed a penalty of $10,000.

6.26 In *Peter Yong*, the third charge brought under s 53(1)(*e*) related to conducting a trigger finger release surgical procedure on a physician's consultation table. This ignored the basic requirements of a sterile environment, technique and adequate lighting, which increased the risk of infection and injury.[58] There was also evidence that the doctor had been previously disciplined by a New South Wales Medical Tribunal for unsatisfactory asepsis and infection control, arguably demonstrating a pattern of deficient professional conduct.[59] Based on the few precedents for deficient professional performance under s 53(1)(*e*), suspensions are warranted when the breach of minimum clinical standards increase the risk of serious harm or death to a patient, or where there is some persistence in the offending behaviour that poses risks to patients. These reported decisions also resonate with the approach to determining deficient professional performance taken by the Australian DTs discussed above, even if the sanctions authorised and meted out here are more onerous.

6.27 On sentencing, the Court of Three Judges' guidance on when the *Wong Meng Hang* framework may be applied to s 53(1) of the MRA cases is to be welcomed. After *Wong Meng Hang* was decided, the SMC appointed a Sentencing Guidelines Committee which published some sentencing guidelines on 15 July 2020. Those guidelines suggested that the framework applies not only to professional misconduct cases under s 53(1)(*d*) of the MRA but could more broadly be extended to apply to non-clinical care offences and to all other limbs under s 53(1)

55 *Ho Tze Woon v Singapore Medical Council* [2024] 3 SLR 1245 at [80]–[81].
56 [2017] SMCDT 2.
57 *In the Matter of Dr Fernandes Mark Lee* [2017] SMCDT 2 at [7].
58 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [11].
59 *Yong Thiam Look Peter v Singapore Medical Council* [2017] 4 SLR 66 at [13]–[15].

of the MRA. Such a suggestion might have stemmed from a lack of full appreciation of the specific context in which the *Wong Meng Hang* framework was developed. Indeed, the approach taken by the Court of Three Judges in the appellant's case is very much consistent with the approach that has been taken by the appellate courts in Singapore in the context of sentencing frameworks in criminal cases. In criminal cases, the appellate courts have consistently been mindful of extending sentencing frameworks developed for a specific variant of an offence to other variants.[60]

C. Professional misconduct – Sentencing

6.28 In *Singapore Medical Council v Wee Teong Boo*,[61] the respondent doctor pleaded guilty before the DT to 20 charges of professional misconduct under s 53(1)(*d*) of the MRA. The first ten related to inappropriate prescriptions of cough mixture containing codeine (an addictive opioid pain reliever) and benzodiazepines (drugs that slow down brain and nervous system activity but can also be addictive), while the remaining charges related to inadequate medical record keeping in relation to the patients who were inappropriately prescribed these drugs.[62]

6.29 In relation to the ten inappropriate prescription charges, the DT applied the *Wong Meng Hang* framework.[63] It concluded that the respondent's culpability was medium level, and the level of harm caused by the respondent's offences to be moderate level. The DT thus held that the appropriate sanction for six of the charges was 12 months' suspension and 18 months' suspension for the other four charges. In relation to the inadequate records charges, the DT imposed three months' suspension for nine of the charges, and four months' suspension for the remaining charge. The DT then found it appropriate for one of the 12-month suspensions to run consecutively with one of the 18-month suspensions. It also decided that a one-third discount was warranted by virtue of the inordinate delay in prosecution of the respondent. The final sentence that it imposed on the respondent was therefore 20 months' suspension.[64] The SMC appealed on the ground that this sanction was manifestly inadequate.

60 See *eg*, *Public Prosecutor v Tan Teck Leong Melvin* [2023] 5 SLR 1666 at [33], *Huang Xiaoyue v Public Prosecutor* [2023] 5 SLR 1609 at [38] and *Public Prosecutor v Manta Equipment (S) Pte Ltd* [2023] 3 SLR 327 at [30]–[39].

61 [2023] 4 SLR 1328.

62 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [13]–[20].

63 *Wong Meng Hang v Singapore Medical Council* [2019] 3 SLR 526.

64 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [21]–[28].

6.30 The Court of Three Judges allowed the appeal on two broad grounds. Firstly, it held that the respondent's culpability in respect of the inappropriate prescription charges should be high (and not only medium).[65] The court preliminarily noted that the respondent had inappropriately prescribed the two types of medications over a period of several years, and did so in some instances at striking frequency.[66] The court then went on to find that the respondent had no clinical basis for his prescriptions, and had prescribed the medications while aware of the fact that the prescriptions were perpetuating the ten patients' drug dependency issues.[67] Overall, the court characterised the respondent's conduct as "a flagrant abuse of his privileges as a medical practitioner",[68] and "evidenced a blatant and systemic disregard for his patients' well-being".[69]

6.31 Additionally, the court took the view that the DT had placed undue weight on the alleged mitigating factors raised by the respondent. The court emphasised that "charges of serious negligence do not necessarily attract findings of lower culpability, compared to charges of intentional and deliberate misconduct".[70] It found that on the facts, the respondent's culpability was similar to a medical practitioner who has been convicted of intentional and deliberate misconduct.[71] Moreover, the court held that the lack of profit motive on the respondent's part was merely a neutral and not mitigating factor.[72]

6.32 Applying the *Wong Meng Hang* framework, and given that the court assessed the respondent's culpability to be high and the level of harm caused to be moderate, the indicative sentencing range for each of the respondent's inappropriate prescription charges was a suspension of two to three years.[73]

6.33 Secondly, the Court of Three Judges went on to highlight that the *Wong Meng Hang* framework functioned only as a guide and can be departed from where it is appropriate to do so.[74] Crucially, it observed as follows:[75]

65 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [38].
66 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [38].
67 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [39]–[56].
68 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [47].
69 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [56].
70 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [58].
71 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [59].
72 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [60].
73 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [61]–[63].
74 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [64].
75 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [64].

> In our judgment, particularly in cases where an errant doctor faces multiple charges, each of which attracts a substantial term of suspension, it would be appropriate for a sentencing tribunal or court to consider if the doctor's overall misconduct warrants an order striking him or her off instead. Given that the statutory cap in s 53(2)(*b*) of the MRA limits the *overall* period of suspension that may be imposed by a disciplinary tribunal to three years, it may well be the case that where an errant doctor has committed multiple counts of professional misconduct, a term of suspension would not adequately reflect the seriousness of the doctor's misconduct and may let the doctor's additional offending go unpunished. Accordingly, while it clearly should not be the case that an errant doctor will be struck off in *every* instance where a disciplinary tribunal would have desired to impose a suspension that exceeds three years … a disciplinary tribunal should nonetheless remain alive to the possibility of striking the errant doctor off, in place of imposing a term of suspension. [emphasis in original]

6.34 In this case, the Court of Three Judges decided that the respondent's misconduct in respect of the inappropriate prescription charges was so egregious such that it rendered him unfit to remain a member of the medical profession. It hence ordered that the respondent be struck off the Register of Medical Practitioners with immediate effect. This was based on the following reasons:

(a) Not only did the respondent prescribe medications to his patients without any sound clinical basis, he did so for the sole purpose of enabling his patients to abuse the substances. He had essentially served as a supplier of the drugs.[76]

(b) The respondent's disregard for his patient's well-being was systemic.[77]

(c) The respondent appeared to demonstrate a persistent lack of insight into the seriousness of his misconduct.[78]

The court did accept that there were a few mitigating factors that operated in the respondent's favour. He had pleaded guilty early and had co-operated with the authorities during investigations. He also faced an inordinate delay in prosecution. Ultimately, however, the court held that these held minimal mitigating weight. This was because the court had to take into account the overall seriousness of his misconduct, as well as his seniority in the medical profession at the time of offending. In the end, there was an overriding need to uphold the standing of the medical profession and effect a sufficient level of deterrence.[79]

76 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [66].
77 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [67].
78 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [68].
79 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [72].

6.35 The following are some particularly noteworthy general points from the court's judgment:

(a) In deciding whether a defendant medical practitioner should be struck off the register, the ultimate question is whether he or she is fit to remain as a member of the medical profession. It is not necessarily the case that the defendant must have caused severe harm to patients.[80]

(b) A sentencing tribunal or court is entitled to draw logical inferences based on the material facts before it.[81]

(c) The primacy of public interest considerations in disciplinary cases means that an offender's personal mitigating circumstances do not carry as much weight as they usually would in criminal cases. In some cases, such circumstances may even have to give way entirely if that is necessary to ensure that the public interest is sufficiently met.[82]

(d) A discount in sentence for any delay in prosecution is neither automatic nor routine. The court will always scrutinise all the circumstances of the case to ascertain how much, if any, mitigating weight should be accorded to the delay.[83]

D. Extension of time for investigations under MRA

6.36 With the recent amendments to the disciplinary procedures under the MRA 1997 brought into force by the MRAA 2020,[84] the time available for inquiry by a Complaints Committee under s 45 of the MRA 1997 is now more tightly regulated, with the intention that proceedings be conducted more expeditiously. This parliamentary intent was given a boost by the General Division in the first two reported decisions on applications for an extension of time under s 45(4) of the MRA 1997. In both cases, the SMC applied for a further extension of three months for the Complaints Committee to complete its inquiry. In the first case, *Re Singapore Medical Council*[85] ("*Re SMC No 1*"), this was to allow the respondent doctor to respond in writing to a further issue raised by the Complaints Committee, while in the second, also *Re Singapore Medical Council*[86] ("*Re SMC No 2*"), the extension was sought to allow the expert

80 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [69].
81 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [49].
82 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [71].
83 *Singapore Medical Council v Wee Teong Boo* [2023] 4 SLR 1328 at [74].
84 Act 34 of 2020.
85 [2023] SGHC 213.
86 [2023] SGHC 212.

witness nominated by the Academy of Medicine to complete the expert report and for the Complaints Committee to consider it.

6.37 The General Division emphasised that the new requirement for leave to extend the time taken for inquiry by a Complaints Committee beyond the additional three months that could be granted by the chairperson of the complaints panel was imposed in order to "facilitate a more expeditious resolution of complaints".[87] Previous delays were substantial and prejudiced both the doctor awaiting resolution of the matter and the public interest in protecting patient safety. The doctor who is ultimately found liable for professional misconduct continues to practice in the interim. Therefore, the burden falls on the applicant under s 45(4) to show adequate reasons for the extension; the application is not a mere formality. Second, sufficient reasons have to be demonstrated and the court will inquire into the reasons for any prior delay observed in the proceedings. Otherwise, the court may refuse the application. Third, if an extension is refused, the Complaints Committee becomes *functus officio* and the complaint cannot proceed.[88] Finally, the court counselled that applications should be brought in a timely fashion once it becomes clear that an investigation cannot be completed in time; parties should not presume that an extension will be forthcoming.[89]

6.38 In *Re SMC No 1*, the court refused the application for a three-month extension, ruling that three weeks would suffice for what remained to be done in the inquiry. The remaining issues to be resolved did not appear complex and no further expert medical opinion was needed. There were also no adequate reasons given for why the Complaints Committee would need three months to consider the doctor's written explanation once it was filed. A greater sense of urgency was required in resolving this process. In *Re SMC No 2*, the court came to the same conclusion in granting an extension of a month and a half instead of the three months requested. No explanation was given as to why the expert needed more than two months to file a report from the time of appointment, for example, because of the complexity of the matter. These needed to be disclosed in order to justify an extension. There were also long gaps in the steps taken by the Complaints Committee in its deliberations that did not appear to be reasonable. The tenor of the General Division decisions seem clear – a greater sense of urgency beyond the normal pace is now expected, and this must be impressed on all the parties involved in

87 *Re Singapore Medical Council* [2023] SGHC 213 at [4].
88 *Re Singapore Medical Council* [2023] SGHC 212 at [2].
89 The application in *Re Singapore Medical Council* [2023] SGHC 212 was brought one day before the expiry of the deadline for the Complaints Committee to complete its inquiry.

medical disciplinary proceedings including medical experts: deadlines must be met.[90]

90 *Re Singapore Medical Council* [2023] SGHC 212 at [5].