IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2024] SMCDT 4

Between

Singapore Medical Council

And

Dr Chen Yun Hian Christopher

… Respondent

GROUNDS OF DECISION

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

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Singapore Medical Council
v
Dr Chen Yun Hian Christopher

[2024] SMCDT 4

Disciplinary Tribunal – DT Inquiry No. 4 of 2024
Prof Ho Lai Yun (Chairman), Prof Ho Khek Yu Lawrence, Ms Chong Chin Chin (Judicial Service Officer)
14 May 2024

Administrative Law – Disciplinary Tribunals

Medical Profession and Practice – Professional Conduct – Suspension

14 August 2024

GROUNDS OF DECISION

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

Introduction

1. The Respondent, Dr Chen Yun Hian Christopher, is a specialist in obstetrics and gynaecology and is a registered medical practitioner registered with the Singapore Medical Council ("**SMC**"), under the Medical Registration Act 1997 ("**MRA**"). At the material times, he was practicing at Christopher Chen Centre for Reproductive Medicine (now known as Advanced Centre for Reproductive Medicine – Fertility Clinic).

2. The Notice of Inquiry dated 20 June 2023 was amended on 30 January 2024 after SMC considered written representations from the Respondent. The amended charges preferred

by the SMC are set out in the Annex to these grounds. For the purposes of the inquiry before this disciplinary tribunal ("**DT**"), the Respondent pleaded guilty to the 2nd charge and agreed to have the 1st alternate charge taken into consideration for purposes of sentencing.

3. It is stated in the 2nd charge that the Respondent had failed to meet the standard of care expected of him in performing a procedure involving a hysteroscopy, chromotubation, laparoscopic removal of adenomyoma, and cauterisation of endometriosis (the "**Surgery**") on one Ms C (the "**Patient**"). The particulars of the charge are reproduced below:

Particulars

(a) On 12 March 2013, you performed the Surgery on the Patient.

(b) At all material times, you should have complied with the standard of care expected of you in performing the Surgery on the Patient, in that:-

(i) you should have ensured that any incision made along the part of the uterine wall overlying the suspected adenomyotic area to access the underlying adenomyotic tissue / nodule was small enough to ensure that the removal of healthy surrounding myometrium tissue is avoided and kept to a minimum, so as to preserve maximal healthy serosal and muscular layer and ensure that the uterine wall defect can be closed without tension; and

(ii) you should have closed the uterine wall defect with absorbable sutures layer by layer i.e. if adenomyotic tissue led to entry into the endometrial cavity, the cavity should be closed first, and uterine anatomy should be meticulously repaired with sutures to obliterate the dead space created between the inner and outer portions of the myometrium, before finally closing the serosal layer.

(collectively, "**Charge 2 Standard**").

(c) At all material times, you failed to meet the standard of care expected of you in performing the Surgery on the Patient i.e. the Charge 2 Standard, in that:-

(i) you made an excessively wide incision along the uterine wall, resulting in the removal of an excessive amount of healthy endometrium and myometrium tissue; and

(ii) you failed to close the uterine wall defect layer by layer by first repairing the endometrial opening, before closing the myometrial layer and then the serosal layer, but had instead placed purse-string sutures through the serosal layer and then had attempted to close the deeper defect in the myometrial layer by using straight a needles,

and 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 in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the MRA.

4. The 1st alternate charge that the Respondent consented to being taken into consideration for the purposes of sentencing concerns the Respondent's failure to obtain informed consent from the Patient for the Surgery as he ought to have ensured that the Patient was adequately informed about her medical condition and options for treatment as well as the benefits, risks and possible complications of the Surgery.

Background Facts

5. The Respondent is a specialist in obstetrics and gynaecology. He was registered as a specialist on 29 September 1998 and he has been a registered medical practitioner since 11 March 1965.

6. On or about 12 January 2013, the Patient and her husband first consulted the Respondent for advice on improving the Patient's chances of pregnancy. The Respondent diagnosed the Patient with adenomyosis and polycystic ovaries, and advised the Patient to undergo an operative video laparoscopy, dilatation and curettage and hysteroscopy, so as to improve her chances of pregnancy. The Surgery took place on 12 March 2013.

7. Following the surgery, the Patient continued with follow-up consultations with the Respondent between March 2013 and 16 July 2014 on the management of the heavy menstruation which she was experiencing and ultrasound scan(s) to get a more accurate estimation of her ovulation dates to increase her chances of pregnancy through natural conception.

8. In or around August 2014, the Patient discovered that she had conceived naturally and she continued to see the Respondent for follow-up consultations until on or about 18 October 2014. On or about 20 October 2014, the Patient suffered a uterine rupture and a miscarriage of her pregnancy in the early 2nd trimester.

9. The SMC received a complaint dated 3 May 2016 (the "**Complaint**") from the Patient. In the Complaint, the Patient raised *inter alia* the following issues:

   (a) That the Surgery conducted by the Respondent resulted in her suffering from a uterine rupture in the course of her pregnancy thereafter; and

   (b) That prior to performing the Surgery, the Respondent did not inform her of the consequences and risks of undergoing the procedure, including whether she will need to deliver via caesarean section in future pregnancies.

10. The SMC thereafter appointed a Complaint's Committee (the "**CC**") and the Complaint was laid before the CC on or about 14 July 2016.

11. A Notice of Complaint dated 15 November 2016 was issued to the Respondent and the Respondent was to provide a written explanation by 6 December 2016. On 26 November 2016, the Respondent requested a copy of the ultrasound images referred to in the Complaint and also asked for an extension of time of six weeks to respond after receipt of the images. This request was made because some time had elapsed between the notice of complaint and the incident in question. The Respondent was informed on 19 December 2016 that the request was refused and that he was to respond by 2 January 2017. The Respondent then sought a further extension of time until 16 January 2017 to respond

because of the year-end festive period and 2 January 2017 was a public holiday. This extension of time was approved by the SMC. On or about 16 January 2017, the Respondent submitted his first written letter of explanation.

12. On 5 April 2019, the SMC wrote to the Respondent to ask for a further explanation to be submitted by 26 April 2019 in response to certain further queries from the CC. This was later extended by agreement to 24 May 2019 and the Respondent submitted a second written letter of explanation on 24 May 2019.

13. On 26 August 2020, the SMC issued a letter informing Respondent that the CC had ordered that a formal inquiry be held by a Disciplinary Tribunal ("**DT**"). The formal Notice of Inquiry dated 20 June 2023 was served on the Respondent.

Plea of Guilt

14. The Respondent pleaded guilty to the 2nd charge for professional misconduct under s 53(1)(*d*) of the MRA and he admitted that the misconduct amounted to serious negligence that objectively portrays an abuse of privileges which accompany registration as a medical practitioner.

15. It is well established that there are at least two situations in which medical misconduct may be made out (see *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("***Low Cze Hong***") at [37]):

    (a) The first is where there has been an intentional, deliberate departure from the standards observed or approved by members of the medical profession who are of good repute and competency; and

    (b) The second is where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

16. For the purposes of this inquiry, it was not in dispute that a responsible and competent doctor performing the Surgery would have:

    (a) ensured that any incision made along the part of the uterine wall overlying the suspected adenomyotic area to access the underlying adenomyotic tissue / module was small enough to ensure that the removal of healthy surrounding myometrium tissue is avoided and kept to a minimum, so as to preserve maximal healthy serosal and muscular layer and ensure that the uterine wall defect can be closed without tension; and

    (b) closed the uterine wall defect with absorbable sutures layer by layer, i.e., if adenomyotic tissue led to entry into the endometrial cavity, the cavity should be closed first and uterine anatomy should be meticulously repaired with sutures to obliterate the dead space created between the inner and outer portions of the myometrium, before fully closing the serosal layer.

    (collectively described as the "**Relevant Standard**").

17. The Respondent agreed that he had breached the Relevant Standard when he performed the Surgery on the Patient, in that he:

    (a) made an excessively wide incision along the Patient's uterine wall, resulting in the removal of an excessive amount of healthy endometrium and myometrium tissue; and

    (b) failed to close the uterine wall defect layer by layer by first repairing the endometrial opening, before closing the myometrial layer and then the serosal layer, but had instead placed purse-string sutures through the serosal layer and then had attempted to close the deeper defect in the myometrial layer by using a needle.

    The above was described as "**the Respondent's Conduct**" in the amended Agreed Statement of Facts.

18. The Respondent agreed that his departure from the Relevant Standard was sufficiently serious to amount to professional misconduct, in that:

    (a) the Respondent's Conduct amounted to a deviation from the Relevant Standard;

    (b) the Respondent's Conduct put the Patient at an increased risk of uterine rupture and miscarriage of her subsequent pregnancy, which in fact materialised; and

    (c) the Patient suffered serious eventual harm i.e., a uterine rupture, a miscarriage and an increased risk of uterine rupture in future pregnancies, which objectively was a foreseeable consequence of the Respondent's misconduct.

DT's Decision on Guilt

19. The DT is satisfied, after reviewing the agreed facts upon which the plea of guilt was taken, that the Respondent was guilty of professional misconduct under s 53(1)(*d*) of the MRA. To meet the disciplinary threshold under *Low Cze Hong*, a three-stage inquiry would have to be conducted. The first stage is to establish that the relevant benchmark standard applicable to the doctor. The second stage is to establish whether there has been a departure from the applicable standard. The third stage is to determine whether the departure in question was sufficiently egregious to amount to professional misconduct under one of the limbs set out in *Low Cze Hong*. The third stage is critical because it is not sufficient to impose disciplinary sanctions on the medical practitioner just because he had committed a negligent act or had made a mistake (through a departure from the applicable standard), it must be shown on the facts that the act in question warrants the imposition of such sanctions. In this connection, the following extract from *Singapore Medical Council v Lim Lian Arn* [2019] 5 SLR 739, at [38] is instructive:

> In our judgment, the critical inquiry is whether the conduct would be regarded as falling so far short of expectations as to warrant the imposition of sanctions. In broad terms, it will be relevant to consider the nature and extent of the misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action. This would depend on a multitude of overlapping considerations including

> the importance of the rule or standard that has been breached, the persistence of the breach and the relevance of the alleged misconduct to the welfare of the patient or to the harm caused to the doctor-patient relationship. Serious negligence portraying an abuse of the privileges which accompany registration as a medical practitioner would generally cover those cases where, on a consideration of all the circumstances, it becomes apparent that the doctor was simply indifferent to the patient's welfare or to his own professional duties, or where his actions entailed abusing the trust and confidence reposed in him by the patient. On the other hand, it would not typically cover one-off breaches of a formal or technical nature where no harm was intended or occasioned to the patient or where harm was not a foreseeable consequence; nor would it ordinarily cover isolated and honest mistakes that were not accompanied by any conduct which would suggest a dereliction of the doctor's professional duties.

20. We are satisfied that the Respondent's departure from the acceptable standard was so serious that it warranted the imposition of disciplinary sanctions. The Patient had consulted him on fertility issues and the purpose of the Surgery was to improve her future chances of conception. Yet, the Respondent had repaired the uterine defect in a way that left the Patient susceptible and vulnerable to serious harm in the future. In this case, the Patient's uterine ruptured in less than two years after the Surgery at the early stages of pregnancy. The Respondent did not dispute that this was a foreseeable harm which he had caused by not adhering to the usual acceptable methods and admitted that the conduct amounted to such a significant departure that it portrayed an abuse of privileges which accompany registration as a medical practitioner. We are satisfied that the elements of the charge were made out on the agreed facts.

Submissions on sentencing

21. The appropriate sentencing approach is set out in *Wong Meng Hang v Singapore Medical Council* [2018] 3 SLR 526 ("***Wong Meng Hang***"). The four steps to be taken in assessing the appropriate sentence to be imposed for professional misconduct in a clinical setting are broadly outlined below:

    (a) Identify the level of harm and the level of culpability. Harm refers to the type and gravity of harm or injury that was caused to the patient and to the society by the commission of the offence. The more direct the connection between the specific type of harm that has been occasioned and the misconduct in question, the

weightier a consideration this would be. It is also essential to examine the culpability of the offender or degree of blameworthiness disclosed by the misconduct. This may be assessed by reference to the extent and manner of the offender's involvement in causing the harm, the extent to which the offender's conduct departed from standards reasonably expected of a medical practitioner, the offender's state of mind when committing the offence, and all the circumstances surrounding the commission of the offence.

(b) Identify the applicable indicative sentencing range. The Court provided a "harm-culpability matrix" (which is set out below) that would guide a sentencing tribunal to determine an appropriate sentence:

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

(c) Identify the appropriate starting point within the indicative sentencing range. After identifying the applicable indicative sentencing range, this third step is to identify the appropriate starting point within that range.

(d) Make adjustments to the starting point to take into account offender-specific factors. At this stage, the relevant aggravating and mitigating factors are to be considered.

22. Both parties relied on the principles laid down in *Wong Meng Hang* and *the Sentencing Guidelines for Singapore Medical Disciplinary Tribunals* June 2020 edition ("**Sentencing Guidelines**") in making their submissions to this DT on the appropriate sentence to be imposed.

(a) SMC's Submissions on Sentence

23. SMC submitted that the level of harm caused by the Respondent's misconduct in the 2nd charge was at the high end of "moderate":

   (a) The eventual harm caused to the Patient is serious because the Respondent's failure to carry out the Surgery in accordance with the standards expected of a reasonable and competent doctor resulted in the Patient suffering a uterine rupture which led to her miscarriage. As a result, the Patient faced an increased risk of uterine rupture in future pregnancies and she had been advised against future conception. The harm caused was grave and irreversible. The Patient had consulted the Respondent due to fertility issues and was now worse off due to the Respondent's misconduct.

   (b) Based on Associate Professor PE's expert report dated 22 March 2023 at [8.30], it was highly likely that the manner in which the Respondent had performed the Surgery caused and/or contributed to the Patient's uterine rupture and miscarriage.

   (c) SMC submitted that public confidence in the medical profession would be undermined by the Respondent's misconduct. This is exacerbated by the fact that the Respondent is a senior medical practitioner with a specialization in obstetrics and gynaecology.

24. As for the Respondent's culpability, SMC submitted that it falls between the "medium" and "high" range:

   (a) The Respondent's deviation from the applicable standards for the conduct of the Surgery was significant. The technique adopted by the Respondent to repair the

endometrial opening was completely different from the generally accepted procedure. Instead of repairing the endometrial cavity, followed by the myometrial layer, and finally the serosal layer, the Respondent sought to mend the serosal layer before the myometrial layer using purse-string sutures.

(b) This was made worse by the unnecessarily wide incision along the Patient's uterine wall, which resulted in the excessive removal of the Patient's healthy endometrium and myometrium tissue.

(c) Senior doctors would generally be more culpable than junior doctors based on [54(e)] of the Sentencing Guidelines. The SMC eventually did not pursue this argument during the oral submissions after we pointed out that the illustration in the Sentencing Guidelines relied on by the SMC was not applicable on the facts.

(d) Referring to [54(j)] of the Sentencing Guidelines, the SMC submitted that patients rely on doctors to address their health issues, not least because there generally exists an asymmetry in training and information between patients and their doctors. The Patient was particularly vulnerable and dependent on the Respondent to provide competent treatment to her given the latter's expertise in fertility issues. The SMC contended that the Respondent had betrayed the trust and confidence that the Patient had reposed on him by performing the Surgery negligently.

25. The SMC referred to two previous cases involving negligent performance of medical procedures that amounted to serious negligence that objectively portrayed an abuse of privileges which accompany the registration of the medical practitioner. The first case is *In the matter of Dr Chan Heang Kng Calvin* [2017] SMCDT 6 ("***Dr Calvin Chan***") where a 6-month suspension was ordered in respect of four charges including a charge for his failure to exercise due care and competence in the management of the patient's right breast mastitis, in that *inter alia* he failed to perform the incision and drainage procedures appropriately and/or thoroughly. The other case is *In the matter of Dr Amaldass Narayana Dass* [2014] SMCDC 2 ("***Dr Dass***") where the medical practitioner was given a four-month suspension and a $5,000 fine for his failure to discharge his duty

of care in the conduct of pre-operative, intra-operative and post-operative management of his patient. As these cases pre-dated *Wong Meng Hang*, the SMC submitted that they may be of limited assistance and did not seek to rely on these cases as relevant precedents.

26. The SMC referred to the case of *In the matter of Dr Islam Md Towfique* [2022] SMCDT 5 ("***Dr Islam***") and submitted that the culpability of the Respondent would be lesser in comparison. In *Dr Islam*'s case, the disciplinary tribunal held that the harm caused was at the high end of "moderate" and the culpability was "high". The appropriate starting point in that case was a suspension period of 36 months (before any sentencing discount was applied). The misconduct of Dr Islam was arguably more egregious as Dr Islam had repeatedly left the operating theatre to attend to non-urgent phone calls and that was a deliberate and intentional departure from the relevant benchmark standard that required a responsible and competent anaesthetist to be "constantly physically present by the patient's side to closely monitor a patient at all times during an operation".

27. Applying the *Wong Meng Hang* sentencing framework, the SMC submitted that a period of suspension between 22 and 28 months would be a reasonable and appropriate starting point in the present case after taking into account the level of harm and culpability.

28. The SMC submitted that an uplift should be made and that an overall suspension term of between 24 and 30 months would be appropriate after taking into account the following:

    (a) The aggregate sentence should also be enhanced given that an additional charge for failure to obtain informed consent for the Surgery was taken into consideration.

    (b) In relation to offender-specific factors, the SMC submitted that the Respondent's seniority in the medical profession is an aggravating factor. The Respondent is a highly experienced and senior doctor, with close to 50 years' experience as a medical practitioner and 15 years' experience as a specialist at the time when the Surgery was performed.

29. In relation to mitigating factors raised by the Respondent, the SMC submitted the personal factors would carry little weight in disciplinary proceedings.

30. On the issue of possible discount for some delay in prosecution, the SMC submitted that only 50% discount should be given notwithstanding that a period of approximately 6 years and 7 months had passed between the issuance of the Notice of Complaint on 15 November 2016 and the Notice of Inquiry on 20 June 2023. The SMC argued that:

    (a) A delay of 2.5 months was attributable to the Respondent as the Respondent had sought an extension of time of six weeks to submit his first written letter of explanation and a further extension of four weeks to submit his second written letter of explanation.

    (b) The SMC had legitimate reasons for the length of time needed to investigate the matters raised in the Complaint:

        (i) The SMC needed time to reach out to other doctors whom the Patient consulted subsequent to the Surgery to obtain their medical records and reports in respect of the Patient.

        (ii) The issues raised in the Patient's complaint involved niche medical issues in the field of obstetrics and gynaecology and the SMC needed to engage experts in that field on opine on whether the Respondent's conduct fell short of the applicable standards expected of him.

        (iii) The SMC required considerable time to source for and engage an expert with a specialty in obstetrics and gynaecology who was willing to act as expert for the SMC. Many of the medical practitioners whom SMC reached out to declined to be involved on the basis of conflict of interest which was ostensibly due to the seniority and eminence of the Respondent. The SMC eventually engaged Associate Professor PE, an expert based overseas.

(c) The SMC submitted that a discount of no more than 50% had been applied in past disciplinary cases.

31. In addition, given that there was a charge that was taken into consideration for sentencing and the presence of an aggravating factor, no further discount to the overall sentence beyond 50% should be given. The SMC submitted that an aggregate suspension period of 12 to 15 months would be appropriate.

(b) Respondent's Submissions on Sentence

32. Applying the sentencing framework in *Wong Meng Hang*, the Respondent admitted that the misconduct caused serious/severe harm to the Patient after taking into account the broad guidelines set out in [52] of the Sentencing Guidelines. The relevant extract from the Sentencing Guidelines is set out below:

Level	Description
Serious harm	• Where the offence caused serious personal injury, including injuries which are permanent in nature and which necessitate surgical attention; • Where the offence caused serious mental injury, in the sense of a recognizable psychiatric illness; • Where the offence seriously undermined public confidence in the medical profession and the healthcare system; and/or • Where the offence seriously undermined public health and safety or the public healthcare system.

33. In terms of culpability, the Respondent submitted that the misconduct fell between the higher end of "low" culpability and the lower end of "medium" culpability:

(a) Counsel for the Respondent submitted that the Respondent believed that he was acting in the Patient's best interest. While the Respondent accepted, with the benefit of hindsight, that he should have been more conservative by excising less

myometrial tissue and that he should have closed the uterine wall defect layer by layer, the Respondent held an honest belief that he had excised an appropriate amount of tissue. He also believed that the use of the purse-string stitch would benefit the Patient by reducing surgical blood loss, resulting in less scarring and enable faster recovery, while being adequate to withstand a subsequent pregnancy.

(b) The Respondent had no malicious intent towards the Patient. He was not motivated by an intention to make financial or other personal gain. He believed that he had conducted the Surgery with due care and diligence.

(c) The Respondent did not dispute that he was seriously negligent in the performance of the Surgery. The Respondent invited the DT to consider precedent cases where the medical practitioners were held to have "medium" level of culpability for the various breaches and submitted that the Respondent was less culpable in comparison. The cases are:

(i) *Singapore Medical Council v Dr Foo Chee Boon Edward* [2018] SMCDT 14 ("***Dr Edward Foo***") – Dr Foo was convicted on a charge for professional misconduct and the disciplinary tribunal found that the conducted amounted to serious negligence. Dr Foo had administered an overdose of oral fleet to a patient and in the process had disregarded the recommended dosage set out in the product insert and ignored the Health Sciences Authority's advisory against use of Oral Fleet for patients with certain conditions. The Disciplinary Tribunal held that Dr Foo's culpability was "medium".

(ii) *Singapore Dental Council Disciplinary Committee Inquiry against Dr Oliver Hennedige* (decision dated 22 February 2021) ("***Dr Hennedige***") – Dr Hennedige was found to be guilty of two charges of professional misconduct. One charge related to a deliberate and intentional departure from acceptable standards where Dr Hennedige had performed surgery for the placement of min-implants on a patient when it was not appropriate or proper to do so after taking into the patient's physical conditions. The other charge related to

serious negligence for failing to exercise due care in the design and execution of the treatment for the patient when he permanently cemented a bridge over the mini-implants. The Disciplinary Committee considered both offences together and held that the charges would fall into the category of serious/severe harm and moderate culpability. His original sentence was a suspension of 2.5 years which was eventually reduced to 15 months after taking into account delay in prosecution and other mitigating factors.

34. It was submitted that the applicable indicative sentencing range should be a suspension between 1.8 to 2.5 years. On the facts of this case, it was submitted that a suspension period of 24 months would be appropriate as a starting point.

35. In mitigation, the Respondent urged this DT to consider the following points:

(a) The Respondent had co-operated with the investigations and had pleaded guilty at an early stage.

(b) He has no prior convictions.

(c) The Respondent is presently 84 years old and has been suffering from ill health. He was diagnosed in 2015 with atrial fibrillation and has had a pacemaker implanted to manage his tachycardia. His hypertension has reached high readings associated with the stress of the disciplinary proceedings according to a report dated 18 September 2023 from the Respondent's cardiologist.

(d) The Respondent had suffered hardship and distress as a result of the lengthy lapse of time spanning close to seven years between the Notice of Complaint on 15 November 2016 to the issuance of the Notice of Inquiry on 20 June 2023. The Respondent suffered a stroke on 24 July 2015 and he managed to return to work by end of 2015 by co-managing patients with other medical practitioners while continuing with his rehabilitation. On 15 November 2016, he received the Notice of Complaint which had caused additional stress and anxiety such that he was

unable to maintain an active clinical practice and other doctors were brought into his clinic to take over his patients. Eventually, his clinic no longer bore his name. It was submitted that the Respondent continued to suffer from stress and anxiety associated with these disciplinary proceedings.

(e) There was inordinate delay in the prosecution of this case. There was almost seven years between the notice of complaint on 15 November 2016 and the Notice of Inquiry on 20 June 2023. Almost two years and three months of the delay took place between the date of the Respondent's submission of his first written letter of explanation on 16 January 2017 and the further request for more information on 5 May 2019. Another one year and three months of delay took place between his submission of his second written letter of explanation and the notification of CC's decision to refer the matter to a DT on 26 August 2020. From the time of the CC's decision to refer the matter to a DT, the SMC took an additional close to three years to issue the Notice of Inquiry.

(f) The over-all risk of re-offending is exceeding low. While the Respondent was assessed to be fit to perform clinical duties after his stroke in 2015, he did not return to surgical practice.

36. In view of the above, the Respondent submitted that a discount of at least 60% should be given. Therefore, a suspension period of not more than 10 months would be appropriate in the circumstances.

DT's Decision on the Appropriate Sentence

37. In determining the appropriate sentence, the DT would have to evaluate the seriousness of the offence with reference to culpability and harm. Our starting position would be the guidance provided by the Court in *Wong Meng Hang*. Before we consider the application of the *Wong Meng Hang* sentencing framework, we were also mindful that the offence of professional misconduct which the Respondent admitted to was one of serious negligence and not one involving intentional and deliberate wrongdoing. Parties

submitted that cases involving intentional and deliberate wrongdoing commonly attract heavier sentences compared to those which concern negligent misconduct. While this is not invariably so as each case must be assessed on its own facts (see *Wong Meng Hang* [28] and [38]), we do not see think that the facts of this case warrants a departure from the common position adopted by the parties.

38. We now turn to the issue of the level of culpability which is the degree of blameworthiness disclosed by the misconduct. Relevant factors would include the extent and manner of the Respondent's involvement in causing the harm, the extent to which the Respondent's conduct departed from standards reasonably expected of a medical practitioner, the Respondent's state of mind when committing the offence, and all the circumstances surrounding the commission of the offence (see *Wong Meng Hang* [30(b)]).

39. The extent of the Respondent's deviation from the applicable standards was significant. As admitted by the Respondent, the manner in which the Surgery was performed by the Respondent was lacking in many respects. Instead of closing the uterine wall defect layer by layer starting from the innermost endometrial cavity followed by the myometrial layer and finally the serosal layer, the Respondent had placed purse-string sutures through the outermost serosal layer and he attempted to close the deeper defect in the myometrial layer by using a needle. This method adopted by the Respondent was entirely inappropriate and the misconduct itself had caused irreparable harm to the Patient. In addition, his incision was unnecessarily wide and that had exacerbated the situation.

40. Turning to the state of mind of the Respondent, the parties agreed that the Respondent's conduct arose from negligence and that his culpability would not be on the higher end as there was no recklessness / wilful disregard or intentional and deliberate departure from standards or guidelines. The DT agrees with the assessment and, on the facts of this case, the culpability should not be pegged at either extreme ends of "low" culpability or "high" culpability.

41. To support the contention that the culpability should be low, the Respondent argued that he had honestly believed that his use of purse-string sutures would benefit the Patient by reducing surgical blood loss and enable faster recovery. We gave very little weight to this assertion. Given the extent of the departure from the acceptable methods, the DT was not persuaded that the Respondent could genuinely believe that his method would be beneficial to the Patient. In addition, there was no evidence tendered before us to suggest that the Respondent's method could be reasonable or acceptable for the Surgery in question. We would be sending a wrong signal to the public if the DT were to hold that a medical practitioner should be considered to have low culpability in these circumstances.

42. In the course of submissions, counsel referred us to a number of cases but we did not find them to be closely analogous to the facts at hand. Nevertheless, having reviewed them, the DT was satisfied that the finding that "medium" culpability would be appropriate on the facts of this case.

43. Counsel for the Respondent relied on the cases of *Dr Edward Foo* and *Dr Hennedige* to support the contention that the DT should find that the Respondent was less culpable or no less culpable in comparison. *Dr Edward Foo*'s case involved a misconduct charge for serious negligence in administering an overdose of Oral Fleet for bowel preparation for a medical procedure as well as a misconduct charge for intentional and deliberate departure from acceptable standards by failing to recognise that the patient was suffering from septic shock. *Dr Hennedige*'s case involved serious negligence due to a failure to exercise due care in the design and execution of a dental treatment where 15 mini-implants were placed to support a 14-unit bridge. In both cases, the respective DT and Disciplinary Committee held that the level of culpability was "medium". In our view, these cases would not advance the Respondent's arguments or explain why the Respondent should be seen as being *less* culpable in comparison. The Respondent should not be seen to be less blameworthy given that the Surgery was a lot more invasive and his significant departure from the acceptable standards caused serious consequences.

44. As for the cases referred to by the SMC, we found that the case of *Dr Calvin Chan* is of little assistance since it was decided before *Wong Meng Hang*. The case of *Dr Dass* was more instructive. Even though it pre-dated the decision in *Wong Meng Hang*, the Court provided guidance on how the *Wong Meng Hang* sentencing matrix would have been applied on the facts at [39]. In that case, Dr Dass did not adequately explain the risks of an open rhinoplasty procedure to his patient; failed to effectively sedate him of stop the procedure even though the patient indicated that he was not properly sedated and was in pain; left a gauze dressing in his nasal cavity without informing the patient; left remnants of a knotted thread in the patient's body; and failed to remove an implant even though there was infection. The Court held that level of culpability was classified as "high" due to his sheer incompetence in the surgical and post-surgical care of the patient. A suspension of two to three years would have been appropriate as "moderate" harm was caused.

45. In *Dr Islam*'s case, the DT ruled that Dr Islam's conduct of leaving the operating theatre repeatedly to attend to non-urgent phone calls during an operation was an international and deliberate departure from the benchmark standard expected of a responsible and competent anaesthetist. Therefore, notwithstanding that Dr Islam pleaded guilty to a charge of serious negligence, the DT held that such deliberate and intentional departures from accepted standards pointed towards a high level of culpability on Dr Islam's part. Dr Islam's conduct demonstrated his disregard of the patient's wellbeing as there was clear evidence that an anaesthetist was required to constantly monitor the patient's condition during the surgery.

46. We agreed with the parties' submissions that what the Respondent did was far less culpable compared to what Dr Dass and Dr Islam did. Dr Dass had committed a number of breaches for both his surgical and post-surgical care. Dr Islam repeatedly left the operating theatre and the breach was not one-off. Having regard to the circumstances of this case, the DT is of the view that the Respondent's culpability level should be pegged at the higher end of the "medium" range.

47. For completeness, we would also deal with the SMC's contention that the Respondent had abused his position of trust and confidence and that this would be a factor that increased the level of culpability under [54(j)] of the Sentencing Guidelines. It was argued that the Patient would have trusted the Respondent (as a senior medical practitioner specializing in fertility treatment) to perform the Surgery properly and by failing to do so, the Respondent had abused his position of trust and confidence. We were not persuaded by the SMC that [54(j)] of the Sentencing Guidelines were applicable on the facts. The Sentencing Guidelines stated that "patients are particularly vulnerable because of their dependence on doctors to treat their health issues, and the information asymmetry between them and their doctors. A doctor who abuses a patient's trust and confidence for his or her own personal gain would be more culpable". In our view, this case did not involve an abuse of trust and confidence for own personal gain. It did not follow that the Respondent would had abused the Patient's trust and confidence just because the Patient would have trusted the Respondent to proper medical care and the latter failed to do so. While it could not be disputed that there would be a certain level of trust between a patient and his doctor as the patient would be relying on the doctor's expertise to provide the proper medical care, evidence must be adduced to demonstrate how the doctor had abused such trust. A mere failure to act in accordance with acceptable standards would be insufficient. In any event, the DT noted that SMC was not able to provide any direct case authority in support of such a general proposition.

48. We next turn to the issue of harm. This refers to the type and gravity of the harm or injury that was caused to the patient and to the society. We note that the Respondent accepted that "severe" harm was caused by his misconduct while the SMC submitted that harm was at the high end of "moderate". We agree with the parties' submissions and it would be appropriate to peg the level of harm somewhere between the higher end of "moderate" and the lower end of "severe". Apart from the actual harm caused to the Patient which we had already dealt with earlier, the misconduct in question has also caused harm by undermining public confidence in the medical profession as the public would expect a senior medical practitioner in the position of the Respondent to adhere to acceptable standards when performing the Surgery.

49. Our view is that an appropriate starting point would be a suspension period of 24 months.

50. After reviewing the offender-specific factors, we are of the view that there should be a further uplift of two months. We had ascribed limited weight to the personal mitigating circumstances which the Respondent sought to rely on. We are mindful that such mitigating factors would generally carry little weight in the context of medical disciplinary cases given the broader public interest objectives of protecting the public and upholding the reputation and confidence in the medical profession ([67] of Sentencing Guidelines). However, we do agree with Counsel for the Respondent that the Respondent's plea of guilt at an early stage has some mitigating value.

51. However, there are aggravating factors in this case which warrant an overall uplift. The first is the Respondent's seniority and we note that he has been a specialist in this field for over 20 years. As explained at [69(b)] of the Sentencing Guidelines, the seniority and eminence of a doctor would attract a heightened sense of trust and confidence in the practitioner and in the profession. The negative impact on public confidence in the integrity of the medical profession is amplified when such an offender is convicted of professional misconduct. The Respondent did not dispute this general principle and accepted that this is an aggravating factor. Another aggravating factor relates to the 1st alternate charge that was taken into consideration for the purposes of sentencing.

52. Taking into account the relevant factors, we hold that a suspension period of 26 months would be appropriate and this would be in line with the sentencing objectives to uphold the standing and reputation of the profession as well as to prevent an erosion of public confidence in the competence of its members.

53. Lastly, we considered the issue of what discount should be given in this cause on account of inordinate delay in the prosecution. The relevant principles for sentencing discount are found in *Ang Peng Tiam v Singapore Medical Council* [2017] 5 SLR 356 ("***Ang Peng Tiam***") and are summarised below:

(a) For delay in the institution or prosecution of proceedings to be taken into account as a mitigating factor, the delay must be inordinate.

(b) Whether or not there has been inordinate delay is not measured in terms of absolute length of time that has transpired, but must always be assessed in the context of the nature of investigations.

(c) The delay must not have been occasioned by the offender.

(d) The court has recognised that mental anguish, anxiety and distress suffered by the offender in having the charge "hanging over his head" during the period of delay is prejudice that might warrant a reduction in sentence. In the context of disciplinary proceedings, this may be exacerbated if news of the investigations for professional misconduct has become public and he has to run his practice under the cloud of a tarnished name and an impending prosecution. Any other types of prejudice, such as loss of income or career opportunities, may be taken into account if the offender can prove that he has suffered such prejudice as a result of delay.

(e) While the underlying rationale for a sentencing discount to be applied in such cases of delay is fairness to the offender as an individual, this may be offset or outweighed by broader countervailing public interest which demands the imposition of a heavier penalty.

54. The parties agreed that there was inordinate delay and that a discount of 50% should be given. The issue is whether a higher sentencing discount is warranted on the facts. Counsel for the Respondent contended that a discount of at least 60% ought to be given since the period of delay was much longer than other precedent cases where a 50% sentencing discount was provided. Further, the Respondent suffered prejudice in not being able to keep up with an active practice. Counsel for the SMC explained that a lot of time was taken to obtain expert opinion and it had a lot of difficulties obtaining expert evidence from local doctors who would be willing to testify against the Respondent. It was also submitted that no further discount should be given on account of any alleged

prejudice caused to the Respondent by not being able to carry on an active practice due to the pending disciplinary proceedings. This was because that the Respondent was already of ill-health even before the Notice of Complaint was served.

55. Having reviewed the chronology of events, we find that there was an inordinate delay in prosecution. On 16 January 2017, the Respondent provided a written explanation to the Notice of Complaint dated 15 November 2016. The Respondent was asked to provide a further clarification on 5 April 2019, almost two years and three months after the first written explanation was provided. A further explanation was provided by the Respondent on 24 May 2019. While the Respondent did request for extensions of time to respond amounting to a total of approximately two and a half months, in our view, this is insignificant compared to the delay on the part of the prosecution. In any event, the requests for extension of time also appeared reasonable in the circumstances. The next step in the prosecution took place more than one year later and that was the decision to refer to the Disciplinary Tribunal and the Respondent was notified on 26 August 2020. Following that, the SMC took almost another three years to issue the Notice of Inquiry on 20 June 2023. In sum, it took six years and seven months for the Respondent to receive the Notice of Inquiry after receiving the Notice of Complaint.

56. In our view, even if the SMC had experienced some difficulties obtaining expert opinion, the length of delay was exceptionally long and the SMC has not provided cogent reasons to explain the delay. It is pertinent to note that the reasons given by the SMC were similarly canvassed and rejected in previous cases such as *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("***Jen Shek Wei***") and *Ang Peng Tiam*'s case.

57. In *Jen Shek Wei*'s case, the court held that there was a delay in prosecuting the case. The Notice of Complaint was sent on 17 July 2012 and Dr Jen gave his response on 2 August 2012. The SMC waited nearly three years thereafter to issue the Notice of Inquiry on 8 July 2015. In response to the explanation given by the SMC that time was needed to find an expert and to draft the charges, the court observed that a delay of three years is overly lengthy by any reasonable measure.

58. In *Ang Peng Tiam*'s case, the court found that there was inordinate delay in prosecution and there was insufficient explanation why the SMC had taken the time it took to issue the Notice of Inquiry to Dr Ang. In that case, there was a time lag of nearly four and a half years between the SMC's receipt of the complaint and its issuance of the Notice of Inquiry to Dr Ang. The Complaints Committee took almost one and a half years to conduct investigations and obtain an expert report. The SMC took another three years to obtain two expert reports, liaise with witnesses, prepare the Notice of Inquiry, and constitute the Disciplinary Tribunal. It is pertinent to note that the court also observed that it was open to the SMC to have begun its search for expert witness overseas much earlier.

59. In both cases, the court ordered a 50% sentencing discount. In the present case, the delay is significantly lengthier in comparison. Looking at the nature of the misconduct, it is unclear to us why such a long time was taken by the SMC to obtain the relevant expert evidence. The SMC also did not provide sufficient explanation as to why foreign experts were not approached earlier. We are satisfied on the facts of this case that the delay in prosecution was inordinate.

60. We also find that the Respondent has not discharged the burden of proving that he had suffered prejudice beyond anxiety and distress of having the disciplinary proceedings hanging over his head. As the Respondent was already in poor health before the notice of complaint was issued, it is for the Respondent to show that the delay in prosecution (and not his existing health conditions) had resulted in his inability of carry on with active practice. We are not satisfied on the evidence presented to us that this was the case.

61. However, it cannot be denied that the Respondent had suffered from anxiety and distress and the court had accepted this as a matter of natural inference (*Ang Peng Tiam* at [123]). Having considered all the circumstances of this case, we are of the view that a higher sentencing discount beyond 50% should be given and an appropriate sentence would be 12 months suspension in total.

Conclusion

62. Accordingly, this Tribunal orders that:

(a) The Respondent be suspended from practice for a period of **12 months**;

(b) The Respondent be censured;

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

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

63. We further order that the period of suspension is to commence 40 days after the date of this order to take into consideration the time frame for parties to appeal and for the Respondent to settle any outstanding matters before commencing his suspension.

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

65. The hearing is hereby concluded.

Prof Ho Lai Yun
Chairman

Prof Ho Kek Yu Lawrence

Ms Chong Chin Chin
Judicial Service Officer

Ms Angelia Thng, Mr Colin Wu, Ms Tang Kai Qing and Mr Glenn Ang
(M/s Braddell Brothers LLP)
for Singapore Medical Council; and

Ms Mak Wei Munn, Ms Koh En Ying and Ms Gloria Tan
(M/s Allen & Gledhill LLP)
for Dr Chen Yun Hian Christopher