IN THE COURT OF THREE JUDGES OF THE REPUBLIC OF SINGAPORE

[2017] SGHC 143

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 16 July 2016 under Section 53 of the Medical Registration Act (Cap 174, 2004 Rev Ed) against Dr Ang Peng Tiam

Originating Summons No 8 of 2016

Between

ANG PENG TIAM

… *Appellant*

And

SINGAPORE MEDICAL COUNCIL

… *Respondent*

And

Originating Summons No 9 of 2016

Between

SINGAPORE MEDICAL COUNCIL

… *Appellant*

And

ANG PENG TIAM

… Respondent

JUDGMENT

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

Ang Peng Tiam
v
Singapore Medical Council and another matter

[2017] SGHC 143

High Court — Originating Summonses Nos 8 and 9 of 2016
Sundaresh Menon CJ, Andrew Phang Boon Leong JA and Judith Prakash JA
13 February 2017

27 June 2017 Judgment reserved.

Sundaresh Menon CJ (delivering the judgment of the court):

Introduction

1 Dr Ang Peng Tiam is a medical oncologist in private practice. He was convicted by a Disciplinary Tribunal ("DT") appointed by the Singapore Medical Council ("SMC") of two charges of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed). The charges were first, that Dr Ang had made a false representation to his patient, one MT, who had been diagnosed with a variety of cancer, on the chances of her disease responding to his prescribed treatment of chemotherapy and targeted therapy; and second, that at the same time, he failed to offer her an alternative option of surgery. The DT imposed on Dr Ang an aggregate fine of $25,000 for both charges.

2 By Originating Summons No 8 of 2016, Dr Ang appeals against his conviction on both charges. By Originating Summons No 9 of 2016, the SMC appeals against the sentence meted out by the DT, on the basis that it is manifestly inadequate and ought to be substituted by an order suspending him from practice for a term of at least six months for each of the two charges.

Background

3 The factual circumstances surrounding the commission of the alleged misconduct are not in dispute.

4 MT, who was 55 years old, first consulted Dr Ang at his clinic at the Parkway Cancer Centre ("PCC") at Mount Elizabeth Hospital on 30 March 2010, following investigations at Tan Tock Seng Hospital. These investigations indicated that MT might be suffering from lung cancer. Dr Ang had MT undergo blood tests, as well as a Magnetic Resonance Imaging ("MRI") scan of the brain and a Positron Emission Tomography-Computed Tomography ("PET-CT") scan. He did not, however, order that MT undergo an epidermal growth factor receptor ("EGFR") analysis to determine her EGFR mutation status. As will shortly become evident, the EGFR mutation test was material to the issues before us.

5 On the following day, 31 March 2010, MT attended a consultation with Dr Ang again, this time to review the test results. Dr Ang explained to MT and her accompanying family members that the PET-CT scan showed "a large FDG avid mass in the upper lobe of [her] right lung with central areas of photopenic lucencies (necrosis)" that measured "up to 8 x 5.8 cm and demonstrate[d] SUVmax 12.9", as well as "[a] few small satellite nodules". FDG, or fluorodeoxyglucose, is a radioactive glucose that serves as a tracer in PET-CT imaging. The presence of an FDG avid mass in a PET-CT scan indicates the

presence of sugar-hungry, fast-growing cells, which is suggestive of cancer because these grow faster than normal cells. The maximum standardised uptake value ("SUVmax") is a semi-quantitative measure of FDG uptake and a value higher than five indicates the presence of an active and aggressive tumour. Central necrosis or, in simple terms, the presence of dead cells in the central area of a mass of cells, also indicates a fast-growing tumour because cells in the centre of a tumour are furthest from the blood supply and so tend to starve and die as the tumour grows. In plain language, the PET-CT scan suggested that MT had a large, fast-growing and aggressive tumour, as well as a few smaller growths (the "satellite nodules"), in her right lung. Dr Ang also explained to MT and her family that the MRI did not show any metastatic disease in her brain, and that MT would need to undergo a biopsy in order to confirm whether or not the mass was cancerous. This was done later that day.

6 MT and her family saw Dr Ang for the third time on 1 April 2010. At this consultation, Dr Ang informed them that the biopsy confirmed that MT was suffering from cancer, with the mass having been diagnosed as adenocarcinoma. He recommended that MT undergo chemotherapy using gemcitabine and cisplatin, together with targeted therapy using an alternate day dosage of gefitinib at 250mg per dose. Gefitinib is a tyrosine kinase inhibitor ("TKI") and goes by the brand name Iressa. MT's husband, who was present at the consultation, recorded part of Dr Ang's explanation to MT and her family, which was conveyed in Mandarin and has been translated as follows:

> Thirdly, we like that she does not smoke. Never had she smoked before…this is what we term as never smoker. Fourthly, we like this cell called 'Adenocarcinoma'. These four you have. As such, we will start your treatment today. We…calculate…difficult to say but I feel that there is at least a 70% chance that the tumour will shrink. We should let it shrink before we do other…70% is a very high percentage. If you want to go to the casino, no one will let you in right? You have 70% chance, there is a high chance that it will lose to you. So I suggest that I will start your

> treatment today. We will use this medicine. I think that your hair should not fall that much.

The contents of the recording, as translated, are not disputed.

7 The foregoing facts gave rise to the first charge against Dr Ang. In the Agreed Statement of Facts put before the DT, Dr Ang and the SMC agreed that following his explanation to MT and her family on 1 April 2010 (a part of which has been set out above), Dr Ang had informed MT that "there was at least a '70% chance' that [her] disease would respond to treatment and achieve control" with his prescribed therapy of "chemotherapy and/or targeted therapy", and that such assessment was premised on MT (a) being Chinese; (b) being female; (c) being a "never-smoker"; and (d) having a tumour diagnosed as adenocarcinoma ("the four phenotypes").

8 Dr Ang listed the four phenotypes on a memo for MT and her family. On the memo below the four phenotypes, Dr Ang also wrote "70%" and drew a circle around it. Below that, he drew another two circles, one bigger than the other, and an arrow pointing from the bigger of the two circles to the smaller one. By that, Dr Ang intended to indicate a large tumour that was expected to shrink.

9 MT underwent the treatment prescribed by Dr Ang. Unfortunately, her disease did not respond well to it. It progressed and she passed away a little more than six months later in October 2010.

10 On 15 December 2010, MT's two daughters jointly lodged a complaint ("the Complaint") to the SMC in respect of Dr Ang's treatment of MT. About half a year later, on 27 June 2011, the SMC's Complaints Committee ("CC") wrote to Dr Ang notifying him of the Complaint and requesting his written

explanation. Dr Ang provided his explanation on 19 July 2011 ("the Explanation"); but it was not till 2 May 2012, almost another year later, that he received a letter from the CC notifying him of its decision to refer the matter to a formal inquiry. It took the SMC a further one and a half years to constitute a DT in late 2013. Further delays ensued, due to events such as the resignation of some members of the original DT. A second DT was eventually constituted on 3 April 2015. A Notice of Inquiry ("NOI") specifying the charges of professional misconduct was served on Dr Ang on 22 April 2015. By then, nearly four and a half years had passed since the Complaint was lodged. The inquiry before the DT eventually took place in two tranches between November 2015 and February 2016. The DT delivered its verdict on conviction and sentence on 12 July 2016. This was more than five and a half years after the Complaint was lodged.

The DT's decision

11 The SMC brought four charges against Dr Ang. The DT convicted Dr Ang on two of the charges, but acquitted him on the remaining two. No appeal has been filed against the DT's decision to acquit Dr Ang of the two charges.

12 The two charges on which Dr Ang was convicted are reproduced below:

> The 1st Charge
>
> That you, DR ANG PENG TIAM, a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Parkway Cancer Centre ("PCC"), you did on 1 April 2010 make a false representation to your patient, one [MT] ("the Patient"), who was suffering from lung cancer, that there was a "70% chance" of the disease responding to treatment and achieving control with chemotherapy and/or targeted therapy.
>
> **Particulars**
>
> (a) On 1 April 2010, the Patient attended a consultation with you at PCC ("the Consultation").

(b) In the course of the Consultation, you informed the Patient that there was a "70% chance" of the disease responding to treatment and achieving control with chemotherapy and/or targeted therapy ("the Statement").

(c) You informed the Patient that the Statement was premised on the following 4 factors:-

(i) That the Patient was of the Chinese race;

(ii) That the Patient was female;

(iii) That the Patient was a "never-smoker"; and

(iv) That the Patient had adenocarcinoma.

(d) The Statement was false as a 70% disease control rate is only achievable in patients who have epidermal growth factor receptor ("EGFR") mutation.

(e) You failed to carry out any EGFR analysis to ascertain the Patient's EGFR mutation status.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174) (2004 Ed.)

The 2nd Charge

That you, DR ANG PENG TIAM, a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Parkway Cancer Centre ("PCC"), on or about 1 April 2010, you failed to offer your patient, one [MT] ("the Patient"), who was suffering from cT3 N0 M0 (stage IIB) lung cancer, the treatment option of surgery.

Particulars

(a) On 1 April 2010, the Patient attended a consultation with you a PCC ("the Consultation").

(b) You failed to inform the Patient of an alternative treatment option of surgery.

(c) Surgery is a viable treatment option that ought to have been presented to the Patient.

and that in relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)*(d)* of the Medical Registration Act (Cap. 174) (2004 Ed.)

13 In relation to both charges, the SMC proceeded under the first limb of professional misconduct laid down in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*"), namely that the alleged misconduct constituted an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competence.

Decision on the 1st Charge

14 Dr Ang did not deny that he had indicated that there was at least a 70% chance that MT's cancer would respond to treatment and achieve control with chemotherapy and targeted therapy, because of the four phenotypes that she presented ("the Statement"). The DT considered that the meaning of the Statement was to be determined objectively bearing in mind the audience to whom it was directed and the relevant context and surrounding circumstances when it was made. On this basis, the DT concluded that a reasonable lay person in the position of MT and her family at that time would have understood the Statement to mean that there was at least a 70% chance that the cancer would *shrink* and be brought under control.

15 The DT then considered whether the Statement was false and found that it was. It also found that Dr Ang had no reasonable basis for making the Statement believing it to be true. In coming to this conclusion, the DT relied on a study that had been cited by the SMC, Tony Mok *et al*, "Gefitinib or Carboplatin-Paclitaxel in Pulmonary Adenocarcinoma", N ENGL J MED 361:10 ("the Mok Paper"), which was published in September 2009. In that study, patients with some of the four phenotypes (being Asians, never smokers or former light smokers, and having adenocarcinoma) were treated with gefitinib. The results showed a dramatic difference in the favourable response

rate to this treatment regime between those who were EGFR mutation positive who reported a 71.2% response rate, and those without the EGFR mutation who reported a favourable response rate of only 1.1%. Turning to the facts of the present case, the DT noted that MT's EGFR mutation status was unknown because Dr Ang had not tested her for this.

16 The DT further relied on the evidence of SMC's expert witnesses Dr Tan Yew Oo and Dr Eric Lim. Dr Tan Yew Oo, a Consultant Medical Oncologist and Hematologist at the Medical Oncology Centre in Gleneagles Hospital and Mount Alvernia Hospital, opined that Dr Ang's statement that there was a "70%" chance that the tumour would shrink would have been fair *if* MT was EGFR mutation positive. This was based on the academic literature suggesting that patients with such mutations have a much higher chance of responding positively to TKIs such as gefitinib. He considered that Dr Ang should have ordered an EGFR mutation test for MT, and found it "curious" that he did not do so. Dr Eric Lim, who was Consultant Thoracic Surgeon at The Royal Brompton Hospital in England, expressed similar views, and observed further that the failure to order an EGFR mutation test for MT could be an "important omission". The DT noted that although EGFR mutation testing was not a mandatory procedure as at 1 April 2010, the test was available and Dr Ang could have ordered it at the time he prescribed various tests and investigations to arrive at a diagnosis and a treatment plan for her.

17 The DT also rejected the submission advanced by counsel for Dr Ang, Mr Edwin Tong SC, that it was reasonable to think, based on other academic literature that was available at that time, that a disease control rate of 70% could be achieved with chemotherapy alone. While several studies were cited to support this, the DT preferred the evidence of Dr Tan Yew Oo, who said that the papers cited by Dr Ang were from the early-1990s and the chemotherapy

drugs that were the subject of those studies had "never stood the test of time to come out to be the standard of care to today's practice". According to Dr Tan Yew Oo, based on the publications released from the mid-2000 onwards, the average response rate for chemotherapy using cisplatin and gemcitabine (being the chemotherapy drugs that Dr Ang prescribed for MT) was "somewhere in the region of 40 per cent to 50 per cent… [a]t most…up to 55 percent, but very rarely…to 70-odd percent". In addition, the DT noted that there was *no* medical literature to support the use of the four phenotypes to evaluate a patient's prospective response to chemotherapy, and accepted the SMC's submission that the four phenotypes *were only relevant* in the context of targeted therapy using TKIs such as gefitinib and in that regard, the literature suggested very significant differences in disease outcomes depending on the patient's EGFR mutation status.

18 The DT therefore concluded that without the results of an EGFR mutation test, Dr Ang had no reasonable basis for making the Statement that there was at least a 70% chance that MT's cancer would respond to treatment and achieve control with chemotherapy and targeted therapy. That was a false representation, and by it, Dr Ang had held out false hope to MT and her family.

19 In addition, the DT found that by making the Statement, Dr Ang departed from the standards observed or approved by members of the medical profession of good repute and competency. According to the DT, the relevant standards were those set out in Guidelines 4.1.1.1 and 4.1.1.5 of the Singapore Ethical Code and Ethical Guidelines ("the Ethical Code"), which provide as follows:

> 4.1.1.1 Adequate clinical evaluation of patients
>
> A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate

> assessment of a patient's condition through good history taking and appropriate clinical examination.
>
> If treatment is suggested or offered to a patient without such personal evaluation, the doctor must satisfy himself that he has sufficient information available and that the patient's best interest is being served. Such information could be transmitted by voice, electronic or other means by a referring doctor…
>
> 4.1.1.5 Duty of care
>
> A doctor shall provide competent, compassionate and appropriate care to his patient. This includes making necessary and timely visits, arranging appropriate and timely investigations and ensuring that results of tests are communicated to the patient and the most appropriate management is expeditiously provided.

The DT was of the view that Dr Ang's departure from these standards were intentional and deliberate, citing our decision in *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 ("*Susan Lim*"), where the medical practitioner was found to have falsely represented the fees of third party doctors in her bills to her patient and to have intentionally and deliberately departed from the standards applicable in that case. This brought Dr Ang within the first limb of professional misconduct as laid down in *Low Cze Hong*.

20 Accordingly, the DT found Dr Ang guilty of the 1st Charge.

Decision on the 2nd Charge

21 Before the DT, one of the key issues in dispute was whether Dr Ang had offered or at least mentioned the option of surgery to MT and her family at the consultation on 1 April 2010. Dr Ang's case was that while he did not offer surgery as an option for MT, he did mention it to her and her family, told them why he did not think surgery was a good option, and accordingly guided them away from it. Dr Ang conceded that he did not advise MT to seek the opinion of a thoracic surgeon on the possibility of surgery.

22 The DT found that Dr Ang neither raised the option of surgery nor discussed it with MT and her family during the consultation on 1 April 2010. In coming to this conclusion, the DT considered the evidence of MT's two daughters, who were both present at the consultation and testified that Dr Ang never mentioned surgery. It was also significant that there was no mention in Dr Ang's case notes that he had ever mentioned surgery at all, much less offered it as a treatment option to MT.

23 The next question was whether surgery was a viable treatment option for MT at the time of the consultation on 1 April 2010. It was not disputed that the tumour was resectable. Further, the Practice Guidelines in Oncology (v.1.2010) for Non-Small Cell Lung Cancer released by the National Comprehensive Cancer Network ("the NCCN Guidelines") state that "surgery is the preferred initial treatment option for stage IIB lung cancer". It was common ground that this was the cancer that MT had as at 1 April 2010. Dr Ang maintained that he did have regard to the NCCN Guidelines but had made a considered assessment that surgery was not a viable initial treatment option for MT. He called the following expert witnesses who supported his case:

> (a) Dr Eugene Sim, a Consultant Cardiothoracic & Vascular Surgeon at Cardiothoracic Surgical Centre Singapore, opined that although surgery may be offered to patients with Stage IIB or IIIA cancer, it was well recognised that for most of these patients, "surgery [would] not be curative as less than a third of Stage IIB patients survive for five years and less than a fifth of those with Stage IIIA survive for five years". He said that "chemotherapy is recommended for patients with Stage IIB and IIIA…as micro metastatic disease is almost certainly present at time of diagnosis". Hence, while surgery might remove the primary tumour, it would not resolve the underlying cancer, which by

this stage, would commonly have metastasised or spread to secondary sites. Finally, he added that "[a]s important as offering a patient the best chance for cure and long term survival, it [was] also of paramount importance to spare the patient a non-curative thoracotomy and its inherent risk".

(b) Dr Thiruganam Agasthian, who was Head and Senior Consultant at the Division of Surgical Oncology at the National University Cancer Institute Singapore, gave evidence that surgery was not a viable primary option before chemotherapy for MT, as she had poor prognostic factors such as multiple satellite nodules which indicated metastatic disease, a tumour size that was greater than 5cm (8cm in her case) and that was abutting the pleura, and a PET SUVmax value that was greater than five (12.9 in her case) which indicated an aggressive tumour. Even if surgery was considered, this would be extensive and carry high morbidity risks and the possibility of incomplete resection which would have no survival benefit at all. In such circumstances, Dr Agasthian said that most surgeons would prefer chemotherapy at the initial stage to reduce the size of the tumour before considering surgery. Dr Agasthian was also of the view that it was not necessary for patients like MT to have been referred to a cardiothoracic surgeon.

(c) Dr Chan Tiong Beng, a Consultant Respiratory Physician in private practice, said that MT had a very high likelihood of systemic micrometastasis. Surgery, while technically possible, would not have helped to address the systemic disease and would not be in her best interest. It should only be considered if she responded to chemotherapy in the first place. Most respiratory physicians would refer MT to an oncologist rather than to a thoracic surgeon.

24 On the other hand, Dr Eric Lim, a thoracic surgeon who testified as SMC's expert witness, was of the view that a body of reasonable medical practitioners would consider surgery as a viable primary treatment option for patients like MT, and would, at least, have presented the patient with the opportunity to discuss the issue with a thoracic surgeon. He also said that most lung cancer specialists would consider surgery as the first line of treatment for patients such as MT.

25 The DT preferred the evidence of Dr Eric Lim over that of Dr Sim, Dr Agasthian and Dr Chan. The DT considered that the material date for determining whether or not surgery was a viable option was 1 April 2010. Dr Ang's three expert witnesses had not only seen MT's 31 March 2010 PET-CT scan, which was the only information available at that date, but had also seen subsequent scans and reports by which time her cancer had already spread to other parts of her body. The DT considered that this would likely have affected their assessment, when the real issue pertained to what ought to have been done on 1 April 2010 before such additional information was available. In contrast, the DT thought that Dr Eric Lim had not seen the subsequent scans and reports, and that his opinion was thus likely to be more reflective of what ought to have been done given what was known of MT's condition on 1 April 2010.

26 The DT was further influenced by the fact that the NCCN Guidelines recommended surgery as the preferred initial treatment option for patients like MT with Stage IIB lung cancer. While the scans available on 1 April 2010 did show that MT had certain poor prognostic factors, the NCCN Guidelines expressly recognise the diversity of Stage IIB tumours and nonetheless provide that the preferred treatment plan for such patients was to begin with surgery. In fact, the NCCN Guidelines prescribed surgery even in cases that were more serious than MT's.

27 The DT thus concluded that surgery was a viable option for MT as at 1 April 2010, and that Dr Ang ought to have offered it to MT at least as an alternative option to chemotherapy. At the very least, Dr Ang ought to have raised this option with MT so that she could have consulted a thoracic surgeon if she so wished. By failing to do any of these, Dr Ang had breached Guidelines 4.2.2 and 4.2.4.1 of the Ethical Code, which provide as follows:

> 4.2.2 Informed Consent
>
> It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternative available to him…
>
> 4.2.4.1 Right to Information
>
> A doctor shall provide adequate information to a patient so that he can make informed choices about his further medical management. A doctor shall provide information to the best of his ability…

28 The DT was further satisfied that Dr Ang had intentionally and deliberately departed from these standards and accordingly convicted Dr Ang on the 2nd Charge.

Decision on sentence

29 The DT sentenced Dr Ang to an aggregate fine of $25,000 for both charges. It also ordered that Dr Ang be censured, and that he be required to give a written undertaking to SMC that he would not engage in the conduct complained of or similar conduct in the future. The DT was of the view that the two charges of which it found Dr Ang guilty were serious, and that the penalty to be imposed on him should reflect their severity so as to deter similar conduct

on the part of other doctors and to uphold the trust and confidence of the public in the medical profession. The DT noted, however, that there had been a long delay in the proceedings against Dr Ang, with the NOI having been sent to him only four and a half years after the Complaint, and that such a long delay must have caused tremendous suffering to Dr Ang over the years. For this reason, the DT decided not to impose any period of suspension on Dr Ang. The DT further took into account several testimonials that "very, very well-known doctors" had written in support of Dr Ang, as well as Dr Ang's contributions to the community over the years.

Our decision

30 In this judgment, we set out the principal arguments that were raised by the parties in the relevant sections where we address each of the principal issues. We begin by setting out the controlling principles which are not disputed.

31 In *Low Cze Hong*, we held that professional misconduct can be made out in at least two situations:

> (a) Where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency; and
>
> (b) Where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

32 High thresholds must be crossed before a conviction of professional misconduct can be sustained: see *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Lawrence Ang*"). The test is not met just by

incompetence or by deficiencies in the practice of the profession. On the other hand, moral turpitude, fraud or dishonesty are not necessary elements for a finding of professional misconduct: *Low Cze Hong* at [32] and [34]. In the present case, the SMC proceeded on both charges under the first limb of professional misconduct as set out above. No allegations of negligence within the meaning of the second limb of professional misconduct have been made. In order for the convictions against Dr Ang to be upheld, the SMC will have to prove, beyond a reasonable doubt, that Dr Ang had committed the acts alleged in the charges (namely, making a false representation to MT and failing to offer MT the treatment option of surgery when this was a viable treatment option), and had, in committing those acts, intentionally and deliberately departed from the standards observed or approved by members of the profession of good repute and competency.

33 In this light, we turn to examine Dr's Ang appeal against his conviction on each of the two charges.

The 1st Charge

34 In respect of the 1st Charge, Mr Tong has mounted what is essentially a two-pronged attack on Dr Ang's conviction. First, he contends that the SMC sought to prove its case not with reference to the charge as it was framed, but to a charge that it had "re-imagined", and that the DT erred when it convicted Dr Ang on the basis of such a re-imagined charge. Secondly, he argues that Dr Ang did not make any false representation because he reasonably believed that the Statement was true. We turn to consider each of these aspects of Dr Ang's case in his appeal against his conviction on the 1st Charge.

Whether there is a fatal error in the framing of the 1st Charge

35 The 1st Charge, which has been set out at [12] above, is reproduced for ease of reference with appropriate emphasis added:

> That you, DR ANG PENG TIAM, a registered medical practitioner under the Medical Registration Act (Cap. 174), are charged that whilst practising at Parkway Cancer Centre ("PCC"), you did on 1 April 2010 make a false representation to your patient, one [MT] ("the Patient"), who was suffering from lung cancer, that there was a *"70% chance" of the disease responding to treatment and achieving control* with chemotherapy and/or targeted therapy.
>
> **Particulars**
>
> (a) On 1 April 2010, the Patient attended a consultation with you a PCC ("the Consultation").
>
> (b) In the course of the Consultation, you informed the Patient that there was a *"70% chance" of the disease responding to treatment and achieving control* with chemotherapy and/or targeted therapy ("the Statement").
>
> (c) You informed the Patient that the Statement was premised on the following 4 factors:-
>
> (v) That the Patient was of the Chinese race;
>
> (vi) That the Patient was female;
>
> (vii) That the Patient was a "never-smoker"; and
>
> (viii) That the Patient had adenocarcinoma.
>
> (d) The Statement was false as a *70% disease control rate* is only achievable in patients who have epidermal growth factor receptor ("EGFR") mutation.
>
> (e) You failed to carry out any EGFR analysis to ascertain the Patient's EGFR mutation status.
>
> and that in relation to the facts alleged, you have been guilty of professional misconduct under section 53(1)*(d)* of the Medical Registration Act (Cap. 174) (2004 Ed.)

36 Consistent with his position before the DT, Dr Ang does not, in this appeal, deny that he had, during the consultation on 1 April 2010, represented to MT and her family that there was a "70% chance" of her disease responding

to treatment and achieving control with chemotherapy and targeted therapy, *because of the four phenotypes that she presented* (referred to above at [7]). In short, he admits that he had made the Statement. His argument, however, is that because of the way in which SMC had chosen to frame the charge, the meaning of the words "70% chance of the disease responding to treatment and achieving control" as stated in the 1st Charge is specifically qualified by the reference to "70% disease control rate" in Particular (d). According to Mr Tong, "disease control rate" is a medical term of art that refers to the percentage of patients who (i) show a "complete response; (ii) show a "partial response"; or (iii) reach "stable disease" on treatment in a clinical trial. In non-technical terms, this covers patients who are *healed*, whose condition *improves*, and most importantly in this context, those whose condition *does not deteriorate*. In contrast, the term "response rate" refers more narrowly only to "the percentage of patients whose cancer shrinks or disappears after treatment" and excludes the percentage of patients who reach stable disease (that is to say, do not deteriorate) with treatment. Mr Tong therefore contends that, for the conviction to be sustained, the SMC must prove the falsity of the Statement with respect to the term "70% disease control rate"; in other words, that it was false for Dr Ang to have said that there was a 70% chance for patients like MT, who possessed the four phenotypes, to show a "complete response, a "partial response", or to reach "stable disease" following chemotherapy and/or targeted therapy. The SMC had not done so, but focused its attention instead on whether it was true that there was a 70% chance of MT's tumour *shrinking* (that is, on whether it was true that there was a 70% "disease response rate" for MT).

37 The DT accepted the SMC's case and in particular accepted that the veracity of the Statement was to be assessed with reference to a "70% chance of shrinkage of the tumour" or a "70% response rate", holding that the technical meaning of "disease control rate" was irrelevant to the assessment of whether

the 1st Charge was made out because it was the meaning that Dr Ang intended to convey when he made the Statement to MT that mattered. This, Mr Tong says, is a serious error affecting the decision of the DT. In support of his contention, Mr Tong relies on our decision in *Lawrence Ang*, where we said (at [86]) that:

> The framing of a charge and the precise wording used are crucial in assessing the case that must be met by the medical practitioner facing the charge (see *Ho Paul v Singapore Medical Council* [2008] 2 SLR(R) 780 at [9]). The charge should be set out with sufficient clarity and precision, and the facts that the respondent intends to rely on should be particularised…

38 We are not persuaded by Mr Tong's arguments. The rationale behind the requirement for precision in the framing of a charge is grounded in fairness and the need for due process in the conduct of the inquiry. The charge must set out, with clarity, the case that a person accused of misconduct must meet, such that he is put on notice and has the opportunity to respond to the allegations against him, instead of being taken by surprise at the inquiry itself. As we said in *Lawrence Ang* (at [87]), in considering whether a deficiency in the framing of a charge renders a conviction unsafe, the real question is whether the person accused was prejudiced or misled by the deficiency (see also *Low Cze Hong* at [48] – [52]).

39 In the present case, we are amply satisfied that a technical definition of "disease control rate", in the way Mr Tong contended before us, has *never* represented the SMC's case. Although the charge could have been framed more clearly, it is clear from the undisputed facts of this case, that there is simply no question of Dr Ang having suffered any prejudice by reason of any infelicity in the way the charge was framed. Dr Ang has never disputed that he had, in fact, represented to MT that there was a "70% chance" that her tumour would *shrink*. For instance, in his Explanation to the CC, he wrote as follows:

> As she was Oriental, female, never smoker with adenocarcinoma of the lung, she fell into the category of people who have been reported to have a good response to treatment and I *conveyed a 70% chance of the disease responding to treatment and achieving control*. I refer to the copy of the drawing, which the family provided of our initial discussion, you will be able to see that I drew a *big tumour which then became small (indicating response)*. This was similarly recorded in my entry of 1 April 2010 in her medical records – "70% chance of *control*"… [emphasis added]

40 Dr Ang maintained the same position at the inquiry before the DT. At the inquiry, Dr Ang referred to the conversation that he had with MT on 1 April 2010 in such terms:

> We spoke in Mandarin, and I just like to use this word "su xiao", "su xiao" means shrink; "kong zhi" means control. So when I was talking, I mean we were using these terms repeatedly, "su xiao", "kong zhi", "su xiao", "kong zhi"…

41 The following exchange between the Prosecution and Dr Ang was also significant:

> Prosecution: …When you put in your notes "control", as you say, that equated to what you explained to the patient which is shrinkage; agree or disagree?
>
> Dr Ang: I don't understand.
>
> Prosecution: No, you told the patient shrinkage?
>
> Dr Ang: "Su xiao".
>
> Prosecution: And then you put in your notes "control." My position to you -- you agree or disagree – you meant the same thing?
>
> Dr Ang: Yes.

42 When asked by the DT whether the "70% chance" that he conveyed to MT referred to a 70% chance of *shrinkage*, Dr Ang's response was:

> Yes, shrinkage. There, it is written there. We calculate difficult to say, but I feel at least a 70 per cent chance the tumour will shrink. It is written there, will shrink, it is not cure…That is why I drew in that picture, a big dot, small dot…We are talking

> about shrinkage, "su xiao". I mean, you must look at the whole discussion. We are talking about, you see how big the tumour is. …

It is not controversial that Dr Ang was referring to the memo that he had given to MT, where he had written down the four phenotypes and "70%", and had drawn two circles, one bigger than the other, (referred to as "big dot" and "small dot" in the foregoing extract) and an arrow pointing from the bigger of the two circles to the smaller one (see [8] above).

43 It is clear to us from the foregoing that as much as a technical definition of "disease control rate" has never represented the SMC's case, Dr Ang too, never had the technical definition in mind when he referred to the word "control" in the Statement to MT. He has never disputed that by the Statement, he had represented to MT that there was a 70% chance that her tumour would shrink, and he had used the words "shrinkage", "control" and "response" interchangeably. Furthermore, throughout the proceedings, he was fully aware of the case that he had to meet, which was to show that he had a reasonable basis for representing to MT that there was a 70% chance that ***her*** *tumour would shrink*. Dr Ang has therefore suffered no conceivable prejudice by virtue of any alleged defects in the framing of the 1st Charge. Accordingly, Mr Tong's contention that the conviction is unsafe because of any such alleged defect must fail. The SMC was entitled to establish its case based on whether Dr Ang's representation that there was a 70% chance that MT's tumour would shrink, was false, and the DT was entitled to convict Dr Ang if it was satisfied that the SMC had proven its case on this basis.

Whether Dr Ang had a reasonable basis in making the Statement

44 We turn to Mr Tong's next contention, that Dr Ang had a reasonable basis for making the Statement, and so cannot be convicted of having made a

false representation. Medical knowledge, by its nature, evolves constantly with new discoveries and learning. What might be regarded as a true statement today based on the current state of medical knowledge may subsequently come to be viewed as false with the emergence of new findings. The converse is equally true. Hence, in a case such as the present where the doctor is charged with misrepresentation, while the threshold question is framed in terms of whether the statement is true or not, because it will often not be possible to establish this in a definitive way, the inquiry is better understood in terms of one that is directed at whether, as an objective matter, the statement was made with a reasonable basis. That question, namely whether Dr Ang had a reasonable basis for making the Statement, must be answered based on the state of knowledge of the doctor in question, and also of scientific knowledge in general, at the relevant time, which, in this case, is 1 April 2010 being the date on which the Statement was made. If the state of medical knowledge as at that date is such that there was no reasonable basis for the Statement, then it will be found to be false. We refer in this connection to the recent decision of the Court of Appeal in *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] SGCA 38 where in the related but admittedly different context of proceedings for medical negligence, the court had this to say at [157]-[159] on the importance of applying the correct time-frame when assessing liability:

> 157 …A ruling of whether there was medical negligence is inevitably one that is made months, if not years after the fact. The material events are reconstructed, with both sides adducing evidence that seek to support their case on some specific act or omission, such as what the doctor should have concluded, what the patient should have been told, or how the doctor should have conducted an operation.
>
> 158 Research suggests that medical experts can exhibit "hindsight bias" in that "a retrospective reviewer, knowing the outcome of an event, may have an exaggerated sense of their own probable ex ante ability to predict it" (Thomas B Hugh and Sidney W A Dekker, "Hindsight Bias and Outcome Bias in the Social Construction of Medical Negligence: A Review" (2009)

> 16(5) JLM 846 at p 848). There is also the related possibility of "outcome bias", which refers to the influence of outcome knowledge upon evaluations of decision quality…
>
> 159 In this regard, we emphasise the critical importance of ensuring that the courts, in evaluating whether the doctor has met the requisite standard of care in any aspect of his interaction with the patient, should apply the relevant tests with reference only to the facts that were known *at the time that the material event occurred*. As was held by the High Court of Australia in *Rosenberg v Percival* [2001] HCA 18 at [68] citing a previous decision of the same court in *Maloney v Commissioner for Railways* (1978) 18 ALR 147 at 148, **"perfection or the use of increased knowledge or experience embraced in hindsight after the event should form no part of the components of what is reasonable in all the circumstances"**.
>
> [emphasis in original in italics, and emphasis added in bold]

45 According to Mr Tong, Dr Ang did have a reasonable basis for informing MT that, in view of the four phenotypes that she presented, there was a 70% chance that her tumour would shrink on receiving the therapy that he had prescribed for her (which is, chemotherapy in combination with targeted therapy using gefitinib, a TKI). His argument was developed in the following way:

(a) A disease control rate of 70% in patients such as MT was thought to be achievable in April 2010 with chemotherapy alone;

(b) The Mok Paper (see [15] above) revealed that a 71.2% disease response rate was achievable amongst patients bearing the EGFR mutation who were treated with gefitinib. Although MT was not tested for EGFR mutation, it was *not a mandatory requirement* for Dr Ang to have ordered the test having regard to the medical standards that applied as at 1 April 2010; and indeed, it was reasonable for him to have relied on the presence of the four phenotypes as a surrogate marker that MT, more likely than not, was positive for EGFR mutation;

(c) It was reasonable for Dr Ang to have informed MT that there was a 70% chance that her tumour would shrink because her chances of responding to treatment were enhanced with Dr Ang's prescribed therapy which consisted not just of chemotherapy alone or targeted therapy using gefitinib alone, but a combination of the two. The effects of these two types of therapy could reasonably be expected to be cumulative, because:

(i) The pharmacodynamics of the chemotherapy drugs that were used and of TKIs such as gefitinib are different; and

(ii) An article by medical practitioners from the National Cancer Centre Singapore CCS, Tham C K *et al*, "Gefitinib in Combination with Gemcitabine and Carboplatin in Never Smokers with Non-Small Cell Lung Carcinoma: A Retrospective Analysis" Journal of Thoracic Oncology 2009; 4: 988-993 ("the Tham Paper"), reported a 62.7% response rate amongst patients who were treated with chemotherapy in combination with gefitinib.

46 We are unable to agree with Mr Tong, for the reasons that follow.

Whether there was a reasonable basis for the Statement because a disease control rate of 70% was thought to be achievable with chemotherapy alone

47 Before the DT, Mr Tong cited a number of studies, published in the early-1990s ("the early-1990s articles") in an effort to establish that disease control rates of 70% or more were achievable with chemotherapy alone. He cited the same studies to us.

48 As noted at [17] above, the DT rejected the submission that a disease control rate of 70% could be achieved with chemotherapy alone, preferring the evidence of Dr Tan Yew Oo, who said that the early-1990s articles cited by Dr Ang were dated and further that the chemotherapy drugs that were used and reported in these studies had "never stood the test of time to come out to be the standard of care to today's practice". Dr Tan's evidence was that based on publications released from around 2005 onwards, the average response rate for chemotherapy using the drugs that Dr Ang prescribed for MT was in the region of between 40% and 50%.

49 On appeal, Mr Tong argues that the DT erred in concluding as it did essentially on the basis of Dr Tan Yew Oo's testimony alone. First, Mr Tong says that Dr Tan, in giving his evidence, referred to the "average response rates" reported in the publications in question but those, according to Mr Tong, were not germane to the charge which centred on "disease control rates". He then refers to three studies published around 2010 ("the 2010 studies") that shows that disease control rates ranging between 78% and 85% were achievable using chemotherapy. We first observe that this argument is premised upon the technical distinctions between "disease control rates" and "disease response rates" and this cannot stand given our decision at [43] above. As we have already noted, Dr Ang at the time was speaking about the tumour *shrinking* and this would entail a *positive response* to the treatment and not just *preventing the deterioration* of the disease. Pertinently, the 2010 studies reported *disease response rates* ranging between 35% and 53%. Second, Mr Tong contends that Dr Tan's criticism that the articles cited by Dr Ang "never stood the test of time" does not stand up to scrutiny because Dr Tan conceded on cross-examination that those articles reported seminal studies which remain highly regarded and relevant even now, despite their relative vintage.

50 In our judgment, this is not ultimately relevant to the real question before us which, in this context, is whether there is any basis for concluding, based on those articles, that there was at least a 70% chance that *MT's* tumour would shrink using chemotherapy alone. While the early-1990s articles reported disease response rates ranging from 60 to 77%, in truth, the data reported in these articles consisted of general data that was not correlated either to the specific chemotherapy drugs that Dr Ang prescribed for MT, or to the four phenotypes that MT presented with. In particular, the chemotherapy treatment that the patients reported in those studies received differed from the chemotherapy regime prescribed for MT. As noted (at [49] above), in the 2010 studies, which involved the use of a newer generation of chemotherapy drugs, the disease response rates reported ranged between 35% and 53%. In the final analysis, because the early-1990s articles cannot be relied on given the different treatment regime, and given that the 2010 studies simply do not bear out the 70% favourable response rate, the first step in Mr Tong's argument, as summarised at [45] above, fails. In essence, we are left with the conclusion that Dr Ang has not provided any evidence for concluding that there was a reasonable basis for believing that there was a 70% chance that *MT's* tumour would shrink on receiving *the chemotherapy regime that he prescribed for her*.

Whether there was a reasonable basis for the Statement on the basis of the Mok Paper

51 We turn to the second step of Mr Tong's argument. which concerns the Mok Paper. This paper was published in September 2009 and reported a study where patients who were East Asians, had never smoked or were former light smokers, and who were suffering from Stage IIIB or IV non-small-cell lung cancer with histologic features of adenocarcinoma, were treated with gefitinib. The majority of the study population (79.5%) were females.

52 The study population was supposedly so selected because the authors had observed that "[t]reatment with EGFR tyrosine kinase inhibitors [have been] most effective in women, patients who have never smoked, patients with pulmonary adenocarcinomas, and patients of Asian origin". This describes the four phenotypes that MT presented with. The study found that within such a group of patients, those who tested positive for EGFR mutation had a response rate of 71.2% to targeted therapy using gefitinib. In contrast, those who tested negative for the mutation showed a response rate of only 1.1% to the same treatment. The Mok Paper therefore concluded that "[t]he presence of an EGFR mutation was a robust predictor of improved progression-free survival with gefitinib", and further recommended that "whenever possible, EGFR-mutation status should be determined before the initial treatment of pulmonary adenocarcinoma".

53 In our judgment, the Mok Paper, which was published just six months before the relevant date in this case (1 April 2010), with its specific linkage of the four phenotypes to the response rate of around 70% to targeted treatment using gefitinib, *was the likely inspiration behind the Statement*. Dr Ang, however, faces a considerable difficulty in relying on the Mok Paper to justify the Statement because that study also establishes clearly that patients who possess the four phenotypes respond very differently to targeted therapy using gefitinib depending on whether or not they have the EGFR mutation. The only way to determine whether a patient has the mutation and so will likely have a favourable response rate to gefitinib (or more generally, a TKI) is to conduct an EGFR mutation test. Since Dr Ang did not order an EGFR mutation test for MT, her EGFR mutation status was unknown. He therefore had no basis, relying on the Mok Paper, for representing to MT that there was a 70% chance that her tumour would shrink given her circumstances and Dr Ang's planned course of treatment with gefitinib (leaving aside, for the moment, the fact that the

Statement was made in the context of a treatment plan comprising chemotherapy in combination with targeted therapy using gefitinib, rather than using gefitinib alone).

54 Mr Tong attempted to circumvent this by observing that as at 1 April 2010, it was not mandatory for Dr Ang to have ordered an EGFR mutation test for MT. Mr Tong also submitted that the presence of the four phenotypes served as a surrogate marker for the presence of the EGFR mutation since within a population with these four phenotypes, there is a 50% to 60% chance that a patient would have the mutation. The former proposition is not disputed as a matter of fact. However, it is irrelevant. Dr Ang is facing the 1st Charge not because he failed to carry out some mandatory step. Instead, the gravamen of the 1st Charge is that he made a representation which he had no basis to believe was true. The only basis for the Statement would have been if the EGFR mutation test had been carried out. It was not.

55 As to the second point, there is some support for this. For instance:

(a) Dr Ang's expert witness, Dr Gilbert Lopes, testified that "[i]f you only used the phenotypes, the EGFR mutation is unknown…but likely to be positive". Dr Lopes said that as at 2010, he would simply rely on the presence of the four phenotypes to select patients to receive chemotherapy and targeted therapy using a TKI, and would not order an EGFR mutation test. We digress to observe *again* that the issue before us is not whether the selection of a TKI-based treatment was wrong in the circumstances, but whether, Dr Ang was entitled fairly to make the Statement.

(b) The Mok Paper states that there is a relatively high incidence of EGFR mutations within populations of Asian, female patients with

pulmonary adenocarcinoma who have never smoked. In fact, 59.7% of the population in that study tested positive for EGFR mutation.

(c) SMC's own expert witness, Dr Tan Yew Oo, stated in his report that lung cancer patients with adenocarcinoma, who are East-Asian by ethnicity, female and had never smoked, have a more than 50% chance of having the EGFR gene mutation.

56 While the experts seem to be in agreement that, within a population of patients who possess the four phenotypes, it is likely that more than half of them will have the EGFR mutation, this does not help Mr Tong's case because we are not concerned with averages in this appeal. It is helpful in this context to have regard to the observations of the Court of Appeal in *Quek Kwee Kee Victoria (executor of the estate of Quek Kiat Siong, deceased) and another v American International Assurance Co Ltd and another* [2017] 1 SLR 461 at [71] – [73]. In particular at [71], the court said as follows:

> In our judgment, the Judge was led to error by this evidence because she equated the *statistical probability* of a person with the Deceased's physical characteristics and medical history suffering an adverse reaction from the combination of drugs at therapeutic levels, with the question of whether, in fact, it was more likely than not that *the Deceased* had consumed no more than his prescribed dose of medication but nevertheless suffered the adverse reactions. The former is about the study of averages involving similar facts. The latter, however, is the central issue the court is required to determine and while the former can aid in the latter, this is not invariably the case. It is important to recognise the limits of statistical evidence, and here, we echo the observations of Lord Nicholls of Birkenhead in *Gregg v Scott* [2005] 2 AC 176 where he explained (at [28]):
>
> > Statistical evidence, however, is not strictly a guide to what would have happened in one particular case. Statistics record retrospectively what happened to other patients in more or less comparable situations. *They reveal trends of outcome.* They are general in nature. The different way other patients responded in a similar

> position says nothing about how the claimant would have responded. *Statistics do not show whether the claimant patient would have conformed to the trend or been an exception from it.* They are an imperfect means of assessing outcomes even of groups of patients undergoing treatment, let alone a means of providing an accurate assessment of the position of one individual patient.
>
> [emphasis in original]

57 In the present case, Dr Ang had made a specific representation to a specific patient that, because she possessed the four phenotypes, *she had a 70% chance* that her tumour would shrink upon treatment with chemotherapy in combination with targeted therapy using gefitinib. Relying on the Mok Paper, the only basis upon which Dr Ang could fairly make that representation was if he had tested MT for the EGFR mutation and she had the mutation. Absent that, the most he could have told her was that she had a better than even chance of a 70% response rate depending on whether she did or did not have the mutation.

Whether there was a reasonable basis for the Statement because the therapeutic effects of chemotherapy and targeted therapy using gefitinib can reasonably be expected to be cumulative

58 The third step of Mr Tong's argument is that because chemotherapy drugs and TKIs such as gefitinib have different pharmacodynamics, with the former operating to kill cancer cells and the latter working to slow cancer cell proliferation, Dr Ang was entitled to assume that the two forms of therapy, when used in combination, would produce cumulative response rates, regardless of whether the patient in question possesses the four phenotypes. We are unable to accept this argument in the absence of *any* supporting medical literature.

59 Mr Tong referred to the Tham Paper (see at [45(c)(ii)] above), which reported a retrospective study of 80 patients who were non-smokers with Stage IIIB or IV cancer. All of the patients were treated at the National Cancer Centre

Singapore between 2003 and 2007. Some of them received only chemotherapy (using the drugs gemcitabine and carboplatin), while the rest were treated with chemotherapy (using the same chemotherapy drugs gemcitabine and carboplatin) in combination with targeted therapy using gefitinib. The authors reported a response rate of 62.7% amongst the group of patients treated with chemotherapy and gefitinib, whereas the response rate in the other group (treated with chemotherapy alone) was 27.6%. They therefore concluded that "it would seem that EGFR TKI[s] [such as gefitinib] could act synergistically with chemotherapy in effecting improved response rate and survival outcome[s]". The patients in the study reported in the Tham Paper had not been tested for the EGFR mutation prior to treatment.

60 Mr Tong relies on the Tham Paper for two propositions. First, he says that it shows that it was an acceptable practice to prescribe targeted therapy using gefitinib in combination with chemotherapy for cancer patients, because even the National Cancer Centre Singapore, which is one of the leading cancer research institutions in Singapore, adopted and in fact still adopts that practice. Secondly, he argues that the results reported in that paper, namely that Stage IIIB and IV patients who were non-smokers had a response rate of 62.7% to treatment with gefitinib in combination with chemotherapy, provide a reasonable basis for Dr Ang to have made the Statement to MT.

61 In our judgment, the first point made by Mr Tong does not address the question that is before this court. *Again* we observe, that the question before us in respect of the 1st Charge is not whether the treatment prescribed by Dr Ang for MT was appropriate or not. Rather, it is whether Dr Ang had a reasonable basis for representing to MT that because of the four phenotypes that she possessed, there was a 70% chance that *her* tumour would shrink upon receiving

the prescribed therapy of chemotherapy in combination with targeted therapy using gefitinib.

62 That question cannot be answered in the affirmative by reason of the Tham Paper.

63 First, there are a number of limitations in the design of the study that was reported in the Tham Paper. The sample size was small (only 51 patients received chemotherapy in combination with targeted therapy using gefitinib) and drawn from a single institution. It was a retrospective study, meaning that the researchers looked back at the outcomes of patients previously treated and then tried to discern patterns that would confirm or reject a current hypothesis, as opposed to a prospective study, where the researchers set out to study certain specific parameters and watch the outcomes in patients as they happen. Further, Dr Tan Yew Oo opined that there was a clear "selection bias" in the study; according to him, the reported response rate of 27.6% among the group of patients who were treated with chemotherapy alone was much lower than the 40 to 50% response rate reported in most other studies using the same combination of chemotherapy drugs. It thus appeared to him that the patient population in the study reported in the Tham Paper might have been deliberately selected to present the response rate to treatment with chemotherapy alone "look bad and to make [the] addition of gefitinib look good". Whether or not there was an active selection bias is not to the point; what is clear, however, is that the response rates for patients who were treated with chemotherapy alone is noticeably lower than the rates reported for such patients in other studies and this at least invites inquiry and explanation.

64 Second, the Statement was made with specific reference to the four phenotypes and whether or not there was a reasonable basis for it must be

assessed in that context. The main patient population selection factor employed in the Tham Paper was the patients' never-smoking status, although they also happened to be Asians. This describes only two of the four phenotypes. It is true that 71.3% of the study population were women and 82.5% of the study population had adenocarcinoma, but the authors of the Tham Paper did not consciously select the patient population based on these phenotypes and the conclusions they reached were not made with reference to these phenotypes. The study reported in the Tham Paper therefore could not exclude the possibility that the better response rate for those on the combination therapy stemmed from the fact that perhaps they *did* have the four phenotypes *and* were EGFR mutation positive although this had not been tested for, and that consistent with the findings of the Mok Paper, it was the use of gefitinib for this group of patients who happened to be EGFR mutation positive that was responsible for the better results.

65 Third, according to the Tham Paper, the response rate of patients treated with chemotherapy in combination with targeted therapy using gefitinib was 62.7%. This falls well short of the "at least" 70% chance that Dr Ang had represented to MT in the Statement. Mr Tong submits that Dr Ang could reasonably expect the response rate in MT's case to be higher than that reported in the Tham Paper, because unlike MT, not all the patients in that study possessed all four phenotypes, and most of the patients there had a more advanced stage of cancer than MT. Further, according to Mr Tong, the drug cisplatin, which Dr Ang prescribed for MT's chemotherapy, has been associated with better response rates than carboplatin which had been used in the study reported in the Tham Paper. In our judgment, this highlights the difficulty with Dr Ang's case. In effect, he has sought to assemble his case from a disparate collection of factors to seek to persuade the DT and us that he had a reasonable basis for making the Statement. But leaving aside the difficulty that there is

nothing in the evidence to suggest this was in fact the way in which Dr Ang had approached the issue at the time, there is also an absence of supporting medical literature to support the particular conclusions that Dr Ang wishes us to draw. And the one study, namely the Mok Paper, which corresponds to the Statement in terms of the phenotypes, the response rates and the timing of its publication, cannot help him because its central conclusion rested on the presence of the EGFR mutation.

66 Finally, and perhaps most importantly, we note that the conclusions reached in the Tham Paper were manifestly tentative. The authors there observed that despite their findings, "selecting the appropriate patients for treatment with EGFR TKI and the optimal way to use this agent remain controversial", and that it was "quite clear that we need to identify the targeted population to treat, given the highly targeted nature of this agent". The authors thus concluded that "the story of EGFR TKI in combination with chemotherapy has not ended yet. Although the benefit of EGFR TKI in never smokers with [non-small cell lung cancer] is well-established, the optimal way to use this agent is not." In its conclusion, the authors also made specific reference to the "Iressa Pan Asian Study", which is the study reported in the Mok Paper, and stated that the final results of that study would help to resolve the matter. The Tham Paper, which did not report any findings at all with respect to the EGFR mutation status of the patients in the study, was published in August 2009, just one month before the Mok Paper was released in September 2009. It is clear to us that whatever significance the Tham Paper had was cast into the shadows with the subsequent findings reported in the Mok Paper. The Mok Paper, in effect, helped to fill a gap identified in the Tham Paper when it showed that within a population of patients with the four phenotypes, only those who tested positive for the EGFR mutation could expect to have a good (71.2%) response rate to treatment with a TKI such as gefitinib, whereas those who do not have

the mutation could expect a dramatically lower response rate of barely 1%. This critical difference appears to have been completely lost on Dr Ang when he made the Statement, and even subsequently when he presented his case before the CC, the DT and finally before us.

67 For these reasons, we find that Dr Ang had no reasonable basis for making the Statement.

Whether Dr Ang, in making the Statement, intentionally and deliberately departed from the applicable standards

68 In order for Dr Ang's conviction on the 1st Charge to be sustained, it is not sufficient to prove – as we have found – that Dr Ang had no reasonable basis for making the Statement. The SMC must additionally prove that in making the Statement without reasonable basis, Dr Ang had intentionally and deliberately departed from the standards observed or approved by members of the profession of good repute and competency.

69 The DT gave little reason for its finding that Dr Ang had intentionally or deliberately departed from the applicable standards. It appeared to have relied on *Susan Lim* for the proposition that any false representation would necessarily constitute an intentional departure from the applicable standards. In our judgment, *Susan Lim* is readily distinguishable. There, the court inferred from all the facts that the doctor had deliberately made false representations to the patient. This is what brought the case within the first limb of *Low Cze Hong*.

70 This, however, does not help Dr Ang. In the present case, we have found that Dr Ang made the Statement without any reasonable basis. This carries with it the necessary conclusion that whatever material Dr Ang allegedly relied on did not in fact provide any basis for him to make the Statement. Dr Ang has not

mounted a case that he was negligent or careless in relying on that material. Nothing has been advanced by him to suggest that this was a case where he made a mistake, a misjudgement, or a misinterpretation of the underlying material. On the contrary, Dr Ang has persisted in his view that he was justified in making the Statement, even though, in truth, he has not adduced any evidence to show that he was so justified. There is no dispute that he made the Statement intentionally; nor, in truth, is there any dispute as to the purport or meaning of the Statement – see [36]–[43] above. In the end, we are left with Dr Ang having made a representation intentionally for which he either knew or ought to have known there was no basis. To intentionally make the Statement without being able to advance a reasonable basis for it would, in our judgment, constitute misconduct within the first limb of *Low Cze Hong*.

71 Before leaving this point, we note that counsel for the SMC, Ms Melanie Ho, also argues that Dr Ang's reliance on the Tham Paper and some of the early-1990s articles was something he came up with after the fact. She reasons that if Dr Ang had in fact relied on these materials when he made the Statement, he would have raised them in his Explanation to the CC in July 2011. This, however, was not the case. We agree that if it were the case that these materials were in fact operating on Dr Ang's mind at the time he made the Statement, one would have expected him to highlight this at the earliest opportunity once he was required to explain himself. To the extent he had not done so, it seems reasonable to infer that these materials were not operating on Dr Ang's mind when he made the Statement.

72 In the circumstances, we find that Dr Ang, had intentionally and deliberately departed from the standards observed or approved by members of the profession of good repute and competency. Accordingly, we uphold his conviction on the 1st Charge.

The 2nd Charge

73 The gravamen of the 2nd Charge is that Dr Ang failed to offer MT the option of surgery, when this was a viable option that ought to have been presented to her, even if Dr Ang might have expressed his reservations as to whether it was in fact the best option for her.

74 As we have already noted, before the DT, one of the key issues was whether Dr Ang had offered or even mentioned the option of surgery to MT on 1 April 2010 (see [21] above). Dr Ang's position then was that although he did not offer surgery as a treatment option for MT, he did mention it and told her why he thought it was not a good idea. The DT found that Dr Ang never mentioned or discussed surgery as an option with MT on 1 April 2010 (see [22] above). We do not think there is any basis to disturb this finding of fact by the DT. In the present appeal, although Dr Ang maintained, through his counsel's written submissions, that he had discussed surgery with MT, Mr Tong informed us during the hearing that Dr Ang was no longer pursuing the point.

75 The thrust of Dr Ang's appeal with respect to the 2nd Charge is that he was not required to offer MT the option of surgery, because that was not a viable treatment option for her based on her condition on 1 April 2010. He accepts that under the NCCN Guidelines, of which he was well aware, surgery is the *preferred* option for patients who were in MT's situation on 1 April 2010. His case is that as a doctor, he was obliged to exercise his clinical judgment in deciding on the viable options for treatment that are to be presented to a patient, instead of blindly and rigidly following the guidelines.

76 The expert witnesses on both sides were in agreement that MT's tumour was resectable. It was also not disputed that MT, who was only 55 years old, had the physical fitness to undergo surgery. Nonetheless, according to Dr Ang,

based on the PET-CT scan results available to him on 1 April 2010 and in the light of his own experience, immediate surgical resection of the primary tumour would not, in MT's specific case, be an appropriate or effective treatment for her, because of the following poor prognostic indicators that she had:

(a) The large size (8 x 5.8cm) of the primary tumour and its position abutting the pleura indicated that any surgery would be extensive and complete resection could not be guaranteed;

(b) There was a high likelihood that systemic micrometastases, although undetectable by the PET-CT scan, might already be present. This high likelihood of micrometastases was suggested by the large size of the tumour, its high SUVmax value, which indicated the aggressive nature of the cancer, the presence of at least three satellite nodules, and the finding of central necrosis of the tumour, which indicated a fast-growing tumour. If this were in fact the case, it would mean that MT's disease would not be treated by surgical resection of the primary tumour alone.

77 In his witness statement put before the DT, Dr Ang stated that he did not offer the option of surgery to MT on 1 April 2010 because, at that time, he considered the above factors and concluded that the preferred course was for her to receive chemotherapy as the initial treatment. He said that such a course of chemotherapy would afford the opportunity for the tumour to be shrunk, control the possible micrometastases, and gauge whether MT's response to chemotherapy warranted consideration of future surgery or radiotherapy. The part of this statement that chemotherapy would afford an opportunity for the tumour to be shrunk before other forms of treatment are considered must be viewed with circumspection, given our findings above that Dr Ang had no

reasonable basis for thinking that there was a 70% chance that MT's tumour would shrink upon chemotherapy. We note, further, that Dr Ang also stated in his witness statement that pre-operative chemotherapy would yield a 13% reduction in the relative risk of death as compared with surgery alone, in support of which he cited a 2014 study. That article, published four years *after* the relevant date of 1 April 2010, provides no assistance to Dr Ang's case since it could not have factored in his assessment of the position on 1 April 2010. But that having been said, the question of whether chemotherapy was better for MT than surgery as at 1 April 2010 is not the question that we have to answer in relation to the 2nd Charge. The question that we must answer is whether surgery, which according to the NCCN Guidelines was the preferred option for patients suffering from the same stage of cancer as MT, *was a viable option that ought to have been presented to her on 1 April 2010*.

78 We agree that in general, a doctor may and should depart from guidelines when there are good reasons for him to do so. A doctor ought not to suspend his clinical judgment, simply because there are guidelines which, after all, are plainly not intended for slavish adherence, but are there to assist and guide a doctor in the exercise of his clinical judgment. A doctor should evaluate the pros and cons of various treatment options for his patient having regard to the specific circumstances of each case.

79 Nonetheless, while Dr Ang was entitled to exercise his clinical judgment in evaluating which treatment options were best for MT, the applicable standards, set out in Guidelines 4.2.2 and 4.2.4.1 of the Ethical Code (see [27] above), required him to share with MT the various *viable* treatment options and the pros and cons that he thought were associated with each. He could and indeed ought to have advised MT as to which, of the various *viable* options, he, in his judgment, thought was the best option for her. But it was not for him to

decide *for MT* which option she must take, by omitting even to mention, for her consideration, other options including those he might have thought were inferior to his planned course of treatment. A doctor might believe that a particular treatment option is in his patient's best interests, but ultimately, it is the patient who must make the decision on her treatment.

80 The crux of the present appeal with respect to the 2nd Charge thus turns on whether surgery was, as on 1 April 2010, a *viable* treatment option for MT. If, objectively, it was not a viable option, we accept there would have been no need to mention it, since the provision of useless information to a patient is likely to confuse rather than assist and empower the patient. But if it was a viable option, then Dr Ang, by omitting to offer it as a treatment option to MT, would have departed from the standards observed or approved by members of the profession of good repute and competency. Having considered the evidence and the submissions of both parties, we find that surgery was a viable treatment option for MT as at 1 April 2010 for the reasons that follow.

81 First, we agree with the DT that although MT's PET-CT scan of 31 March 2010 might have revealed certain poor prognostic factors, the NCCN Guidelines expressly recognise the diversity of Stage IIB tumours (which was the stage of cancer that MT was suffering from at that time), such as whether there are satellite nodules or chest wall invasion, and recommend different treatment options for each subclass of Stage IIB tumours. For a patient like MT, the NCCN Guidelines recommend immediate surgery followed (if appropriate) by adjuvant chemotherapy/concurrent chemoradiation. In fact, as the DT had pointed out, the NCCN Guidelines prescribe surgery even in cases that are more serious than MT's. The NCCN Guidelines represents the consensus of an international group of experts and they suggest that surgery was not only a viable but the *preferred* initial treatment option for MT.

82 Second, with respect to the alleged high likelihood of micrometastasis, the unchallenged evidence of Dr Eric Lim was that a patient with Stage IIB cancer who undergoes surgery would still need to undergo preventive chemotherapy after surgery, and the preventive chemotherapy would help address any micrometastasis. In other words, a high likelihood of micrometastasis, in and of itself, would not exclude surgery as a viable, if not the preferred, initial treatment option for Stage IIB lung cancer patients.

83 Third, in considering whether surgery was a viable treatment option that ought to have been presented to MT, it is significant to note that surgery was, by Dr Ang's own admission, MT's *only* chance of *cure*. Dr Ang's evidence, when questioned by the DT during the inquiry, was as follows:

> DT: Because the treatment using surgery is kind of critical?
>
> Dr Ang: Yes.
>
> DT: The moment that option is out of the way, then it is just --
>
> Dr Ang: Palliation.
>
> DT: There is no cure?
>
> Dr Ang: Yes.

84 Fourth, apart from his admission that surgery was the *only prospect of cure* for MT's cancer, Dr Ang could also only say that the risk of systemic recurrence in MT's case was "beyond 80%". This meant that in Dr Ang's assessment, MT might have had up to a 20% chance that she would be free of metastases and be cured by initial surgery. 20% is by no means a fanciful possibility, and a 20% chance of *cure* must mean that surgery was a viable option for MT. Whether or not MT would have taken the 20% chance and opted for surgery ought to have been a choice for her to make. But Dr Ang admitted, when questioned by the DT, that he did not present MT with that choice:

> DT: But a patient may look at it the other way, 10 or 20 per cent. 100 per cent, "I will not go for surgery, actually no point", but a patient may want to consider 10 or 20 per cent, if it is their only chance of cure. So, was that made clear to the patient in your guidance? Because after that the patient can realise, "Oh, 20 per cent I don't want to take the chance"?
>
> Dr Ang: Right.
>
> DT: But there may be some patients, "This is my only chance for cure, even 10 per cent I will take it". So was that made clear to the patient?
>
> Dr Ang: I don't think it was made clear in that manner. I mean the way you have described it, I think my honest answer is no, I did not make it clear in that manner. But we were working towards surgery was clear to me; I hope it was clear to them, but that is what -- that was the position which I took. Surgery was in the cards, but the way you have put it, in other words, you can go for surgery now, but, you know, you have a 20 per cent chance that with the surgery, you may still die. I don't think I put it in that manner.
>
> DT: No, no, not that you would advise the surgery.
>
> Dr Ang: I know.
>
> DT: As a professional oncologist, you will say, "Oh, the indications are bad. Your chance is only 5 per cent, 10 per cent, or whatever per cent that you are metastasis free". But was it made clear to the patient, before they kind of made the choice they are going to follow your line of therapy?
>
> Dr Ang: …The likelihood to the answer is, no, I did not put it in such explicit terms, that is the honest answer.

85 Finally, Mr Tong contends that the DT erred in preferring the evidence of SMC's expert witness, over that of Dr Ang's expert witnesses. The evidence of SMC's expert witness, Dr Eric Lim, was that surgery was a viable option for MT as at 1 April 2010, whereas Dr Ang's expert witnesses said it was not. The reason given by the DT for preferring the evidence of Dr Eric Lim was that Dr Ang's experts had, prior to giving their opinion, seen scans and reports of MT subsequent to 31 March 2010 (see [25] above). Their opinions of whether surgery was a viable option for her as at 1 April 2010 might thus have been tainted by hindsight, because MT's cancer progressed significantly in the

months following 1 April 2010 so that surgery subsequently ceased to be a viable option for her. The DT was under the impression that, unlike Dr Ang's experts, Dr Lim had not seen the scans and reports that became available after 31 March 2010, and that his opinion as to how MT's condition should be assessed as at 1 April 2010 would therefore be more helpful. Mr Tong correctly pointed out that the DT had been mistaken because the evidence suggests that Dr Eric Lim did in fact see the PET-CT scans of MT that were taken in June and August 2010 prior to the preparation of his report. That having been said, we are satisfied that this does not have a material impact on the DT's finding that surgery was a viable treatment option for MT as at 1 April 2010. Indeed, we agree with this finding, for the reasons that we have set out above.

86 In our judgment, Dr Ang departed from the standards observed or approved by members of the profession of good repute and competency, because he omitted to offer MT the option of surgery even though it was, as we have found, a viable option. Further, we find that the departure was deliberate and intentional, bringing the omission within the first limb of professional misconduct set out in *Low Cze Hong*. We therefore uphold Dr Ang's conviction on the 2nd Charge. Dr Ang knew that the NCCN Guidelines suggested that surgery is the preferred treatment option for patients with the same stage of cancer as MT, and he had, by his own admission, assessed that there was up to a 20% chance that MT might be cured if she had undergone surgery (see [84] above). He was, however, of the view that in MT's specific case, chemotherapy in combination with targeted treatment using gefitinib was a *better* option for her than surgery. By not putting all these facts to MT, Dr Ang effectively made the decision as to which option would be taken for MT. The following extract of Dr Ang's testimony before the DT is telling:

> Dr Ang: … In the NCCN Guidelines, under T3NOMO, they provided three options. They were very clear in that the first

> option is "Surgery (preferred)" and then it made provision for chemoradiation and chemotherapy.
>
> Yes, I was aware that surgery would be considered as a preferred option in some patients with T3NO. But T3NO, being a very heterogenous group, *it is important for the clinician to decide when it is appropriate to deploy the preferred option of surgery and when we should use chemoradiation and when we should use upfront chemotherapy or pre-operative chemotherapy.*
>
> Prosecution: And the surgical option which was not offered was based on your own evaluation without a surgical consult?
>
> Dr Ang: That is correct.
>
> [emphasis added]

In upholding Dr Ang's conviction on the 2nd Charge, we are not making any finding on whether surgery was a preferable option for MT over that prescribed by Dr Ang. The 2nd Charge is concerned only with Dr Ang's failure to present a viable option to MT, so that *she* could make a considered decision on her own treatment. In our recent decision in *Yong Thiam Look Peter v Singapore Medical Council* [2017] SGHC 10, we underscored (at [9]), in a broadly similar context, that it will generally be a matter for the patient to decide on the treatment she will receive. To enable the patient to exercise this right, the doctor must provide the patient with enough information so that she can meaningfully participate in decisions to be made about the treatment and care she is to receive. These considerations are equally applicable here. In the present case, it was not open to Dr Ang to *limit* MT's treatment options by excluding from her consideration, those which he, even if for good reason, thought were not the best options for her. It was not Dr Ang's role to decide, but to inform. Unfortunately, he did not do so, and so denied MT of her right to choose. We therefore uphold the conviction on the 2nd Charge and dismiss Dr Ang's appeal.

The SMC's appeal on sentence

87 Ms Ho, for the SMC, submits that a suspension term of six months is warranted for each of Dr Ang's two charges of professional misconduct. She argues that the global fine of $25,000 that the DT imposed on Dr Ang was manifestly inadequate and wholly inconsistent with the DT's holding that Dr Ang's misconduct was serious and called for a penalty that would deter similar conduct.

88 In urging us to allow the appeal against the sentence, Ms Ho contends that the DT, in exercising its sentencing discretion, erred in failing to give sufficient consideration to aggravating factors such as Dr Ang's seniority. Further, she alleges that Dr Ang had induced MT, through his false representation, to agree to his proposed course of treatment, which involved "a toxic regimen of chemotherapy with attendant harmful side effects", that there was a "lack of probity and/or dishonesty" on his part, and that his misconduct had monetary repercussions for MT and her family (in view of the high cost of the gefitinib pills). She also argues that the DT had accorded too much mitigating value to the alleged delay by SMC in instituting the proceedings against Dr Ang, and also to the testimonials written by eminent doctors attesting to Dr Ang's professionalism and his contributions to the community.

89 We begin with the observation, which might be rather obvious, that the overarching consideration in sentencing is that the sentence imposed must be fair and just in the light of all the circumstances of the case. It will also be helpful to reiterate the function of sanctions in medical disciplinary proceedings, as this forms the background in our consideration of the appropriate sentence. In *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201 ("*Kwan Kah Yee*"), we observed (at [50]) that sanctions in medical disciplinary proceedings

serve two functions: first, to ensure that the offender does not repeat the offence so that the public is protected from the potentially severe outcomes that may arise from the conduct of errant doctors; and second, to uphold the standing of the medical profession. Further, in a case like the present, we consider that the sentence may be informed, in particular, by the sentencing objective of general deterrence. The sentence will further be affected by the personal mitigating or aggravating circumstances. It is to these we now turn.

The aggravating factors

90 The DT did not make a finding that the treatment of chemotherapy and targeted therapy prescribed by Dr Ang for MT was inappropriate. Neither has this been the SMC's case. There was also no allegation by the SMC before the DT, or any finding, that Dr Ang had acted "dishonestly". Therefore, the SMC cannot now claim that these are aggravating factors that should be taken into account for the purpose of sentencing. With respect to the allegedly high cost of MT's treatment, the DT did not permit the SMC to raise this in its submissions on sentence below, because this too was not included in the charges brought against Dr Ang. We agree with the DT and so do not permit the SMC to raise these matters before us.

91 The SMC cited several cases where disciplinary tribunals have considered a doctor's eminence and/or seniority as an aggravating factor in disciplinary proceedings: see, for instance, the *Decision of the Disciplinary Committee for the Disciplinary Inquiry for Dr Lim Chong Hee* held on 4 May 2012 at [10(a)] and the *Grounds of Decision of the Disciplinary Tribunal for the Disciplinary Inquiry for Dr Fong Wai Yin* held on 25 July 2016 at [33]. Similar considerations have factored in cases of professional misconduct involving other professions: see, for instance, *Re Knight Glenn Jeyasingam* [1994] 3

SLR(R) 366, where the court held (at [19]) that a senior officer of the Singapore Legal Service who was holding a "position of not inconsiderable significance within the legal profession and one which frequently placed him in the public eye" undermined public confidence in the integrity of the legal profession as a whole by reason of that prominence and seniority when he was convicted on a corruption charge and was subsequently found guilty of conduct implying a defect of character under s 83(2)(*a*) of the Legal Profession Act (Cap 161, 1990 Rev Ed).

92 In this case, Dr Ang is a senior doctor who has been in practice for about 35 years. He was the founding head of the Department of Medical Oncology at the Singapore General Hospital, a past President of the Singapore Society of Oncology, and former Clinical Associate Professor at the National University of Singapore. He is presently the Vice-Chairman of the Singapore Cancer Society, a Visiting Consultant at the National Cancer Centre, and the Medical Director and Senior Consultant of the PCC. The SMC argues that as Dr Ang is in a position where he is expected to set an exemplary standard and to serve as a role model for fellow practitioners, his misconduct in respect of the present two charges is aggravated.

93 We agree that, in the specific context of disciplinary proceedings for professional misconduct, an offender's eminence and seniority is an aggravating factor. As stated at [89] above, one of the key functions that disciplinary proceedings serve is to uphold the standing of the medical profession in the eyes of the public. Seniority and eminence are characteristics that attract a heightened sense of trust and confidence, so that when a senior and eminent member of the profession is convicted of professional misconduct, the negative impact on public confidence in the integrity of the profession is correspondingly amplified. We also note, however, that outside the context of disciplinary proceedings for

professional misconduct, an offender's seniority and/or eminence and distinguished record of public service has sometimes been regarded as a mitigating factor in criminal sentencing. For instance, in *Knight Glenn Jeyasingam v Public Prosecutor* [1992] 1 SLR(R) 523, the offender had his sentences for an attempted cheating charge and a corruption charge reduced on appeal on account of his distinguished record of public service as a senior officer of the Singapore Legal Service (see [27] of the judgment). As has been noted above, the offender's seniority and eminence was to later count against him when he was subsequently subjected to disciplinary proceedings upon his conviction of the criminal charges.

94 In the present case, the DT accepted as a mitigating factor the fact that Dr Ang had, through his long and distinguished career, made considerable contributions to the medical profession and to the community. We consider in our discussion on mitigating factors below the principles governing when credit can be given to an offender's past service records and contributions. We will also consider how this interplays with the competing consideration, which occurs specifically in the context of disciplinary proceedings for professional misconduct, that an offender's seniority and eminence can be an aggravating factor because of the greater harm to public confidence in the integrity of the profession that is occasioned by his misconduct.

The mitigating factors

95 The SMC submits that the DT erred in placing undue emphasis on the testimonials written by fellow doctors in favour of Dr Ang, on his contributions in community work, and also on the long delay between the SMC's receipt of the Complaint and its issuance of the NOI to Dr Ang.

Testimonials attesting to Dr Ang's dedication as a doctor and his contributions to the community

96 The DT took into account eight testimonials from members of the medical profession and respected members of society, attesting to Dr Ang's dedication and professionalism as a doctor. The SMC does not deny that Dr Ang has made significant contributions to society. For instance, he has served the Singapore Cancer Society for about 26 years, and with other such institutions for varying periods of time. He has also made significant contributions in having raised funds for needy patients and in the area of public education. In recognition of his contributions, he was nominated for a National Day Award in 2015.

The relevant principles

97 Courts and tribunals have, not infrequently, recognised as a mitigating factor an offender's good character, as indicated by his past contributions to society, favourable testimonials, or an unblemished record. Two justifications have been articulated as to why such an offender may be given some credit. First, it has been said that good character may, in some circumstances, suggest that an offender's actions in committing the offence were out of character and thus likely to be a one-off aberration, with a low likelihood that he would re-offend. The second proffered justification is that a person of good character is less deserving of punishment when he commits an offence, as compared to some other person who commits a similar offence but who is not regarded as being of good character. The High Court of Australia in *Ryan v The Queen* [2001] HCA 21 ("*Ryan*") observed as follows (at [29]-[30]):

> 29 … In the sentencing context, however, being of otherwise good character may in some circumstances suggest that the prisoner's actions in committing the offence for which he or she is being sentenced were "out of character" and that he or she is

> unlikely to re-offend. For that purpose, the absence of previous convictions is usually regarded as evidence of good character. On the other hand, many previous convictions suggest that the offence for which sentence is being passed was not an "uncharacteristic aberration".
>
> 30 Another, but less articulated, reason for considering "good character" in the sentencing context appears to involve the idea that a "morally good" person is less deserving of punishment for a particular offence than a "morally neutral or bad" person who has committed an identical offence. …

98 Doubts have been expressed as to whether the second justification is sound in principle. In *Ryan*, the court noted (at [30]) that writers Nigel Walker and Nicola Padfield have described in *Sentencing: Theory, Law and Practice* (Butterworths, 2nd Ed,1996,) at pp 53-54 as "remarkable":

> "… cases in which the court is influenced by meritorious conduct which has nothing to do with the offence. Men have had prison terms shortened because they have fought well in a war, given a kidney to a sister, saved a child from drowning or started a youth club. Such cases are interesting because they seem to result from two assumptions: (i) that offenders are being sentenced not for the offence but for their moral worth; and (ii) that moral worth can be calculated by a sort of moral book-keeping, in which spectacular actions count for more than does unobtrusive decency…

99 In our judgment, the second justification, which is evidently premised on an offender's moral worth, is unprincipled. For one thing, it goes against the fundamental principle that when a sentencing court passes a sentence, that sentence is to punish the offender for the wrong he has done and the harm he has occasioned *in committing that particular offence*. His good character, or his past contributions to the society, insofar as they are unrelated to the offence, should be regarded as irrelevant when it comes to sentencing. As Andrew Ashworth notes in *Mitigating and Aggravation at Sentencing* (Julian v Roberts Ed) (Cambridge University Press, 2011) ("*Mitigation and Aggravation in Sentencing*") at p 28:

> In principle there seems to be no reason why [contributions to the society] should have any impact on the imposition of a proportionate sentence. It is a quite separate matter, which is more appropriately marked by some kind of civic award relevant to what has been done…

100 We also find persuasive, the same author's observations in *Sentencing and Criminal Justice* (Cambridge University Press, 6th Ed, 2015) at p 190, as follows:

> To grant mitigation on [grounds of good character] implies that passing sentence is a form of social accounting, and that courts should draw up a kind of balance sheet when sentencing. The offence(s) committed would be the major factor on the minus side; and any creditable social acts would be major factors on the plus side…One argument [in favour of recognising such social contributions] is that good deeds, like remorse, suggest that the offender needs less punishment in order to reintegrate him or her into society. But even if it were justifiable to give preference to rehabilitative reasoning at this point, what is the evidence for asserting that those who do occasional good deeds are less likely to reoffend than those who cannot claim such 'social contributions'? *In any event, is it a court's proper function to concern itself with these matters? The court is passing sentence for the particular crime(s) committed.…* [emphasis added]

101 We therefore reject the view that an offender's general good character, or his past contributions to society (such as volunteer work and contributions to charities) can be regarded as a mitigating factor insofar as this rests on the notion that it reflects the moral worth of the offender. First, it is not the place of the court to judge the moral worth of those who are before it. Second, such considerations will generally have no relevance to the offender's culpability or the harm that he has caused by the commission of the offence for which he is being sentenced. Third, as observed in *Mitigation and Aggravation in Sentencing* at p 11, treating contributions to society as mitigating may be perceived as unfairly favouring the privileged who will often be more likely to

be able to make such contributions because of their station in life, than will be the case with less privileged offenders.

102 On the other hand, we accept that evidence of an offender's long and unblemished record may be regarded as a mitigating factor of *modest* weight if, and to the extent, such evidence fairly allows the court to infer that the offender's actions in committing the offence were "out of character" and that therefore, he is unlikely to re-offend. This is the first justification outlined in *Ryan*.

103 However, even in such cases, the mitigating weight to be placed on this will be readily displaced if the court is satisfied that there are other sentencing considerations that override this. Thus, little if any weight will be placed on the fact that the offender has had a long and unblemished record if the key sentencing objective is general deterrence, because the focus then would be on sending a clear message to others of the harsh consequences that await those who might be thinking of following in the offender's footsteps. The law must also not be misconstrued as providing those with an established good track record a free pass for misconduct on the basis that it is out of character.

104 This will equally be true in the context of medical disciplinary proceedings, where any mitigating value that an offender's good track record might attract must also be balanced against the wider interests of protecting public confidence in and the reputation of the medical profession. As we have noted at [91]-[93] above, a doctor's eminence and seniority will generally count as an aggravating factor for the purpose of sentencing, because when a senior member of the profession is convicted of professional misconduct, the harm occasioned in undermining public confidence in the integrity of the profession is amplified. Therefore, it may be said, generally, that when a senior and

eminent member of the medical profession is found guilty of professional misconduct, any mitigating value that can be accorded on account of his good track record as a doctor will at best be modest, especially when the offence committed is one that calls for general deterrence.

The mitigating value to be accorded in this case

105 It is not disputed that Dr Ang has had a long, distinguished track record as a doctor, and has also made significant contributions to the medical profession and to society through his various appointments. Nonetheless, for the reasons that we have already set out, in our determination of the appropriate sentence to be meted out in respect of the two charges in this case, we do not accord any mitigating value to his general contributions to the profession and to society. We do take into account the fact that but for the current two charges, Dr Ang has had an otherwise unblemished tracked record through his more than 30 years of practice, and consider that his conduct leading to the present charges may be seen as an aberration, as a result of which there would be less need to have regard to the interest of specific deterrence in this case. While the offences are serious, there is no finding of any dishonesty. More than seven years have passed since the offences were committed on 1 April 2010, and during this period, Dr Ang has remained in active practice without any further complaints of possible misconduct that we are aware of. In our judgment, Dr Ang does not manifest a propensity to re-offend.

106 However, as we have observed at [89] and [103] above, in a case like the present, the weight to be given to this consideration will be limited because the key sentencing objective at play is general deterrence. Further, we are also bound to have regard to the need to protect public confidence and the reputation of the medical profession (see [104] above). With Dr Ang's seniority and

eminence, the negative impact on public confidence in the integrity of the medical profession upon his conviction on the current two charges is likely to be amplified.

107 In all the circumstances, we consider that Dr Ang's past record has limited relevance in mitigation.

Delay in the SMC's institution of the proceedings against Dr Ang

108 We turn next to the other mitigating factor considered by the DT. The DT, in sentencing Dr Ang to an aggregate fine of $25,000 for both charges, placed significant weight on the fact that there had been a long delay in the proceedings against Dr Ang. The SMC had taken four and a half years to serve the NOI on him following receipt of the Complaint (see [29] above). The DT considered that such a long delay would have caused Dr Ang considerable suffering over the years.

109 The first local reported judgment that appears to have explored the relevance of delay as a mitigating consideration is the decision of the High Court in *Tan Kiang Kwang v Public Prosecutor* [1995] 3 SLR(R) 746 ("*Tan Kiang Kwang*"). There, Yong Pung How CJ held (at [20]) that although delay in prosecution might not, in itself, be a mitigating factor, the court could exercise its discretion to discount the sentence if the following cumulative conditions were met:

(a) There has been a significant delay in prosecution;

(b) The delay has not been contributed to in any way by the offender; and

(c) The delay has resulted in real injustice or prejudice to the offender.

110 Similarly, in *Chan Kum Hong Randy v Public Prosecutor* [2008] 2 SLR(R) 1019 ("*Randy Chan*"), V K Rajah JA held that while there is no general proposition that any or all delays in prosecution would merit a discount in sentencing (at [31]), the court may discount the sentence if the delay was inordinate, and the offender was in no way responsible for the delay (at [32]-[33]). While *Tan Kiang Kwang* and *Randy Chan* were both decisions concerning criminal sentencing, the principles enunciated there are, in our judgment, also applicable in quasi-criminal proceedings such as this.

111 Fairness is the underlying rationale that explains the court's willingness to apply a discount in such circumstances. As noted in *Randy Chan* (at [23]) and *Tan Kiang Kwang* (at [20]), from the point of view of fairness to the offender, where there been inordinate delay in prosecution, the sentence should reflect the fact that the matter has been pending for some time, likely inflicting undue suffering on the offender stemming from the anxiety, suspense and uncertainty. This, however, is subject to certain qualifications. As stated at [109] above, there are a number of conditions that must be met before delay in proceedings can be considered a mitigating factor for the purpose of sentencing. In addition, while the underlying rationale for a sentencing discount to be applied in such cases of delay is fairness to the offender as an individual, broader public interests which demand the imposition of stiff penalties may sometimes take precedence. Each of these elements are elaborated below.

The type of delay that may warrant a reduction in sentence, and how delay is to be measured

112 For delay in the institution or prosecution of proceedings to be taken into account as a mitigating factor, the delay must be inordinate. Time is needed for criminal and quasi-criminal processes to run their course. In the time taken for these processes to run their natural course, an offender may be subject to stress, anxiety and uncertainty. But unless there is *inordinate* delay in the process, no discount in sentence can be considered.

113 Whether or not there has been inordinate delay is not measured in terms of the absolute length of time that has transpired, but must always be assessed in the context of the nature of investigations. In *Randy Chan*, the court emphasised (at [36]) that:

> …[T]he length of delay involved must always be assessed in the context of the nature of the investigations – *viz*, whether the case involves complex questions of fact which necessarily engender meticulous and laborious inquiry over an extended period, or whether the case may be disposed of in a relatively uncomplicated manner (for instance, where the offender has fully admitted to his complicity). In the former scenario, an extended period of investigations might not only be expected, but also necessary and vital to uncover sufficient evidence to bring the accused to trial. …

The delay must not have been occasioned by the offender

114 A sentencing discount will not be considered when the delay is occasioned by the offender himself: see *Randy Chan* at [32]-[33]. The underlying rationale for sentencing discounts to be applied in appropriate cases of delay is fairness to the offender. However, there will be no unfairness to the offender if, by virtue of his own conduct or of matters that are within his control, he chooses to prolong the process. He must, in such situations, suffer the consequences of his own decisions and actions.

The kind of prejudice suffered that may be taken into account

115 The court has recognised that the 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: see *Tan Kiang Kwang* at [20] and *Randy Chan* at [24].

116 In the context of disciplinary proceedings for professional misconduct, such prejudice might be exacerbated if, for instance, news that a doctor has been investigated for professional misconduct has become public such that he has had to run his practice under the cloud of a tarnished name and an impending prosecution which remains in the public eye even as it is delayed.

117 In appropriate cases, other types of prejudice, such as the loss of income or career opportunities, may also be taken into consideration. In all cases, however, the burden is on the offender to prove that he has suffered particular prejudice by reason of the delay.

Countervailing public interest considerations

118 The underlying rationale of fairness to the offender which justifies the imposition of a sentencing discount in cases of delay may, on occasion, be offset or outweighed by the public interest which demands the imposition of a heavier penalty. As the court noted in *Randy Chan* (at [35]), considerations of fairness to the individual offender may be substantially irrelevant if the offence in question is particularly heinous or where the offender is recalcitrant or has numerous antecedents. As stated (at [89] above), in the context of disciplinary proceedings for professional misconduct, the relevant public interests that must be considered include the need to protect public confidence and the reputation

of the profession, as well as the need to protect the public from the potentially severe outcomes arising from the actions of errant members of the profession.

Whether there has been an inordinate delay in the SMC's institution of proceedings against Dr Ang and the effect of such delay in sentencing

119 In that light, we turn to the facts and circumstances of the present 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 NOI to Dr Ang. By the time the DT delivered its verdict on conviction and sentence, more than five and a half years had passed since the Complaint was lodged.

120 The SMC concedes that there was a long time lag between its receipt of the Complaint and its issuance of the NOI, but says that the delay was not inordinate. According to the SMC, investigations by the CC and the preparation of the case against Dr Ang required a longer time due to the complexity of the medical issues involved, as borne out by the many articles that were presented by both parties during the inquiry before the DT. It also says that its search to find senior specialists in the two fields of oncology and thoracic surgery who were willing and able to act as expert witnesses (as well as panel members on the DT) was unusually difficult and protracted, because many potential appointees declined to be involved ostensibly on account of conflict of interest (whether actual or apparent), having regard to the seniority and eminence of Dr Ang. Eventually, SMC had to incur additional expense to locate an international expert thoracic surgeon to be one of its experts. There were also other causes of delay which were beyond SMC's control, such as the resignation of the chairman of the DT due to ill health.

121 Even if we accept all these as true, they are insufficient to explain why the SMC had taken the time it took to issue the NOI to Dr Ang. In particular, we note:

(a) The CC took almost one and a half years to conduct investigations, obtain an expert report from Dr Gilberto Lopes, and deliberate.

(b) The SMC then took another three years to obtain two further expert reports, liaise with the witnesses, prepare the NOI, and constitute the DT. Even if the SMC had difficulty finding expert witnesses locally as it says it had, it was open for the SMC to have begun its search for expert witnesses overseas much earlier.

(c) Between January and March 2014, one member of the first DT recused herself and the chairman resigned on account of ill health. However, it was not till a year later on 11 March 2015 that the SMC revoked the appointment of the first DT and not till April 2015 that the second DT was constituted.

122 We therefore find that there has been inordinate delay on the part of the SMC in instituting and prosecuting the proceedings against Dr Ang. The delay in this case cannot be attributed to Dr Ang. The SMC carries a regulatory and adjudication function affecting the professional livelihood of doctors. We stress, as we did in *Low Cze Hong* (at [89]), that the SMC must approach the prosecution of disciplinary cases with due expedition and care.

123 The SMC argues that there is no evidence that the delay had caused any prejudice to Dr Ang. We do not accept that. Dr Ang was first notified by the CC of the Complaint on 27 June 2011. He provided the Explanation as requested by the CC on 19 July 2011, but it was not till 2 May 2012 that he heard back from

the CC that the matter would be referred for a formal inquiry (see [10] above). He then had to wait another three years, before he received any further information on the charges against him. Dr Ang says that the matter has been hanging over his head and caused him great anxiety and distress. We accept this as a matter of natural inference.

124 However, we do not think that Dr Ang has suffered any prejudice in the conduct of his defence that can be attributed to the delay. He was notified by the CC of the Complaint on 27 June 2011 by letter, about six months after the Complaint was lodged, and asked to provide his Explanation. While the allegations against Dr Ang that were stated in that letter were somewhat different from the charges that were eventually brought against him, we are satisfied that it would have sufficiently alerted Dr Ang to the need to collate and preserve the relevant evidence with respect to his treatment of MT.

125 Dr Ang also says that he has suffered prejudice in the form of lost opportunities for him to expand his practice overseas during the period of delay, leading to serious monetary repercussions. He says that he requires a certificate of good standing from the SMC to expand his practice overseas, but once a complaint against a doctor is lodged with the SMC, the SMC will hold the doctor's certificate of good standing in abeyance until the conclusion of the proceedings. Nonetheless, Dr Ang has furnished no evidence that he had lost any real chances to expand his practice overseas, or that he has suffered any other impediment to his business and career development during the period of delay. In fact, from the time of the Complaint, Dr Ang has held and continues to hold the position of Medical Director and Senior Consultant of the PCC. He also remains a council member of the Singapore Cancer Society, and was even nominated by the society for a National Day award in 2015. Further, from the time Dr Ang and a group of other doctors incorporated a medical oncology

service provider named TalkMed Group Limited ("TalkMed") in 2013 and then had it listed in 2014, Dr Ang has held the position of Chief Executive Officer and Executive Director of the company. TalkMed has since expanded its services beyond Singapore's shores to China and Vietnam. The SMC further informs us that following a general announcement by TalkMed on 18 July 2016 regarding Dr Ang's conviction by the DT on the two charges, there has been little or no impact on the prices of TalkMed's shares.

126 Accordingly, we are satisfied that Dr Ang has not discharged his burden of proving that he has suffered prejudice beyond the anxiety and distress of having the proceedings hanging over his head, that can be attributed to the delay.

Our decision on sentence

127 In the final analysis, we are satisfied that even though there was no allegation that Dr Ang's treatment of MT was inappropriate, or that MT's disease outcome would have been better but for Dr Ang's professional misconduct, his misconduct in relation to both charges was serious. Taking the two charges together, what Dr Ang had done was to give MT (and her family) a false hope, by presenting an optimistic picture that she was likely to have her disease under control with his prescribed therapy, when he did not in fact have any reasonable basis for such optimism. At the same time, having misrepresented the position, Dr Ang then denied her of the opportunity to consider and perhaps to choose the alternative course of surgery, which was not only viable but was in fact her only, albeit slim, chance of cure.

128 The sentence to be meted to Dr Ang must reflect the severity of the charges. Taking into account the aggravating factors as we have set out above, we would have imposed on him a suspension for an aggregate period of 16 months in respect of the two charges. However, we do then take into

consideration the inordinate delay in the institution and prosecution of the proceedings which has caused him prejudice in the form of having to endure the anxiety and distress of the proceedings hanging over him for a prolonged period. Having considered these matters and balancing that against the relevant interests of protecting public confidence and the reputation of the profession, we consider that the aggregate sentence of suspension in this case ought to be halved to a period of eight months.

Conclusion

129 For these reasons, we dismiss Dr Ang's appeal in Originating Summons No 8 of 2016. His conviction in respect of both charges is upheld. We allow the SMC's appeal in Originating Summons No 9 of 2016, and substitute the DT's sentence of a global fine of $25,000 in respect of both charges with a total term of suspension for eight months. This term of suspension is to commence four weeks from the date of this judgment. The DT's other orders that Dr Ang be censured, and that he give a written undertaking to the SMC that he will not engage in the conduct complained of or similar conduct in the future, are to stand.

130 The parties, unless they come to an agreement on costs, are to make submissions by letter, limited to eight pages, on the appropriate orders as to costs. These submissions are to be filed within 14 days of the date of this judgment.

Sundaresh Menon	Andrew Phang Boon Leong	Judith Prakash
Chief Justice	Judge of Appeal	Judge of Appeal

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