IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2018] SMCDT 9

Between

Singapore Medical Council

And

Dr Lim Lian Arn

… *Respondent*

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Fine

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Singapore Medical Council
v
Dr Lim Lian Arn

[2018] SMCDT 9

Disciplinary Tribunal — DT Inquiry No. 9 of 2018
Dr Vaswani Chelaram Moti Hassaram (Chairman), Prof Tsang Bih Shiou @ Tsang Charles and Mr Victor Yeo Khee Eng (Legal Service Officer)
20 June 2018

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Fine

15 November 2018

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

INTRODUCTION

1. The Respondent, Dr Lim Lian Arn ("**Dr Lim**"), pleaded guilty before this Tribunal to one charge of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap 174) ("**MRA**") for having failed to obtain informed consent from his patient before administering an injection into the patient's left wrist, in particular, that he did not advise the patient of the risks and possible complications that could arise from the injection.

2. The charge read as follows:

"*That you, Dr Lim Lian Arn, a registered medical practitioner under the Medical Registration Act (Cap. 174, 2014 Rev Ed) are charged that on 27 October 2014, whilst practising at Alpha Joints & Orthopaedics Pte Ltd, Gleneagles Medical Centre, 6 Napier Road, #02-20, Singapore 258499, you had acted in breach of Guideline 4.2.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition) ("**ECEG 2002**") in that you failed to obtain informed consent from your patient, one Ms P ("**Patient**"), as would be expected from a reasonable and competent doctor in your position, in that you failed to advise the Patient of the risks and possible complications arising from the administration of 10mg of triamcinolone acetonide with 1% lignocaine in a total volume of 2ml ("**H&L Injection**"), before administering the H&L Injection into the Patient's left wrist:*

Particulars

(a) on 27 October 2014, the Patient consulted you regarding pain in her left wrist;

*(b) you conducted a physical examination of the Patient's left wrist during the consultation on 27 October 2014 and advised the Patient to undergo a Magnetic Resonance Imaging ("**MRI**") scan;*

(c) the Patient went for a MRI scan during the consultation on 27 October 2014;

(d) during the consultation on 27 October 2014:

(i) you informed the Patient of the results of the MRI scan;

(ii) you offered the Patient the option of (1) bracing and oral medication; or (2) the H&L Injection, bracing and oral medication;

*(iii) you administered the H&L Injection into the Patient's left wrist in the region of the Triangular Fibrocartilage Complex and the Extensor Carpi Ulnaris ("**Injected Area**");*

(e) before you administered the H&L Injection into the Injected Area, you did not advise the Patient of the risks and possible complications that can arise from the H&L Injection, namely:

(i) post-injection flare, in particular, that:

(1) the Patient may experience increased pain and inflammation in the area injected that can be worse than the pain and inflammation caused by the condition being treated;

> (2) *the onset of the post-injection flare is usually within 2 hours after the injection and typically lasts for 1 to 2 days;*

> (ii) *the post-injection flare can be treated by rest, intermittent cold packs and analgesics;*
>
> (iii) *change in skin colour including depigmentation (loss of colour), hypopigmentation (lightening), and hyperpigmentation (darkening);*
>
> (iv) *skin atrophy (thinning);*
>
> (v) *subcutaneous fat atrophy;*
>
> (vi) *local infection; and*
>
> (vii) *tendon rupture;*

(f) *the Patient experienced swelling and pain in the Injected Area about two hours after the H&L Injection;*

(g) *the Patient subsequently developed a "paper-thin skin with discoloration, loss of fat and muscle tissues" in the Injected Area;*

(h) *the complications experienced by the Patient at paragraphs 1(f) and 1(g) above are complications that the Patient should have been informed about pursuant to paragraph 1(e) above;*

(i) *you are aware that you are required under Guideline 4.2.2 of the ECEG 2002 to ensure that the Patient is made aware of the benefits, risks and possible complications of the H&L Injection and any alternatives available so that the Patient is able to participate in decisions about her treatment and to provide informed consent;*

(j) *a reasonable and competent doctor in your position would have obtained the Patient's informed consent by informing the Patient of the risks and possible complications arising from the H&L Injection stated at paragraph 1(e) above before administering the H&L Injection in the Injected Area;*

and that in relation to the facts alleged, your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, and that you are thereby guilty of professional misconduct under section 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed)."

Background and Agreed Statement of Facts

3. The Statement of Facts as agreed between the parties revealed that Dr Lim is registered as a specialist in orthopaedic surgery. At the material time, Dr Lim practised under the name of Alpha Joints & Orthopaedics Pte Ltd, Gleneagles Medical Centre, 6 Napier Road, #02-20, Singapore 258499 (the "**Clinic**").

4. The Complainant is Ms P (the "**Complainant**" or "**Patient**"). By way of a Statutory Declaration dated 11 January 2016, the Complainant filed a complaint against Dr Lim regarding his failure to advise her on the possible complications arising from an injection of 10mg of triamcinolone acetonide with 1% lignocaine in a total volume of 2ml ("**H&L Injection**") in her left wrist joint, and his recommendation that she undergo physiotherapy.

5. On 2 March 2016, Dr Lim provided a written explanation to the Complaints Committee for the said complaint.

6. At all material times, Dr Lim was aware that he was bound by the 2002 edition of the Singapore Medical Council Ethical Code and Ethical Guidelines ("**2002 ECEG**"). In particular, Dr Lim knew that he was required to ensure that the complainant was made aware of the benefits, risks and possible complications of the H&L Injection and any alternatives available so that she was able to participate in decisions about her treatment and to provide informed consent under Guideline 4.2.2 of the 2002 ECEG.

Facts relating to the Charge

7. On 27 October 2014, the Complainant consulted Dr Lim at the Clinic regarding pain in her left wrist. Dr Lim conducted a physical examination of her left wrist during the consultation and advised her to undergo a Magnetic Resonance Imaging ("**MRI**") scan.

8. At Dr Lim's advice, the Complainant went for a MRI scan on the same day. Thereafter, Dr Lim (a) informed the Complainant the results of the MRI scan; (b)

offered her the option of (i) bracing and oral medication; or (ii) the H&L Injection, bracing and oral medication; and (c) administered the H&L Injection into the Complainant's left wrist in the region of the Triangular Fibrocartilage Complex and the Extensor Carpi Ulnaris ("**Injected Area**").

9. Before Dr Lim administered the H&L Injection into the Injected Area, he did not advise the Complainant of the risks and possible complications that could arise from the H&L Injection, namely:

    (a) post-injection flare, in particular, that:

        (i) the Complainant may experience increased pain and inflammation in the area injected that can be worse than the pain and inflammation caused by the condition being treated;

        (ii) the onset of the post-injection flare is usually within two hours after the injection and typically lasts for one to two days;

    (b) the post-injection flare can be treated by rest, intermittent cold packs and analgesics;

    (c) change in skin colour including depigmentation (loss of colour), hypopigmentation (lightening), and hyperpigmentation (darkening);

    (d) skin atrophy (thinning);

    (e) subcutaneous fat atrophy;

    (f) local infection; and

    (g) tendon rupture.

10. The Complainant experienced swelling and pain in the Injected Area about two hours after the H&L Injection. Subsequently, she developed a "*paper-thin skin with discoloration, loss of fat and muscle tissues*" in the Injected Area. The complications experienced by the Complainant are complications that Dr Lim should have informed her about.

11. Accordingly, Dr Lim acted in breach of Guideline 4.2.2 of the 2002 ECEG when he failed to advise the Complainant of the risks and possible complications arising from the H&L Injection before administering the H&L Injection into her left wrist as would be expected of a reasonable and competent doctor in his position.

Findings

12. As Dr Lim pleaded guilty to the charge in the Amended Notice of Inquiry dated 10 May 2018 and admitted to the Agreed Statement of Facts without any qualification, the Tribunal accordingly found him guilty of professional misconduct under section 53(1)(*d*) of the MRA.

Mitigation

13. Mr Eric Tin ("**Mr Tin**"), the learned Counsel for Dr Lim, tendered a written mitigation plea. In the mitigation plea, Mr Tin highlighted that Dr Lim faced only a single charge of professional misconduct involving only one patient.

14. Dr Lim had pleaded guilty at the first available opportunity, thereby saving considerable time and resources of the Tribunal, and sparing the Complainant and prosecution expert from having to testify. In this regard, Dr Lim had also co-operated with the authorities during the investigations.

15. The learned Counsel highlighted that Dr Lim had apologised to the Complainant and this reflected his true remorse and showed insight of his error and willingness to accept responsibility.

16. Mr Tin further submitted that this was an isolated incident and wholly uncharacteristic of Dr Lim's usual clinical practice as he would normally outline all treatment options to his patients, including possible complications of the treatment. To illustrate this, Mr Tin tendered anonymised case notes of other patients; both prior and after the encounter with the Complainant, to show his usual level of documentation.

17. In this respect, Mr Tin also highlighted that it was not a universal practice to take a written consent for H&L Injection performed in the consultation room setting. However, it was good clinical practice and medical record keeping to document

in the case notes that the patient has been adequately informed and was agreeable to the injection.

18. The learned Counsel further submitted that Dr Lim did not intentionally or deliberately depart from the applicable ethical standards. Dr Lim admitted that it was serious negligence on his part but he did not offer the H&L Injection as the sole treatment, nor did he actively recommend or push this treatment to the Patient. In fact, he had offered the alternative of "*bracing and oral medication*", which was a conservative treatment without any injection.

19. Mr Tin urged the Tribunal to consider the low degree of culpability, and the limited nature and extent of harm. In this regard, his learned Counsel submitted that Dr Lim's error was not pre-meditated or calculated, and there was no dishonesty, such as deliberate suppression of key information, forgery of the Patient's consent, or other manner of deceit involved. It was a one-off transgression on a singular occasion.

20. The learned Counsel further highlighted that the complications which the Complainant experienced, namely, swelling and pain in the injected area about two hours after the H&L Injection, and "*paper-thin skin with discolouration, loss of fat and muscle tissues*" in the injected area, were limited in nature and extent.

21. The learned Counsel submitted that after this incident, Dr Lim has become more vigilant in documenting his usual practice of listing options and discussing the risks of steroid injections. He has put in concrete efforts and taken remedial steps to improve his consent taking and documentation of patient medical records. This was an indication that Dr Lim has insight into his shortcomings and was willing to change in order to improve patient care.

22. Mr Tin further submitted that there was inordinate delay in the disciplinary proceedings and Dr Lim had been under anxiety and distress after receiving the Notice of Complaint in January 2016 and the Notice of Inquiry was received in December 2017, nearly two years after.

23. Finally, the learned Counsel highlighted the following personal mitigating factors:

a) This was Dr Lim's first disciplinary offence in his 29 years of medical career;
b) Dr Lim was of good character and enjoyed good standing in the medical profession;
c) Dr Lim was a hardworking and dedicated and caring doctor; and
d) Dr Lim's contributions to the medical and wider community.

24. His learned Counsel cited, *inter alia*, the guidance by the Court of Three Judges in the recent case of **Lam Kwok Tai Leslie v SMC [2017] 5 SLR 1168** ("**Dr Leslie Lam**"), and the case of ***Eric Gan Keng Seng*** ("**Dr Eric Gan**"), a case of informed consent-related breaches, and submitted that the present case is closest to that of Dr Eric Gan, where the latter received a fine of $5,000 (half of the prescribed statutory maximum fine under the old MRA).

25. Mr Tin submitted that Dr Lim's breach was not so egregious as to merit a suspension term as there was an absence of aggravating factors and that any deterrence must be tempered by proportionality. Mr Tin urged the Tribunal to impose the maximum fine of $100,000 as it could serve the aim of a proportionate general deterrence, and would be the most appropriate sentence. However, if the Tribunal was of the view that suspension was necessary as a type of punishment for general deterrence, Mr Tin submitted that the minimum suspension period term of three months would be adequate.

Submission on Sentencing

26. In its written submission on sentencing, Counsel for the Singapore Medical Council ("**SMC**"), Mr Chia Voon Jiet ("**Mr Chia**") highlighted the sentencing principles, the relevant facts and sentencing benchmarks, and submitted that the appropriate, proportionate and effective sentence in this case should be:

a) a suspension period of five (5) months; and

b) the usual orders of censure, provision of written undertaking to abstain in future from the conduct complained of or in any similar conduct, and the payment of costs of and incidental to the inquiry ("**Usual Orders**").

27. Counsel for the SMC highlighted that the Tribunal should have regard to the applicability of general and specific deterrence to the facts of the case and submitted that the nature of the Respondent's misconduct warranted a suspension. In fact, Mr Chia informed the Tribunal that if not for the Respondent's early plea of guilt, the SMC would have requested a longer suspension term of six to eight months.

28. In this respect, Mr Chia cited the following non-exhaustive list of factors set out in Dr Leslie Lam that should be considered by the Tribunal in determining the appropriate sentence:

a) The materiality of the information that was not explained to the patient, namely, whether there was evidence that the patient would have taken a different course of action had such information been conveyed;
b) The extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and
c) The possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information. This follows from the court's observation in ***Yong Thiam Look Peter v SMC*** [2017] 4 SLR 66 (at [12]) ("**Dr Peter Yong**") that when harm ensues in a case where the harm does not form an element of the charge, the causation of such harm would be a "*seriously aggravating*" factor; on the other hand, the absence of such harm would "*generally be a neutral consideration without any mitigating value*".

29. The learned Counsel submitted that the Respondent's failure to obtain informed consent was a serious dereliction of his professional duties and warranted a period of suspension. Mr Chia also submitted that the Tribunal should not interpret the observations made by the Court of Three Judges in Dr Leslie Lam as indication

that a high fine would provide sufficient deterrence in cases involving a doctor's failure to obtain informed consent moving forward.

30. Mr Chia further highlighted that there was a serious and direct breach of the relevant rules and/or statutory provisions in that the Respondent was aware of his obligations under the 2002 ECEG that the Patient should be able to participate in decisions about her treatment and to provide informed consent under Guideline 4.2.2 of the 2002 ECEG.

31. Moreover, the complications experienced by the Patient were complications that the Respondent should have informed her about. Hence, the risks and possible complications that may arise from the H&L Injection would be considered material information that should be communicated to the Patient. Therefore, the Respondent's failure to inform the Complainant of the risks and possible complications undermined her autonomy to make an informed decision on her own, namely, between the option of (a) bracing and oral medication; or (b) the H&L Injection, bracing and oral medication.

32. Further, Mr Chia highlighted the aggravating factors present, in particular, the seniority and standing of the Respondent, the harm caused to the Patient, and public safety considerations and general deterrence.

33. Mr Chia urged the Tribunal not to give any weight to the mitigating factors such as the potential hardship to the Respondent arising from the conviction, the testimonials, character references and acts of community service, and the Respondent's long, distinguished track record.

<u>Reasons for the DT's Orders</u>

34. In deciding on the appropriate sentence to impose on the Respondent, the Tribunal carefully considered the respective sentencing submissions of the parties, and agreed that the main issue before the Tribunal was whether a suspension should be imposed on the Respondent, and if so, what the period of suspension should be, having regard to all the facts and circumstances of the case.

35. First and foremost, the Tribunal agreed with the SMC's Counsel, Mr Chia that it is trite that a doctor's duty to obtain informed consent from his patient is a serious one, and that a doctor must judiciously explain the benefits, risks and possible complications of a procedure and any alternative available to the patient before the patient consents to the said procedure. A failure to obtain informed consent is a serious dereliction of the doctor's professional duties as the patient's autonomy and trust of the doctor would be undermined. In determining the appropriate sentence, the Tribunal should have regard to the applicability of general and specific deterrence.

36. That said, the Tribunal is also of the view that not every instance or conviction for a charge of failure to obtain informed consent must necessarily attract a sentence of suspension. As pointed out in Mr Chia's sentencing submission, the appropriateness of a sentence is very much fact-dependent.

37. This is borne out by the sentencing precedents cited by both parties, which showed that cases of professional misconduct involving, amongst others, the failure to obtain informed consent received sentences of a fine (in the range of $5,000 to $10,000), or a suspension order (ranging from three to 12 months), or both. Much turned on the whether the conduct of the errant doctors was egregious and whether there were serious aggravating factors.

38. In the interest of brevity, the Tribunal does not propose to go through each and every one of those cases as they have been comprehensively and competently dealt with by both learned Counsel. The Tribunal would only make reference to those precedents that, in its view, are most relevant to the present case.

Considerations as set out in Dr Leslie Lam

39. As a starting point, the Tribunal is guided by the recent case of Dr Leslie Lam, where the Court of Three Judges set out some considerations which are relevant in sentencing errant doctors for professional misconduct under section 53(1)(*d*) of the MRA in the form of a failure to obtain informed consent. Dr Leslie Lam's case

is significant in that the Court of Three Judges, in reversing the conviction of the Appellant doctor, took the opportunity to provide guidance on sentencing in disciplinary proceedings against doctors, and how sentencing in a case such as the present would likely be impacted by the Medical Registration (Amendment) Act 2010 (Act 1 of 2010), which increased the maximum fine for an offence of professional misconduct from $10,000 to $100,000.

40. The Court of Three Judges referred to then Minister for Health, Mr Khaw Boon Wan, during the second reading of the bill, who stated that the purpose of increasing the maximum fine which could be imposed under the MRA as it then stood, was to enable the SMC to "*mete out a penalty that is appropriate to the severity of the case*". The Court of Three Judges concluded that it was clear that Parliament's intention in increasing the maximum fine was to "*bridge the gap between the then maximum financial penalty of $10,000 and the minimum suspension period of three months*."

41. The Court of Three Judges went on to state that this raised the possibility that doctors who might previously have been disciplined with three months' suspension from practice could now, in similar circumstances, possibly be sentenced to a high fine instead, and cited the decision in ***Eu Kong Weng v SMC* [2011] 2 SLR 1089** as a possible example.

42. In that case, the Disciplinary Committee ("**DC**") found Dr Eu Kong Weng ("**Dr Eu**") guilty of one count of professional misconduct for having failed to obtain informed consent from his patient for a staple haemorrhoidectomy and imposed a three-month suspension. The DC considered that a failure to obtain informed consent to an invasive surgery to be a serious form of professional misconduct, and that the process by which the failure took place involved a serious breach of the 2002 ECEG.

43. The DC considered that Dr Eu was the Head of Department and had endorsed a practice that clearly departed from the doctors' responsibilities that the patient was adequately informed so that he could participate in decision-making and be aware of the benefits, risks, possible complications and the alternatives available. The

DC was of the view that the circumstances warranted a strong signal to members of the profession that their patients' consent must be obtained properly, both in spirit as well as procedurally.

44. The Court of Three Judges upheld the three-month suspension imposed by the DC as it found that the then maximum fine of $10,000 inadequate, but also noted that it would have imposed a shorter period of suspension than the statutory minimum period if they had the discretion to do so. While the Court of Three Judges in Dr Leslie Lam did not express an opinion as to the correctness or otherwise of the sentence imposed on Dr Eu, nevertheless, it opened the possibility that where a Tribunal is of the view that a doctor who had failed to obtain informed consent from the patient is not deserving of the statutory minimum three-months' suspension, a high fine could be imposed instead.

45. Suffice for the Tribunal to note, in our assessment, the facts and circumstances in Dr Eu's case is certainly more egregious and aggravating than the present case.

46. Turning back to the case of Dr Leslie Lam, the Court of Three Judges observed that for disciplinary offences under the MRA following the 2010 amendment, ***fines at the higher end of the enhanced range should be imposed where the offences are not so serious as to deserve the statutory minimum of three months' suspension*** [emphasis added], but too serious to be punished merely by the sanctions set out in section 53(2)(*f*) and 53(2)(*g*) of the MRA, i.e. censure and undertaking.

47. A Tribunal faced with such a case of professional misconduct in the form of a failure to obtain informed consent should consider the non-exhaustive list of factors in sentencing as set out in paragraph 90 of the judgment in Dr Leslie Lam's case.

48. In so far as (a) the materiality of the information was concerned, the Tribunal agreed with the learned Counsel for SMC that the risks and possible complications of the H&L Injection were material information that should be explained to the Patient. However, as rightly pointed out by Mr Chia for SMC, there was no

evidence that the Patient would have taken a different course of action had such information been conveyed to her.

49. Furthermore, the Tribunal also considered that this was not a case where the doctor had deliberately suppressed the information, or intentionally or deliberately departed from the ethical standards. The Tribunal accepted the submission of the learned Counsel for Dr Lim that this was an isolated one-off incident, involving one patient, and that it was an honest omission on Dr Lim's part.

50. As to (b), the extent to which the patient's autonomy to make an informed decision on her own treatment was undermined as a result of the failure to convey or explain the necessary information, the Tribunal was of the view that the Patient's autonomy was not substantially undermined, neither was the Patient "*robbed of her autonomy*" (in the words of Mr Chia in his submission) to make an informed decision on her own as to whether she was willing to take on the full extent of the risks and possible complications.

51. In our view, the Patient retained much of her autonomy, and as noted above, there is no evidence to suggest that she would not have undergone the H&L Injection if she was informed of the risks and possible complications that could arise.

52. More importantly, the Agreed Statement of Facts revealed that Dr Lim had informed the Patient of the results of the MRI scan on her left wrist, and offered the Patient the option of (i) bracing and oral medication; or (ii) the H&L Injections, bracing and oral medication, before he administered the H&L Injection into the Patient's left wrist.

53. In this respect, the Tribunal considered that Dr Lim had offered the Patient the alternative option of conservative treatment without any injection, i.e. "*bracing and oral medication*", and that he did not offer the H&L Injection as the sole treatment, nor did he actively recommended or pushed this particular treatment to the Patient.

54. As for the point (c), the possibility of harm and where applicable, the materiality of harm which resulted from the doctor's failure to explain the necessary information, the Tribunal accepted the SMC's submission that some harm had ensued in that the Patient experienced swelling and pain in the Injected Area about two hours after the H&L Injection, and that she subsequently developed a "*paper-think skin with discolouration, loss of fat and muscle tissues*" in the Injected area. Suffice to note, the Tribunal observed that these were recognised adverse effects of the H&L Injection, and the Tribunal agreed that the complications experienced by the Patient were complications that Dr Lim should have informed her about.

55. However, the Tribunal was of the view that the H&L Injection administered by Dr Lim was nonetheless, an appropriate and reasonable treatment for the Patient, unlike the more egregious cases where the errant doctor should not have recommended an inappropriate treatment or advised the particular treatment option at all. Moreover, the Tribunal considered that the H&L Injection was not a complicated or highly invasive procedure, or one that required sedation or anaesthesia, to be performed in an Operating Theatre setting.

56. In other words, the harm to the Patient did not negate the appropriateness or reasonableness of Dr Lim's treatment, which was clearly guided by the Patient's symptoms and after proper investigations were done by Dr Lim. As explained above, the H&L Injection administered by Dr Lim was a minimally invasive and commonly performed procedure in the clinic that required no sedation or anaesthesia. The treatment administered by Dr Lim and management option was also one which clearly commensurate with Dr Lim's area of practice.

57. Hence, while the Tribunal recognised that the Patient suffered some side effects and complications resulting from the H&L Injection, as rightly submitted by Dr Lim's counsel, there is nothing to suggest that the complications experienced by the Complainant were in any way permanent or debilitating. To that extent, the Tribunal agreed with Mr Tin that Dr Lim's degree of culpability is on the low end, and that the harm that ensured is limited in nature and extent.

58. The Tribunal also considered the strong mitigation plea submitted on Dr Lim's behalf by his learned Counsel. In this respect, the Tribunal considered Dr Lim's unblemished record of 29 years and gave full credit to Dr Lim for having pleaded guilty at the earliest available opportunity, that he was co-operative with the investigations, that he was genuinely remorseful for his error and has apologised to the Complainant. More significantly, Dr Lim has taken remedial steps to improve his consent taking and documentation of the patient medical records.

59. It is pertinent to note that according to the report submitted by the SMC's expert witness, A/Prof PE, Senior Consultant, Hospital A, it was not a universal practice to take a written consent for H&L Injection that is performed in the consultation room setting. However, it was good clinical practice and medical record keeping to document in the case notes that the patient had been adequately informed and was agreeable to the injection.

60. The Tribunal agreed with A/Prof PE that Dr Lim should have informed the Patient about the possible complications arising from the H&L Injection, and that he should have provided adequate information to the Patient and document the details in the case notes to ensure that the informed consent was obtained.

61. Having carefully considered the case precedents cited by both parties, the Tribunal was more inclined to agree with Mr Tin that on the analysis of the cases involving informed consent-related breaches, the present case is closest to the case of **Dr Eric Gan**.

62. In that case, Dr Gan, a specialist in general surgery with an interest in surgical oncology, pleaded guilty to three charges under the pre-2010 MRA. One of the charges was for breach of informed consent for having failed to explain to the patient the possible risks and complications involved in an Endovenous Laser Treatment ("**EVLT**") procedure for the treatment of recurrent varicose veins, in particular, nerve injury.

63. The SMC sought a suspension from practice for nine months for Dr Gan, while his counsel submitted a fine of $5,000. While the DC made clear that the failure

to obtain informed consent from a patient of providing adequate information was a clear breach of a duty owed by the doctor to his patient, the DC was of the view that a fine of $5,000 would reinforce the high ethical standards required of doctors and was commensurate with the level of trust and esteem that society reposes it the medical profession.

64. The DC took into consideration that Dr Gan's mistake of not informing the patient of the risk must be seen in the context of the treatment as a whole, in that the patient went to Dr Gan specifically asking about the EVLT procedure and the medical management of the patient spanned several consultations. Dr Gan did not immediately advise the EVLT procedure or other surgery, and recommended non-invasive and conservative treatments. Dr Gan also provided the patient with some but not adequate information about the EVLT procedure. Dr Gan did not deliberately suppressed information or that he was trying to push the patient into doing a certain procedure.

65. The DC further distinguished Dr Eu's case as the surgery in Dr Eu's case was highly invasive, and there was no discussion of alternative treatment options, let alone the associated risks.

66. This Tribunal agreed with the observations made by the DC in Dr Gan's case that suspension was appropriate in egregious cases of a doctor failing to provide informed consent, and that factors such as forgery of a patient's consent or the deliberate suppression of key information from a patient, would be sufficient to render a doctor's conduct as egregious. The DC found that Dr Gan made an honest mistake and did not consider his conduct to have been egregious in this regard.

67. Thus, having carefully considered the above factors, and having regard to all the facts and circumstances, this Tribunal came to the conclusion that Dr Lim's conduct was not so egregious as to deserve a suspension, or that there were serious aggravating factors that would warrant the imposition of the statutory minimum three-months' suspension.

68. The Tribunal, having determined that the facts and circumstances of the case did not warrant a suspension, proceeded to decide on the appropriate fine to impose on Dr Lim.

69. In this regard, the Tribunal considered that Dr Lim is a specialist in orthopaedic surgery and a senior doctor who has been in practice for close to 30 years. The Tribunal is mindful of the observations made by the Court of Three Judges in ***Ang Peng Tiam v SMC*** **[2017] 5 SLR 356**, noting that an offender's eminence and seniority was an aggravating factor given that seniority and eminence were characteristics that attract a heightened sense of trust and confidence, so that when a senior and eminent member of the profession was convicted of professional misconduct, the negative impact on public confidence in the integrity of the profession would be corresponding amplified.

70. The Tribunal also took into consideration the fact that the risks and possible complications that can arise from the H&L Injection are material information that Dr Lim should have provided the Patient for her to make an informed decision. Furthermore, the Patient experienced complications after the H&L Injections, and these complications were complications that Dr Lim should have informed her about. Whilst not deserving of the statutory minimum three months' suspension, nevertheless, the Tribunal was the view that these considerations would certainly justify imposing a fine at the higher end of the fine range.

71. As stated above, the Tribunal was satisfied that Dr Lim's error was an isolated incident and that it was not deliberate but an honest oversight. He has shown genuine remorse and has apologised to the Complainant. He has also taken positive actions to review and improve his own practice for informed consent taking and document. To that extent, the Tribunal agreed with his counsel that Dr Lim was unlikely to re-offend, and hence, the need for a specific deterrence in this case is not strong.

72. However, the Tribunal was of the view that it was also important to send a strong signal that general deterrence still plays a significant role in sentencing cases that involved the failure to obtained informed consent.

73. In this regard, it is imperative to underscore the fundamental principle of informed consent as stated by the Court of Three Judges in ***Yong Thiam Look Peter v SMC* [2017] 4 SLR 66** [at 69]: that the rule requiring that the patient's informed consent be obtained is guided by the important concept of patient autonomy. It seeks to ensure that patients give their considered consent to any medical test or treatment and that in doing so, they have been given enough information to enable them to meaningfully participate in decision about the care that they may receive from medical practitioners. This would include the nature of the procedure or treatment that was contemplated, the associated benefits and risks, possible complications and alternative courses.

74. All considered, having regard to the gravity of the professional misconduct in this case, and the need for a general deterrence sentence, the Tribunal agreed with the learned Counsel's submission that the imposition of the maximum amount of fine of $100,000 would be appropriate sentence, and that it would serve the aim of a proportionate general deterrence.

75. For completeness, the Tribunal did not find that there was any inordinate delay in the institution or prosecution of proceedings in this case. We agreed with the learned Counsel for the SMC that the duration of less than two years from the Notice of Complaint to the issuance of the Notice of Inquiry did not constitute an inordinate, unreasonable or excessive delay given that time is required for the processes to run its natural course. Accordingly, the Tribunal did not think that a reduction or a discount in the sentence was warranted.

<u>Orders by this Disciplinary Tribunal</u>

76. Having fully considered all the facts and circumstances, the respective submissions of the parties, and the sentencing precedents cited, the Tribunal ordered that the Respondent:

   a) be fined **S$100,000**;
   b) be censured;

c) give a written undertaking to the SMC that he will not engage in the conduct complained of or any similar conduct; and

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

Publication of Grounds of Decision

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

78. The hearing is hereby concluded.

Dr Vaswani Chelaram Moti Hassaram
Chairman

Prof Tsang Bih Shiou @ Tsang Charles

Mr Victor Yeo Khee Eng
Legal Service Officer

Mr Chia Voon Jiet and Ms Koh Choon Min (Drew & Napier LLC)
for Singapore Medical Council; and
Mr Eric Tin Keng Seng and Mr Cheryl Tsai (Donaldson & Burkinshaw LLP)
for the Respondent.