IN THE COURT OF THREE JUDGES OF THE REPUBLIC OF SINGAPORE

[2017] SGHC 139

Originating Summons No 10 of 2016

In the matter of Section 55(1) of the Medical Registration Act (Cap 174, 2004 Rev Ed)

And

In the matter of a decision of the Disciplinary Tribunal of the Singapore Medical Council made on 30 June 2016 under Section 53 of the Medical Registration Act (Cap 174, 2004 Rev Ed) against Dr Chia Foong Lin

Between

Chia Foong Lin

… *Appellant*

And

Singapore Medical Council

… *Respondent*

JUDGMENT

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

Chia Foong Lin
v
Singapore Medical Council

[2017] SGHC 139

High Court — Originating Summons No 10 of 2016
Chao Hick Tin JA, Andrew Phang Boon Leong JA, and Judith Prakash JA
27 February 2017

27 June 2017 Judgment reserved

Chao Hick Tin JA (delivering the judgment of the court):

Introduction

1 This is an appeal brought by Dr Chia Foong Lin ("Dr Chia"), a paediatrician of 23 years' standing, against the decision of a Disciplinary Tribunal ("DT") appointed by the Singapore Medical Council ("SMC") in relation to certain alleged misconduct by Dr Chia. The DT found Dr Chia guilty and convicted her of one charge of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("MRA"). The DT imposed a punishment of three months' suspension from practice on Dr Chia.

2 The charge arose from a complaint lodged by the mother of one [A] ("the Patient"), a one year old patient of Dr Chia, in relation to Dr Chia's management of the Patient during his hospital admission from 25 February 2013 to 1 March 2013 and during a clinic review on 3 March 2013 ("the Relevant Period"). By

the time the Patient was admitted in hospital, he had already been suffering from high fever for three days and had displayed some symptoms of the incomplete variant of Kawasaki Disease ("Incomplete KD"). Dr Chia, however, did not conduct any supportive tests to rule out KD or Incomplete KD. It was only after the Patient's parents sought a second opinion from Dr Lee Bee Wah ("Dr Lee") that the Patient was recognised as having KD and was treated for it.

3 After hearing the parties' oral submissions on 27 February 2017, we reserved judgment. Having carefully considered the parties' submissions, we now dismiss the appeal and set out the detailed grounds for our decision.

The relevant factual background

4 On 25 February 2013, at or about 11.25pm, the Patient, who had just turned one year old, was admitted into the Accident & Emergency Department ("A&E") of Gleneagles Hospital ("GH") when Dr Chia was on call. The Patient had had a high fever for the previous three days (from 23 to 25 February 2013) with mild bilateral conjunctivitis, mild cough, a single episode of diarrhoea, poor intake, and vomiting. Dr Chia's diagnosis was that of a viral infection. She gave the Patient symptomatic supportive treatment using intravenous hydration.

5 On 26 February 2013, Dr Chia noted one spike of fever at 7am. She uncovered no major new findings on examination and Dr Chia observed that the Patient was better. She advised the Patient's parents to have the Patient stay for one more day for further observation. None of the particulars of the Charge relate to the events that happened on this day.

6 On 27 February 2013, the Patient had a spike of fever overnight, with slight cough and vomiting. He was fretful on examination, had red lips with scabs, but his conjunctivitis had improved. Features such as strawberry tongue,

oedema of peripheries, and lymphadenothy were absent. Dr Chia's diagnosis remained that of a viral infection. Later at night, a maculopapular rash was observed.

7 On 28 February 2013, the Patient had a spike of fever in the early morning, maculopapular rash appearing with red, and cracked lips. The conjunctivitis was also improving. Dr Chia specifically considered a differential diagnosis of KD and looked out for features of KD. She observed that there was no significant lymphadenothy and oedema of peripheries. Her clinical impression remained that of a viral infection as she noted there were "no full features of KD".

8 From 25 to 28 February 2013 (*ie*, throughout the time when the Patient was admitted in GH), the Patient's clinical chart revealed that the Patient displayed remitting fever with the spikes that were observed on 25, 26, and 28 February 2013.

9 On 1 March 2013, Dr Chia noted that the Patient's fever had settled. He had a mild cough and his lips were still slightly red and cracked. However, no rashes were seen and his eyes were better. Dr Chia's diagnosis remained that of a viral infection, with no evidence of KD. Because the Patient's temperature was on a downward trend, Dr Chia thought he would benefit with symptomatic treatment at home. She therefore discharged the Patient with an appointment two days later at her clinic ("the Clinic"). The DT was of the view that when the Patient was discharged on this day, his fever had not totally settled.

10 On 3 March 2013, Dr Chia reviewed the Patient at the Clinic. She recorded from the Patient's mother that the Patient had a fever during the two nights after discharge, but that he had been afebrile during the day. According

to Dr Chia, he was also afebrile on examination. His conjunctivitis and rashes had resolved and his lip condition had improved. Dr Chia's diagnosis remained that of a viral fever as she found that not all of the criteria for the diagnosis of KD were present. She sent the Patient home with a review scheduled on 5 March 2013.

11 On 4 March 2013, the Patient had a high fever of 39.3°C. His parents took him to see Dr Lee at Mount Elizabeth Hospital ("MEH") for a second opinion. Dr Lee, a Consultant Paediatrician, observed that clinically, the Patient was febrile and irritable. There was maculopapular rash on his upper trunk and mild redness of his palms and soles. He had a short systolic cardiac murmur at the apex. His cervical lymph nodes on the right were also slightly prominent. Dr Lee thus suspected a clinical diagnosis of KD, and conducted some supportive tests. A 2D Echocardiogram showed trivial mitral and tricuspid regurgitation and bilateral coronary dilation. The results of a C-reactive protein ("CRP") test were significantly raised. These confirmed that the Patient was suffering from KD. The Patient was therefore admitted into MEH from 4 to 6 March 2013 and treated with intravenous gamma globulin ("IVIG") and dose aspirin. He responded well to the treatment and the fever settled.

12 The Patient's mother subsequently filed a complaint against Dr Chia. On 14 November 2013, the SMC sent Dr Chia a Notice of Complaint. After reviewing the explanatory statements that were tendered by Dr Chia on 5 December 2013 in response to the Notice of Complaint and conducting its own investigations, the SMC informed Dr Chia on 26 September 2014 that the Complaints Committee had, after having reviewed the material, ordered that a formal inquiry be held by a DT. On 3 July 2015, the SMC sent Dr Chia a Notice of Inquiry, which set out the charge, which read as follows ("the Charge"):

Charges

1. That you [Dr Chia] are charged that, whilst practising as paediatrician on paediatric call at [GH] and having your registered place of practice at [the Clinic], you failed to exercise due care in the management of [the Patient], during the period of the Patient's hospital admission from 25 February 2013 to 1 March 2013 ("the Period of Hospitalisation") and during the clinic review on 3 March 2013 in that:-

Whereas you had attended to the Patient for the Period of Hospitalisation and during a clinic review on 3 March 2013, including when he presented with non-specific symptoms of fever of 3-day duration and was first admitted into the [A&E of GH] on 25 February 2013, and whereas [KD] is a common prolonged febrile illness seen in infants which may result in late occurrence of coronary artery dilation in 15 to 30% of patients, you acted in breach of sections 4.1.1.1 and 4.1.1.5 of the Singapore Medical Council Ethical Code and Ethical Guidelines in that you had:

Particulars

i. Failed to include [KD] as the foremost differential diagnosis despite observing and noting in your clinical notes that the Patient had bilateral conjunctivitis (commonly known as red eye) on 25 Feburary [*sic*] 2013 being Day 3 of the Patient's fever;

ii. Failed to include KD as a probable diagnosis despite observing and noting in your clinical notes that the Patient had maculopapular rash over the body on 27 February 2013 being Day 5 of the Patient's fever;

iii. Failed to make a diagnosis of "Incomplete [KD]" for the Patient on 28 Feburary [*sic*] 2013 being Day 6 of the Patient's fever;

iv. Failed to take active steps to discuss treatment options for the Patient of standard therapy with Intravenous Immunoglobin and Asprin with the Patient's parents such that they were able to make an informed treatment choice and consequently, failed to provide active treatment for KD on 1 March 2013 being Day 7 of the Patient's fever;

v. Discharged the Patient on 1 March 2013 being Day 7 of the Patient's fever with a diagnosis of Viral Fever and failed to consider [KD] as a possible diagnosis and consequently, failed to (a) address the possibility of [KD] with the Patient's parents, (b) advise the Patient's parents on the signs of [KD] to look out for upon discharge, and (c) devise a follow up plan for the treatment of the Patient for [KD]; and

> vi. Failed to seriously consider a diagnosis of [KD] and consequently, failed to provide appropriate treatment for the Patient on 3 March 2013 being Day 9 of the Patient's fever when the Patient attended [the Clinic] for a review;
>
> thereby resulting in a late diagnosis of [KD] by another paediatrician, [Dr Lee] on 4 March 2013 being Day 10 of the Patient's fever and exposing the Patient to probable serious consequences which may arise in the absence of appropriate and/or timely treatment including increasing the risk of coronary aneurysm and cardiac morbidity;
>
> 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 have been guilty of professional misconduct under Section 53(1)(d) of the [MRA].

The DT's Decision

13 The DT first dealt with a preliminary objection raised by Counsel for Dr Chia that the Charge was defective and ambiguous in that it did not set out a "clear and precise" offence for Dr Chia to address. The DT disagreed with this objection and held that the Charge was sufficiently detailed and clear. This issue was not pursued on appeal before us.

14 The DT noted that both parties' experts agreed that the diagnosis of KD is "not straightforward" and that Dr Chia was "not to be judged with the benefit of hindsight". Nonetheless, "considering that KD is the most commonly acquired cardiac condition in children under five years of age and given the serious implications of significant cardiac morbidity seen in KD", the DT held that it should be "reasonably expected of a paediatrician to be able to diagnose KD competently and to provide the treatment effectively", especially one with Dr Chia's experience (of 23 years in practice) and credentials.

15 The DT agreed with both experts that Dr Chia "could not be faulted" for not including KD as a differential diagnosis on 25 February 2013, the first day the Patient was admitted into GH.

16 However, the DT "seriously doubted if [Dr Chia] had truly appreciated or indeed considered a diagnosis of Incomplete KD". The DT explained that by 27 February 2013, when maculopapular rash appeared all over the Patient's body and when the Patient would already have had five days of fever with the diagnostic features of conjunctivitis, red lips, and rash, it was clear that Dr Chia "did consider KD and was looking out for other signs of KD". But on 28 February 2013, Dr Chia again documented that there were "no full features of Kawasaki" when "quite clearly a diagnosis of Incomplete KD should be seriously considered". Even on 1 March 2013, being day 7 of the Patient's fever, and with the presentation of clinical evidence of KD, Dr Chia again noted there was no evidence of KD.

17 The DT added that considering that the diagnosis of viral fever and KD are two very different diagnoses and are totally different disease entities, and given the very significant coronary artery complications associated with KD as opposed to a self-limiting viral fever, one would "reasonably expect a competent physician to either exclude the differential diagnosis or to confirm it" through the use of supportive tests such as "[Erythrocyte Sedimentation Rate ("ESR") and CRP, and 2D Echocardiogram". Dr Chia's failure to do so "amounted to a serious negligence on [her] part". The DT "could not accept the reasons for [Dr Chia] relying on her 'hunch' and not conducting the supportive tests". Nor did it think that the imposing of such a standard would result in "defensive medicine".

18 The DT agreed with the SMC's expert witness, Associate Professor Chao Sing Ming ("A/Prof Chao"), that the Patient's fever "did not totally settle" when he was discharged on 1 March 2013 with a diagnosis of viral fever. By discharging the Patient on 1 March 2013 without adequately addressing the possibility of KD and without any advice or discussion about KD, Dr Chia "clearly fell short of the reasonable standard of due care and attention expected of her". This "clearly amounted to serious negligence".

19 When the Patient visited Dr Chia 3 March 2013 at the Clinic, Dr Chia "again did not see it fit to conduct any tests or investigations to rule out KD and repeated her diagnosis of viral fever" despite the Patient's prolonged fever. It agreed with A/Prof Chao that such conduct was "wholly unacceptable".

20 After considering the evidence adduced in the inquiry, the DT found that Dr Chia's management of the Patient amounted to "such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as medical practitioner within the second limb of the test laid down in *Low Cze Hong v Singapore Medical Council* [[2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [37]]". The DT therefore found Dr Chia guilty of the Charge.

21 The DT concluded that an order of suspension for a period of three months was warranted to maintain the highest professional standards expected of medical professionals. The following factors were taken into account:

(a) Dr Chia's unblemished record of medical practice, the fact that she was a first offender, and the many testimonials and character references of her good character and contributions to the community;

(b) Dr Chia's conduct fell on the "lower side of culpability" in view of the fact that the diagnosis of KD could be challenging and that she

did not intentionally or deliberately depart from the standards observed or approved by members of the profession of good repute and competency;

(c) Although Dr Chia's expert, Associate Professor Quek Swee Chye ("A/Prof Quek"), opined that the Patient's outcome and long-term prognosis was excellent, this was not a mitigating factor that Dr Chia could claim credit for. The timely intervention by Dr Lee was purely fortuitous.

(d) Dr Chia faced only a single charge;

(e) The nature of the disease entity in question, the potential harm and the potentially life threatening illness which could inflict the Patient;

(f) There were "several aggravating factors":

(i) The Patient, who was barely one year old, suffered prolonged fever and presented clinical features of KD during the early period of hospitalisation and under Dr Chia's care and management. Yet, she did not see it fit to conduct any tests and investigations to either exclude the diagnosis or confirm it.

(ii) There were at least three occasions of serious lapses on Dr Chia's part: first, on either 27 or 28 February 2013; second, when Dr Chia discharged the Patient on 1 March 2013; and third, on 3 March 2013 when the Patient was reviewed at the Clinic.

(iii) The preponderance of the cases cited were dealt with by way of suspension instead of a fine. In the limited cases where a fine was imposed, these cases were unhelpful as they were somewhat dated and were not directly on point.

22 Accordingly, the DT ordered that Dr Chia:

(a) Be suspended from medical practice for three months ("the Suspension order");

(b) Be censured;

(c) Give a written undertaking to the SMC that she would not engage in the conduct complained of and or any similar conduct; and

(d) Pay the cost and expenses of and incidental to the proceedings, including the costs of the solicitors of the SMC.

The parties' submissions

Dr Chia's submissions

23 Dr Chia submitted that the DT erred in finding that she ought to have diagnosed Incomplete KD and/or ordered supportive tests.

24 Dr Chia took the view that the DT failed to articulate what the applicable standard of care was and why she Chia had breached the standard of care. It therefore erred in concluding that she had committed professional misconduct by failing to diagnose Incomplete KD and/or ordering supportive tests.

25 Dr Chia argued that, based on the medical literature and expert evidence, the applicable standard of care required of a physician is to exercise reasonable clinical judgment in ascertaining after a full assessment of the patient's characteristics *and* after an exclusion of other differential diagnoses, whether there is a high enough degree of suspicion of Incomplete KD to warrant the ordering of supportive tests. In this regard, Dr Chia relied heavily on Jane W Newburger *et al*, "Diagnosis, Treatment, and Long-Term Management of

Kawasaki Disease" American Heart Association 2004; 110:2747-2771 ("AHA Scientific Statement"), which the DT, A/Prof Quek, and A/Prof Chao also recognised as reflecting a standard for diagnosis of Incomplete KD.

26 Dr Chia further argued that her exercise of clinical judgment was reasonable (*ie*, it was reasonable for her to have maintained a primary diagnosis of viral infection and to have chosen not to order supportive tests). This was so for four reasons. First, her primary diagnosis of viral fever was consistent with her holistic assessment of the Patient's characteristics (including, at most three non-specific clinical features of KD on 28 February 2013, namely rash, red lips, and conjunctivitis). It was also not contradicted by the laboratory results (the Patient's blood test results were consistent with a viral picture and his urinalysis showed pyuria which was possible in viral fevers). Second, the Patient had a slight cough and no extreme irritability, which were characteristics inconsistent with a clinical presentation of KD. Third, KD mimics other disease processes including viral infections, the latter being a much more common and leading cause of fever in children. Fourth, the Patient presented improving signs following the symptomatic treatment of viral infection. By 3 March 2013, the only clinical feature consistent with KD was red lips, and this was resolving.

27 Dr Chia submitted that if the court finds that it was reasonable not to seriously consider KD or Incomplete KD as a diagnosis, then it would not have been necessary for Dr Chia to inform the Patient's parents about the possibility of KD or KD treatment plans, or advise on looking out for signs of KD upon discharge. Otherwise, she would have alarmed or agitated the Patient's parents.

28 In the alternative, Dr Chia submitted that even if her conduct amounted to a breach of the standard of care, it did not amount to gross negligence, which is a "high threshold" to cross (Sin*gapore Medical Council v Wong Him Choon*

[2016] 4 SLR 1086 ("*Wong Him Choon*") at [50]). She argued that her conduct was but a mere error in clinical judgment for an evolving disease which has no known diagnostic test or diagnostic clinical feature. Further, she had not displayed a "serious disregard or persistent failure to meet [the] standards" imposed by the SMC Ethical Code and Ethical Guidelines (January 2002) ("the SMC Ethical Code") (*Low Cze Hong* at [37]). It is not disputed that the necessary IVIG treatment had in fact been initiated within the first 10 days of fever, albeit by Dr Lee.

29 Finally, Dr Chia submitted that a three-month suspension was manifestly excessive. She argued that there were no aggravating factors in her case, and suspension orders were more suitable for cases where there was a conviction on more than one charge of misconduct and where the facts or conduct involved were more egregious. In comparable precedents, fines were given without suspension orders. The DT had also found that Dr Chia's "conduct fell on the lower side of culpability", which should be considered a mitigating circumstance.

SMC's submissions

30 The SMC submitted that the DT was correct in finding that Dr Chia should have ordered supportive tests to verify the Patient's symptoms. This entailed taking all reasonable steps to verify or disprove that diagnosis. The SMC submitted that a doctor had to have a high index of suspicion for KD. According to the AHA Scientific Statement, supportive tests therefore had to be ordered once a patient exhibited symptoms consistent with Incomplete KD. Dr Chia's suggestion that a supportive test should be ordered only after a set of criteria has been fulfilled defeats the whole point of having a supportive test in the first place.

31 The SMC further submitted that although the DT did not articulate the standard for gross negligence, its finding of gross negligence was based on Dr Chia's wilful blindness to the signs of the Patient's symptoms and her subsequent refusal to verify them. According to the SMC, Dr Chia's wilful blindness rose to the level of gross negligence because it displayed a lack of concern for the Patient's welfare. It also showed that contrary to section 4.1.1.1 of the SMC Ethical Code, Dr Chia did not adequately assess the Patient's condition at all. Dr Chia's failure to alert the Patient's parents to the possibility of KD was a further sign of her wilful blindness.

32 Finally, the SMC submitted that the three months' suspension was well within the reasonable range of sanctions that the DT could have imposed. The relevant precedents show that a suspension term is justified for the type of professional misconduct that Dr Chia was convicted of (see for example, the case of Dr Teh Tze Chen Kevin). There were also several aggravating factors that justified the suspension order. First, Dr Chia had failed to conduct any tests despite having considered a differential diagnosis of two very different disease entities (*ie*, fever and KD). Second, there were at least three occasions of serious lapses by Dr Chia (see above at [21(f)(ii)]). Third, paediatricians play the crucial role of ensuring the most vulnerable segments of society are protected from harm and provided with adequate care when the need arises. Finally, Dr Chia did not display any remorse and maintained that it was right of her not to have ordered supportive tests despite the clear signs of Incomplete KD.

The role of the court in hearing appeals from decisions of the SMC

33 Section 55(1) of the MRA allows a registered medical practitioner or the SMC to appeal to the High Court against the decision of a DT appointed by the SMC.

34 In considering an appeal, a court will be slow to interfere with the findings of the DT unless the grounds in s 55(11) of the MRA are satisfied:

> In any appeal to the High Court against a decision referred to in Section 53(2), (4) or (5) or 54, the High Court shall accept as final and conclusive *any finding* of the Disciplinary Tribunal *relating to any issue of medical ethics or standards of professional conduct* unless such finding is in the opinion of the High Court *unsafe, unreasonable or contrary to the evidence.* [emphasis added]

35 The court would likewise be slow to overturn an order made by a DT unless it is unsafe, unreasonable, or contrary to evidence. This court in *Low Cze Hong* at [40] has accepted the approach adopted by Lord Hailsham of St Marylebone LC in *Julius Libman v General Medical Council* [1972] AC 217 (see also *Tan Sek Ho v Singapore Dental Board* [1999] 2 SLR(R) 70 and *Chia Yang Pong v Singapore Medical Council* [2004] 3 SLR(R) 151). Lord Hailsham explained (at 221) that it would be "difficult for an appellant to displace a finding or an order of a [DT]":

> … unless it can be shown that something was clearly wrong either (i) in the conduct of the trial or (ii) in the legal principles applied or (iii) unless it can be shown that the findings of the committee were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread.

36 This court has also stated in *Low Cze Hong* at [42] that whilst deference would be paid to the views of the DT, it will not give undue deference in a way which will effectively render nugatory the appellate powers granted by s 55(11) of the MRA. Nevertheless, where all material evidence has been placed before the DT and it has given due consideration to the relevant factors, the court should place weight on the expertise brought to bear by the members of the DT in evaluating how best the needs of the public and the profession should be protected (*Council for the Regulation of Health Care Professionals v General*

Medical Council and Ruscillo [2005] 1 WLR 717 at [78], cited with approval in *Low Cze Hong* at [42]).

37 With these considerations in mind, we now turn to address the issues that arise in the present appeal.

The issues

38 The central question before this court is whether the DT's decision on the following matters is "unsafe, unreasonable or contrary to the evidence" (*Low Cze Hong* at [39]–[40]):

(a) The DT's finding that Dr Chia's failure to diagnose KD or Incomplete KD and/or order supportive tests to verify the symptoms amounted to a breach of the standard of care reasonably expected of a paediatrician;

(b) The DT's finding that Dr Chia's failure to discuss or advise the Patient's parents about the possibility of the Patient being infected by KD amounted to a breach of the standard of care reasonably expected of a paediatrician;

(c) The DT's finding that Dr Chia's breaches as set out at (a) and (b) above amounted to professional misconduct by reason of gross negligence (*ie*, the second limb in *Low Cze Hong*); and

(d) The DT's decision to impose a three-month suspension on Dr Chia.

Our decision

39 Having regard to all the evidence which was before the DT, in our view, the DT's decision to convict Dr Chia of professional misconduct and to impose the Suspension order is not unsafe, unreasonable, or contrary to evidence.

40 Before proceeding with our substantive analysis of the issues, it would be appropriate to set out the facts pertaining to Incomplete KD and KD, which are not in dispute, and which provide the necessary context for the examination of the issues raised in the present appeal.

Incomplete KD and KD

41 KD is an acute, self-limited vasculitis that occurs predominantly in young children below the age of five. There is no specific diagnostic or confirmatory diagnostic test for KD. KD is diagnosed clinically based on the presence of a persistent fever for five days or more, together with four or more of the five principal clinical features:

(a) Changes in the extremities, including erythema of the palms and soles; edema of the hands or feet; and peringual peeling of the fingers and toes within two to three weeks after the onset of fever;

(b) Polymorphous exanthema (rash);

(c) Bilateral bulbar conjunctival infection without exudate;

(d) Changes in the lips and oral cavity including erythema, cracked lips, a strawberry tongue, and diffuse injection of oral and pharyngeal mucosae; and

(e) Cervical lymphadenopathy (>1.5cm in diameter).

42 Children less than one year old and adolescents often present incomplete features of KD (*ie*, Incomplete KD). Incomplete KD and "classical" KD are the same type of disease, and the same diagnostic treatment protocols apply to both. Incomplete KD occurs when a patient diagnosed does not fulfil the classical diagnostic criteria mentioned in [41] above. These patients present fever and two or three of the classical signs, which may not all be present at the same time.

43 The fever that is symptomatic of KD or Incomplete KD is typically high spiking and remittent, with peak temperatures generally above 39°C. However, the fever is also self-resolving, and persists for a mean of 11 days.

44 Although there is no specific diagnostic or confirmatory diagnostic test for KD, supportive tests can be ordered. These tests provide supportive evidence of KD or Incomplete KD if the disease is indeed present. Such tests include tests for acute inflammatory markers such as ESR and CRP, and a 2D Echocardiogram. They are non-invasive and non-prohibitive methods that can be used to exclude KD or Incomplete KD.

45 KD and Incomplete KD, if left untreated, can lead to very significant coronary artery complications. According to the AHA Scientific Statement, coronary aneurysms or ectasia develop in approximately 15–25% of untreated children with the disease and may lead to myocardial infarction, sudden death, or ischemic heart disease.

The standard of care and breach thereof

46 Contrary to Dr Chia's submission, the DT did set out the applicable standard of care in its decision, namely, that paediatricians are required to maintain a "high index of suspicion when [a patient] presented with features of KD". This entails ordering supportive tests once a patient presents with

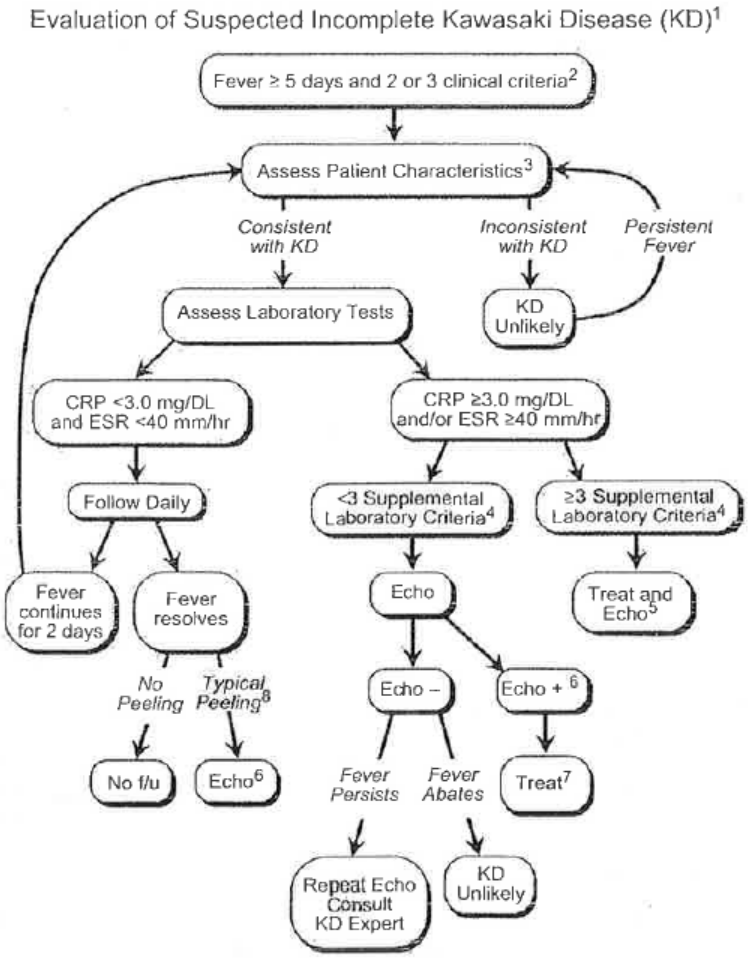
persistent fever for more than five days and has been assessed to have at least two of the classical characteristics of KD. We would reiterate that the reason why paediatricians are expected to maintain a high index of suspicion is due to the possible dire consequences if no timely proper treatment is given for KD. Having failed to order the supportive tests, Dr Chia was therefore in breach of the applicable standard of care. We find that the DT's decision in this respect was not unsafe, unreasonable, or contrary to the evidence.

47 Although the DT did not expressly state that it was setting out the applicable standard of care in determining the lapse on the part of Dr Chia, that is clear from [37] of its decision where it stated that "[g]iven the clinical presentations of the Patient and the significant risks of adverse and severe consequences resulting from delayed or missed diagnosis of KD, it would be reasonably expected of [Dr Chia] to order [supportive] tests during the course of the Patient's hospitalisation in [GH]". The DT had also clearly adopted the standards set by the AHA Scientific Statement as seen from [13] of its decision. The present case can be distinguished from that of *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San Lawrence*"), in which the High Court held at [44]–[45] that the DT's finding that a medical practitioner "ought to take into account all these considerations and then manage the patient with good clinical practice safely … to achieve the best outcome" was not articulated as the relevant standard of conduct.

48 The AHA Scientific Statement, which both parties and the DT rely upon, sets out the applicable standard of care as described in [46]. It states that "[KD] should be considered in the differential diagnosis of a young child with unexplained fever for $\geq$ 5 days that is associated with any of the principal clinical features of this disease". Incomplete KD, on the other hand, "should be

considered in all children in whom such fever takes place for ≥ 5 days and is associated with 2 or 3 of the principal clinical features of [KD]".

49 The AHA Scientific Statement provides an algorithm for an "Evaluation of Suspected Incomplete Kawasaki Disease" ("Figure 1"). Figure 1 of the AHA Scientific Statement (on which both parties rely) shows that once characteristics "[c]onsistent with KD" appear, supportive tests should be conducted. We reproduce Figure 1 here:



50 Although the difficulties of diagnosing KD and Incomplete KD are well-established, KD and Incomplete KD are also "being diagnosed with increased frequency" (Maurice Levy and Gideon Koren, "Atypical Kawasaki disease" Paediatric Infectious Disease Journal 1990; 9(2): 122-126). According to the AHA Scientific Statement, "[I]ncomplete [KD] is more common in young infants than in older children, making accurate diagnosis and timely treatment especially important in these young patients who are at substantial risk of developing coronary abnormalities". It adds that "[t]herefore, although laboratory findings in [KD] are nondiagnostic, they may prove useful in heightening or reducing the suspicion of incomplete [KD]". Further, children less than one year old and adolescents often present incomplete features of KD. It would therefore be reasonable to expect doctors, especially paediatricians, to have a heightened awareness of the possibility of such cases occurring and for them to order supportive tests once two or three of the principal clinical features of the disease appear. This is the applicable standard of care, which Dr Chia breached when she failed to conduct the supportive tests by 28 February 2013 when the Patient presented six days of fever and more than two principal clinical features of KD (namely, maculopapular rash, bilateral conjunctivitis, and red and cracked lips).

51 Dr Chia argued that it was reasonable for her not to have ordered the supportive tests because the Patient presented slight cough throughout the Relevant Period, a symptom that appeared to be more consistent with a viral fever. Dr Chia also highlighted during oral submissions that the Patient's white blood cell count was elevated, which is more consistent with an infection. On 27 February 2013, for instance, the Patient's urinalysis laboratory report reflected a spike in the Patient's white blood cell count to 144, which is significantly beyond the normal range of 0 to 6.

52 In our view, it is entirely possible that the Patient could have been suffering from *both* Incomplete KD and viral fever. Dr Chia accepted during oral submissions that a high white blood cell count is not inconsistent with KD or Incomplete KD. We find that because the Patient also displayed other symptoms that were consistent with Incomplete KD, Dr Chia had the duty of conducting the supportive tests to exclude the disease. According to the AHA Scientific Statement, given the potential seriousness of the complications, together with the efficacy and safety of early treatment, high sensitivity of the treatment criteria is more important than high specificity.

53 Although Dr Chia testified that she had considered Incomplete KD as a possible diagnosis, we find, as the DT did, that Dr Chia had failed to seriously consider or even appreciate the possibility of Incomplete KD throughout the Relevant Period. By 28 February 2013, the Patient had presented more than five days of persistent and remitting fever, as well as more than two of the five classical features of KD. According to the AHA Scientific Statement, it is not necessary and it is in fact typical that all of the clinical features of KD are not present at a single point in time. Yet, as the DT noted, on 28 February 2013, Dr Chia documented that there were "no full features of [KD]" when quite clearly a diagnosis of Incomplete KD should have been considered. The evidence thus suggested that Dr Chia was unduly fixated on her diagnosis of viral fever. She had therefore failed to consider a diagnosis of Incomplete KD even though its symptoms were clearly present.

54 Dr Chia relied also on the AHA Scientific Statement in arguing that "other diseases with similar diagnoses should be excluded" before supportive tests need to be carried out. The AHA Scientific Statement, however, does not support such a proposition. In fact, the statement "other diseases with similar diagnoses should be excluded" appears in the "Diagnosis" section of the AHA

Scientific Statement. In other words, that statement only goes so far as to suggest that in order to *diagnose* KD, "other diseases with similar diagnoses should be excluded". It is indeed logical to say that tests should be conducted to exclude other diseases in order to *diagnose* KD. But it cannot be said that it is only when such other diseases are excluded that a doctor should *order* supportive tests. We agree with the SMC that this would defeat the whole purpose of the nature of supportive tests, which is to aid in the diagnosis of a disease. This is especially the case given the need for "accurate" and "timely treatment" of KD, a disease which can have debilitating consequences for infants.

55 We note Dr Chia's argument that following the case of *Ang Pek San Lawrence*, the DT's decision should be set aside because it failed to articulate its reasons for preferring A/Prof Chao's views over A/Prof Quek's views about Dr Chia's management of the Patient. We disagree that the DT had failed to do so. In *Ang Pek San Lawrence*, the High Court stated at [84] that "[w]hen there is a conflict in medical opinion, the preference of one body of opinion over another should not only be stated, but also explained". While the DT had recognised that A/Prof Quek was "knowledgeable and objective" and "open and balanced", it also stated that his view was "more sympathetic and charitable". This must have meant that his views on the standard of care and on Dr Chia's conduct were not sufficiently stringent. The same reasons which the DT used to explain why Dr Chia breached the standard of duty of care must necessarily apply to the DT's decision to reject A/Prof Quek's more sympathetic and charitable views of Dr Chia's conduct.

56 In view of the Patient's symptoms during the Relevant Period, we agree with the DT that the applicable standard of care would require Dr Chia to order the supportive tests to determine if Incomplete KD or KD could have been

excluded. We agree with the DT that Dr Chia should not have relied solely on her "hunch" to guide her decision on whether or not to order the supportive tests. Because she failed to order these tests on 28 February 2013, and even up till 3 March 2013, when she ought to, she was in breach of the applicable standard of care. This is especially given the severe consequences a late diagnosis could have for the Patient and the fact that non-invasive and non-prohibitive measures could have been taken to prevent such consequences. The logical conclusion is that Dr Chia also breached her duty to inform the Patient's parents about the possibility of Incomplete KD so that they could make an informed decision on treatment choice or to suggest a plan of management, including the ordering of supportive tests to rule out KD.

57 For these reasons, we hold that the DT's finding in relation to the applicable standard of care and Dr Chia's breach thereof is not unsafe, unreasonable, or contrary to the evidence.

Gross negligence

58 We also see no basis to disagree with the DT's finding that Dr Chia's conduct amounted to professional misconduct on the basis of gross negligence.

59 Although the DT did not expressly articulate the standard for gross negligence in its decision, it appears that its reasons for finding that Dr Chia had breached her standard of care apply equally from the DT's finding that she was grossly negligent. The DT explained at [37] of its decision that its finding that Dr Chia's failure to order supportive tests "amounted to serious negligence" was based on the "clinical presentations of the Patient" and "the significant risks of adverse and severe consequences resulting from delayed or missed diagnosis of KD". It also stated at [40] of its decision that Dr Chia had discharged the Patient even though his fever "did not totally settle" and she therefore "had not

adequately addressed the possibility of KD". Neither did she seek any "advice or discussion about KD". According to the DT, Dr Chia therefore "clearly fell short of the reasonable standard of due care and attention expected of her and this clearly amounted to serious negligence on [her] part".

60 In *Low Cze Hong*, the court stated at [32] that "misconduct" means "more than mere negligence". It added that "[g]ross negligence might amount to relevant misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient." Mere errors of judgment and professional incompetence are insufficient to lead to a finding of gross negligence (*Low Cze Hong* at [32]; *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 ("*Pillai v Messiter*") at 200).

61 Although the threshold to be crossed is "high" (*Wong Him Choon* at [50]), there is nothing on the facts to suggest that the DT's decision was unsafe, unreasonable, or contrary to evidence. While we recognise that the line between an error of judgment and gross negligence could in certain circumstances be fine and that an error of judgment does not*, ipso facto*, constitute professional misconduct, it is the entire picture which will be determinative. In our view, and here we agree with the DT, the following circumstances were critical and justified the conclusion of the DT that the line had been crossed in the present case:

(a) It is not disputed that the consequences of a delayed or missed diagnosis of KD can be severe. Neither is it disputed that KD and Incomplete KD are not uncommon among infants. These are two vitally important factors.

(b) The DT found that the Patient's fever "did not totally settle" when he was discharged on 1 March 2013. This means that the Patient

presented persistent fever throughout the Relevant Period. Yet, despite the presence of at least two characteristics of classical KD and remitting fever, Dr Chia fixed her eyes on viral fever as the diagnosis and failed to conduct a holistic assessment of the Patient's condition.

(c) As an "experienced paediatrician of 23 years' standing", Dr Chia was expected to be aware of the possibility of Incomplete KD. She was also expected to conduct the supportive tests to exclude the disease in view of the severe consequences a patient may face if she failed to do so in a timely manner.

(d) Dr Chia had multiple opportunities to rule out KD by ordering supportive tests (on 28 February, 1 and 3 March 2013). Yet, she failed to do so. Also, she did not seek the advice of her colleagues who were present at GH during the Relevant Period. Instead, she acted without any advice or discussion with the parents of the Patient on KD, relying only on her "hunch". The failure to order supportive tests on 28 February 2013 might be a mere lapse of judgment. But, as the DT noted, there were "at least three occasions of serious lapses on [Dr Chia's] part.

62 It may be argued that because KD tends to mimic characteristics of other sicknesses (such as viral fever), Dr Chia's failure to identify Incomplete KD as a possible diagnosis and to order supportive tests to rule it out, could be construed as a mere error in judgment as opposed to gross negligence. While we accept that such a view could be taken as of 28 February, or even 1 March 2013, this could not be so as of 3 March 2013 when the Patient visited Dr Chia at her Clinic with red lips and having had fever for the past two nights. When the available tests to exclude KD are simple to undertake and when the consequences of no timely treatment of KD could be severe, it is not for a doctor

to take chances with the well-being of a patient. If there was a need to take chances, that determination should be left for the patient (or his parents if the patient is an infant) to make on an informed basis. We struggle to understand why such exclusionary tests, which were not harmful to the Patient, were not undertaken, or why the parents of the Patient were not informed of their availability. It is here that Dr Chia badly faltered.

63 In any event, as the High Court noted in *Ang Pek San Lawrence* at [33], in the area of assessing expert evidence, as the DT is "a specialist tribunal with its own professional expertise and understands what the medical profession expects of its members", the High Court should be slow to overturn the findings of the DT (*Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 at [29]). For the aforementioned reasons, we see no reason to disturb the DT's finding that Dr Chia's conduct was sufficiently negligent so as to "attract the strong reprobation of professional brethren of good repute and competence" (*Pillai v Messiter* at 208; see also *Low Cze Hong* at [33]) and to "maintain the highest standards so as to protect the public and to preserve the reputation of the profession" (*Low Cze Hong* at [88]).

Punishment

64 We now turn to the issue of punishment. In order to determine whether the punishment imposed by the DT is appropriate, the court will need to consider whether the punishment imposed falls outside the reasonable range of sanctions available to the tribunal in the circumstances (see *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201, the Court of Three Judges (at [31]) citing with approval the observations of Leveson J in *Council for the Regulation of Health Care Professionals v General Medical Council* [2004] 1 WLR 2432 at [14]).

65 According to s 53(2)(*b*) of the MRA, the minimum period of suspension is three months. Section 53(2)(*e*) also provides the alternative of imposing a "penalty not exceeding $100,000". The DT found that Dr Chia's conduct fell on the lower end of culpability and imposed the shortest period of suspension allowed under the MRA.

66 In our view, the penalty imposed by the DT is within the acceptable range as established by precedents relied upon by both parties. We disagree with Dr Chia that a suspension would be more suitable only where there is a conviction on more than one charge of misconduct. In the case of Dr Amaldass s/o Narayana ("*Dr Amaldass s/o Narayana*"), for example, the medical practitioner was suspended after being convicted of one charge of professional misconduct. Likewise, in the case of Dr AAD ("*Dr AAD*"), a suspension of three months was imposed in relation to one charge of professional misconduct. This shows that there is no existing benchmark that a fine should be preferred over a term of suspension when a medical practitioner is convicted of one charge. Much will turn on the nature of the misconduct in question.

67 It also cannot be said that the punishment imposed by the DT fell outside the reasonable range. Dr Chia has argued that the doctor's conduct in *Dr Amaldass s/o Narayana* was more egregious than in the present case. This would indeed be the case since the doctor there "failed to uphold are the most basic and elementary of professional standards" (*Dr Amaldass s/o Narayana* at [17]). The doctor was accordingly punished more severely than Dr Chia; he was given four months' suspension and a fine of $5,000.

68 Dr Chia, however, has failed to explain how her misconduct is significantly less culpable that that of the doctors in *Dr AAD* or the cases of Dr Fong Wai Yin and Dr AAX. In all these cases, the doctors were also punished

with three months' suspension. Although they each faced more than one charge, they, unlike Dr Chia, pleaded guilty to the charges. Like the doctors in these precedents, Dr Chia faced a disease that was not uncommon. As a paediatrician of 23 years, Dr Chia should have been aware that KD or Incomplete KD was a disease that commonly plagued individuals like the Patient and could lead to severe consequences (even death) if not diagnosed in time. Yet, she failed to order supportive tests even though the Patient had presented characteristics consistent with Incomplete KD. She failed to do so on no less than three occasions (on 28 February, 1 and 3 March 2013) even though the Patient presented persistent fever throughout the time. Taking all these factors into account as well as the precedents, we find no reason to disturb the DT's imposition of a three months' suspension on Dr Chia.

Conclusion

69 For these reasons, we find no basis to conclude that the DT's finding of gross negligence and the sentence it imposed was unsafe, unreasonable, or contrary to evidence.

70 We pause to note, however, that we are not suggesting that Dr Chia was totally indifferent to the Patient's welfare. Before the discharge of the Patient on 1 March 2013, she did schedule two follow-up reviews for 3 and 5 March 2013, although the latter review did not take place. Dr Chia documented all the Patient's symptoms and ordered tests, such as a blood test and urinalysis, to assist in the diagnosis of the Patient's condition. However, it is crucial for a paediatrician to maintain a high index of suspicion in relation to KD. He or she must also remain updated as to the evolving nature of KD and the ways in which KD is likely to manifest in infants and young children. If she had kept an open mind and maintained a proper appreciation of the symptoms related to KD or

incomplete KD, and not been consumed by her own initial diagnosis of viral fever, she would not have failed to undertake the requisite tests to exclude KD. It was not simply an error of judgment but a serious oversight. It was entirely fortuitous that the mother of the Patient was worried due to the prolonged illness of her child and had the presence of mind to seek a second opinion from Dr Lee; otherwise one would dread to think what irreparable harm would have been caused to the Patient due to the further delay.

71 We accordingly dismiss the appeal. Dr Chia shall serve the three month suspension from such date as may be agreed with the SMC. Dr Chia shall bear the costs of these proceedings.

Chao Hick Tin	Andrew Phang Boon Leong	Judith Prakash
Judge of Appeal	Judge of Appeal	Judge of Appeal

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