IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2017] SGHC 260

Originating Summons No 11 of 2016

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

And

In the matter of Order 55 of the Rules of Court (Cap 322, Rule 5)

And

In the matter of an Order by the Disciplinary Tribunal of the Singapore Medical Council made on 29 November 2016 under Section 53 of the Medical Registration Act (Cap 174, 2004 Rev Ed) against Dr Lam Kwok Tai Leslie

Between

LAM KWOK TAI LESLIE

… *Appellant*

And

SINGAPORE MEDICAL COUNCIL

… *Respondent*

JUDGMENT

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

Lam Kwok Tai Leslie
v
Singapore Medical Council

[2017] SGHC 260

High Court — Originating Summons No 11 of 2016
Sundaresh Menon CJ, Andrew Phang Boon Leong JA and Steven Chong JA
27 July 2017

20 October 2017 Judgment reserved.

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

Introduction

1 The appellant in this originating summons, Dr Lam Kwok Tai Leslie ("Dr Lam"), is a cardiologist in private practice. He commenced practice in 1967, and until the present proceedings, had maintained an unblemished record of professional service. The present proceedings stem from an invasive procedure known as a Percutaneous Coronary Intervention ("PCI") that he carried out on a patient ("the Patient") in 2011. Following a complaint made by the Patient, three charges were brought against Dr Lam. An inquiry was conducted by a Disciplinary Tribunal ("DT") appointed by the Singapore Medical Council ("the SMC"), at the end of which Dr Lam was convicted of one charge of professional misconduct under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("the MRA") for having failed to obtain informed consent from the Patient prior to carrying out the PCI, in breach

of Guideline 4.2.2 of the 2002 edition of the SMC's Ethical Code and Ethical Guidelines ("the SMC ECEG"), which was the edition in force at the material time. Dr Lam was acquitted of the other two charges. The DT imposed a sentence of three months' suspension from practice on him, and also ordered him to pay one-third of the costs and expenses of the inquiry to the SMC.

2 By way of this originating summons, Dr Lam appeals against his conviction; in the alternative, he appeals against the sentence of three months' suspension and submits that if his conviction is upheld, he should be sentenced to a fine instead. The main issue in this appeal is whether the DT erred in finding professional misconduct on Dr Lam's part, having regard to the evidence that was led before it.

Background

3 A PCI is a procedure used to open a blocked coronary artery by placing stents, which are small mesh tubes, in the affected artery to support its inner wall. It was described by one of the SMC's expert witnesses as a "complex, invasive [procedure] with higher risk".

4 The complaint in question was brought by the Patient, a foreign national, arising from Dr Lam's management of his condition in March 2011. The Patient had a history of coronary artery disease, hypertension and hyperlipidaemia. He had previously undergone a PCI at Raffles Hospital in 2006, when three stents had been placed. In March 2011, the Patient visited Singapore and sought a suitable doctor to provide follow-up treatment.

5 On 10 March 2011, the Patient had his first consultation with Dr Lam. The following tests were carried out to establish the Patient's condition: (a) an Electrocardiogram ("ECG"); (b) an Echocardiogram; (c) an Exercise Stress

Test; and (d) a Computed Tomography ("CT") Angiogram. It was Dr Lam's case that at this consultation, he explained to the Patient the benefits, risks and possible complications of a PCI as well as the alternative treatment options available (collectively referred to hereafter as "the PCI benefits, risks, complications and alternatives"). The results of the CT Angiogram became available the following day, 11 March 2011, which was the date of the second consultation. The Patient's coronary arteries appeared to be in good condition, with indications of only minor stenosis (the narrowing of blood vessels, leading to restricted blood flow) at some locations. No stenosis was evident in the Left Anterior Descending Artery ("LAD Artery") proximal or distal to the stents that had previously been inserted. However, Dr Lam told the Patient that he did not consider the CT Angiogram results to be sufficiently reliable, and advised him to undergo a Conventional Angiogram as well. Dr Lam also informed the Patient that he should proceed with a PCI if any high-grade stenosis were found in the course of the Conventional Angiogram. The consultation concluded with the Patient leaving to consider Dr Lam's advice.

6 The third consultation took place on 17 March 2011. On that occasion, Dr Lam again informed the Patient of his view that the findings from the CT Angiogram were not sufficiently reliable, and recommended that the Patient undergo a Conventional Angiogram and, if necessary, a PCI. It was Dr Lam's case that he explained the PCI benefits, risks, complications and alternatives to the Patient again at this consultation; the Patient was also provided with brochures on Conventional Angiograms and Coronary Stenting. The Patient evidently accepted Dr Lam's advice, and agreed to undergo a Conventional Angiogram and, if necessary, a PCI. He then signed a consent form for a "Coronary Angiogram Keep in View Coronary Angioplasty" ("the KIV Form") at Dr Lam's clinic.

7 The Conventional Angiogram was carried out on 18 March 2011. Immediately after the Conventional Angiogram, Dr Lam told the Patient that there was high-grade stenosis in his proximal LAD Artery, and advised him that that artery could be opened up by using a single drug-eluting agent. This involved placing in the artery a stent, which would then release, in a slow and controlled manner, a drug to prevent cell proliferation. The Patient agreed to let Dr Lam perform the PCI immediately. This was then done.

8 The following day, 19 March 2011, Dr Lam apprised the Patient more fully of what had transpired during the PCI and showed him the DVD recording of the procedure. In particular, Dr Lam informed him that two stents had been inserted. This was because the first stent had missed the site of the stenosis, as a result of which, a second stent was needed. The second stent had slipped back proximally and protruded partially into the left main stem. It is not in dispute in this appeal that despite this, the Patient did not suffer any harm as a result of Dr Lam's actions and his condition in fact improved after the PCI.

9 The Patient lodged a complaint against Dr Lam with the SMC on 17 August 2011. The essence of his complaint was that Dr Lam had performed the PCI when it was unnecessary, and, further, that in doing so, he had failed to apply the requisite skill. The Patient described the PCI as having been "shoddily done" [emphasis in bold in original omitted]. He also mentioned in his complaint that "[Dr Lam] proceeded with the PCI procedure without even once … informing [him] or explaining to [him] what [were] the potential risks and complications associated with the procedure" [emphasis in bold in original omitted]. The SMC sent Dr Lam a Notice of Complaint on 12 April 2012. This was more than a year after the PCI had been carried out. In response to the Notice of Complaint, Dr Lam tendered his written explanatory statement (the "Explanatory Statement") a little over a fortnight later on 28 April 2012. The

SMC then conducted further investigations before informing Dr Lam on 4 October 2013, more than 17 months after he submitted his Explanatory Statement, that the Complaints Committee had ordered a formal inquiry to be held by a DT.

10 Approximately two years later, on 25 September 2015, the SMC sent Dr Lam a Notice of Inquiry setting out three charges. The first charge ("Charge 1") was for professional misconduct under s 53(1)(*d*) of the MRA for having advised and persuaded the Patient to undergo a Conventional Angiogram and a PCI without due clinical evaluation of his test results. The second charge ("Charge 2"), which was brought under s 53(1)(*e*) of the MRA, was for failure to use proper skill and care in performing the PCI and stenting procedure on the Patient. The third charge ("Charge 3") was for professional misconduct under s 53(1)(*d*) of the MRA for having failed to "adequately advise the Patient of all the benefits, risks and possible complications of the [PCI] procedure and any alternatives available to him".

11 Charge 3 is the sole subject matter of the present appeal. It reads as follows:

> That you [Dr Lam] … are charged that, whilst being a registered medical practitioner at The Cardiac Centre …, [you] failed in your duty of care to … [the Patient] in that you had breached section 4.2.2 of the [SMC ECEG] in failing to ensure that the Patient was adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment in that:
>
> **PARTICULARS**
>
> (i) You failed to adequately advise the Patient of all the benefits, risks and possible complications of the Percutaneous Coronary Intervention ("PCI") procedure and any alternatives available to him;
>
> and that in relation to the facts alleged you have been guilty of professional misconduct under section 53(1)(d) of the [MRA].

12 It is undisputed that Dr Lam's clinical notes from his consultations with the Patient do not record that he explained the PCI benefits, risks, complications and alternatives to the Patient. However, it is also undisputed that the KIV Form, which was signed by the Patient, states in general terms that the Patient had been informed of "the nature, purpose, risks and alternatives" pertaining to a PCI.

The DT's decision

13 Dr Lam contested all three charges. The DT conducted the inquiry on 6, 7 and 21–23 June 2016. The SMC called Prof Lim Yean Leng ("Prof Lim") and Dr Ho Kay Woon ("Dr Ho") as its expert witnesses at the inquiry. Prof Lim's evidence related to Charges 1 and 2, while Dr Ho's evidence related to the consent-taking process in Charge 3. Dr Lam called Assoc Prof Philip Wong En Hou and Dr Philip Koh Siam Soon ("Dr Philip Koh") as his expert witnesses (collectively, "the Defence experts"); he also called his staff nurse, Siti Sundari binte Sudri ("the Staff Nurse"), as a factual witness. After the hearing on 23 June 2016, there was a break of almost six months before the DT convened a further hearing on 14 November 2016. About a fortnight later, on 29 November 2016, the DT delivered its written decision ("the Decision"), in which it acquitted Dr Lam of Charges 1 and 2 but convicted him of Charge 3.

Acquittal on Charges 1 and 2

14 Before we turn to the DT's assessment of Charge 3, it is worth noting the basis upon which the DT dismissed the first two charges. The particulars of Charge 1 asserted that Dr Lam had misinterpreted the Patient's test results, and, further, that this misinterpretation was not supported by the objective evidence and was also not in line with accepted standards of practice. It was alleged that consequently, Dr Lam induced the Patient to believe that a PCI was necessary when there was insufficient basis to warrant this conclusion. This was

purportedly done with a view to financial gain. The particulars of Charge 2 stated that the two stents had been implanted in a "suboptimal" manner, thereby exposing the Patient to "potential serious medical consequences".

15 The DT stated that its findings on Charges 1 and 2 "almost entirely turned on [its] evaluation of the expert evidence" (at [52] of the Decision). In relation to these two charges, the DT preferred the Defence experts' evidence to Prof Lim's evidence, and, among other things, noted Prof Lim's failure to take into account the results of the ECG done on 10 March 2011, the inconsistencies between his oral testimony and his written expert report, as well as the lack of supporting medical literature for some of his claims (at [53]–[55] of the Decision). The evidence of the Defence experts, in contrast, was found to be "logical, consistent, thorough, objective, reasoned and well-supported by medical literature" (at [59] of the Decision). In relation to Charge 2, the DT accepted the Defence experts' evidence that the PCI had been carried out with proper care and skill (at [87]–[88] of the Decision), and also noted that there had in fact been an improvement in the Patient's condition after the procedure.

16 Aside from preferring the Defence experts' evidence to Prof Lim's evidence on Charges 1 and 2, the DT also made some significant findings in relation to the Patient's factual testimony on Charge 1. This was relevant because those parts of the complaint which related to the matters dealt with in Charge 1 were overlaid with the Patient's suggestion that the PCI was ultimately unnecessary and had been contrived by Dr Lam for financial gain in the form of the associated fees that he stood to earn. On this, the DT was clear that the Patient was not "an unwitting patient who [had been] taken advantage of by [Dr Lam]" (at [69] of the Decision) despite the Patient's efforts to portray himself in that way. The DT stated as follows (at [68] of the Decision):

> … The Patient had sought to convey to the DT the impression that he was completely reliant on [Dr Lam]. On the record, the evidence revealed that:
>
> (a) by the time the Patient consulted [Dr Lam] on 10 March 2011, *he was as well-informed and knowledgeable as any lay person* [*sic*] *could be on matters concerning diagnosis and treatment options for [Coronary Artery Disease]*;
>
> (b) the Patient accepted at the inquiry that his discussions with [Dr Lam] were a "two-way" thing; and
>
> (c) *the Patient was an individual who had a fixed mind-set and knew what he wanted. He was certainly not afraid of discussing his medical condition with his doctor; and agreed with Counsel for [Dr Lam] that he was a person who was knowledgeable and had his own views.*
>
> [emphasis added; emphasis in original omitted]

17 On the basis of these findings, the DT concluded that the SMC had failed to prove Charge 1 beyond reasonable doubt, and, in particular, that Dr Lam had not misinterpreted the Patient's test results and had not induced the Patient to undergo unnecessary procedures with a view to financial gain. These findings are relevant to our decision on this appeal, as we shall explain further at [50]–[51] below.

Conviction on Charge 3

18 As mentioned earlier, Charge 3 concerned Dr Lam's alleged failure to "adequately advise the Patient of all the benefits, risks and possible complications of the [PCI] procedure and any alternatives available to him", in breach of Guideline 4.2.2 of the SMC ECEG. The SMC's case was that this breach was an "intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency" under the first limb of the test for professional misconduct set out in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") (at [37]).

19 The DT made the following observations:

(a) Charge 3 was "not about [Dr Lam]'s failure to maintain proper documentation" (at [99] of the Decision). However, the state of Dr Lam's documentation was nonetheless relevant in deciding whether Dr Lam's or the Patient's version of the material events relating to Charge 3 should be accepted. The fact that a doctor did not record the obtaining of informed consent from a patient was a relevant factor in deciding whether informed consent had actually been obtained (see likewise [99] of the Decision).

(b) Obtaining informed consent was not a matter of simply "supplying the patient with, and/or getting the patient to sign a set of comprehensive documents … containing all the information on the surgical procedure in question including the risks and complications and a list of alternative treatments" (at [100] of the Decision). If the doctor failed to personally take the time and make the effort needed to explain the relevant information to the patient and address any questions that the patient might have, he would have failed to discharge his legal obligation to obtain the patient's informed consent before performing the procedure even if the patient's signature had somehow been procured on a standard consent form.

(c) The DT noted that Dr Lam's case in relation to Charge 3 "was premised on the basis that he should be absolved from responsibility because the Patient '*appeared*' to be well-informed about his condition" [emphasis in original] (at [101] of the Decision). The DT rejected this argument because it considered that a doctor could not abdicate his professional responsibility simply because the patient appeared to him

to be well-informed. The knowledge of the patient was irrelevant since the onus was on the doctor to provide the patient with all the information that was necessary for him to make an informed decision on his treatment (see likewise [101] of the Decision). In obtaining informed consent, the doctor must not make any assumptions as to what the patient already knew, especially if the patient was new to him (at [102] of the Decision).

20 The DT was of the view that "[m]uch of the contest on Charge 3 turned on whether the DT accepted the Patient['s] or [Dr Lam]'s account of [the] events" (at [103] of the Decision). It held that it was "compelled to conclude on the evidence that there was no obtaining of informed consent by [Dr Lam]" (at [105] of the Decision), and found that the SMC had proved Charge 3 beyond reasonable doubt. This conclusion was based on the following reasons:

(a) Under cross-examination, Dr Lam said that he could not specifically recall whether the Patient had signed the KIV Form in his presence and whether he had explained to the Patient the contents of the Conventional Angiogram and Coronary Stenting brochures provided to him at the third consultation (at [111] of the Decision). Similarly, the Staff Nurse was not certain whether those brochures had indeed been handed to the Patient because she had not been present at the material time (at [100] of the Decision).

(b) The objective evidence supported the Patient's assertion that Dr Lam "did not personally explain to him the nature, procedural risks and complications of the [C]onventional [A]ngiogram and PCI" (at [104] of the Decision). Dr Lam could not produce any documentation such as his clinical notes to show that he had explained these matters to

the Patient, and this lack of documentation had to be assessed in the light of the requirement in Guideline 4.1.2 of the SMC ECEG that doctors keep "clear records of patient consultations". Furthermore, Dr Lam's assertion that he had explained these matters to the Patient was not corroborated by any independent witness or other objective evidence (at [105] of the Decision).

(c) Dr Lam's Explanatory Statement to the SMC, which was his "first written explanation to the SMC" in response to the Notice of Complaint, "made no mention … that he [had] told the Patient of the risks, complications and alternatives of a PCI procedure" (at [106] of the Decision). This lent support to the SMC's submission that Dr Lam's detailed assertion to the contrary in his statement of evidence-in-chief dated 27 May 2016 ("SEIC"), which was written more than five years after the PCI was performed, was an afterthought (at [107] of the Decision).

(d) Although the Patient had signed the KIV Form stating that he had been apprised of "the nature, purpose, risks and alternatives" pertaining to a PCI, it was not disputed that the form itself did not contain that information, which Dr Lam maintained he had communicated to the Patient (at [104] and [111] of the Decision).

21 The DT found that Dr Lam had breached Guideline 4.2.2 of the SMC ECEG, which it described as "a yardstick for taking informed consent … [in respect of which] any breach would have amounted to professional misconduct per the first limb of the test in *Low Cze Hong*" (at [113] of the Decision). Dr Lam, the DT held, had a duty to explain "the 'benefits, risks and possible complications' of the procedure and any alternatives available to the Patient

before carrying out the [PCI]" [emphasis in original omitted], and this duty crystallised just before the Patient signed the KIV Form (at [115] of the Decision). The DT found that Dr Lam had failed to discharge this duty. As the DT "had reasons to believe that [Dr Lam] knew or ought to have known the duty under [G]uideline 4.2.2 of the SMC ECEG to obtain informed consent, and [Dr Lam] failed to discharge that duty", the DT held that "the only compelling conclusion was that [Dr Lam]'s said failure constituted an intentional and deliberate departure from the applicable standard of conduct" (see likewise [115] of the Decision).

Sentence and costs order

22 The DT then went on to consider the SMC's submission that a sentence of at least three months' suspension from practice should be imposed, Dr Lam's submission that a censure and the imposition of a fine would be sufficient, as well as the precedents cited by the parties. The DT imposed a three-month suspension as it found the High Court's decision in *Eu Kong Weng v Singapore Medical Council* [2011] 2 SLR 1089 ("*Eu Kong Weng (HC)*") the most relevant and helpful. The DT found that Dr Lam's case and *Eu Kong Weng (HC)* shared various similarities. In both cases, the doctors in question were very senior and experienced, and their culpability was correspondingly similar in that both doctors failed to obtain informed consent from patients who were to undergo invasive surgery (at [125] of the Decision). The DT also pointed out (likewise at [125] of the Decision) that in *Eu Kong Weng (HC)*, the court had expressly upheld the imposition of a three-month suspension from practice on the basis that it was "warranted in those circumstances", even though the court was "of the view that the statutory minimum of three months['] suspension was a little on the high side".

23 The DT noted that the maximum penalty which could be imposed under the MRA for professional misconduct had been increased ten-fold from $10,000 (the statutory maximum applicable in *Eu Kong Weng (HC)*) to $100,000, and considered whether a monetary penalty would be sufficient in Dr Lam's case. In this regard, the DT took guidance from *Eu Kong Weng (HC)*, where the High Court was of the view that the threshold for suspension had been crossed given the circumstances in that case. The DT accordingly found that even the maximum penalty of $100,000 would not be a sufficient deterrent in Dr Lam's case (at [126]–[127] of the Decision).

24 The DT also ordered Dr Lam to bear one-third of the SMC's costs and expenses arising out of the inquiry, given that he had been found guilty of one out of the three charges preferred against him (at [131] of the Decision).

Dr Lam's grounds of appeal

25 In his appeal against his conviction, Dr Lam raised three main points. In summary, they are as follows:

> (a) The DT erred in preferring the Patient's testimony on Charge 3. In particular, the DT failed to evaluate the Patient's credibility in the light of its acceptance of Dr Lam's testimony over the Patient's where the other two charges were concerned, especially in relation to the first charge. This "[could] only mean that the DT found Dr Lam more credible than the Patient" in that regard. Further, the DT failed to consider the Patient's admission under cross-examination that he had been "advised on some risks and complications of the PCI procedure, and that two-way discussions on the same [had taken] place during the consultations he had with Dr Lam". These factors weighed against the DT's conclusion that the Patient had undergone the PCI without being

apprised beforehand of any of the PCI benefits, risks, complications and alternatives. The DT also did not adequately consider the inconsistencies between the Patient's written and oral testimonies. All of these points were germane in evaluating which of the two competing versions of the material events was to be believed.

(b) The DT failed to accord sufficient weight to the fact that the KIV Form, "which expressly stated that the Patient had understood the nature, purpose, risks and alternatives of the procedure as explained to him by Dr Lam", was contemporaneous documentary evidence of Dr Lam's actions and of the fact that he had advised the Patient of the matters stated in the form. The DT also failed to consider or explain why the Patient would have signed the form if he had not in fact been advised by Dr Lam on the matters stated therein.

(c) The DT conflated the issue of whether informed consent *had been taken* with how the act of taking consent should be *documented*. The DT gave undue weight to the lack of contemporaneous clinical notes evidencing the taking of informed consent and Dr Lam's alleged failure to address this issue in his Explanatory Statement. The lack of documentation was only one factor in assessing whether the SMC had discharged its burden of proving Charge 3 beyond reasonable doubt and should not have been treated as virtually conclusive of the issue. Nor should Dr Lam's failure to deal in detail in his Explanatory Statement with the process of obtaining informed consent be treated as conclusive evidence that he had not in fact done what was incumbent on him to do.

26 In relation to the question of sentence, Dr Lam contended as follows:

(a) A fine was more appropriate than the three-month suspension imposed by the DT, especially in the light of the fact that the maximum fine stipulated in the MRA for professional misconduct had been increased from $10,000 to $100,000. A fine at the higher end of the enhanced range would be adequate, and would also be appropriate to serve the ends of justice and fairness.

(b) The DT erred in law when it treated as irrelevant the question of whether or not the Patient was already aware of many of the PCI benefits, risks, complications and alternatives. The Patient in fact possessed all the relevant and material knowledge pertaining to a PCI, given that he had previously undergone the same procedure in 2006, and therefore had not suffered any loss of his autonomy to make an informed decision on matters concerning his own treatment. Indeed, as the DT acknowledged, the Patient actually experienced an improvement in his condition after the PCI. If this did not exculpate Dr Lam, at the very least, it very significantly mitigated his culpability.

(c) The DT gave little or no weight to the other mitigating factors in the present case, such as the fact that Dr Lam "had no intention to harm the Patient", as well as the fact that he had a "long and distinguished service in the medical profession" and a "previously unblemished record". This conviction had come towards the end of "a long and distinguished career", and Dr Lam, who was already 75 years old this year, was close to retirement. A suspension in such circumstances would be "unduly harsh and severe".

27 In relation to costs, Dr Lam contended that even if he failed in this appeal, it would be more appropriate for him to bear only 20% of the costs and

expenses of the inquiry before the DT because much more time and effort had been channelled towards dealing with Charges 1 and 2, where the evaluation of competing expert evidence had been required, and in respect of which Dr Lam was eventually acquitted.

The applicable legal principles

28 Under s 55(11) of the MRA, the High Court "shall accept as final and conclusive any finding of the [DT] relating to any issue of medical ethics or standards of professional conduct unless such finding is in the opinion of the High Court unsafe, unreasonable or contrary to the evidence". In *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*") (at [39], citing *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 at [32]), we reiterated that the court would have to make one or more of the following findings before it could interfere with the decision of a DT:

(a) there was something clearly wrong either:

(i) in the conduct of the disciplinary proceedings; and/or

(ii) in the legal principles applied; and/or

(b) the findings of the DT were sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence had been misread.

29 Further, in assessing a DT's decision, the court should be mindful that the DT had had the benefit of hearing oral evidence and was "a specialist tribunal with its own professional expertise and underst[ood] what the medical profession expect[ed] of its members": *Wong Him Choon* at [40], citing

Gobinathan Devathasan v Singapore Medical Council [2010] 2 SLR 926 at [29].

The particularity with which a charge is framed

30 Before turning to our decision on Dr Lam's appeal, we find it necessary to first make some observations on the particularity with which Charge 3 was framed by the SMC in the Notice of Inquiry, even though this was not a point raised by Dr Lam. The particulars of Charge 3 were effectively a reproduction of the contents of the duty in Guideline 4.2.2 of the SMC ECEG, which states:

> 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 alternatives available to him.* … [emphasis added]

For ease of comparison, we set out again the particulars of Charge 3 below:

> (i) You failed to adequately advise the Patient of ***all*** *the benefits, risks and possible complications* of the Percutaneous Coronary Intervention ("PCI") procedure and any alternatives available to him … [emphasis added in italics and bold italics]

31 In our judgment, Charge 3 was framed in ambiguous terms because, on a plain reading, there are at least two possible interpretations of the SMC's case on this charge – that Dr Lam's misconduct lay in: (a) informing the Patient of *some, but not all,* of the PCI benefits, risks, complications and alternatives; or (b) informing the Patient of *none* of these matters. If it were the SMC's case that *some, but not all,* of the PCI benefits, risks, complications and alternatives had been explained to the Patient, then it was incumbent on the SMC to list and describe specific material benefits, risks, complications and alternatives that had allegedly been omitted. If, on the other hand, it were the SMC's case that *none*

of these matters had been communicated to the Patient, then quite apart from the fact that it seems to us that adopting this stance on Charge 3 might not be wise (for reasons which we shall shortly explain), it would be necessary for the SMC to frame the particulars of the charge in such terms. This is vital because in order to rebut a charge of failing to advise a patient on *any* of "the benefits, risks and possible complications of [a] procedure and any alternatives available to him", the doctor concerned would only have to show that he had informed the patient of one or some of the relevant benefits, risks, complications and alternative treatment options. In our judgment, any other view would likely result in unfairness to the doctor as well as lead to proceedings that would likely be unfocused and/or unnecessarily prolonged. This is in line with the Court of Appeal's recent holding in *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] 2 SLR 492 ("*Hii Chii Kok*") (at [132]), in the context of a medical negligence action, that it was a threshold requirement for the patient to "identify the exact nature of the information that he allege[d] was not given to him and establish *why* it would be regarded as relevant and material" [emphasis in original]. In that case, the identification of the omitted information was necessary in order to determine whether the doctor possessed that information at the material time, and if so, whether the withholding of the information was justified. The underlying concern in *Hii Chii Kok* is the same as that in the present case, which is to ensure that the scope of the dispute is clearly delineated so that the litigation process or disciplinary proceedings (as the case may be) are focused and fair to the doctor facing the allegations.

32 At the hearing of this appeal, we clarified the ambiguity in Charge 3 with the SMC's counsel, Mr Philip Fong ("Mr Fong"), who informed us that the SMC's case on this charge was that *none* of the PCI benefits, risks, complications and alternatives had ever been conveyed or explained to the

Patient. We return here to the point that we have just alluded to in the previous paragraph, which is that this might not always be a wise course to take in respect of a charge of failure to obtain informed consent. As noted above, on the basis of the SMC's case on Charge 3, if Dr Lam could prove that he had specifically communicated to the Patient just a single benefit, risk, complication or alternative treatment option pertaining to a PCI, it would appear that Charge 3 would fail. But this seems not to get to the real concern in this context, which is what information had in fact *not* been conveyed and the materiality of the omitted information.

33 A precise formulation of a charge, whether in criminal or quasi-criminal proceedings like the present case, is critical because it serves to put the respondent on notice of the exact case that he must meet. The concern that the respondent is given fair and adequate notice of the allegations against him is not new: see, for instance, *Viswanathan Ramachandran v Public Prosecutor* [2003] 3 SLR(R) 435 at [24]. It is a cardinal principle of natural justice that no person shall be condemned unless he has been given notice of the allegations against him and afforded a fair opportunity to be heard. In our judgment, the particulars laid out in Charge 3 did not give Dr Lam a sufficiently clear idea of the precise allegations that he had to meet. Further, the lack of particulars could at the very least have had implications on sentencing if it turned out that Dr Lam had conveyed some of the PCI benefits, risks, complications and alternatives to the Patient, but not others. However, this would only be material if Dr Lam's conviction were upheld, and it is to this issue that we now turn.

Our decision

34 Having considered the record of proceedings and the parties' submissions, we are satisfied that Dr Lam's conviction on Charge 3 is unsafe.

In summary, we arrive at this view because, in our judgment, the DT placed undue emphasis and weight on the fact that the taking of consent was not adequately reflected in Dr Lam's contemporaneous notes. As we explain below, we think that while this was a relevant factor in the present case, it should not have been treated as one that was virtually determinative of the central issue in Charge 3, namely, whether or not Dr Lam had in fact obtained the Patient's informed consent. The burden was on the SMC to establish beyond reasonable doubt that Dr Lam had not done so. In assessing whether the SMC had discharged this burden, the DT had to consider the *totality* of the evidence that was adduced before it, including the absence of contemporaneous notes documenting the taking of consent. In our judgment, the DT failed to do this. When the totality of the evidence is considered, we are satisfied that Dr Lam's conviction on the third charge cannot stand.

35 Before we set out the reasons for our decision, we should state that it is the *totality* of these reasons which causes us to be amply satisfied that reasonable doubt has been raised in respect of Dr Lam's guilt, even though it is possible that at least some of these reasons standing on their own might have sufficed.

Preliminary observations on the approach to the evidence

36 The starting point of the analysis in this case is to consider the relevant burden of proof. From Dr Lam's perspective, all he had to show was reasonable doubt in the SMC's case on Charge 3. In assessing this, it was incumbent on the DT to have regard to several points. For convenience, we list them as follows:

(a) the Patient's overall credibility, having regard to the inconsistencies in his evidence as well as in the light of how the DT had received his evidence on the other charges against Dr Lam;

(b) the KIV Form evidencing Dr Lam's case that the Patient had been advised of the PCI benefits, risks, complications and alternatives, which had to be carefully considered in the context of the applicable burden of proof;

(c) Dr Lam's unchallenged evidence as to his usual practice in obtaining the informed consent of his patients;

(d) Dr Lam's explanation for the brevity of his Explanatory Statement in relation to Charge 3; and

(e) the Patient's own awareness of the relevant benefits, risks, complications and alternative treatment options.

37 The DT failed to give proper consideration to the above matters. Instead, it treated the lack of contemporaneous documentation setting out the *details* of the consent-taking process as virtually determinative of the SMC's case against Dr Lam on Charge 3. In our judgment, this was erroneous as a matter of principle.

38 Because much of our analysis in this appeal turns on the correct approach to evaluating the evidence and weighing the burden of proof, it is helpful for us to make further observations on this point. Where a court (or tribunal, as the case may be) is concerned with the standard of proof beyond reasonable doubt, it should be mindful that this standard is unlikely to be satisfied if all that is before it are two competing and equally plausible versions of the material facts. It is incumbent on the court in such circumstances to examine each side's contentions in the light of other objective facts and consider the extent to which it can properly be said that the party bearing the burden of proof has in fact discharged it.

39 In this regard, the decision of the English Court of Appeal in *In re Bramblevale Ltd* [1970] 1 Ch 128 provides helpful guidance. There, one Mr Hamilton, the managing director of a company in winding-up proceedings, failed to comply with a registrar's order to produce the company's books and records in full. Mr Hamilton became the subject of committal proceedings commenced by the liquidator and was committed to prison as a result because the judge did not believe his explanation that the documents which had not been produced had been damaged as a result of a car accident on 25 October 1967 and subsequently thrown away. The judge dismissed Mr Hamilton's application for release, taking the view that there were "as a matter of logic" only two possibilities (at 130) – either Mr Hamilton still had the documents in question, or he no longer had them, whether by reason of loss, destruction, transfer to third parties or otherwise. Since the evidence showed that Mr Hamilton's possession of the documents had never been terminated, Mr Hamilton had not purged his contempt and therefore should not be released. The appeal from the judge's decision was allowed by the English Court of Appeal, with Lord Denning MR delivering the leading judgment. His Lordship held that the burden of proof for contempt of court in civil proceedings was proof beyond reasonable doubt, and observed (at 137D–F) that:

> On this charge, the court has to see whether there is sufficient evidence that Mr. Hamilton did have these books in the week of November 28 to December 5 of 1968. On his own confession, he had them on October 25, 1967; but there is nothing more. That confession leaves two possibilities: either that he had them on that date in November, 1968, and wrongfully refused to deliver them; or alternatively, that he got rid of them before that time so that he could not deliver them. *Those two possibilities are equally likely. It is not possible to say which of them is correct. The court cannot be satisfied beyond reasonable doubt that he still had the books in November, 1968. That would be conjecture rather than inference – surmise rather than proof. Where there are two equally consistent possibilities open to the court, it is not right to hold that the offence is proved beyond reasonable doubt.* Mr. Hamilton's conduct in telling lies was

> very reprehensible. But it is not sufficient ground for holding that he committed contempt of court about these two books. … [emphasis added]

40 It is therefore clear that if it is simply the case that two competing versions of the material events are "equally likely", then the standard of proof beyond reasonable doubt would not be met. In the present case, it is *not* our position that the DT was wrong to take into account the lack of accurate and contemporaneous documentation of consent-taking as evidence which might suggest that Dr Lam in fact failed to obtain the Patient's informed consent. Indeed, we note that in other cases that were cited to us concerning a doctor's failure to obtain a patient's informed consent, such as the decisions of the Disciplinary Committee (the then equivalent of the DT) in *Singapore Medical Council v Dr Koh Gim Hwee* (13 June 2011) ("*Koh Gim Hwee*") and *Singapore Medical Council v Eu Kong Weng* (10 July 2010) ("*Eu Kong Weng (DC)*"), the lack of accurate and contemporaneous documentation of consent-taking was found to be relevant in determining whether informed consent had in fact been obtained. *However*, in those cases, other factors were also taken into account.

41 For instance, in *Eu Kong Weng (DC)*, the Disciplinary Committee, in coming to its decision to convict the doctor, took into account the inconsistencies in the doctor's evidence regarding the signing of the consent form by the patient (at [3]). It pointed out that the initial explanation which the doctor provided to the Complaints Committee omitted any reference to the provision of advice to the patient, which contrasted sharply with his later witness statement (at [22]). The Disciplinary Committee also found that the doctor's conduct in obtaining the patient's consent moments before performing the procedure was "unsatisfactory" and did not constitute the taking of informed consent (at [40]). In addition, the Disciplinary Committee considered the patient's testimony as to the circumstances in which he came to sign the consent

form despite not being sufficiently informed, and accepted the patient's testimony (that he was in a vulnerable state when he signed the consent form) in preference to the doctor's (at [44]). The Disciplinary Committee's decision was subsequently upheld by the High Court in *Eu Kong Weng (HC)*.

42 In *Koh Gim Hwee*, the doctor was found guilty of professional misconduct for (among other things) failing to obtain the patient's informed consent for a procedure known as "an induction of labour for trial of VBAC [vaginal birth after a Caesarean section]" at any point in time during his management of her pregnancy, specifically, from the day on which the patient first consulted him up to the day of the induced labour. The Disciplinary Committee noted the doctor's written explanation to the SMC as to his usual practice in explaining the risks of the procedure to his patients and his assertion that he had discussed the procedure with the patient. The Disciplinary Committee accepted that the antenatal advice provided by the doctor was routine, such that the lack of documentation did not count against him (at [7.2.2(c)]). However, the Disciplinary Committee went on to make a specific finding that on the day of the induced labour, when it became increasingly clear that the patient's situation was "far from routine" and not optimal for the procedure, the doctor ought to have obtained the patient's informed consent for the procedure at two critical junctures, but failed to do so (at [7.2.3]). In that regard, besides considering the lack of documentation of consent-taking in the doctor's clinical notes and the lack of specific mention of this in the doctor's written explanation to the SMC, the Disciplinary Committee also took into account the transcript of a conversation between the patient, the patient's husband and the doctor that had been secretly taped by the patient's husband, which supported the inference that the doctor had failed to obtain the patient's informed consent (at [7.2.2(d)]).

43 In short, in *Koh Gim Hwee* and *Eu Kong Weng (DC)*, the lack of accurate and contemporaneous documentation of consent-taking was taken into consideration *together with the totality of the other evidence* before the respective Disciplinary Committees concluded that on the whole, the charge of failure to obtain informed consent was made out.

44 In contrast, as will shortly become evident, the DT in the present case failed to consider or give sufficient weight to all the other pieces of evidence besides the lack of contemporaneous documentation of consent-taking. In particular, what the Patient said in his complaint in relation to Charge 3 was shaken by his evidence during cross-examination. In addition, the DT had rejected material parts of his evidence on Charge 1. Yet, these points were not considered by the DT when it came to assessing his evidence against Dr Lam's on the taking of consent. Further, while the DT placed considerable weight on the lack of contemporaneous notes of consent-taking in Dr Lam's file, it failed to adequately consider this against the KIV Form, which had been signed by the Patient and which directly contradicted the allegation in Charge 3. The DT also did not consider the significance of the fact that Dr Lam's testimony on his consistent practice in obtaining his patients' informed consent was not challenged. And although Dr Lam did respond in his Explanatory Statement to the allegation of failing to obtain the Patient's informed consent, unlike the doctor in *Eu Kong Weng (DC)*, the DT appeared to think that he had not done so at all.

45 At the same time, we wish to make an observation on the importance of proper record-keeping by doctors. Given the number of patients which doctors see daily, it is not unusual for them to be unable to recall the specifics of their interactions with a particular patient. It is for this reason that the accurate and contemporaneous documentation of each and every consultation is crucial. Such

notes would serve as a safeguard against disputes of the present kind from arising. In this regard, we note the recent decision of *Law Society of Singapore v Lau See Jin Jeffrey* [2017] 4 SLR 148, where the Court of Three Judges reminded the legal profession of the importance of the ethical duty to keep "accurate and contemporaneous attendance notes" (at [21]). The court observed there that an advocate and solicitor who failed to do so and whose account of the events relating to the complaint against him was at odds with his client's account ran the risk of a court rejecting his account in favour of his client's and/or drawing an adverse inference against him. In our judgment, the same duty to keep accurate and contemporaneous notes applies to doctors.

46 In the present case, we do not find Dr Lam's record-keeping satisfactory, but, as the DT itself noted at [99] of the Decision (see [19(a)] above), failure to maintain proper documentation is not what Dr Lam was charged with. We reiterate that the present case concerns the taking of informed consent, and not the keeping of accurate and contemporaneous records. In our judgment, despite Dr Lam's failure to fulfil the latter obligation, reasonable doubt was raised in the SMC's case in respect of the former obligation. In the light of the requirement in the 2016 edition of the SMC ECEG, which came into force on 1 January 2017, that doctors "must maintain clear, legible, accurate and contemporaneous medical records of sufficient detail" (see Guideline B3(1) thereof), we would expect that the SMC, moving forward, will consider preferring charges for failure to keep proper records in cases such as Dr Lam's.

47 We now turn to our analysis of the evidence.

Failure to consider the Patient's credibility as a whole

48 We begin by noting that the Patient's testimony on the taking of consent was diametrically opposed to Dr Lam's. The Patient's evidence (and what he said in his complaint) was that there had been no discussion on the PCI benefits, risks, complications and alternatives at all. Dr Lam, on the other hand, said that these matters had been discussed.

49 The Patient's complaint, consisting of three pages, focused largely on his dissatisfaction with various aspects of his interactions with Dr Lam, which formed the subject matter of the first two charges. In particular, much of the complaint was taken up with the Patient's dissatisfaction over the allegedly poor skill with which Dr Lam carried out the PCI, and the Patient's view that he had been misled into undergoing the Conventional Angiogram and then compelled or pressured into undergoing the PCI. The Patient complained, in essence, that he had been charged a large sum of money for an unnecessary procedure which had been poorly done. The complaint was 12 paragraphs long, and the Patient's dissatisfaction with not having been informed of "the potential risks and complications associated with [a PCI]" appeared only in the last sentence of para 6 and in the middle of para 10:

> 6 … And [Dr Lam] proceeded with the PCI procedure without even once (since I first stepped into his clinic on 10-03-11) informing me or explaining to me what are the potential risks and complications associated with the procedure.
>
> …
>
> 10 … The indiscretion on his part was all the more irresponsible and reckless as his poor skill at coronary intervention would have placed me at greatly increased risk of the potential serious complications which, as mentioned in Para 6 above, he had never even briefed me once. [NB: *I have since come to learn* that some potential serious complications of the PCI procedure are as follows: (a) During the procedure e.g. heart attack, stroke, coronary artery perforation, retained equipment [*sic*], severe allergic reactions, etc. (b) After the procedure e.g. stent

> thrombosis, contrast-induced kidney malfunction/failure, etc.]
> …
> [emphasis added; emphasis in bold in original omitted]

50 In our judgment, on a fair reading of the complaint, it is evident that its sting lay not in Dr Lam's alleged failure to inform the Patient of "the potential risks and complications associated with [a PCI]", but rather, in Dr Lam's alleged conduct in essentially pushing and railroading the Patient into undergoing an unnecessary and "shoddily done" procedure for monetary gain. The allegation of failure to obtain informed consent was appended almost as an afterthought. This has a material bearing on how the DT ought to have approached the evidence on Charge 3, which turned essentially on which of the competing versions of the material events the DT preferred. In that regard, we consider that it was incumbent on the DT to take into account as well how the Patient's evidence on the other charges against Dr Lam had been received as those charges formed a much larger part of the dispute. It will be noted that the DT did not accept the Patient's testimony on the other charges (see [16] above). Given these circumstances, the DT should have explained why, despite its rejection of the Patient's testimony on the other charges, it nonetheless preferred his testimony on Charge 3. However, this was not addressed by the DT at all in the Decision.

51 In this regard, it is material to note that, as the DT found, the Patient sought to present himself as an unwitting patient, wholly reliant on his doctor, who had in fact been taken advantage of by the latter (see [16] above). This was similar to the point which the Patient sought to make in relation to the taking of consent. He presented himself in his complaint as someone who was unaware of the risks and potential complications that he faced and whose ignorance was exploited by Dr Lam. But, as the DT noted in the Decision at [68], the Patient was in fact very "well-informed", "had a fixed mind-set" and "knew what he

wanted"; in short, he "was a person who was knowledgeable and had his own views". Further, he was apparently forthcoming in his discussions with Dr Lam on his medical condition. In our judgment, the Patient's evidence that he then underwent the PCI without any discussion on the relevant benefits, risks, complications and alternative treatment options, many of which he was evidently already aware of, seems improbable in this light.

52 In this context, it also bears noting that at para 10 of his complaint, the Patient stated that he did not know of the "potential serious complications of the PCI procedure" before he underwent the procedure. However, this was shown to be clearly untrue in the course of cross-examination by Dr Lam's counsel, Mr Lek Siang Pheng, when the Patient admitted that he had prior knowledge of many of the "risk[s] and complications" that could arise from a PCI:

> Mr Lek: … [A]ren't you trying to tell us that before the procedure on the 18th [of March 2011], you never knew what the risk and complications were and since then you have learned those things …?
>
> [The Patient]: Yeah, yeah, I didn't know, I didn't know in hindsight that I, I knew. Before that, I knew nothing about the risk and, and possible complications before the 18th of March 2011. But I didn't know, that time, I, I knew nothing. I, I, *I'm saying that I, I knew something, even quite something but it's not so complete.*
>
> …
>
> Mr Lek: Do you – before you underwent the procedure on the 18th of March 2011, did you know that there was a risk of stent thrombosis?
>
> [The Patient]: Ah, stent thrombosis? *Yes, Yes. This one I know.*
>
> Mr Lek: Did you know –
>
> [The Patient]: Yeah, there is a danger of stent thrombosis.
>
> Mr Lek: Did you know about the risk that if you had a stent in you, okay, that in itself increases the risk of stenosis?
>
> [The Patient]: Oh, increases the risk of stenosis? Uh, increases the risk of stenosis. Let me see ah. *Stenosis. Uh, yes.*

> …
>
> Mr Lek: Did you before the 18th of, of March 2011 ah, know, know that the risk of undergoing the procedures ah include heart attack, stroke, perforation of the coronary artery, during the procedures?
>
> [The Patient]: Uh, okay. *Heart attack or, or stroke, this one yes.* But the perforation of the coronary arteries ah, this one I don't know yet. I never heard of that one. This one I find out, find out later. …
>
> [emphasis added]

53 The Patient's admission in this regard was not surprising because, as we have already noted (at [4] above), he had undergone a similar procedure in 2006, which had involved the insertion of stents in the same area of the heart that was involved in the present PCI. In our judgment, this was a significant matter that affected the Patient's credibility because it showed that he had embellished the facts in his complaint. In view of this, it was incumbent on the DT to assess whether the Patient's evidence that there had been *no discussion* with Dr Lam at all on the PCI benefits, risks, complications and alternatives could be accepted as true beyond reasonable doubt, considering that the Patient: (a) was knowledgeable and well-informed about his illness generally as well as about the procedure specifically; (b) knew many of the relevant risks and complications; and (c) as mentioned at [16] and [51] above, had been found by the DT to be a person who "had a fixed mind-set and knew what he wanted", who "was certainly not afraid of discussing his medical condition with his doctor" and who had participated in "two-way" [emphasis in original omitted] discussions with his doctor on the same (at [68(b)]–[68(c)] of the Decision).

54 In our judgment, these factors, together with the fact that the Patient's testimony on Charges 1 and 2 had been rejected (see [16] above), ought to have been given careful consideration by the DT in assessing the evidence pertaining to Charge 3; and had this been done, we think it implausible that the Patient's

version of the material events relating to Charge 3 would have been so readily accepted. In our judgment, the DT erred in failing to consider the Patient's credibility in the light of the entirety of his evidence.

Failure to give sufficient consideration to the KIV Form and to correctly apply the burden of proof

55 The conviction of Dr Lam on Charge 3 appeared to rest very heavily on the absence of any contemporaneous documentation kept by Dr Lam evidencing the taking of consent from the Patient. As we have noted above, it is true that such documentation is lacking. However, the Patient did sign the KIV Form at his third consultation with Dr Lam. As Dr Lam pointed out during cross-examination, this signing came at the end of "3 days, three full sessions to discuss PCI with [the Patient]" (see the extract from Dr Lam's cross-examination reproduced at [69] below). Furthermore, as the DT found, these sessions had been with a knowledgeable, confident and assertive patient who, as we have already noted, was described by the DT (at [68(a)] of the Decision) as being "as well-informed and knowledgeable as any lay person [*sic*] could be on matters concerning diagnosis and treatment options" for his medical condition even at the time of the first consultation.

56 The KIV Form is a short form which begins with this material clause:

> I, the undersigned, consent to undergo the operation/procedure of Coronary Angiogram Keep in View Coronary Angioplasty *having understood the nature, purpose, risks and alternatives which were explained to me by Dr Leslie Lam.* [emphasis added]

57 The only other relevant clause in the KIV Form, which came immediately after the above clause and shortly ahead of the Patient's signature, was a consent to blood transfusion should the need arise, to "further or alternative operative measures or procedures as may be found [to be] necessary"

and to Dr Lam "seeking consultation or assistance from other relevant specialists if the need arises".

58 The KIV Form is not a prolix form, nor is the material clause therein buried in fine print. Moreover, in at least two places, there is, in bold capital font, a description of the form as one to give "**CONSENT FOR OPERATION OR PROCEDURE**" [emphasis in bold in original]. In these circumstances, it was incumbent on the DT to apply its mind to why the Patient would have signed the KIV Form, which it is not disputed he did, even as he maintained that the very thing which the form said had happened – namely, the explanation by Dr Lam to him of "the nature, purpose, risks and alternatives" pertaining to a PCI – had not in fact happened.

59 It is apposite to set out the DT's reasoning in this regard:

> 104. On this issue of obtaining informed consent, the inquiry merely uncovered the Patient signing a consent form on 17 March 2011 for the coronary angiogram and KIV PCI. Even then, based on the Patient's account, [Dr Lam] did not personally explain to him the nature, procedural risks and complications of the coronary angiogram and PCI procedure. It did not help [Dr Lam] that *the consent form did not contain the risks, complications and alternative treatment options*. Apart from the document evidencing the risk of contrast administration and its inherent risks, *[Dr Lam] was unable to produce any documentation such as the clinical notes* to show that he had explained to the Patient the nature, risks and alternatives to the coronary angiogram and PCI.
>
> 105. ***Given the above, the DT was compelled to conclude on the evidence that there was no obtaining of informed consent by [Dr Lam].*** *The clinical notes that [Dr Lam] disclosed to the SMC [were] absent of any informed consent from the Patient on the procedures in question.* … It did not help [Dr Lam]'s case that the [Staff Nurse] … could not say for certain if she saw [Dr Lam] explaining to the Patient about the procedures that he would undergo. … As [the Staff Nurse]'s evidence was not particularly helpful, [Dr Lam]'s assertion of having obtained informed consent was not independently corroborated. On the other hand, *the Patient's complaint that he*

> *did not give informed consent was* ***substantiated*** *by the clinical records maintained and produced by [Dr Lam].*
>
> [emphasis added in italics and bold italics]

60 Reading these paragraphs of the Decision, one is driven to conclude that the DT convicted Dr Lam on Charge 3 based almost entirely on the lack of documentation of consent-taking *alone*. This would be a clear error on one of two bases.

61 First, Charge 3 was not one of failing to document the taking of the Patient's consent (see [46] above). Yet, at [104] of the Decision, the DT's focus appeared to be on the fact that the KIV Form did not set out the PCI benefits, risks, complications and alternatives, and that the explanation of this information to the Patient was also not reflected in any other documentation such as Dr Lam's clinical notes. If the DT was of the view that Charge 3 was made out simply by Dr Lam's failure to document in detail his discussion with the Patient on the PCI benefits, risks, complications and alternatives, then it was seriously mistaken. Furthermore, the DT overlooked the fact that the KIV Form, on its face, was documentary evidence that Dr Lam *had* explained to the Patient "the nature, purpose, risks and alternatives" pertinent to a PCI. The DT appeared to be preoccupied with the fact that the precise "nature, purpose, risks and alternatives" had not been set out in the form. With respect, this was an incorrect way to approach Charge 3. As we noted earlier (at [32] above), the SMC's case on this charge was that *no discussion* of any sort on the PCI benefits, risks, complications and alternatives had taken place at all. That allegation was directly contradicted by the KIV Form. The SMC's case was not that specific matters in this regard had not been disclosed to the Patient; if that had been the SMC's case, then the DT's objection to the KIV Form might have been more germane.

62 In addition, despite not having considered the evidentiary significance of the KIV Form to the issue of whether some discussion on the PCI benefits, risks, complications and alternatives had taken place, the DT focused on the lack of other contemporaneous notes of consent-taking by Dr Lam to conclude that therefore, he had not shown that such a discussion had taken place. With respect, this was simply illogical.

63 We turn to consider the second basis on which to view the DT's approach to Charge 3. Here, we proceed on the alternative hypothesis that the DT treated the lack of documentation of consent-taking as an evidentiary matter only, meaning that the absence of such documentation was evidence that a discussion on the PCI benefits, risks, complications and alternatives had not taken place. In principle, we accept that the DT would have been entitled to proceed in that way *provided* it did not lose sight of the fact that the burden of proof remained on the SMC to establish beyond reasonable doubt that indeed, no such discussion had taken place. On this approach, the DT would have considered the absence of documentation as *one* factor in the overall balance. But it would then also have had to consider two other relevant matters – the evidentiary significance of the KIV Form, and the Patient's testimony as to why he signed that form even though (so he claimed) he had not been told of any of "the potential risks and complications associated with [a PCI]".

64 This is where the DT, on this alternative hypothesis, would nonetheless be found to have fallen into serious error. We return here to what we said at [38] above about the need for a court (or tribunal) to critically assess the competing and equally plausible contentions before it in the light of other objective facts and evidence, and, in that light, consider whether the party bearing the burden of proof beyond reasonable doubt has indeed discharged it. In the present case, the DT did not address the critical issue of why the Patient, whom it found to be

confident, knowledgeable, unafraid to raise issues concerning his medical condition with his doctor and clear about what he wanted, would, over the course of three consultations, have neglected to make a single inquiry about the PCI benefits, risks, complications and alternatives (many of which he was found to have been already aware of) and then merely signed the KIV Form indicating that these matters had been explained to him by Dr Lam if no such explanation had in fact been given to him. The Patient's testimony during cross-examination was that the signing of the KIV Form was not his first time signing a consent form of that nature, and that he "[had] not read the small print" on the KIV Form before signing it. But this, with respect, invited scrutiny. As we have noted above (at [58]), the material clause in the KIV Form could not be described by any stretch as being in "small print". Furthermore, it was one of only *two* relevant clauses in the form. Considering that the form was signed in advance of the PCI, it seemed to us implausibly convenient for the Patient to contend that he had signed the form unwittingly without having read it thoroughly. Indeed, the fact that the Patient had signed similar consent forms in the past meant that he could be expected to know the nature of the contents of such forms, which was to confirm that the benefits, risks, complications and alternative treatment options pertaining to a medical procedure had been explained by the doctor to the patient. Unfortunately, none of this appeared to have been considered by the DT.

65 In fact, it is evident from [105] of the Decision that the DT did not proceed in the way of carefully weighing the evidence at all. Instead, the DT treated the absence of documentation of consent-taking as virtually conclusive of the question of whether or not the Patient's informed consent had been obtained. This was where it made a serious error. It then compounded this error by: (a) suggesting that the burden was on Dr Lam to prove that he had obtained

the Patient's informed consent; and (b) counting the lack of documentation of consent-taking against Dr Lam. The burden on Dr Lam was only to raise reasonable doubt in the SMC's case on Charge 3. While the lack of documentation of consent-taking, if that were proved, might be taken into consideration, it could not possibly be conclusive. The DT appeared to reverse the burden of proof by approaching Charge 3 as if it was incumbent *on Dr Lam* to prove that the Patient's informed consent had been obtained.

66 Finally, we note that the DT's statement at [105] of the Decision that the Patient's complaint was "*substantiated* by the clinical records" [emphasis added] was erroneous. The clinical records did not state whether or not informed consent had been obtained from the Patient. They were therefore neutral and could not be said to have "*substantiated*" [emphasis added] the SMC's case that no informed consent had been obtained.

Failure to consider the unchallenged evidence of Dr Lam's consistent practice in relation to consent-taking

67 Dr Lam stated in his evidence that his consistent practice was to explain the "benefits, risks and possible complications" of coronary procedures such as Conventional Angiograms and PCIs to his patients before carrying out the procedures. This was not challenged during the inquiry, but it too was not considered by the DT.

68 In his Explanatory Statement, Dr Lam stated that "I have explained to [the Patient] this procedure way many times". He explained that his clinic's consistent practice was that "the patient must benefit from the procedure before we proceed with it. We also take great length[s] to explain to the patients and their family the procedure before the event." While the Explanatory Statement did not answer the allegation of failure to obtain informed consent in the precise

phraseology of explaining the PCI benefits, risks, complications and alternatives to the Patient, this has to be seen in the context of Dr Lam's unchallenged evidence that he had written the Explanatory Statement "rather hastily … without legal help", and also in the context of the fact that, as we noted earlier at [49]–[50] above, that part of the complaint which concerned the failure to obtain informed consent formed a relatively minor part of the Patient's narrative. In our view, the lack of precise phraseology in the Explanatory Statement did not detract from Dr Lam's assertion therein that he had explained the PCI benefits, risks, complications and alternatives to the Patient and that this was his clinic's consistent practice. The contents of the Explanatory Statement concerning Dr Lam's general practice in this regard were not challenged during cross-examination.

69 During cross-examination by the SMC's counsel, Mr Fong, Dr Lam reiterated his point that it was his consistent practice that the PCI benefits, risks, complications and alternatives would have been discussed during the Patient's consultations with him:

> Mr Fong: … [W]ouldn't you agree that explaining to [the Patient] alternative forms of treatment is a very important fact?
>
> Dr Lam: This is of course – but don't you talk to – when we talk to our patients, we talk about every kind of treatment. That has been brought about by him. Is it – let me put it that way to you. Um, [the Patient] coming to Singapore, all the way. He has seen many other cardiologists, and he would have done research to look for who he wants and so on. So obviously he knows exactly who he wants, what he wants. Now to come and say he doesn't know any of these things, … I mean …
>
> Mr Fong: So are you saying that because he is um, in your mind, knowledgeable of PCI treatments, you didn't owe a duty to ensure that he um, gave informed consent for the PCI procedure?
>
> Dr Lam: No, in fact, as I said, it is rare that we get three full sessions with us before he went for the angiogram and PCI, and trying to say that I coerced him – it's impossible, because on the

> 11th [of] March when I saw him after his CT Coros [*sic*], six days to think about what to do before he came back for the angiogram and PCI.
>
> Mr Fong: Okay, thanks for explaining that. So because of that, you feel that it wasn't necessary to ensure that he was fully informed of the risks? Because he had 6 days to contemplate?
>
> Dr Lam: No, no that's not what I said.
>
> Mr Fong: No, I'm just trying to understand and because your [*sic*] answered my question with that comment.
>
> Dr Lam: No, all I said was he had ample time to think, it doesn't mean that I didn't – *we had 3 days, three full sessions to discuss PCI with him. Surely for three sessions, we would have talked about all these kinds of things over and over again.*
>
> …
>
> Mr Fong: Well, I um – I'm going to suggest to you that you didn't respond to the complaint that he was not informed of the risks and alternative treatments for – of or for PCI procedures, because in fact, that is true. You didn't inform him of the risks and alternatives for the PCI procedure. Do you agree?
>
> Dr Lam: No, because every time when we discussed PCI, and in three separate occasions we discussed PCI with him, the risks would have cropped up. I mean, how can you talk about PCI – *I told him for example, there is a risk of one per 1,000 deaths, yes I definitely told him that. So, you mean to say that after three long sessions with me, that I had not discussed PCI at all? Once you discuss PCI, you must discuss the risks, which is the main thing.*
>
> [emphasis added]

70 Again, during cross-examination directed at the absence of clinical notes on the taking of informed consent, Dr Lam's response was that as a matter of his general practice, he would have and had in fact explained the PCI benefits, risks, complications and alternatives to the Patient:

> Mr Fong: … [T]here is nowhere in these clinical records which states that you had explained the risks of PCI to him, correct?
>
> Dr Lam: In the records, no. But I have – by the fact that he even admitted he took all the pamphlets, that *he signed the thing*. I just – write it down, I didn't know I was supposed to write it

> down every time when we explain notes of risk to the patient. We do this.
>
> Mr Fong: So you agree that you didn't record any informed consent in your clinic notes.
>
> Dr Lam: Not in my clinic notes, but when he signed the thing, he signed in front of us. When he signed the form saying that he has been informed. Unless he is saying that he signed it blindly.
>
> Mr Fong: Now I'm going to suggest to you that you did not explain the risks or complications associated with the PCI to [the Patient], because you assumed that he already knew the risks or complications.
>
> Dr Lam: *No, I have to disagree, because as I said, we had three sessions together. We were not going to talk about anything besides PCI – coronary angiogram and PCI.*
>
> …
>
> Mr Fong: Now, [the Patient] has given evidence that he did not sign the [KIV Form] in front of you. But you are saying that he did, correct?
>
> Dr Lam: *If you ask me four years ago did he sign in front of me, by and large most of the patients … signed in my room.* But suppose it so happens that [the Patient] walked out before he signed it and another patient comes in, then he signed it there – and to be true, the nurse will countersign. I really cannot remember. See, *so many patients sign so many of these forms, whether he was actually in the room with me when he signed it – but by and large the majority, yes, sign in front of me.*
>
> [emphasis added]

71 In our judgment, it is evident from these extracts of the evidence that Dr Lam asserted in his Explanatory Statement and then maintained throughout the course of cross-examination that he would have and had indeed explained the PCI benefits, risks, complications and alternatives to the Patient. It is true that he was driven at one point to base this on his practice, but we do not find this surprising because, as Dr Lam explained, he could not claim to have a specific recollection of a particular conversation of this nature which had taken place some years earlier. At no stage was Dr Lam challenged on his evidence

as to his practice in obtaining informed consent from his patients before performing coronary procedures such as PCIs. The cross-examination by the SMC's counsel seemed to be directed towards showing that the taking of consent was not documented in Dr Lam's clinical records. This was an unnecessary exercise since the lack of documentation was true as a matter of objective fact. When it was then put to Dr Lam that because of this, the inference to be drawn was that a discussion with the Patient on the PCI benefits, risks, complications and alternatives had not in fact taken place, Dr Lam disagreed. He pointed to, among other things: (a) his established practice of discussing "benefits, risks and possible complications" with his patients before they underwent coronary procedures; (b) the fact that the KIV Form had been signed; and (c) the fact that he had had "three complete sessions" with the Patient prior to the signing of the KIV Form, such that he found it "really unbelievable" that the Patient had complained that the requisite discussion had not taken place throughout that time. Unfortunately, the DT did not deal with Dr Lam's response in this regard at all.

Failure to consider Dr Lam's explanation for the lack of details on consent-taking in his Explanatory Statement

72 We turn to the next point, which relates to how the DT dealt with Dr Lam's explanation for the brevity of his Explanatory Statement when it came to addressing Charge 3. In arriving at its decision to convict Dr Lam of this charge, the DT relied in part on the contrast in the level of detail between Dr Lam's Explanatory Statement, which was fairly brief and prepared closer to the time of the Patient's consultations with Dr Lam, and Dr Lam's SEIC, which was much more detailed and prepared closer to the time of the inquiry. The DT viewed this contrast in the level of detail as supporting the SMC's contention that Dr Lam's claim in his SEIC that he had explained the PCI benefits, risks,

complications and alternatives to the Patient was an afterthought (see [20(c)] above).

73 In our judgment, the DT failed to assess Dr Lam's explanation for this contrast in the level of detail in the right context because, to begin with, it erred in finding (at [106] of the Decision) that in the Explanatory Statement, Dr Lam "made *no mention* … that he [had] told the Patient of the risks, complications and alternatives of a PCI" [emphasis added]. The DT stated (at [110] of the Decision) that Dr Lam's assertion that he had explained the procedure to the Patient "way many times" appeared only in a "*subsequent* written explanation to the SMC" [emphasis added]. This is clearly wrong because the Explanatory Statement, which contained Dr Lam's brief response to the complaint of failure to obtain informed consent, was the *first* written response by Dr Lam to the SMC's Notice of Complaint, and in it, he said that he had discussed the relevant PCI-related information with the Patient "way many times" (see [68] above). Therefore, it is not the case that Dr Lam made no mention in the Explanatory Statement of his having provided the Patient with the necessary information.

74 In addition, the DT failed to give sufficient weight to Dr Lam's testimony as to why the Explanatory Statement was so brief in responding to the allegation of failure to obtain informed consent. Dr Lam's testimony in this regard was an important and relevant consideration because the DT treated the brevity of the Explanatory Statement in relation to Charge 3 as corroborative of Dr Lam's failure to obtain the Patient's informed consent by virtue of that document having been prepared closer to the time of the events in dispute. Dr Lam's testimony during cross-examination was that he had always perceived the sting of the complaint against him to be directed at his clinical expertise and management of the Patient. He also testified that the point in the complaint

about his alleged failure to obtain the Patient's informed consent had not really caught his attention:

> Mr Fong: Did you take the notice of complaint very seriously? Or you didn't take it very seriously? What is the evidence?
>
> Dr Lam: *I just thought that someone is trying to judge on what my clinical expertise is, that's all.* That's the only part that I saw. And I didn't know it is such a, such a serious thing. …
>
> Mr Fong: Hmm. And I think you mentioned that you didn't try and even address the point about informed consent.
>
> Dr Lam: Yes, because *that actually never even caught my attention.*
>
> …
>
> Mr Fong: So when you read the – when you received the complaint, … you fully understood what the [P]atient was complaining about, correct?
>
> Dr Lam: No, *I really thought it was just about my clinical adjustments and so on.* That's why I was trying to reply to that. *It never occurred to me about – the word 'consent' also never even cracked into my mind then.*
>
> …
>
> Mr Fong: … I suggest to you that you are aware that one of the key complaints by the [P]atient was that he was not informed of the risk[s] and alternative options in respect of the PCI procedure, by you. Do you agree?
>
> Dr Lam: That's what he complained, yes.
>
> Mr Fong: So you are aware.
>
> Dr Lam: *No, the only part I read in the letter that came through loud and clear was the clinical part that I put in the stent … that I put in a stent unnecessarily and so on. So that was the only point I was trying to answer to.* Unfortunately – I definitely made the mistake there. But if you insinuate that I ignored that, that's not true.
>
> [emphasis added]

75 We should first say that Dr Lam was mistaken if he had indeed meant to agree with Mr Fong that he "didn't try and even address the point about informed consent" in his Explanatory Statement (see [74] above). As we noted

at [68] above, Dr Lam testified that the Explanatory Statement had been "rather hastily written without legal help". That also went towards explaining the brevity with which he touched on the issue of obtaining the Patient's informed consent in that statement.

76 In our judgment, Dr Lam's explanation was not unreasonable, given our own view that the sting of the Patient's complaint lay in the allegations forming the basis of the other charges against Dr Lam, in particular, Charge 1 (see [50] above). In the premises, we do not think there was any basis for the DT to draw any adverse inference from the brevity of the Explanatory Statement in relation to Charge 3 when it came to assessing the SMC's case against Dr Lam on this charge.

Failure to take into account the Patient's own knowledge

77 The DT took the view that the Patient's own knowledge about the PCI benefits, risks, complications and alternatives was irrelevant to the issues presented in its consideration of Charge 3. In our judgment, this was not correct. That charge, which (as we mentioned at [30] above) mirrors Guideline 4.2.2 of the SMC ECEG, requires that it be proved that Dr Lam failed to "ensure that the Patient was adequately informed about his medical condition and options for treatment". In our view, the duty set out in Guideline 4.2.2 did not impose an absolute and unyielding obligation on Dr Lam to explain *all* the PCI benefits, risks, complications and alternatives to the Patient regardless of his existing knowledge; instead, it imposed on him only an obligation to *ensure* that the Patient was apprised of the relevant information about PCIs. In our view, this obligation would be satisfied if Dr Lam had *reasonable grounds* to believe that the Patient was already well-acquainted with such information. There was nothing in either Charge 3 or Guideline 4.2.2 which required Dr Lam to

mechanically convey the PCI benefits, risks, complications and alternatives to the Patient without regard to what the Patient might already know. That said, we do emphasise that where a doctor seeks to defend himself against a charge of failure to obtain informed consent on the basis that the patient is already familiar with the relevant benefits, risks, complications and alternative treatment options, the burden is on the doctor to demonstrate that he had reasonable grounds for believing that the patient was already sufficiently informed of these matters.

78 On the facts of this case, it was clear that the Patient was already well-acquainted with at least some of the relevant information. It is no longer disputed that the Patient had considerable knowledge of the PCI benefits, risks, complications and alternatives: see, for instance, the DT's findings on this very issue, which we noted at [16] above (among other paragraphs); the extract of the transcript of the Patient's cross-examination which we reproduced at [52] above; and the Patient's previous medical history, including his experience with this very procedure in 2006 (see [4] above). And given that Dr Lam had not only taken down the Patient's medical history (including the details of the PCI done in 2006) at the first consultation on 10 March 2011, but had also had "3 days, three full sessions to discuss PCI with [the Patient]", he would have been aware of how much knowledge the Patient already had about PCIs.

79 Turning to the specific aspects of the relevant information in the present case, it would have been evident to the Patient what the potential *benefits* of a PCI were. It was the Patient who sought out Dr Lam for the specific purpose of ascertaining the state of his coronary artery disease and taking the necessary remedial measures. Moreover, as we have already noted, he had previously undergone a PCI in 2006 and was thus familiar with the nature and purpose of the procedure. It therefore seems implausible that he was not aware of the

potential benefits of the procedure. With regard to the *risks* of undergoing a PCI, the Patient listed in his complaint many "potential risks and complications" which he was allegedly unaware of; but, as we pointed out earlier (at [52] above), it became evident during cross-examination that his claims were clearly untrue. As for the *alternatives* to a PCI, the Patient was already on a high dosage of medication, and given the high-grade stenosis that was found in his proximal LAD Artery during the Conventional Angiogram performed on 18 March 2011, a PCI was the best option and definitely preferable to a heart bypass operation. In this regard, Dr Lam stated that considering the extent to which the Patient's coronary arteries had deteriorated, there was not much in the way of viable alternatives to a PCI. The evidence of one of the Defence experts, Dr Philip Koh, to a similar effect (see [74] of the Decision) – namely, that a PCI was appropriate and that further medical therapy was "not an option" – was accepted by the DT, leading to Dr Lam's acquittal on Charge 1.

80 In our judgment, in these circumstances, in order to sustain the case on Charge 3 in the way that the SMC chose to run it, it would have been necessary for the SMC to establish not only that no discussion between Dr Lam and the Patient on the PCI benefits, risks, complications and alternatives had taken place at all, but also that Dr Lam, despite his interactions with the Patient over the course of three consultations, had no reasonable grounds for thinking that the Patient had any of the knowledge about PCIs that he in fact had. We find this improbable in the light of the DT's strong findings (as set out at [16] above) on the knowledge which the Patient already had in this regard and his attitude during his interactions with Dr Lam.

81 Aside from this, we also think that if we had had to consider the question of sentencing, the Patient's actual knowledge of the PCI benefits, risks, complications and alternatives would likely have had a bearing on the

appropriate sentence to impose on Dr Lam since the degree to which the Patient's autonomy to make an informed decision on his own treatment had in fact been compromised lies at the heart of Charge 3.

82 In all the circumstances, we do not think Dr Lam's conviction on this charge can stand and we accordingly set it aside.

General observations on sentencing in disciplinary proceedings against doctors

83 Given our decision to acquit Dr Lam of Charge 3, the question of sentence does not (as we have just mentioned) arise in the present circumstances. Nevertheless, we wish to make some brief observations on the sentencing approach that should have been adopted in this case. We do so in the context of two factors.

84 First, we note that it has taken a total of more than six years for the Patient's complaint to reach this court. On the face of it, and without having examined the reasons for this, it seems to us that this is an inordinately long time to dispose of such a matter. As we noted in our recent decision in *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] SGHC 143 at [128], an "inordinate delay" in the institution and prosecution of disciplinary proceedings against a doctor could lead (in the event of a conviction) to a reduction in sentence on account of the suffering that would have been endured by the doctor, who would have had to face the uncertainty and strain of having to deal with the prospective charges over a prolonged period. We urge the SMC to scrutinise its procedures to avoid such delays.

85 Second, sentencing in a case such as the present would likely be impacted by the Medical Registration (Amendment) Act 2010 (Act 1 of 2010),

which increased the maximum fine for an offence of professional misconduct from $10,000 to $100,000: see s 53(2)(*e*) of the MRA. There has thus far been no guidance from the High Court in this regard, although we note that a number of decisions at the DT level have applied the higher fines which may now be imposed.

86 An enhancement in the maximum prescribed punishment for an offence is often a manifestation of the Legislature's intention that the offence should henceforth attract a heavier sentence: see Kow Keng Siong, *Sentencing Principles in Singapore* (Academy Publishing, 2009) at para 5.008. However, this is not always the case. As Chao Hick Tin JA pointed out in *Keeping Mark John v Public Prosecutor* [2017] SGHC 170 (at [28]), an increase in the maximum sentence for an offence "does not automatically have a conclusive effect" that the offence should thereafter attract heavier sentences, especially when Parliament states otherwise. For example, when the Penal Code (Amendment) Act 2007 (Act 51 of 2007), which enhanced the prescribed fines for a number of offences in the Penal Code (Cap 224, 1985 Rev Ed), was passed, it was made clear that this was aimed at giving the courts greater flexibility to impose heavier fines and shorter imprisonment terms where this was warranted on the facts of the case: see *Sentencing Principles in Singapore* at para 5.010.

87 In the context of disciplinary proceedings against doctors, the then Minister for Health, Mr Khaw Boon Wan, observed during the second reading of the Medical Registration (Amendment) Bill 2009 (Bill 22 of 2009) that there was a "significant gap in the range of penalties in [the MRA as it then stood]" as the maximum financial penalty which could be imposed on a doctor was a fine not exceeding $10,000 whereas the next level of punishment was suspension from practice for a period of between three months and three years.

He stated that the purpose of increasing the maximum fine which could be imposed under the MRA as it then stood was to enable the SMC to "mete out a penalty that is appropriate to the severity of the case" (see *Singapore Parliamentary Debates, Official Report* (11 January 2010) vol 86 at col 1900).

88 It is clear that Parliament's intention in increasing the maximum fine set out in s 53(2)(*e*) of the MRA in 2010 was to bridge the gap between the then maximum financial penalty of $10,000 and the minimum suspension period of three months. This raises the possibility that doctors who might previously have been disciplined with three months' suspension from practice could now, in similar circumstances, possibly be sentenced to a high fine instead. *Eu Kong Weng (HC)* offers a possible example. There, the High Court upheld the three-month suspension imposed by the Disciplinary Committee because it found the then maximum fine of $10,000 inadequate, but it also noted (at [7]; see also the DT's observation in the present case at [22] above) that it "would have imposed a shorter period of suspension" had three months not been the statutory minimum period. The doctor in such a case could now possibly be appropriately sanctioned instead with a high fine, perhaps one at the higher end of the enhanced range prescribed in s 53(2)(*e*) of the MRA.

89 In the context of disciplinary proceedings against professionals, recalibrating the appropriate punishment in the light of amendments to the relevant legislation is not unusual. Where the legal profession is concerned, s 83(1) of the Legal Profession Act (Cap 161, 2001 Rev Ed) was amended in 2008 to provide for the additional sanction of a monetary penalty for disciplinary offences committed by lawyers. Prior to that amendment (which came into effect on 1 December 2008), the court could only strike off a lawyer from the roll of advocates and solicitors of the Supreme Court, suspend him from practice for a period not exceeding five years or censure him. There was

perceived to be a gap between disbarment and suspension on the one hand, which were sometimes unduly harsh, and a censure on the other, which sometimes appeared unduly lenient. In *Law Society of Singapore v Andre Ravindran Saravanapavan Arul* [2011] 4 SLR 1184, the first case heard after the 2008 amendment, the court observed (at [36]) that in the light of the new punishment option in the form of a fine that had become available by reason of the 2008 amendment, fines should be imposed for "disciplinary offences that [were] too serious to be punished with mere censures, but insufficiently serious to deserve the punishment of suspension from practice". In our judgment, the same could be said for disciplinary offences under the MRA following the 2010 amendment: fines at the higher end of the enhanced range set out in s 53(2)(*e*) should be imposed where the offences are not so serious as to deserve the statutory minimum of three months' suspension, but too serious to be punished merely by the sanctions set out in ss 53(2)(*f*) and 53(2)(*g*).

90 Finally, it is apposite for us to set out some considerations which are relevant in sentencing errant doctors for professional misconduct under s 53(1)(*d*) of the MRA in the form of a failure to obtain informed consent. In our judgment, a DT faced with such a case should consider the following non-exhaustive list of factors in sentencing:

(a) the materiality of the information that was not explained to the patient, namely, whether there is evidence that the patient would have taken a different course of action had such information been conveyed;

(b) the extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and

(c) the possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information. This follows from the court's observation in *Yong Thiam Look Peter v Singapore Medical Council* [2017] SGHC 10 (at [12]) that when harm ensues in a case where the harm does not form an element of the charge, the causation of such harm would be a "seriously aggravating" factor; on the other hand, the absence of such harm would "generally be a neutral consideration without any mitigating value".

Conclusion

91 For the reasons set out above, we allow Dr Lam's appeal and set aside his conviction on Charge 3. We also set aside the DT's orders on the sentence and the costs of the inquiry below. Unless the parties are able to come to an agreement on costs, they are to furnish, within 14 days from the date of this judgment, written submissions, limited to seven pages each, setting out their respective positions on the appropriate costs orders, including the quantum.

Sundaresh Menon Chief Justice	Andrew Phang Boon Leong Judge of Appeal	Steven Chong Judge of Appeal

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