IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2019] SGHC 102

Originating Summons No 8 of 2018

Between

Kevin Yip Man Hing

… *Appellant*

And

Singapore Medical Council

… *Respondent*

Originating Summons No 9 of 2018

Between

Singapore Medical Council

… *Appellant*

And

Yip Man Hing Kevin

… *Respondent*

JUDGMENT

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

TABLE OF CONTENTS

Yip Man Hing Kevin
v
Singapore Medical Council and another matter

[2019] SGHC 102

High Court — Originating Summonses Nos 8 and 9 of 2018
Andrew Phang Boon Leong JA, Judith Prakash JA and Quentin Loh J
31 January 2019

23 April 2019 Judgment reserved.

Andrew Phang Boon Leong JA (delivering the judgment of the court):

Introduction

1 In the decision of this Court in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*"), two broad (and interrelated) principles were emphasised right at the outset. Indeed, these broad principles form the important backdrop against which the specific legal principles are applied to the facts at hand.

2 The first principle underscores the critical role of the doctor in healing, as well as empathising with, his or her patients. As the Court in *Wong Him Choon* put it (at [1]):

> It is an understatement of the highest order to state that doctors are part of the bedrock of our society. This is so not least because they care for people by helping to heal them, *regardless of* their situation or station in life. And even in the direst of circumstances, for example, when physical death is at the

> patient's doorstep, their kindness and assistance is no less (and may be even more) important. That is why all of us look up to doctors and respect them for the high calling that is rightfully theirs to claim. And that calling is of course embodied in the Hippocratic Oath. [emphasis in original]

3 The second underscores the importance of *perspective* in performing one's role as a doctor. Again, as this Court observed in *Wong Him Choon* (at [4]):

> This case also – as we shall also elaborate upon below – concerns the important issue of *perspective*. In particular, the doctor must also be cognisant of *the patient's position and welfare*. And this entails placing himself or herself in the shoes of the patient, so to speak. In this regard, the following oft-cited advice from a father to his daughter in a famous novel ought to be noted (see Harper Lee, *To Kill A Mockingbird* (William Heinemann Ltd, 1960; reprinted in the New Windmill Series, 1966) at p 35):
>
> > First of all, … if you can learn a simple trick, Scout, you'll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view – … until you climb into his skin and walk around in it.
>
> [emphasis in original]

4 As we shall see below, these two broad principles will be brought into sharp relief in the context of one of the present appeals – albeit not in their observance but (on the contrary) in their neglect.

5 We turn now to deal with the precise facts and issues in the present appeals. There is, first, an appeal by Dr Kevin Yip Man Hing ("Dr Yip") against the decision of the Disciplinary Tribunal ("the DT") appointed by the respondent, the Singapore Medical Council ("the SMC"). The DT had found Dr Yip guilty of professional misconduct in his treatment of Mr Zhang Ru Lin, a construction worker (specifically, a bricklayer) by profession ("the Patient") and imposed a sentence of five months' suspension on him. Dr Yip appeals

against both his conviction as well as the sentence imposed on him. There is also an appeal by the SMC against the sentence imposed by the DT on Dr Yip: the SMC argues that a higher sentence ought to have been imposed on Dr Yip.

Background facts

The essence of the case

6 It is, in our view, of the first importance to commence with the overall medical condition of the Patient himself – stated in its *unadorned essence*. This is the basic starting point and will help this Court to focus on the various arguments proffered by both parties, thereby avoiding any irrelevant arguments that *distract from* this central focus.

7 Put simply, the Patient had a serious fall and *fractured* his right clavicle (collarbone). He *also* suffered *fractures* to two to four (lower) ribs as well as a *1cm laceration to his head* and a *contusion to his wrist*. *Viewed* ***holistically***, the Patient had suffered from ***multiple injuries*** that emanated from ***one and the same*** *accident*. ***This*** was the medical condition of the Patient which faced Dr Yip. It is essential to bear ***this*** *condition* in mind when considering Dr Yip's conduct *vis-à-vis* the Patient (together with the reasons he furnished for such conduct). It was decided that *surgical fixation* of the clavicle fracture was necessary, and to that end, the Patient underwent surgery in the late hours of that same day, and the procedure was completed in the early hours of the next. After a period of convalescence, the Patient was discharged later in the morning. He was given hospitalisation leave for the surgery (spanning those two days), and was certified fit for light duties thereafter. No additional sick leave was given. These were the ***essential facts*** before us.

8 In essence, the DT found that Dr Yip's conduct in failing to prescribe *any* sick leave and instead certifying the Patient fit for light duties *fell below* the standards expected of him as a medical practitioner in *two separate and distinct* respects. The first applicable standard of conduct was that, given the medical condition of the Patient in light of the available expert evidence, Dr Yip ought to have granted the Patient ***sick leave*** (instead of light duties). In failing to do so, Dr Yip had intentionally and deliberately departed from this applicable standard and was therefore guilty of professional misconduct. The DT also held that Dr Yip had also intentionally and deliberately departed from ***another*** *(and second) applicable standard of conduct* in not proactively ensuring that there were adequate conditions for rest and rehabilitation for the Patient before prescribing light duties for him. Unfortunately, the DT did not explain how these two standards were related (if at all) and we return to this point at [65] below.

9 Following the DT's analysis of the two standards, Dr Yip's case on appeal consists of two major planks. The first plank is that the first applicable standard of conduct did not, having regard to the medical condition of the Patient and in light of the available expert evidence, necessarily require the grant of sick leave to the Patient and that, even if it did, Dr Yip had not intentionally and deliberately departed from that standard. The second plank is that, in relation to the second applicable standard (which, unlike the first applicable standard of conduct, he did not controvert), he had discharged his duty to establish that there were adequate conditions for rest and rehabilitation by discussing the existence and types of light duties with the Patient, and obtaining the Patient's agreement to try light duties.

10 We would like to pause at this juncture to note that although the DT appeared to accept that there were *two* applicable standards of conduct as just

set out above, it could be said that the second (*viz*, ensuring proactively that there were adequate conditions for rest and rehabilitation for the Patient before prescribing light duties) was not only inextricably linked to but (*instead of* comprising a *separate* applicable standard of conduct) could be considered to be *an integral part of* the ***first*** applicable standard (requiring the grant of sick leave) inasmuch as it *qualified* the first applicable standard by providing that light duties *may* be prescribed *in lieu* of sick leave *if* – and only if – the doctor first ascertains and satisfies himself that there would be adequate conditions for rest and rehabilitation. In our view, it might be preferable in future cases for the DT to adopt the approach just mentioned so that, instead of considering two applicable standards of conduct, it should focus on ***just one*** applicable standard of conduct in the manner set out above.

The facts

11 Dr Yip was at the material time an orthopaedic surgeon who practised at his own medical clinic, the Singapore Sports and Orthopaedic Clinic ("the Clinic") located at the Gleneagles Medical Centre. The Patient was a 47-year-old Chinese national employed as a bricklayer by Soon Tat Construction Engineering Private Limited ("Soon Tat").

12 On 7 July 2011, the Patient fell from a scaffolding platform at a worksite and was brought to the Clinic. He was accompanied by his supervisor, Mr Krishnan Muthukannan ("Mr Muthukannan"). Mr Lin Sheng ("Mr Lin"), the boss of Soon Tat, arrived some time later. Dr Yip examined the Patient and found that he had fractured his right clavicle and his 7th to 9th right ribs, and suffered a 1cm head laceration, among other injuries. Dr Yip recommended surgical treatment for the clavicle fracture and conservative (*ie*, non-surgical)

treatment for the rib fractures. The appropriateness of these two treatment orders is not in issue before us.

13 On that same day, Dr Yip performed an Open Reduction Internal Fixation ("ORIF") surgery on the Patient's right clavicle. The procedure commenced at about 10.55pm on 7 July 2011 and was completed at around 12.12am on 8 July 2011. Following a period of rest, the Patient was then discharged on the same day at around 10.10am. Dr Yip gave the Patient sick leave for 7 to 8 July 2011, and certified the Patient fit for light duties from 9 to 11 July 2011 (*ie*, from the first post-operative day).

14 On 11 July 2011, the Patient attended at the Clinic for a scheduled follow-up appointment ("the first follow-up review"), accompanied by Mr Lin. The Patient's clavicle fracture was assessed to be stable, and, in relation to the rib fractures, he had not developed any chest infection or pneumothorax. A fracture of the 6th right rib, which had likely gone undetected by the previous radiologist, was detected upon examination of a further X-ray report, but Dr Yip was of the view that there was no material change in the Patient's condition. Dr Yip certified the Patient fit for light duties from 12 to 18 July 2011.

15 On 18 July 2011, the Patient attended at the Clinic ("the second follow-up review"), again accompanied by Mr Lin. Dr Yip found the Patient to be recovering well, and certified the Patient fit for light duties from 19 to 25 July 2011.

16 A third follow-up review was scheduled for 25 July 2011, but the Patient did not turn up for the appointment. Instead, on 22 July 2011, the Patient went to the Tan Tock Seng Hospital ("TTSH") Emergency Department complaining of persistent giddiness, nausea and right pleuritic chest pain, and was

hospitalised. On 23 July 2011, he was discharged with hospitalisation leave from 22 to 28 July 2011 and was referred to the National Neuroscience Institute ("NNI") and the TTSH Orthopaedic Surgery Department for follow-up.

17 The Patient subsequently approached the Humanitarian Organisation for Migration Economics ("HOME") for assistance with wage compensation issues. On 24 October 2011, a complaint was lodged with the SMC ("the Complaint") by one Mr Jolovan Wham ("Mr Wham"), a social worker at HOME. The nub of the Complaint was that Dr Yip should not have given only two days' sick leave to the Patient – none of which was of a post-operative nature (see also [13] above).

18 On 22 May 2012, Dr Yip was informed about the Complaint by the Investigation Unit of the SMC, and, just over a month later on 29 June 2012, Dr Yip gave his Explanation to the Complaints Committee ("Explanation").

19 On 2 April 2015, Dr Yip was notified by the Complaints Committee that a formal inquiry would be convened, and a Notice of Inquiry ("NOI") was subsequently issued on 3 November 2015.

The charges

20 A total of three charges ("the Charges") and three alternative charges ("the Alternative Charges") were brought against Dr Yip under s 53(1)(*d*) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("the MRA").

21 For context as to how the charges were framed, this Court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") accepted that the "professional misconduct" sanctioned under s 53(1)(*d*) of the MRA can be made out in at least two situations (at [37]):

(a) where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency ("the first limb"); or

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

22 The Charges and Alternative Charges were based on exactly the same factual substratum, the difference being that the Charges were brought under the first limb, whereas the Alternative Charges were brought under the second limb.

23 The essence of the first, second and third Charges was that Dr Yip, on each of the three occasions he had examined the Patient (*ie*, 8, 11 and 18 July 2011), (a) had failed to ensure that adequate sick leave was given to the Patient in light of his condition and the nature of his occupation, and (b) had inappropriately certified the Patient as fit for light duties. We set out the relevant portions of the first Charge and first Alternative Charge relating to Dr Yip's conduct on 8 July 2011 (the second and third Charges as well as the second and third Alternative Charges adopt the same wording, albeit with reference to different dates, *viz*, 11 and 18 July 2011, respectively):

1st CHARGE

That you DR KEVIN YIP MAN HING … on 8 July 2011, did fail to ensure that adequate sick leave was given to your patient, one Zhang Ru Lin (the "Patient"), in light of his condition and the nature of his occupation.

Particulars

…

(g) Given the nature of the Patient's occupation, his condition on 8 July 2011 and the requisite post-

> operative management of the Patient after the Surgery, sick leave should have been given to the Patient upon his discharge, and it was inappropriate of you to certify the Patient as being fit for light duties from 9 July 2011 to 11 July 2011.
>
> In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.
>
> ALTERNATIVE 1st CHARGE
>
> That you DR KEVIN YIP MAN HING … on 8 July 2011, did fail to ensure that adequate sick leave was given to your patient, one Zhang Ru Lin (the "Patient"), in light of his condition and the nature of his occupation.
>
> Particulars
>
> …
>
> (g) Given the nature of the Patient's occupation, his condition on 8 July 2011 and the requisite post-operative management of the Patient after the Surgery, sick leave should have been given to the Patient upon his discharge, and it was inappropriate of you to certify the Patient as being fit for light duties from 9 July 2011 to 11 July 2011.
>
> In relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) in that your conduct demonstrated such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

The DT's decision

24 The Disciplinary Inquiry was conducted over ten days and the DT delivered its grounds of decision on 28 March 2018 ("GD"). Both parties called expert witnesses to give evidence on the appropriate medical status to be attributed to a person in the Patient's circumstances. The SMC called Dr Diarmuid Murphy ("Dr Murphy"), an Appointed Consultant at the Division of Musculoskeletal Trauma at the National University Hospital. Dr Yip called

Dr Chang Wei Chun ("Dr Chang"), a Consultant Orthopaedic and Trauma Surgeon practising at various private medical institutions, including the Gleneagles Medical Centre, and Dr Peter Tio Man Kwun ("Dr Tio"), a Specialist in Orthopaedics and Traumatology practising in Hong Kong. The SMC called six factual witnesses: the two social workers from HOME, namely Mr Luke Tan and Mr Wham, as well as the four doctors who had examined the Patient at TTSH and NNI. By the time of the hearing, the Patient had returned to China and was unavailable to testify. For the Defence, Dr Yip, Mr Muthukannan and Dr Sebastian Chua, the anaesthetist for the surgery, gave oral testimony. Mr Lin had returned to China and was unavailable as a witness.

25 In addition, Dr Yip relied on two further categories of evidence. First, Dr Yip tendered reports from five other foreign doctors, one local doctor and three physiotherapists, that were prepared after reviewing various documents relating to the Patient's matter (collectively, "the Additional Reports"). Their authors were not called to testify with regard to their views. Second, Dr Yip commissioned a survey of 1,513 orthopaedic surgeons from various jurisdictions who had treated patients with clavicle fractures to be conducted by three different survey companies. Two of these companies sent representatives to give evidence on their methodology and findings in the proceedings, and Dr Yip called an Associate Professor of mathematics at the National University of Singapore, Dr Ma Siu Lun ("Dr Ma"), to give evidence on his analysis of the survey data.

Conviction

26 The DT's decision to convict Dr Yip followed an analysis of four issues (GD at [23]):

(a) In respect of the Charges:

(i) Whether it was the practice ("the first applicable standard") among members of the medical profession of good standing and repute to certify a worker with the Patient's injuries fit for light duty on the first post-operative day following clavicle surgery and conservative treatment of two to four rib fractures ("the first issue").

(ii) Whether Dr Yip had intentionally and deliberately departed from the first applicable standard ("the second issue").

(iii) Given that it was undisputed that Dr Yip had a duty to establish that there were adequate conditions for rest and rehabilitation ("the second applicable standard"), whether Dr Yip had departed from the second applicable standard, and if so, whether that departure had been intentional and deliberate ("the third issue").

(b) In respect of the Alternative Charges, whether there had been serious negligence on Dr Yip's part, and whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner ("the fourth issue").

27 In respect of the first issue, the DT found that it was not the practice among members of the medical profession of good standing and repute to certify a worker with the Patient's injuries as fit for light duties on the first post-operative day (GD at [68]). In reaching this conclusion the DT made the following findings and observations:

(a) Dr Murphy's evidence had been that for a person with the Patient's injuries, six weeks of sick leave would have been appropriate,

or at least a minimum of two weeks' sick leave with reassessment thereafter (GD at [29]).

(b) Dr Tio's evidence did not fully support Dr Yip's position; despite advocating early mobilisation, he had accepted that, on the first post-operative day, there would have been pain over the clavicle and that light duties would have been "very difficult" for a few days (GD at [27]).

(c) While the literature indicated that early mobilisation of the injured area was beneficial, that did not mean that the Patient should have received zero post-operative sick leave and certification to return to light duties immediately (GD at [67]). Dr Yip had been unable to point to any literature supporting giving *zero* days of sick leave to a patient with *multiple* fractures. The only medical literature that supported immediate return to sedentary work was to be found in the Prince Edward Island Guidelines ("the PEI Guidelines") that suggested a range of zero days to four weeks for clavicle fractures ***or*** zero days to two weeks for rib fractures. *However*, given that the Patient had suffered *multiple* fractures of both the clavicle and the ribs, it was not appropriate to apply the recovery timelines at the lowest end of the scale (GD at [30], [34] and [41]). The other medical literature referred to by Dr Yip as supporting a return to heavy duties on the first post-operative day concerned highly motivated patient populations (*eg*, athletes), who would have shorter recovery times than the Patient (GD at [33]).

(d) While the Additional Reports generally affirmed early mobilisation and return to work, even those most favourable to Dr Yip were "not clear authoritative endorsements of giving no sick leave" or

for certifying fitness to return to light duties from the first post-operative day (GD at [53] and [55]).

(e) No weight was given to the survey commissioned by Dr Yip due to several flaws and errors in the conduct and design of the survey, the most "troubling" of which was that a question had been omitted from the final results ("the Omitted Question"), the responses to which were adverse to Dr Yip's position (GD at [61] and [64]).

28 In so far as the second issue was concerned, the DT found that Dr Yip's departure from the first applicable standard had been intentional and deliberate (GD at [74]). The DT rejected Dr Yip's attempt to justify such departure on medical grounds (*viz*, that he had assigned light duties to the patient to facilitate rehabilitation) and made the following findings:

(a) Dr Yip conceded that he would have given the Patient sick leave if there was no agreement on light duties or if light duties were unavailable (GD at [70]).

(b) Dr Yip's attempt to justify giving the Patient light duties in the interest of the Patient's welfare was without merit as:

(i) for someone in the Patient's condition, the commute to and from the dormitory would have been painful (GD at [72]);

(ii) light duties could not replace rehabilitation and mobilisation specifically directed at the injured area (GD at [72]); and

(iii) there was no basis to suggest that the Patient needed supervision to carry out the necessary mobilisation (GD at [73]).

29 In respect of the second applicable standard, the DT observed that it was undisputed that Dr Yip had a duty to establish that there were adequate conditions for rest and rehabilitation. The third issue was therefore whether Dr Yip had intentionally and deliberately departed from this standard, and this turned to a significant degree on a single question of fact: whether or not Dr Yip had in fact discussed the existence and types of light duties with the Patient, and obtained the Patient's agreement to try light duties (GD at [75]). The DT found that Dr Yip had failed to prove that fact on the balance of probabilities as (GD at [95]):

(a) the alleged discussion had not been mentioned in his Explanation to the Complaints Committee nor in any of his case notes; and

(b) Mr Muthukannan did not persuasively corroborate Dr Yip's account.

The DT also found it "troubling" that Dr Yip claimed that he had not been aware that the Patient had not in fact worked *at all* since the day of his accident until Mr Lin informed him of the same almost a year later; if, indeed, the light duties had been a part of Dr Yip's treatment plan, it was strange that he did not discover during the first and second reviews that the Patient had not been doing any light duties (GD at [92] and [95]).

30 Based on the foregoing, the DT found that the Charges against Dr Yip were made out.

31 In respect of the fourth issue, the DT stated that having found Dr Yip guilty of professional misconduct under the first limb of *Low Cze Hong*, it would have found Dr Yip guilty under the second limb as well. The evidence showing that Dr Yip had not taken steps to establish the existence and types of

light duties available or to obtain the Patient's agreement to try light duties demonstrated that Dr Yip had been seriously negligent on all three occasions (GD at [100] and [103]). Therefore, in the DT's view, the Alternative Charges were also made out.

Sentence

32 The DT referred primarily to the decision of this Court in *Wong Him Choon* and the decision of the disciplinary tribunal in *In the Matter of Dr Sanjay Srinivasan* [2017] SMCDT 1 ("*Sanjay*"). The DT considered that the present facts were "more aggravated" than those in *Sanjay*, and had "similar aggravating factors" to those in *Wong Him Choon*. In particular, the DT took the view that Dr Yip had disregarded the Patient's welfare and interests when he did not consider the Patient's injuries serious enough to warrant sick leave and when he equated early mobilisation with the Patient's light duties as a construction worker. This disregard for the Patient's welfare and interests constituted "the most aggravating factor" (GD at [125]). Based on the foregoing, the DT considered that a term of suspension was warranted (GD at [126]). The DT also noted that all three of the Charges "were of similar nature and arose from three examinations that had taken place over a short period", and therefore thought it appropriate to "sanction the professional misconduct of Dr Yip as a whole, instead of separately for each Charge" [emphasis in original omitted] (GD at [127]). In the premises, the DT thought an aggregate term of suspension of ten months appropriate (GD at [128]).

33 This aggregate term was, however, halved to a total term of suspension of five months owing to what the DT considered to be the SMC's inordinate delay of some three-and-a-half years between the time Dr Yip gave his Explanation and when the SMC issued the NOI (GD at [121] and [129]).

The DT also ordered that Dr Yip be censured, give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct, and to pay costs (GD at [130]).

The appeals

34 Both Dr Yip and the SMC appealed against the DT's decision. Originating Summons No 8 of 2018 ("OS 8") is Dr Yip's appeal against both conviction and sentence. His primary contention was that the DT's decision to convict him on all three Charges was "unsafe, unreasonable and contrary to the evidence" within the meaning of s 55(11) of the MRA, and that, in any case, the sentence imposed was manifestly excessive. Subsequently, the SMC lodged a cross-appeal by way of Originating Summons No 9 of 2018 ("OS 9") against the sentence imposed on the ground that it was, *inter alia*, manifestly inadequate.

35 We shall deal first with Dr Yip's appeal against conviction in OS 8, before turning to the parties' respective appeals against sentence, which engage issues raised in both OS 8 and OS 9.

The parties' submissions on conviction

Dr Yip's submissions

36 Dr Yip's contentions on appeal are as follows. He first raised a preliminary contention that the DT had failed to apply its mind to the second and third Charges: the DT's framing of the issues focused on the propriety of giving the Patient light duties *on the first post-operative day*, and made no reference to the propriety of that same conduct on the third and tenth post-operative days, which relate to the second and third Charges, respectively.

37 In relation to the first issue concerning the first applicable standard, Dr Yip's principal submission was that the medical evidence did not support a finding that light duties could not be given on the first post-operative day. His case was that it was medically appropriate to issue the Patient with light duties from the first post-operative day if it would facilitate immediate and active mobilisation (and therefore, rehabilitation) of the affected area, and referred to Dr Tio's and Dr Chang's evidence in support of this point.

38 As an overarching point, Dr Yip argued that the DT had erroneously reversed the burden of proof, and had, in effect, placed the onus on *him* to prove that a prescription of light duties was appropriate; had the DT correctly placed the burden on the SMC to prove that a prescription of light duties was inappropriate, it would have found the SMC's evidence wanting.

39 In relation to the expert evidence on the first applicable standard, Dr Yip submitted that the DT had failed to explain its reasons for preferring Dr Murphy's evidence over that of Dr Tio's and Dr Chang's, and that, in any event, on Dr Murphy's own evidence, patients who have had their clavicles surgically fixed may return to sedentary work "in a matter of days". In so far as the medical literature was concerned, Dr Yip focused on the PEI Guidelines and submitted that the DT had misread and failed to address the recommended recovery timelines therein to the effect that patients with clavicle *or* rib fractures may, on the lower end of the spectrum, return to sedentary work immediately. In addition, it was also argued that the DT had wrongly excluded the survey evidence and had erroneously found that the Additional Reports were not clear, authoritative endorsements of Dr Yip's decision not to give any sick leave.

40 In so far as the issue whether Dr Yip had deliberately and intentionally departed from the first applicable standard was concerned (*viz*, the second

issue), Dr Yip submitted that the DT's findings were in error for two reasons. First, the DT had failed to apply its mind to the question as to whether Dr Yip was *conscious* of the first applicable standard, and that even if it had, any finding that Dr Yip was conscious of that standard would have been made contrary to evidence.

41 In relation to the issue of whether Dr Yip had deliberately and intentionally departed from the second applicable standard requiring him to ascertain whether there were adequate conditions for rest and rehabilitation (*viz*, the third issue), Dr Yip contended that the DT's finding that he had not discussed light duties with the Patient was wrong for the following two reasons:

(a) The DT had misread Dr Yip's evidence as to his knowledge of the 2002 SMC Ethical Code and Guidelines ("the 2002 C&G") on the documentation of discussions with patients on sick leave.

(b) The DT had wrongly excluded Mr Muthukannan's direct evidence that Dr Yip did indeed discuss and obtain the Patient's consent in relation to the question of light duties.

42 In relation to the issue of whether Dr Yip had been guilty of gross negligence under the second limb of *Low Cze Hong* (*viz*, the fourth issue), Dr Yip argued that the mere fact that he had been ignorant of the Patient's not having worked since the accident did not mean that the discussion had not taken place; the reason why he did not know was that he was not informed of that fact by either the Patient or Mr Lin during the two follow-up reviews on 11 and 18 July 2011.

The SMC's submissions

43 In response to Dr Yip's preliminary argument on the second and third Charges, the SMC contended that the DT had applied its mind to those charges, particularly in its analysis of whether Dr Yip had discharged his duty to make proper inquiry at the follow-up sessions.

44 In relation to the first applicable standard, the SMC defended the DT's finding that it was not the practice among members of the medical profession to certify a worker with the Patient's injuries as fit for light duties on the first post-operative day, and argued that this conclusion was rightly arrived at based on the expert evidence and medical literature before it. In particular, the DT had rightly rejected Dr Yip's attempts to justify giving light duties on the basis of facilitating mobilisation. Further, the DT had rightly decided to give no weight to the survey evidence, and had correctly concluded that the Additional Reports did not assist Dr Yip's defence in relation to this issue.

45 In relation to the second issue, the DT had rightly rejected Dr Yip's attempt to justify the departure on medical grounds in the interest and welfare of the Patient, and was correct to find that Dr Yip had intentionally and deliberately departed from the first applicable standard.

46 In so far as the third issue was concerned, the DT rightly found that Dr Yip had failed to prove that he had discussed the existence and types of light duties that were available and obtained the Patient's agreement to try light duties, as the discussion was not mentioned in his Explanation nor in his contemporaneous clinical notes, Mr Muthukannan did not persuasively corroborate Dr Yip's account, and Dr Yip's account was at odds with the Patient's subsequent conduct in not taking on any light duties at all, as well as

with Dr Yip's claim that he never knew about this until after the Complaint came to his attention. Even if the alleged discussion did take place, Dr Yip had not discharged his duty to ensure that the type of light duties that were available (one of which was assisting to distribute safety stores) were suitable for the Patient's rest and rehabilitation; indeed, Dr Chang had agreed that storekeeping would have been very difficult if not impossible for the Patient to do.

47 In relation to the fourth issue, the DT had rightly held that the *mens rea* of "serious negligence" was clearly made out, the clearest indication of which was Dr Yip's ignorance that the Patient had not worked at all since the accident.

The applicable legal principles

The scope of review by the High Court

48 Section 55(11) of the MRA provides that 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 "unsafe, unreasonable or contrary to the evidence". In this regard the High Court has repeatedly affirmed the test for intervention set out in *Low Cze Hong* at [39]–[40], *viz*, that the High Court would have to make the following findings before it can intervene in the decision of a DT (*Wong Him Choon* at [39]):

(a) there is 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 are sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence has been misread.

49 The Court should be mindful that a DT has had the benefit of hearing oral evidence and is "a specialist tribunal with its own professional expertise and understands what the medical profession expects of its members", and should therefore accord an appropriate degree of respect to a DT's decision, though not an undue deference to the DT's views such as to render its own powers nugatory (*Wong Him Choon* at [40], citing *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San Lawrence*") at [33]).

Professional misconduct under the MRA

50 As noted above (at [21]), the Charges and Alternative Charges were framed in terms of the two limbs set out in *Low Cze Hong*. The following must be proved to make out a charge under the first limb of *Low Cze Hong* (*Wong Him Choon* at [49(a)]):

> (a) what the applicable standard of conduct was among members of the medical profession of good standing and repute in relation to the actions that the allegation of misconduct relates to;
>
> (b) if the applicable standard of conduct required the said doctor to do something and at what point in time such duty crystallised; and
>
> (c) whether the said doctor's conduct constituted a departure from the applicable standard of conduct, and if so, whether the departure was intentional and deliberate, in that the doctor was *conscious of the applicable standard* when he decided to depart from the applicable standard (*Wong Him Choon* at [53]).

51 In relation to the second limb of *Low Cze Hong*, the following must be proved to make out the charge (*Wong Him Choon* at [49(b)]):

(a) whether there was serious negligence on the part of the doctor; and

(b) whether such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner.

Our decision on conviction

Our decision on the Charges

Preliminary points

52 Before commencing our analysis, it might be apposite to briefly mention two preliminary points that were raised by Dr Yip.

53 The first is Dr Yip's submission that the DT had conflated the charges preferred against him and failed to apply its mind to each individual charge (see [36] above). In essence, Dr Yip's complaint was that, while the three Charges were framed in respect of Dr Yip's giving light duties on *each of the three occasions that he saw the Patient* (*ie*, on 8, 11 and 18 July 2011), the first issue as framed by the DT pertained to the practice of certifying the Patient fit for light duty on the *first post-operative day* only. We reject this submission. It is clear from a close perusal of the DT's decision that the DT *was* conscious of the fact that it was dealing with three separate and distinct charges (see GD at [96]). While the first issue, as framed, does appear to focus on the standard of conduct applicable on 8 July 2011, the DT's analysis and findings deal squarely with the applicable standard of conduct on the third and tenth post-operative days (*ie*, the first and second follow-up sessions) in respect of which, the DT found, Dr Yip

had *conceded* that sick leave should have been given at each session until the next follow-up session, had light duties not been available (see GD at [97]).

54 The second relates to Dr Yip's submission that the DT had reversed the burden of proof which rightly lay on the SMC (see above at [38]). Nothing in the DT's reasoning suggests that the DT had in fact done this. In fact, the DT made clear references to the medical literature tendered by the SMC (see GD at [34]), as well as the evidence adduced through SMC's expert, Dr Murphy (see GD at [39] and [41]), in coming to its decision on the first applicable standard. In any event, in our view, the DT could not be faulted for considering Dr Yip's evidence as it was an integral part of the adjudication process; indeed, it seemed to us that the DT was simply making the point that Dr Yip had not, having regard to his evidential burden, satisfactorily rebutted the SMC's evidence with evidence of his own.

Introduction

55 As noted at [10] above, the DT proceeded on the basis that Dr Yip had departed from two *separate and distinct standards*. Put simply, the first applicable standard states that it would be inappropriate for a person in the Patient's condition to be certified fit for light duties from the first post-operative day, and that such a person should be given sick leave instead. The second applicable standard states that a doctor should, before certifying a patient fit for light duties, first ascertain whether there were adequate conditions for rest and rehabilitation. We had, at the beginning of this judgment ([10] above), expressed our view that a more appropriate approach may have been to describe the two aforementioned standards as two aspects of a single standard. We return to this point shortly (at [65] below). For present purposes, *both* parties have advanced their cases on appeal on the basis that *two* independent standards

applied; the SMC argues that Dr Yip had intentionally and deliberately departed from *both* standards, whereas Dr Yip submits that he had not (and, indeed, while accepting the second applicable standard, controverts the first applicable standard as well). We therefore proceed with our analysis of the issues as they were advanced before us by the parties.

The first issue

56 In respect of the first applicable standard, the DT found that it was not the practice among members of the medical profession of good standing and repute to certify a worker with the Patient's injuries as fit for light duties on the first post-operative day, and that it was instead necessary to order sick leave. It would be no exaggeration to state that Dr Yip has mounted a root and branch attack on the DT's findings on this particular issue. Indeed, his arguments have been summarised above. We now proceed to deal with them.

57 We turn first to Dr Yip's criticism of Dr Murphy's evidence that it was necessary, in light of the facts and the expert evidence in this particular case, not to certify the Patient fit for light duties but to grant him sick leave instead. Counsel for Dr Yip, Mr Navin Joseph Lobo ("Mr Navin"), argued that Dr Murphy's evidence (which was relied upon by the SMC) was unclear and inconsistent: Dr Murphy had said in his report that he would have given six weeks' sick leave to a patient in the Patient's circumstances, but a *minimum* of two weeks' sick leave for an office worker with a sedentary job, and, under cross-examination, he accepted that it would be possible for patients with sedentary jobs to return to work "in just a matter of days". However, as counsel for the SMC, Ms Chang Man Phing ("Ms Chang"), correctly pointed out, *the clear (and, in our view, inexorable)* ***common thread*** *underpinning Dr Murphy's evidence was that* ***sick leave*** *was* ***necessary*** *in the context of the facts of the*

present case. The different periods of sick leave Dr Murphy referred to were (as Ms Chang again correctly pointed out) in relation to different scenarios (depending, for example, on patient motivation as well as on the type of work the patient was expected to return to) and did not detract in any way from the clear thread just referred to.

58 Dr Yip also argued that the DT had misread Dr Tio's evidence when it recorded that Dr Tio accepted that light duties would be "very difficult". A quick perusal of the record of proceedings shows that Dr Tio did indeed accept that light duties would be "very difficult" for the first few days:

> Q: … And … would you expect a patient would just first post-op day after ORIF, to still have pain over the clavicle?
>
> A: Yes, of course.
>
> …
>
> A: Yes. But then if compared with the pain before the operation …
>
> …
>
> A: -- it will be less than before the operation.
>
> …
>
> Q: … And I think you did mention just now that sometimes even light duties, it would be you have to explain to the patient that it would be very difficult for the first few days –
>
> A: Yes, definitely.
>
> …
>
> Q: Okay, so it could be very painful but you tell him to bear with it?
>
> A: It could be painful, but not very painful.

59 While we accept that the main thrust of Dr Tio's evidence was that it was appropriate to encourage the patient to push through and mobilise the

injured area *despite* the pain, we do not think the DT had erred in finding that Dr Tio's evidence did not support Dr Yip's position in the manner in which it was run (that it was appropriate to certify the Patient fit for light duties *immediately*) given Dr Tio's *concessions* that the pain would have been quite severe (to the point that there would have been pain when laughing and coughing) and that light duties would be "very difficult" at least for the first few days. In fact, these concessions lent credence to Dr Murphy's opinion that there should be an "initial period of time" when the patient should be allowed to rest.

60 We turn next to the medical literature referred to by the parties. Mr Navin relied upon the PEI Guidelines for the argument that it was possible *not* to grant any sick leave at all. According to those guidelines, a patient with a clavicle fracture would need anywhere from four weeks' to zero days' sick leave before returning to sedentary work, and a patient with a rib fracture would need between zero days' to two weeks' rest. Unsurprisingly, Mr Navin focused heavily on the PEI Guidelines as they were the only piece of medical literature before us which suggested that a patient with a clavicle fracture or rib fracture might return to sedentary work immediately, without any sick leave. *However*, those Guidelines pertained *only* to patients with either a fractured clavicle *or* fractured rib(s), whereas the Patient in the present case had (as we have already noted above) a ***combination*** of ***serious*** *injuries*. In the circumstances, the DT took the view that it would not be appropriate to apply the estimated recovery times at the lower end of the scale since the Patient had suffered not just a clavicle *or* rib fracture, but *both*, amongst other injuries. In our view, this was an inference that the DT, as a specialist tribunal, was more than entitled to make, and we see no basis on which to disturb that finding.

61 We should also add that the PEI Guidelines were, of course, but *guidelines*. They were developed based on the accepted practice in the Canadian

province of Prince Edward Island, and as such, did not bind the DT in its determination of the standard to be applied *in Singapore*. It bears emphasis also that the PEI Guidelines were the *only* set of guidelines before us which permitted an immediate return to work for patients with clavicle *or* rib fractures; the other set of Canadian Guidelines referred to (the New Brunswick Guidelines) prescribed *at least* one week of sick leave for a clavicle fracture and three days' rest for a rib fracture. Ultimately, and in any case, neither of these Guidelines, taken on their face, addressed the precise situation which we faced in the present appeal because neither of them pertained to a patient with *multiple* injuries.

62 We also agree with the DT that the other medical literature (apart from the PEI Guidelines (considered above at [60])) did not support the prescription of light duties from the first post-operative day after surgical treatment of a fractured clavicle and conservative treatment of rib fractures; indeed, Dr Yip quite candidly conceded as much under cross-examination. As for the Additional Reports, we do not think there is any merit to Dr Yip's criticisms of the DT's decision on the basis of the reports prepared by Dr Howard Marans and Prof Nicola Maffulli. While we accept that these two reports suggested that, in some cases, immediate post-operative mobilisation might be appropriate, neither Dr Marans nor Prof Maffulli were called as witnesses, and, in any case, their evidence had to be weighed against the rest of the expert evidence and medical literature stating otherwise.

63 Finally, we come to the survey evidence adduced by Dr Yip. At the hearing before us, Mr Navin did not (correctly, in our view) seek to rely in any significant manner on the survey which Dr Yip had commissioned. Indeed, these results were subject to trenchant criticism by the SMC on the basis that an adverse statistic had been conveniently left out by Dr Yip (see GD at [61]). The

"most important and representative" result in that survey, according to Dr Ma (who had been engaged by Dr Yip to conduct data analysis of the survey results), had been that 48% of the respondent orthopaedic surgeons have, in the past, issued two days or less of sick leave to patients who had undergone operative fixation of a fractured clavicle and conservative treatment of rib fractures. This conclusion was, however, contradicted by the results in respect of another question where only three of 93 respondents said that they gave an average of less than one week of sick leave to patients in the Patient's circumstances, and, that for those three, an average of three to five days' sick leave was given. This adverse statistic was eventually *omitted* from the final results. While Dr Yip claimed that the question was omitted because he had realised midway through the conduct of the survey that data relating to an *average* number of days of sick leave given would not be as relevant as the *range* of durations given, we found this a rather thin explanation given that the questions had been drafted by Dr Yip himself. Moreover, even if that were indeed the case, we found it quite troubling that Dr Yip chose to *omit* the adverse result entirely, instead of publishing it and explaining its relevance (or irrelevance). In the circumstances, the DT's finding that the survey evidence was of no probative value was eminently justified.

64 For all of the foregoing reasons, we did not see any reason to disturb any of the DT's findings on the evidence in relation to the first applicable standard, *viz*, that it was not the practice to certify a patient in the Patient's condition fit for light duties from the first post-operative day.

65 That said, and as we had earlier mentioned, the DT then went on to consider whether Dr Yip had ascertained that there were adequate conditions for rest and rehabilitation, referring to this as a *second* applicable standard of conduct. The DT did not, however, explain how these standards were related (if

at all). That omission was rather unfortunate since it would appear that the *second* applicable standard – requiring that Dr Yip ascertain that there were adequate conditions for rest and rehabilitation before prescribing light duties – would be moot if the *first* applicable standard – requiring that sick leave be issued *regardless of the rehabilitative value and availability of light duties* – applied. For this reason, and as we alluded to at [10] above, it appeared to us that embarking on a consideration of the *second* applicable standard implicitly entails a *qualification* of the *first* applicable standard, in that that first standard, instead of requiring absolutely and invariably that sick leave be issued, allows instead that light duties *may possibly* be issued, *provided* that the doctor first ascertains that there are adequate conditions for rest and rehabilitation should light duties be assigned. Bearing this in mind, the first and second applicable standards referred to by the DT would, in our view, be more appropriately articulated as two aspects of a ***single*** standard. That ***single*** standard would require that a doctor examining a patient (with the Patient's injuries and in the Patient's circumstances) either prescribe him sick leave, *or* certify him fit for light duties, having ascertained that there are adequate conditions for rest and rehabilitation if light duties are assigned.

66 Returning to the present facts, since Dr Yip did not prescribe any sick leave and issued light duties instead, the applicable standard required that Dr Yip ascertain that there were adequate conditions for rest and rehabilitation before issuing light duties. Had he done so, he would not have departed from the applicable standard at all. We pause to note that the ***result*** would, in ***substance***, be the ***same*** under the analysis taken by the DT; if Dr Yip had made the necessary inquiries, he would *also* have met what the DT referred to as the second applicable standard of conduct. Indeed, Dr Yip's case ***is precisely*** that

the second applicable standard applies, and that he had in fact met it via proactive inquiry with the Patient.

67 It is important, however, to note at this juncture that, even though the result would, in substance, be (as noted in the preceding paragraph) the same under the so-called "two standards approach" adopted by the DT in the present case, such an approach is, with respect, both apt to confuse and may (more importantly) lead to possible errors as a result. In our view, this confusion could have been avoided had the DT not lost sight of the fact that, at any given point in time in relation to a given charge, there should ***only*** be ***a single applicable standard of conduct***. This applicable standard may, depending on the circumstances, comprise two or more practices or courses of action which are medically appropriate. But, crucially, the relationship between these practices must be clearly set out. For example, on the present facts, the relationship between the so-called first and second applicable standards could (as already alluded to at [65] above) have been clarified as a *single* standard requiring that sick leave be given if the doctor cannot ascertain or has not ascertained that suitable light duties were available. Disciplinary Tribunals should henceforth ascertain, with respect to each charge, what the *single* applicable standard of conduct is pursuant to the first limb of *Low Cze Hong* before proceeding to ascertain whether the said doctor's conduct constituted a departure from *that* applicable standard conduct and, if so, whether the departure was intentional and deliberate. Indeed, this same guidance would apply equally to the SMC when framing and particularising the charges brought against doctors.

The second issue

68 It will be recalled that Dr Yip had argued that he had not deliberately and intentionally departed from the first applicable standard because the DT had

failed to apply its mind to the question as to whether he had been conscious of this standard and that, even it had, a finding of such consciousness was made contrary to the evidence (see [40] above). With respect, we find this argument disingenuous. In this regard, we would also endorse as well as apply the following observations from *Wong Him Choon* (at [81]−[82]) to the present case as well:

> 81 … We highlight, in any case, that pursuant to para 4.1.1.1 of the SMC's Ethical Code and Ethical Guidelines ("the Code and Guidelines"), it would be incumbent on a doctor to ensure that he conducts an adequate assessment of his patient's condition. The said paragraph provides as follows:
>
> > *A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.*
> >
> > If treatment is suggested or offered to a patient without such personal evaluation, the doctor must satisfy himself that he has sufficient information available and that the patient's best interest is being served. Such information could be transmitted by voice, electronic or other means by a referring doctor. Only in exceptional or emergency circumstances should a diagnosis or treatment be offered without personal contact and without the intermediation of a referring doctor.
> >
> > [emphasis added]
>
> 82 The Code and Guidelines represent "the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore" and "the minimum standards required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore" (see para 1 of the Code and Guidelines). As the Code and Guidelines represent so fundamentally ***the most basic aspects of clinical practice***, we emphasise that an errant practising doctor would be hard put to argue that he has no knowledge of matters which are covered by the said Code and Guidelines. On the contrary, there would be a strong presumption that he has knowledge of the matters contained therein. It would otherwise be all too convenient for an errant doctor to allege that he did not depart from the applicable standard intentionally on the basis that he did not know of the applicable standard at the relevant time. To the extent outlined, we would have

> additionally been prepared to find that Dr Wong knew of the applicable standard by virtue of it being broadly encapsulated in para 4.1.1.1 of the Code and Guidelines.
>
> [emphasis in original]

Indeed, Dr Yip is, in fact, an extremely experienced orthopaedic surgeon of many years standing and the observations just quoted would apply in an *a fortiori* manner to him.

69 Further, to the extent that Dr Yip attempts to justify his departure from the first applicable standard on medical grounds (see [28] above), this raises – in substance – the third issue, to which our attention now turns.

The third issue

70 The parties were agreed as to the content of the second applicable standard. Both Dr Yip and his experts readily accepted that it would be incumbent on the doctor to first ascertain that adequate conditions for rest and rehabilitation existed before certifying a patient fit for light duties. In other words, it was agreed that *sick leave* would have to be given *if* light duties were unavailable, or if no agreement had been reached with the Patient as to light duties.

(a) Dr Tio would have given the Patient about six to ten weeks' sick leave if no light duties were available:

> A: Sick leave, because if you have no light duty, go back to your dormitory, please.
>
> …
>
> Q: … So in that situation, if there is no light duty and we don't know if the employer is prepared –
>
> A: If there is no light duty, no other question. Go back to your dormitory.

(b) Dr Chang agreed that it would be reasonable that the Patient would need about six weeks' sick leave if no light duties were available:

> Q: … Dr Tio … said that, "Look, if there was actually no light duties available and no discussion with the patient, it would have been detrimental to send the patient back to work on a construction site, won't you agree?
>
> A: That would be correct.
>
> …
>
> Q: … And for him, in that situation, he would have given six to ten weeks of medical leave …
>
> A: … I would see the workman regularly and give medical leave as and when required.
>
> Q: … Dr Murphy also says I think at the first instance, he would give at least two weeks of medical leave and then ask the patient to come back to re-assess.
>
> A: That would be reasonable.
>
> …
>
> Q: … would it be fair to say that overall, this patient might need six weeks of medical leave … to go back to his construction work?
>
> A: That would be a reasonable timing.

(c) Dr Yip also agreed that he would have issued medical leave if the patient had not agreed to do light duties:

> Q: If the patient has said that he does not agree to do light duties, you would have issued medical leave?
>
> A: Just like many of my patients.
>
> …
>
> Q: And how long would that medical leave be for?
>
> A: I would issue until the next time I see them.
>
> …

> Q: And on the 18th, if again he says he's not doing light duties, you would issue until the 25th?
>
> A: That is correct.

71 As there was no dispute as to the applicability and content of the second standard, the only question was whether Dr Yip had intentionally and deliberately departed from it.

72 As noted, the second applicable standard required that, before certifying the Patient fit for light duties, Dr Yip must have first ascertained that there existed adequate conditions for rest and rehabilitation. Dr Yip claimed that he had indeed done so via a discussion with the Patient during which (i) the types of light duties available were discussed and (ii) the Patient *agreed* to try light duties to mobilise the injured area as part of a rehabilitation plan. The DT rejected Dr Yip's version of events, and found that no such discussion had taken place. Having carefully considered the evidence, we do not think there is any basis for disturbing that finding. We say this for the following reasons.

73 First, if indeed such a discussion had taken place, one would have expected at least *some mention* of it to have been made in the contemporaneous clinical notes. Instead, the alleged discussion between Dr Yip and the Patient was mentioned *for the first time* in Dr Yip's Witness Statement for the hearing before the DT; it was not mentioned in any of the contemporaneous clinical notes, nor even in Dr Yip's Explanation given in response to the complaint lodged against him.

74 On appeal, Dr Yip sought to explain the dearth of any contemporaneous record of the discussion on grounds that the 2002 C&G (which were the prevailing guidelines at the time) did not specifically require doctors to record discussions with patients on light duties; that requirement had only been inserted

in the 2016 edition of the SMC Ethical Code and Ethical Guidelines. Ultimately, this submission does not take Dr Yip very far. Indeed, while the 2002 C&G did not have *specific* guidelines on recording discussions regarding light duties, para 4.1.2 contains general guidance on the keeping of clinical notes, and requires that medical records be *of sufficient detail so that another doctor reading them would be able to take over the management of a case*:

> 4.1.2 Medical records
>
> Medical records kept by doctors shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards. *Medical records shall be of sufficient detail so that any other doctor reading them would be able to take over the management of a case.* All clinical details, investigation results, *discussion of treatment options*, informed consents and treatment by drugs or procedures should be documented.
>
> [emphasis added]

75 Importantly, Dr Yip's own expert witness, Dr Chang, agreed that he would have recorded such a discussion with a patient and/or his employer on light duties:

> Q: … I think just now we said everything hinges on whether the light duties was discussed with the patient … So in that kind of situation, if you are going to give light duties instead, wouldn't you then make sure that such a discussion and agreement is recorded?
>
> A: I would.
>
> …
>
> Q: … [Dr Yip] says there was … about half an hour at least of the discussion, half to one, I think he said 3.00 to 4.00 pm, with the patient and with Mr Lin Sheng the boss.
>
> …
>
> Q: … was it surprising to you if there wasn't even an entry for this 3.00 pm discussion, which allegedly lasted an hour, about such an important topic.

A: I mean I would normally make some note about it.

76 In our view, the absence of *any* contemporaneous notes corroborating Dr Yip's account seriously undermines his assertion that he did indeed have that discussion. In *Singapore Medical Council v Mohd Syamsul Alam bin Ismail* [2019] SGHC 58 ("*Mohd Syamsul Alam*"), the doctor had been charged for, amongst other things, failure to perform an adequate clinical assessment of the patient. The doctor claimed, in his explanatory statement, that he had performed a physical examination of the patient, despite the fact that nothing of the sort was mentioned in the contemporaneous consultation note. The Court found it remarkable that the doctor was able to offer such a vivid recollection of the material events (*eg*, how he had positioned the patient to examine the perianal region, and the location and size of a lump found on the patient's buttocks) in his explanation, prepared some *twenty* months after the consultation in question, without the benefit of detailed consultation notes (*Mohd Syamsul Alam* at [7]–[8]). The same point applies *a fortiori* in the present case: Dr Yip's first mention of the alleged discussion came not even in his Explanation, but only in his Witness Statement, prepared some *five years* after the discussion had allegedly taken place. Yet, he claimed to be able, without the aid of any notes whatsoever, to recall intricate details of the alleged discussion such as the specific types of light duties available and the specific location at which workers would be sent to perform their light duties.

77 Further, it was, in our view, quite telling that no mention of the discussion was made in Dr Yip's Explanation. This Explanation was prepared on 29 June 2012 in direct response to the Notice of Complaint dated 22 May 2012, in which Dr Yip was specifically invited to "address the allegations put forth by the complainant, in particular … (a) Your failure to provide more than two days of medical leave to [the Patient] …", and, it was clear from

Ms Chang's cross-examination of Dr Yip on this point at the inquiry that Dr Yip was well aware that addressing that allegation would have entailed explaining *why* he gave light duties instead of sick leave. Yet, no mention was made of the discussion, during which, it must be remembered, the Patient *allegedly agreed to undertake light duties*. It is highly unlikely that such a material fact would have gone unmentioned by Dr Yip in his Explanation if indeed it were true.

78 Secondly, we agree with the DT (see GD at [95]) that Mr Muthukannan's testimony was less than persuasive. Dr Yip's case rested heavily on Mr Muthukannan's evidence; as Dr Yip put it, since both the Patient and Mr Lin had returned to China and were unavailable to testify, Mr Muthukannan's evidence was the only "direct independent third party evidence" of the discussions which took place. Mr Muthukannan's evidence was therefore crucial in corroborating Dr Yip's own account. Ultimately, however, we found Mr Muthukannan's evidence wanting in several respects. First and foremost, Mr Muthukannan acknowledged that his evidence was based entirely on his own recollection of the events (which, as already mentioned, would have taken place some five years before the DT's inquiry). Indeed, Mr Muthukannan admitted that he could not recall the incident perfectly, and could only recall the parts about light duties. We agree with the SMC that it was simply too convenient that Mr Muthukannan could only remember certain selected details (*eg*, the specific types of light duty that Mr Lin had informed Dr Yip of) but not others (*eg*, whether Dr Yip had explained the concept of early mobilisation). This, in our view, cast serious doubt not just on the reliability of his evidence, but also its objectivity.

79 Thirdly, and perhaps most fundamentally, Dr Yip's claim that he had discussed light duties with the Patient was inconsistent with his own evidence that he was wholly unaware that the Patient had not done any light duties at all

after he was discharged. If, indeed, Dr Yip had given the Patient light duties as part of a carefully-considered rehabilitation plan, one would have expected that during the reviews he would have checked on the types of light duties the Patient had been engaged in so as to ensure that they were having their intended rehabilitative effects. The fact that this was not done during the follow-ups casts serious doubt on his contention that he had issued light duties on medical grounds as part of the post-operative management plan, and that he had discussed light duties with the Patient pursuant to that plan.

80 For all of the above reasons, we did not see any reason to disturb the DT's finding that Dr Yip did not ascertain that adequate conditions for rest and rehabilitation existed because he did not in fact have a discussion with the Patient as claimed. In failing to do so, Dr Yip had departed from the second applicable standard.

81 We turn next to consider if Dr Yip's departure from the second applicable standard of conduct had been "intentional and deliberate". The relevant inquiry is whether or not Dr Yip was *personally conscious* that he ought to have discussed the availability and suitability of light duties with the Patient before prescribing light duties to the Patient (*Wong Him Choon* at [63]). This was undoubtedly the case since Dr Yip had ***conceded*** that he would have given sick leave if the Patient had not agreed to try light duties (see [70(c)] above).

82 On Dr Yip's case, the standard of conduct applicable to him required that he first ascertain that there would be adequate conditions for rest and rehabilitation before certifying the Patient fit for light duties. Crucially, we saw no basis on the evidence before us to interfere with the DT's finding that the alleged discussion between Dr Yip and the Patient never took place, and that Dr Yip had therefore intentionally and deliberately departed from the standard

of conduct applicable to him. We therefore affirm the DT's finding that the Charges against Dr Yip had been proven beyond a reasonable doubt.

83 We also note that the observations from *Wong Him Choon* (at [81−[82]) (which were quoted at [68] above) apply in the context of the present issue as well.

The fourth issue

84 Given the analysis set out above, it is also clear, in our view, that there had in fact been serious negligence on Dr Yip's part and that such negligence objectively constituted an abuse of the privileges of being registered as a medical practitioner. In this connection, the DT found that the *mens rea* of serious negligence had been made out, and that the "clearest indication" of this had been Dr Yip's ignorance that the Patient had not done any light duties at all since the accident (GD at [103]). We agree, and would therefore have found Dr Yip guilty of the Alternative Charges even if the Charges had not been made out.

Conclusion on the Charges

85 For all of the foregoing reasons, we affirm the DT's finding that the Charges proffered against Dr Yip were made out on the evidence beyond a reasonable doubt.

The parties' submissions on sentence

The SMC's submissions

86 In its cross-appeal in OS 9, the SMC sought an increase in the term of suspension to a term of six months' suspension per charge, for a total suspension

term of 18 months. In addition, it was submitted that if a discount was warranted on account of a delay in the proceedings, the final suspension imposed should not fall below 12 months.

87 In support of its contention that the sentence imposed was manifestly inadequate, the SMC advanced the following arguments:

(a) The DT had erred in taking the view that it was appropriate to sanction the professional misconduct of Dr Yip *as a whole* without considering the adequate sentence for each charge. In so doing, the DT did not give a principled and transparent explanation as to how the aggregate term of ten months' suspension was arrived at.

(b) The DT had failed to ensure parity of sentencing with the relevant sentencing precedents, chief amongst which was this Court's decision in *Wong Him Choon*, with the result that the sentence imposed ought to be enhanced. Further, the DT ought to have accorded more weight to the aggravating factors in the present case. Compared to *Wong Him Choon*, Dr Yip's behaviour in the management of the Patient was more egregious.

(c) The DT had erred in awarding a blanket 50% discount to the sentence following its finding that there had been an inordinate delay in prosecuting proceedings. In any case, Dr Yip did not suffer any significant prejudice due to the delay in the proceedings.

Dr Yip's submissions

88 In his appeal, Dr Yip seeks a reduction of the sentence of suspension imposed on grounds that it is manifestly excessive. In support of this submission, Dr Yip relies on the following arguments:

(a) If individual sentences are to be imposed in respect of each of the charges, they should be made to run concurrently since the charges relate to a single transaction of alleged wrongdoing.

(b) Dr Yip also argued that the DT had failed to ensure parity of sentencing with the sentencing precedents, and argued that such an exercise would require a reduction of the aggregate suspension term. In this connection, the DT had wrongly identified the aggravating factors in the present case. Properly identified, there were fewer aggravating factors in the present case than in *Wong Him Choon*.

(c) The DT correctly found that there had been an inordinate delay, and that a discount of the sentence was therefore warranted.

Our decision on sentence

The aggregate sentence imposed

89 Having convicted Dr Yip on all three of the Charges, the DT imposed an *aggregate* sentence in respect of all three of the Charges instead of specifying the sentences for each individual charge, explaining as follows (GD at [127]):

> We noted that the three Charges that Dr Yip faced *were of similar nature and arose from three examinations that had taken place over a short period.* In the circumstances, the [DT] took the view that it was appropriate to sanction the professional misconduct of Dr Yip as a whole, instead of separately for each Charge. [original emphasis in underlining; emphasis added in italics]

90 When dealing with a defendant convicted of multiple charges, whilst it may not always be necessary for the sentencing court or tribunal to state explicitly what the individual sentence is for *each individual charge* the defendant has been convicted of, this ought to have been done in the present case. It is, for example, not possible to know if the DT had considered ten months' suspension to be appropriate for each charge, running them concurrently; or if some lower term of suspension per charge was appropriate, the ten-month suspension being an aggregate sum of the sentences running consecutively.

91 The next question is whether the individual sentences imposed in respect of each of the Charges ought to run consecutively or concurrently. In this connection, we find Ms Chang's argument to the effect that the three charges preferred against Dr Yip represented separate and distinct offences which merited separate sanctions persuasive. Let us elaborate.

92 While, at first blush, it might appear that all three of the Charges pertained to the same type of failure by Dr Yip towards the same patient, that does not detract from the fact that on *each* separate occasion, Dr Yip had *a distinct duty* to assess the patient based on the circumstances prevailing *at that particular point in time* and taking into account changes in the patient's condition when prescribing sick leave or light duties. This point was underscored by the fact that, on the facts before us, the Patient's condition was indeed *changing* – the first follow-up review on 11 July 2011 involved checks for pneumothorax, removal of the sutures on his head laceration, and the discovery of an additional fracture of the Patient's 6th right rib. It matters not that, in the present case, these changes in the Patient's condition might have been immaterial from the perspective of the actual medical treatment prescribed – the point remains that the doctor's duty to assess the patient's condition at

each separate consultation is *a fresh and distinct duty* that arises each time he sees the patient. Viewed in this light, Dr Yip's failure to issue an appropriate duration of sick leave on each of the three occasions that he saw the Patient was a *separate and distinct* default, for which individual sentences ought to be imposed, and ought (in the circumstances) to run *consecutively*.

The aggravating factors

93 In our view, the most aggravating factor in this case was Dr Yip's complete disregard for the Patient's welfare and interest. This manifested itself throughout his post-operative treatment of the Patient when he failed to consider the Patient's multiple serious injuries as significant enough for sick leave, and, perhaps most appallingly, when he failed to check on how the Patient was coping with the light duties (or, indeed, not even bothering to ascertain what sort of light duties the Patient had been doing in the first place), despite claiming that he had prescribed the Patient light duties as part of the post-operative rehabilitation regime for the Patient. As the DT noted, if indeed the issuance of light duties had been part of a treatment plan, that plan had been a complete failure.

94 This was made worse by the fact that the Patient had suffered *multiple serious injuries*, including a fractured clavicle and several rib fractures, which, as Dr Tio opined, would have made even *laughing and coughing* painful. He also suffered two other injuries – a 1cm head laceration and a wrist contusion – which, although not meriting issuance of sick leave in their own right, fell to be considered with the other injuries in assessing the totality of the Patient's condition (see GD at [50]). These injuries paint a picture of the physical and medical condition the Patient was in when he presented before Dr Yip, and, as was emphasised at [6] above, this forms the *central focus* of this case. The fact

that Dr Yip acted with such callous disregard for the Patient's welfare in the face of the severity of the injuries that he had sustained was in our view a significantly aggravating factor.

95 On his part, Dr Yip submitted that the present facts were *less* aggravated than those in *Wong Him Choon*. While we accept that no *direct* harm was caused to the Patient as a result of Dr Yip's misconduct (unlike in *Wong Him Choon*), we were of the view that the *other* aggravating factors placed the present facts in a more severe category than *Wong Him Choon*.

96 Another key point of distinction, according to Dr Yip, was that Dr Wong's reasons for giving light duties had been unfounded and irrelevant, whereas his reasons were premised on medical considerations; in particular, his genuine belief in prescribing light duties to mobilise the injured area. However, as was noted (at [93] above), this argument was seriously undermined by the fact that Dr Yip did not even know (and did not find out) that the Patient had not been doing light duties at all. Further, as we pointed out during oral submissions before this Court to Mr Navin, the Patient could have equally been able to mobilise himself even whilst on sick leave – a point which he (correctly, in our view) accepted.

97 Nor did we find any merit in Dr Yip's argument that he, unlike Dr Wong, had not displayed any willingness to let the Patient's employer, Soon Tat, decide on the Patient's rest because he had discussed the same with the Patient, and that the decision to try light duties was left up to the Patient. This, of course, was rejected by the DT when it found that no such discussion had taken place (GD at [95]), a finding which, for the reasons given above, we found no reason to disturb.

98 Taking all of the above factors into consideration, we are of the view that each charge merited a period of suspension of four months and, as was noted, there was no reason why the periods of suspension should not run consecutively, giving an aggregate sentence of a period of suspension of twelve months.

Inordinate delay

99 However, we also note that there was delay in the institution of proceedings against Dr Yip – for which the DT halved the period of suspension.

100 For the delay in the institution or prosecution of proceedings to be taken into account as a mitigating factor, (i) the delay must have been significant, (ii) the delay must not have been contributed to in any way by the offender, and (iii) the delay must have resulted in real injustice or prejudice to the offender (see *Ang Peng Tiam v Singapore Medical Council and another matter* [2017] 5 SLR 356 ("*Ang Peng Tiam*") at [109], citing *Tan Kiang Kwang v Public Prosecutor* [1995] 3 SLR(R) 746). Whether or not there has been inordinate delay is not measured in terms of the absolute length of time that has transpired, but must always be assessed in the context of the nature of investigations (*Ang Peng Tiam* at [113]).

101 In the present case, the Complaint was lodged on 24 October 2011. Dr Yip was notified of the same on 22 May 2012, and he issued his Explanation on 29 June 2012. Almost three years later, on 2 April 2015, Dr Yip was notified that a formal inquiry would be convened, and the NOI was issued on 3 November 2015, almost three-and-a-half years after Dr Yip had sent in his Explanation (GD at [119]). This was comparable to the delays in *Ang Peng Tiam* and *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943 ("*Jen Shek*

Wei"), for which a discount of 50% was given in respect of the suspension imposed (GD at [121]).

Real injustice or prejudice

102 At the hearing below, the SMC submitted that a distinction ought to be made between a material delay due to investigations *before* notification of a formal inquiry to the respondent and a material delay that arises *between* notifying the respondent of a formal inquiry and the issuance of the NOI. It was argued that a delay which occurs in the *latter* period would have more impact on the respondent doctor due to the certainty that charges will be brought against him. On this footing, the SMC sought to distinguish the precedents relied on by Dr Yip (*ie*, *Ang Peng Tiam* and *Jen Shek Wei*), in which the material delay occurred *after* the respondent doctors had been notified of the formal inquiry, and the present case, in which the material delay occurred *before* Dr Yip had been notified of the formal inquiry. The SMC submitted that since the bulk of the delay arose *before* Dr Yip had been notified of the formal inquiry to be brought against him, this was not a situation "where Dr Yip had charges 'hanging over his head' for an unduly long or indefinite period".

103 The DT declined to draw that distinction (GD at [120]), and we agree. While we are prepared to accept that in general, the anxiety and distress might be *greater* after the notice of a formal inquiry is issued, it would not be right to ignore the consequences of any delay prior to that. As Ms Chang had herself acknowledged in her closing submissions before the DT, receiving a complaint is "not a nice thing". We accept, as the Court in *Ang Peng Tiam* did, that the doctor would, as a matter of "natural inference", suffer great anxiety and distress from having the matter hang over his head.

Public interest considerations

104 Whilst we acknowledge the fact that there was delay in the present case, we are also cognisant of the fact that countervailing public interest considerations ought, in the circumstances, also to be taken into account. The latter includes "the need to protect public confidence and the reputation of the profession, as well as the need to protect the public from the potentially severe outcomes arising from the actions of errant members of the profession" (see *Ang Peng Tiam* at [118]).

105 The SMC argued that the public interest in safeguarding the health and safety of workers was engaged, and we agree. Indeed, foreign transient workers like the Patient may be considered vulnerable patients, not least because they will almost invariably have no kin with them here in Singapore and are consequently largely dependent on their employers (and the healthcare professionals engaged by their employers). We note that the Ministry of Manpower and the Ministry of Health have jointly issued no fewer than three circulars – first on 19 June 2013, again on 7 July 2014, and most recently on 16 September 2016 – reminding medical practitioners of the need to exercise good clinical assessment so that workers' and their colleagues' health and safety are not jeopardised. We reproduce an extract of that last mentioned circular here:

> 1. In 2013, MOH and MOM issued a circular [footnote omitted] to medical practitioners to remind them that the issuance of adequate medical leave should be based on good clinical assessment and be commensurate with the nature and severity of the worker's injury, and that stern action would be taken against medical practitioners who did not do so.
>
> 2. Subsequently, acting on continual feedback received that some employers were still attempting to pressurise medical practitioners to shorten the prescribed duration of medical sick leave, a reminder [footnote omitted] was issued to medical practitioners in 2014. It reminded medical practitioners to

> follow the recommended practice, and that potentially errant medical practitioners would be referred to Singapore Medical Council (SMC) for investigation.
>
> 3. In May 2016, the Court of Three Judges allowed an appeal filed by the SMC against the decision of a Disciplinary Tribunal and convicted Dr Wong Him Choon (Dr Wong) of professional misconduct. Dr Wong was sentenced to 6 months suspension [footnote omitted]. SMC had earlier found that Dr Wong failed to exercise due care in the management of a patient by certifying insufficient medical leave and inappropriately certifying the patient fit for light duties.
>
> 4. We urge all medical practitioners to take note of the importance of the applicable standards of conduct and recommended practice in managing patients as stated in the 2013 Circular (refer to the Annex) and reminder circular in 2014. Medical sick leave given should be based on good clinical assessment and be commensurate with the nature and severity of the workers' injuries.
>
> …

106 Lest a dry and arid technical (as well as literalist) argument be sought to be made that the circulars referred to in the preceding paragraph were issued after the events that are the subject of the present case had taken place, we would note that these circulars merely underscore what are *timeless* principles of common humanity which apply in an *a fortiori* manner to foreign transient workers such as the Patient – consistent with the overarching duty of a doctor which was described in the decision of this Court in *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 as follows (at [39]−[41]):

> 39 Turning to *the medical profession*, the idea that the practice of medicine is, above all, a calling of the highest order is a historical cornerstone of the medical profession. It can be traced through the millennia – through countless doctors who have taken, in one form or another, a version of what has oft been hailed as one of the world's first *ethical* codes, the Hippocratic Oath (and see also, in this regard, the *general* definition of a "profession" in the [*Oxford English Dictionary* (Clarendon Press, 2nd Ed, 1989)] referred to above at [30]). In Singapore, this oath currently takes the form of the Singapore Medical Council Physician's Pledge (presently found in the Second Schedule to, read with reg 16(2) of, the Medical

Registration Regulations 2010 (S 733/2010)), which is taken by every doctor upon being admitted as a fully registered medical practitioner and which reads as follows:

> I ***solemnly pledge to dedicate my life to the service of humanity***; give due respect and gratitude to my teachers; ***practise my profession with conscience and dignity***; ***make the health of my patient my first consideration***; respect the secrets which are confided in me; ***uphold the honour and noble traditions of the medical profession***; respect my colleagues as my professional brothers and sisters; not allow the considerations of race, religion, nationality or social standing to intervene between my duty and my patient; maintain due respect for human life; ***use my medical knowledge in accordance with the laws of humanity***; comply with the provisions of the Singapore Medical Council's Ethical Code and Ethical Guidelines; and constantly strive to add to my knowledge and skill.
>
> I make these promises solemnly, freely and upon my honour.
>
> [emphasis added in bold italics]

40 This pledge is *even more explicit* in its reference to *ethical* obligations and values than the corresponding declaration taken by lawyers (pursuant to r 30 of, read with the First Schedule to, the Legal Profession (Admission) Rules (reproduced above at [32])). In our view, this pledge constitutes no mere rhetoric. Instead, it embodies – as the summary with regard to the *legal* profession set out above (at [38]) underscores – a calling that seeks, amongst other obligations, to be *helpful to others in an important way* (here, by curing the sick) and goes *beyond* mere money-making and the advancement of self-serving interests.

41 Indeed, the proposition that the spirit of public service and the existence of *ethical* obligations underpin all professional practice applies with equal (and, arguably, even greater) force to medical practitioners, whom we collectively entrust with our health, our well-being and, in certain instances, our lives. In this respect, the medical profession occupies a unique societal position of both great privilege and commensurate responsibility. In this regard, the following observations by the then Governor of the Straits Settlements, Sir John Anderson, in his speech on the occasion of the formal opening of the very first medical school in Singapore on 28 September 1905 are particularly apposite (published in *The Straits Times* of 29 September 1905 (available at <http://newspapers.nl.sg/Digitised/

> Article/straitstimes19050929-1.2.47.aspx> (accessed 24 June 2013)), also quoted (in part) in *Transforming Lives: NUS Celebrates 100 Years of University Education in Singapore* (Singapore University Press Pte Ltd, 2005) at p 11):
>
> > … What I want you to remember is that the course of study you are about to enter upon is ***not merely*** *a course of study which is* ***intended to enable you to earn a living***, but … a passport to *membership of* ***a very great profession****, a profession* ***in many instances*** *of* ***unselfish devotion and splendid achievement****, a profession with very* ***lofty ideals*** *and one which calls for* ***all the best qualities****, mental* ***and moral****, which a man can give.* It demands not only freshness and vigour of body, but steadiness and skill in hand and eye. *It wants infinite patience* ***and keenest sympathy****, and to all these qualities there has to be added* ***unfaltering courage****.*… [emphasis added in italics and bold italics]
>
> As also articulated by this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [36]:
>
> > … The importance of maintaining the highest level of professionalism and ethical conduct has been duly acknowledged by the [Singapore Medical Council] in the Introduction section of the [Singapore Medical Council] Ethical Code (at p 1):
> >
> > > The medical profession has always been held in the highest esteem by the public, who look to their doctors for the relief of suffering and ailments. In modern medical practice, ***patients and society at large expect doctors to be responsible both to individual patients' needs as well as to the needs of the larger community. Much trust is therefore endowed upon doctors to do their best by both.*** *This trust is contingent on the profession maintaining the highest standards of professional practice and conduct.*
> >
> > …
> >
> > [High Court's emphasis in *Low Cze Hong* in italics; emphasis added in bold italics]
>
> [emphasis in original]

107 Taking into account the countervailing public interest considerations, we are of the view that the aggregate period of suspension should be reduced by

one-third, giving an aggregate sentence of a period of suspension of eight months.

Conclusion

108 For the reasons set out above, Dr Yip's appeal in OS 8 is dismissed and the SMC's appeal in OS 9 is allowed. In the premises, the DT's sentence of a period of suspension of five months is increased to a period of suspension of eight months. This term of suspension is to commence four weeks from the date of this judgment. The DT's other orders that Dr Yip be censured, and that he give a written undertaking to the SMC that he will not engage in the conduct complained of or similar conduct in the future, are to stand.

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

Andrew Phang Boon Leong Judge of Appeal	Judith Prakash Judge of Appeal	Quentin Loh Judge

Navin Joseph Lobo, Shaun Oon Kim San, Cheng Liqi and Yap Chun Kai (Bird & Bird ATMD LLP) for the appellant in Originating Summons No 8 of 2018 and the respondent in Originating Summons No 9 of 2018;
Chang Man Phing Jenny, Chua Sin Yen Jacqueline and Lim Wan Yu Cheronne (WongPartnership LLP) for the respondent in Originating Summons No 8 of 2018 and the appellant in Originating Summons No 9 of 2018.