IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2019] SGHC 134

Originating Summons No 11 of 2018

Between

Singapore Medical Council

… *Appellant*

And

Looi Kok Poh

… *Respondent*

Originating Summons No 12 of 2018

Between

Looi Kok Poh

… *Appellant*

And

Singapore Medical Council

… *Respondent*

JUDGMENT

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

Singapore Medical Council
v
Looi Kok Poh and another matter

[2019] SGHC 134

High Court — Originating Summonses Nos 11 and 12 of 2018
Sundaresh Menon CJ, Judith Prakash JA and Tay Yong Kwang JA
4 March 2019

27 May 2019 Judgment reserved.

Judith Prakash JA (delivering the judgment of the court):

1 The cross-appeals before this court relate to disciplinary proceedings taken by the Singapore Medical Council ("the SMC") against one Dr Looi Kok Poh. The Disciplinary Tribunal ("the Tribunal") found Dr Looi guilty on two charges of professional misconduct in that he had failed to ensure that adequate medical leave was given to his patient. As a consequence, the Tribunal suspended Dr Looi from practice for a total of six months. Dr Looi has appealed against both the sentence and the conviction while the SMC has appealed against the sentence.

Background facts

Parties to the dispute

2 Dr Looi is a medical practitioner with a registered speciality in hand surgery. In 2011, he was practising in a medical centre run by West Point Hospital Pte Ltd ("the Hospital").

3 Vadamodulu Tata Rao ("the Patient") is an Indian national who was in his early 30s in 2011. He was then employed by Tellus Oceanic Pro Pte Ltd ("Tellus") as a welder at a shipyard. He is right-handed.

The Patient's history

4 On 7 August 2011, while at work, the Patient sustained a crush injury to the fingertip of his right middle finger resulting in loss of the soft tissue and a comminuted fracture of the finger. The Patient was taken to the Hospital, and seen by Dr Looi on that day. Dr Looi performed the first stage of a two-stage thenar flap surgery on the Patient's finger. The first stage of the surgery involved attaching the Patient's injured finger to a skin flap from the thenar eminence (*ie*, the group of muscles at the base of the thumb on the palm side) of the same hand ("the First Stage surgery"). The purpose of the First Stage surgery was to allow the blood vessels in the palm to sustain the tissue of the finger as it healed. The second stage would then involve detaching the healed finger from the flap by dividing the flap ("the Second Stage surgery").

5 After the surgery, the Patient was hospitalised for one night. Dr Looi left notes for the staff of the Hospital instructing them to discharge the Patient the next day with one day of medical leave and seven days of light duties thereafter. He also stated that he would review the Patient the next day. That night, the

Patient reported a pain score of nine (out of ten). A score of ten indicated "severe pain", while a score of six to nine indicated "moderate pain".

6 A nurse's case sheet recorded that the Patient was visited on the morning of 8 August 2011 by Mr Jimmy Chia ("Mr Chia"), a safety officer with Tellus who had asked for the Patient to be discharged. The Patient was then seen by Dr Stephen Tan, the Resident Medical Officer, who obtained Dr Looi's confirmation and discharged the Patient. On discharge, Dr Stephen Tan issued a medical certificate granting the Patient two days' medical leave, ending 8 August 2011 (*ie*, that day), only. No light duties were given. In accordance with Dr Looi's instructions, Dr Stephen Tan held the Patient back following discharge to see Dr Looi that same afternoon. That afternoon, Dr Looi recorded that the Patient's wound was clear, and scheduled him for a follow-up review on 12 August 2011. No certification for medical leave or light duties was given at this consultation.

7 On 12 August 2011, after examining the Patient, Dr Looi scheduled him for another review on 22 August 2011, and certified him fit for light duties from 12 to 22 August 2011.

8 On 20 August 2011, the Patient visited Singapore General Hospital ("SGH") complaining of "pain over the stitch area". He was tended to by Dr Tan Chong Hun. He indicated a pain score of five out of ten. Dr Tan Chong Hun noted that the Patient's general condition was good, his right finger and hand wound were clean, slightly wet, and had no pus discharge. Dr Tan Chong Hun gave the Patient medical leave from 20 to 22 August 2011, which was the date of the Patient's next review with Dr Looi.

9 On 22 August 2011, the Patient went back to Dr Looi for his review. At this session, Dr Looi recorded "flap well", "no infection" and "viable". At that time, the Patient refused Dr Looi's offer of one week of medical leave.

10 On 7 September 2011, the Patient returned to SGH and was seen by Dr Sreedharan Sechachalam ("Dr Sreedharan"). Dr Sreedharan recorded that the Patient "did not want to be seen in [the Hospital]" due to "short MC". He also recorded that according to the Patient, he was "forced to go to work daily by employer [and] mark attendance". He noted that the flap was viable. Dr Sreedharan gave the Patient three days of medical leave, from 7 to 9 September 2011.

11 On 9 September 2011, Dr Sreedharan performed the Second Stage surgery. Dr Sreedharan gave the Patient hospitalisation leave from 10 September 2011 to 14 October 2011.

12 The Patient has since returned to India.

Procedural history

13 The SMC received the complaint forming the subject of these proceedings ("the Complaint") on 3 October 2011. It was lodged by Mr Jolovan Wham from the Humanitarian Organisation for Migration Economics. Dr Looi was notified of this on 24 May 2012. On 7 July 2012, Dr Looi submitted his explanation to the SMC. Sometime later, on 27 January 2016, the SMC issued the Notice of Inquiry to Dr Looi. The Notice of Inquiry was amended on 8 November 2016 to include two alternative charges.

14 Dr Looi faced two charges (collectively, "the Charges"), and two charges in the alternative (collectively, "the Alternative Charges"), for professional misconduct under s 53(1)(d) of the Medical Registration Act (Cap 174, 2014 Rev Ed) ("the Act"). The Charges and the Alternative Charges related to Dr Looi's reviews with the Patient on 8 and 12 August 2011. It was alleged that, on each occasion, Dr Looi failed to ensure that adequate medical leave was given to the Patient, in light of the Patient's condition and occupation.

15 The First Charge stated:

> That you, DR LOOI KOK POH, a medical practitioner, are charged that whilst practising at [the Hospital] on 8 August 2011, did fail to ensure that adequate medical leave was given to [the Patient], in light of his condition and the nature of his occupation.
>
> Particulars
>
> …
>
> (f) The Thenar Flap surgery would be done in two stages, with an intervening period of 14 to 21 days between the two stages. The Patient would require adequate rest of his right hand during the intervening period and would be unable to use his right hand effectively for many activities of daily living and for work.
>
> (g) The Patient was not given any medical leave for the period from 9 August 2011 to 11 August 2011, both dates inclusive, prior to his next review scheduled for 12 August 2011.
>
> (h) Given the nature of the Patient's occupation, his condition on 8 August 2011, the requisite post-operative management of the Patient after the first stage of the Thenar Flap Surgery and the upcoming second stage of the Patient's Thenar Flap surgery, you failed to ensure that adequate medical leave was given to the Patient.
>
> And that in relation to the facts alleged, you have been guilty of professional misconduct under [Section 53(1)(*d*) of the Act] in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.

[emphasis in original omitted]

16 The Second Charge was largely similar, except that the relevant date was 12 August 2011, and specified that the Patient had gone back to Dr Looi for a follow-up review on that date. The Second Charge stated:

> That you, DR LOOI KOK POH, a medical practitioner, are charged that whilst practising at [the Hospital] on 12 August 2011, did fail to ensure that adequate medical leave was given to [the Patient], in light of his condition and the nature of his occupation.
>
> Particulars
>
> …
>
> (e) During the intervening period, the Patient's right middle fingertip was attached via a Thenar flap to the volar side of the metacarpo-phalangeal joint region of the thumb. The Patient would require adequate rest of his right hand during the intervening period and would be unable to use his right hand effectively for many activities of daily living and for work.
>
> (f) At a follow-up review of the Patient on 12 August 2011, you gave the Patient light duties for a period of eleven (11) days from 12 August 2011 to 22 August 2011, and no medical leave.
>
> (g) Given the nature of the Patient's occupation, his condition on 12 August 2011, the requisite post-operative management of the Patient after the first stage of the Thenar Flap surgery and the upcoming second stage of the Patient's Thenar Flap surgery, medical leave should have been given to the Patient, and it was inappropriate for you to certify the Patient fit for light duties from 12 August 2011 to 22 August 2011.
>
> And that in relation to the facts alleged, you have been guilty of professional misconduct under Section 53(1)(*d*) of [the Act] in that your conduct demonstrated an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency.
>
> [emphasis in original omitted]

17 It is evident that the Charges were framed pursuant to the first limb of the test for professional misconduct as laid down in *Low Cze Hong v Singapore*

Medical Council [2008] 3 SLR(R) 612 ("*Low Cze Hong*"). In *Low Cze Hong*, the High Court held that professional misconduct could be made out in at least two situations as follows (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; and
>
> (b) where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

18 The Alternative Charges essentially mirrored the Charges in terms of the particulars, except that they were framed pursuant to the second limb of the test for professional misconduct as stated in *Low Cze Hong*.

19 At the inquiry, the SMC called five witnesses, namely, Mr Wham; Dr Stephen Tan; Dr Tan Chong Hun and Dr Sreedharan, the two doctors from SGH who had seen the Patient; and Dr Vaikunthan Rajaratnam ("Dr Rajaratnam"), a Senior Consultant Hand Surgeon in the Department of Orthopaedic Surgery at Khoo Teck Puat Hospital, as its expert witness.

20 Dr Looi testified in his own defence, and also called five witnesses, namely, Mr Tay Boon Leong ("Mr Tay"), the Health, Safety and Environment Manager at Sembawang Shipyard Pte Ltd; Mr Chia, the safety officer with Tellus; Ms Vicki Pang Pik Kwan ("Ms Pang"), an occupational therapist; Ms Joanne Ho Pek Ling ("Ms Ho"), a Senior Staff Nurse at the Hospital; and Dr Tan Soo Heong, a Senior Hand Consultant at Mount Elizabeth Medical Centre, as his expert witness.

The Tribunal's decision

21 The Tribunal delivered its written decision ("the GD") in May 2018, and convicted Dr Looi on the Charges. The Tribunal ordered that Dr Looi:

(a) be suspended for a term of six months;

(b) be censured;

(c) give a written understanding to the SMC that he would not engage in the conduct complained of or any similar conduct; and

(d) pay the costs and expenses of incidental to the proceedings, including the costs of SMC's solicitors, to the SMC.

22 The Tribunal held that the First Charge was made out. In reaching this decision, the Tribunal made the following findings:

(a) Dr Looi, as the primary doctor who in fact reviewed the Patient on the afternoon of discharge, could not avoid responsibility for the Patient's post-operative management on the basis that there had been a miscommunication between him and Dr Stephen Tan in the morning of discharge. Further, even taking Dr Looi's *intended* plan of one day of medical leave and seven days of light duties, the Tribunal found that it was not the practice to have ordered light duties on the second post-operative day for someone in the Patient's circumstances.

(b) With regard to Dr Looi's contention that he had used good surgical technique – in particular, an axial pattern thenar flap surgery, as opposed to a random pattern thenar flap surgery – the Tribunal noted that Dr Looi's medical records did not refer to an axial pattern flap,

Dr Looi had raised his use of an axial pattern flap only belatedly, and Dr Looi's expert reports similarly omitted mention of such a technique. Despite that, the Tribunal was prepared to accept his evidence that he had performed an axial pattern flap surgery. However, Dr Looi did not adduce evidence to support his claim that axial pattern flap surgery had such a significant effect on post-operative management that it permitted light duties from the second post-operative day.

(c) Dr Looi had not clinically assessed the Patient's suitability for light duties. He had decided almost immediately after the First Stage surgery on the type and amount of leave, and admitted that he had not even considered the Patient's pain score of nine on the night of 7 August 2011. His plan also failed to take into account the sedating effect of the Patient's medication.

(d) The Tribunal accepted the evidence that medical leave ought to have been provided until the flap was divided, particularly given the 7% loss of function in the Patient's dominant hand, and the need to protect the flap until the Second Stage surgery.

(e) Dr Looi had no good explanation for failing to check the Patient's medical leave when he reviewed the Patient on the afternoon of 8 August 2011. Dr Looi had also ignored basic factors such as the Patient's injury, the recovery that he needed until the Second Stage surgery, and the Patient's pain levels when he decided on the Patient's medical leave. The Tribunal thus found that Dr Looi's departure from acceptable practice had been intentional.

(f) Dr Looi had, in his conduct, intentionally and deliberately departed from his duty to establish that there were adequate conditions for rest and rehabilitation, in particular, his duty to establish the existence and nature of light duty arrangements. There was no evidence that Dr Looi made efforts to establish the existence and nature of light duties. Instead, he had left it to Tellus to decide how the Patient would spend the time until the review on 12 August 2011.

23 On the Second Charge, the Tribunal found, on similar reasoning as per the First Charge, that Dr Looi had intentionally and deliberately departed from the accepted practice of the medical profession. In particular, it was not the practice to certify a welder with the Patient's injuries as fit for light duties on the fifth post-operative day following First Stage surgery and pending division of the flap at the Second Stage surgery. Further, the Tribunal noted that Dr Looi could not explain why he offered the Patient a week of medical leave, or why the Patient refused the medical leave, at the review on 22 August 2011.

24 On the Alternative Charges, the Tribunal noted that it would *also* have found Dr Looi guilty of the Alternative Charges. The Tribunal stated that Dr Looi had, by his own admission, failed to consider the Patient's pain levels, let alone the existence and nature of light duty arrangements when he ordered the same.

25 On sentencing, the Tribunal noted that the SMC sought 18 months' suspension for each charge, with the suspensions to run consecutively, while Dr Looi sought a fine of $20,000 to $30,000. The Tribunal considered the various aggravating and mitigating factors and decided that in the circumstances a fine would not be sufficient, and a term of suspension was appropriate. As the

Charges were of a similar nature and arose from two appointments over a short period, the Tribunal took the view that it was appropriate to sanction Dr Looi for his professional misconduct as a whole, instead of separately for each Charge as urged by the SMC. The Tribunal considered that an aggregate term of suspension for 12 months was appropriate, but reduced it by half (*ie*, six months) on account of the inordinate delay on the part of the SMC in instituting proceedings against Dr Looi.

The parties' cases on appeal

Dr Looi's submissions

26 As a preliminary point, Dr Looi submits that the Tribunal was wrong to find that notwithstanding the miscommunication between Dr Looi and Dr Stephen Tan, Dr Looi remained responsible for the Patient's post-operative management because he was the primary doctor. For the purpose of determining whether there had been professional misconduct, it should be taken that Dr Looi had prescribed medical leave of one day and light duties for seven days.

27 In that context, Dr Looi submits that the Tribunal erred in convicting him on the Charges, and in the alternative, on the Alternative Charges, for the following reasons:

> (a) The Tribunal erred in convicting Dr Looi on the basis of Dr Rajaratnam's evidence that he would have given medical leave between the First Stage surgery and the Second Stage surgery. This was based on his opinion on a random pattern thenar flap, whereas the procedure that had actually been carried out on the Patient was an axial pattern thenar flap. Further, the Tribunal failed to explain why it had

ignored the evidence of both Dr Rajaratnam and Dr Tan Soo Heong that certification for light duties was adequate, and in some cases could be beneficial to a patient.

(b) The Tribunal erred in finding that Dr Looi had not considered whether adequate conditions for rest and rehabilitation were present. Among other things, the SMC did not produce evidence showing that the Patient's condition or his work environment rendered light duties inappropriate. Further, that finding is at odds with the Tribunal's other findings that Dr Looi had knowledge of light duty arrangements at the Patient's workplace, and that the Patient attended a rehabilitation programme rather than engaging in his pre-injury job of welding.

28 On the sentence imposed, Dr Looi contends that it is manifestly excessive, and that an appropriate sentence would be a fine of $20,000 to $30,000.

The SMC's submissions

29 The SMC first makes the preliminary point that the Tribunal erred in finding that the axial pattern thenar flap procedure was used by Dr Looi, and submits that the random pattern thenar flap procedure was used by Dr Looi instead. In that context, the SMC submits that the Tribunal's decision to convict Dr Looi on the Charges was correct for the following reasons:

(a) Dr Rajaratnam's evidence was that medical leave should have been given, and that light duties were inappropriate for the Patient prior to the Second Stage surgery. His evidence was to be preferred over Dr Tan Soo Heong's evidence that light duties were appropriate as the

latter was against "uncontroverted contemporaneous records and unsupported by any medical literature".

(b) The Tribunal correctly took the view that the burden of proof was on Dr Looi to show that he was aware that there were adequate conditions at the Patient's workplace to cater for the Patient's rest and rehabilitation if light duties were issued. As he could not show that he knew whether the Patient would require the use of his injured hand, it follows that it was inappropriate for him to have assigned the Patient light duties.

30 On the issue of sentence, the SMC submits that the appropriate sentence should be 12 months' suspension in respect of each of the Charges, and that they should run consecutively, such that the total term of suspension would be 24 months.

Scope of review by the High Court

31 Under s 55(11) of the Act, the High Court shall accept as final and conclusive any finding of the disciplinary tribunal relating to any issue of medical ethics or standards of professional conduct "unless such finding is in the opinion of the High Court unsafe, unreasonable or contrary to the evidence". As has been affirmed in *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 ("*Wong Him Choon*") at [39], and more recently in *Yip Man Hing Kevin v Singapore Medical Council and another matter* [2019] SGHC 102 ("*Kevin Yip*") at [48], this requires the High Court to make the following findings before it can intervene:

(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 disciplinary tribunal are sufficiently out of tune with the evidence to indicate with reasonable certainty that the evidence has been misread.

32 In assessing the decision of a disciplinary tribunal, the court would be mindful that a disciplinary tribunal 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". Consequently, the court would accord an appropriate degree of respect to the decision of a disciplinary tribunal, and would be slow to overturn its findings. That said, a disciplinary tribunal's decision would nevertheless have to be reached reasonably and in accordance with the law and the facts, and to that extent, the court would not give undue deference to the views of a disciplinary tribunal and thereby render its own powers nugatory (*Wong Him Choon* at [40]; *Kevin Yip* at [49]).

Decision on conviction

33 Having considered the record of proceedings and the submissions made before us, we are satisfied that the Tribunal erred in convicting Dr Looi on the Charges, and in the alternative, on the Alternative Charges. In particular, we are of the view that the Tribunal's finding on the applicable standard of conduct from which Dr Looi departed – *ie*, that it was not the practice among members of the medical profession of good standing and repute to certify a welder with the Patient's injuries as fit for light duties on the second post-operative day (in respect of the First Charge) and on the fifth post-operative day (in respect of the Second Charge) – was unsafe, unreasonable and contrary to the evidence.

On the evidence before us, it could not be said that Dr Looi had departed from the applicable standard of conduct among members of the medical profession of good standing and repute. We elaborate on this after dealing with two preliminary points that arise for our consideration: (a) whether Dr Looi had carried out a random pattern thenar flap or an axial pattern thenar flap procedure; and (b) whether it should be taken that Dr Looi had prescribed medical leave of one day and light duties for seven days, notwithstanding the actual medical leave prescribed by Dr Stephen Tan was just medical leave without light duties.

The procedure performed on the Patient

34 As mentioned earlier, the SMC challenges on appeal the Tribunal's finding that an axial pattern thenar flap procedure was used by Dr Looi on the Patient. This arises as a preliminary point for our decision because the type of surgery that was in fact carried out by Dr Looi is significant for two reasons. First, at a general level, the type of surgery that was performed would have a bearing on the appropriate medical leave or aftercare that ought to be given to the Patient after surgery. Both Dr Rajaratnam and Dr Tan Soo Heong agreed that this was so. Second, and more specifically, Dr Looi relied on the assertion that he had performed an axial pattern thenar flap to diminish the weight of Dr Rajaratnam's evidence as to the appropriate medical certification that ought to be given to the Patient after the surgery because Dr Rajaratnam's views were premised on a random pattern thenar flap having been performed.

35 The difference between the two procedures was described in similar terms by both Dr Rajaratnam and Dr Looi at the inquiry:

(a) According to Dr Rajaratnam, an axial pattern thenar flap procedure would result in a flap which is more robust, drawn closer to the fingers thereby requiring less flexion of the fingers, and resulting in a lesser degree of immobilisation of the thumb, as compared to the random pattern thenar flap procedure.

(b) According to Dr Looi, the key difference between the axial pattern thenar flap and the random pattern thenar flap procedures is that, in the former, the flap is drawn closer to the finger, and therefore the finger is not stretched as much as it would be if the random pattern thenar flap procedure had been followed. The random pattern thenar flap requires the flap to be drawn at the base of the thumb, whereas the axial pattern thenar flap allows it to be drawn closer to the middle of the palm. Consequently, the axial pattern thenar flap procedure gives the patient significantly more mobility in his other fingers, and also provides for better revascularisation from the finger to the flap. That an axial pattern thenar flap procedure was performed would not however mean that a patient could do light duties in all cases.

36 As was mentioned above, the Tribunal was prepared to accept Dr Looi's evidence that he had performed an axial pattern thenar flap on the Patient. We are satisfied that the Tribunal was right to have taken that view. Crucially, there is evidence that the axial pattern thenar flap is by far the preferred procedure in Singapore.

37 Dr Looi explained that the random pattern thenar flap was "originally described more than half a century ago", and "very few people practise this anymore". This was because the random pattern thenar flap results in tension,

pain and discomfort, such that a patient would find it difficult to mobilise even the uninjured fingers. Over time, the thenar flap procedure was developed into the axial pattern thenar flap, which uses the "vascularity of the skin around the thenar area", *viz*, the "muscular area at the base of the thumb".

38 Dr Tan Soo Heong put it even more strongly. Dr Tan Soo Heong first explained that the thenar flap procedure has developed over time from the random pattern to the axial pattern. The axial pattern thenar flap was, in his view, a more robust, stronger and better flap. In particular, Dr Tan Soo Heong stated in clear terms that the state of practice in Singapore had reached the point where the random pattern thenar flap was, to the best of his knowledge, no longer being practised. His precise responses when referred to an article from 1982 describing the random pattern thenar flap were as follows:

> Q … So I am asking you, Dr Tan, can you comment on the development in thenar flap surgery since 1982?
>
> A … it is not done anymore because this is a historic paper. Even when I teach my trainees, I don't teach with this method anymore.
>
> Q Just to confirm, well, let me rephrase my question. To what extent is the procedure described in paragraphs 11, 12 and 13, and the 1982 article still practised in Singapore?
>
> A As far as I know, for the past 10 years, I haven't taught thenar flap in this way, nor do I know of any doctors [*sic*] that does thenar flap this way. I mean the principle is there, in terms of harvesting it, but not the way it is done.

That the axial pattern thenar flap is the preferred procedure in Singapore was not controverted by Dr Rajaratnam, or indeed any other evidence before the Tribunal.

39 At the hearing before us, counsel for the SMC, Ms Josephine Choo, suggested that Dr Looi had not performed the axial pattern thenar flap procedure because he had failed to record in his medical notes that he had performed this procedure. We do not accept this suggestion. If, as the evidence by Dr Tan Soo Heong suggests, virtually the entire local medical community in the field was practising the axial pattern thenar flap, the omission by Dr Looi to record the specific procedure that he carried out leads more readily to the inference that he simply considered it unnecessary to highlight the name of the procedure (because it was obvious), rather than the inference that he had instead carried out the less common procedure, *ie*, the random pattern thenar flap.

40 On this first preliminary point therefore, we affirm the Tribunal's finding that an axial pattern thenar flap procedure was performed by Dr Looi on the Patient. In our view, the evidence provided sufficient basis for the Tribunal's decision and it cannot be overturned.

The relevance of Dr Stephen Tan's decision on medical leave

41 The second preliminary point that arises for our consideration comes from Dr Looi. He contends that the Tribunal was wrong to have taken the view that despite the miscommunication with Dr Stephen Tan resulting in the Patient being discharged with *just* medical leave and no light duties, Dr Looi remained responsible for the Patient's post-operative management. Dr Looi contends that it should be taken that he had prescribed one day of medical leave and seven days of light duties to the Patient.

42 This seems to us to be a misreading of the Tribunal's reasoning and decision. Although the Tribunal did state that Dr Looi "could not avoid responsibility for the Patient's post-operative management", it went on to

consider, in the very next paragraph, Dr Looi's "intended plan of one day of sick leave, and seven days of light duties". Having considered that, the Tribunal concluded that it was not the practice of members of the profession of good standing and repute to have ordered *light duties* on the second post-operative day for someone in the Patient's circumstances. That this was the focus of the Tribunal's analysis is made even clearer by the subsequent analysis of whether Dr Looi had sought to ascertain the availability of light duties at the Patient's workplace, Tellus. Put differently, it is clear to us that the Tribunal assessed Dr Looi on the basis of his *intended* post-operative management plan for the Patient, rather than what was in fact provided by Dr Stephen Tan.

43 This was, in our view, a principled approach. To hold otherwise would be to hold Dr Looi accountable for Dr Stephen Tan's conduct in not following the post-operative treatment instructions that Dr Looi had given. That in turn would engage a number of policy issues, for instance with regard to how hospitals operate in terms of delegating the responsibility for patients amongst doctors, and the extent of a senior doctor's duty to supervise a junior doctor. The proper resolution of such issues would have required specific expert evidence to have been put before the Tribunal first, as the specialist tribunal with its own professional expertise. Ultimately, this did not happen because the Charges were framed as a failure to ensure that adequate medical leave was given to the Patient, and the parties did not proceed on the basis that the relevant departure from the applicable standard on the part of Dr Looi was his failure to supervise Dr Stephen Tan, and to ensure that the proper post-operative management plan was administered. For completeness, we note that, for the purposes of these appeals, although the SMC sought to challenge the Tribunal's finding that there had been a miscommunication between Dr Looi and Dr Stephen Tan as to the Patient's post-operative management plan, the SMC

did not take the position that we ought to assess Dr Looi's culpability on the basis of the medical leave that was *actually* given by Dr Stephen Tan.

44 For these reasons, on the second preliminary point, we adopt the approach taken by the Tribunal, *ie*, for the purpose of assessing whether Dr Looi is culpable under the First Charge, we shall take it that Dr Looi had prescribed one day of medical leave and seven days of light duties to the Patient.

The First Charge

The applicable legal principles

45 We turn now to consider Dr Looi's appeal against his conviction on the First Charge. The Charges were framed in terms of the first limb of professional misconduct as set out in *Low Cze Hong*. In order to substantiate a charge under the first limb of professional misconduct, the following had to be established by the SMC and found by the Tribunal (*Kevin Yip* at [50]; *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 related to;
>
> (b) whether the applicable standard of conduct required the respondent doctor to do something and at what point in time such duty crystallised; and
>
> (c) whether the respondent 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 it (*Wong Him Choon* at [53]).

46 As this court held in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San*") at [40], these are discrete elements that have to be proved by the SMC. They set out high thresholds that have to be crossed before a conviction can be sustained. These requirements are also different from and "more exacting than those applicable to establishing civil liability both in terms of the *standard of misconduct* that must be shown *as well as the burden of proof that must be discharged*" [emphasis added]. Being elements of a charge that carries with it the possibility of penal sanctions, it follows that it is for the SMC to prove each element beyond a reasonable doubt.

47 With regard to the present case, the second of the three elements stated above, *ie*, whether the applicable standard of conduct required the doctor to do something and, if so, at what point in time such duty crystallised, is not in dispute. It is understood that the only relevant points in time were when Dr Looi was deciding what type of medical leave to give to the Patient, *ie*, 7 August 2011 in respect of the First Charge, and 12 August 2011 in respect of the Second Charge. The present case may be contrasted with other situations where timing is crucial in determining what the applicable standard of conduct required a doctor to do. For instance, in *Ang Pek San*, the central concern of the charge against the doctor was "whether, and if so, at what point a duty arose on the appellant to arrange for a neonatologist to be present at or placed on standby for the delivery of the complainant's baby" (at [77]). A time-sensitive inquiry was necessitated because the doctor in *Ang Pek San* ultimately did call for a neonatologist, although this was only after the baby had been delivered. Consequently, in order for the SMC to prove in that case that the doctor had

departed from the applicable standard of conduct, the SMC had to show that the duty to call for a neonatologist arose *before* the doctor eventually called for one.

48 Accordingly, that leaves for our consideration just the first and third of the three elements referred to above. Put simply, for the SMC to establish the Charges, it had to prove (a) the applicable standard of conduct that Dr Looi ought to have followed; and (b) that Dr Looi deliberately or negligently departed from that standard of conduct.

The applicable standard of conduct

(1) The parties' cases

49 The first element that the SMC had to prove was the applicable standard of conduct. As we understand it, the SMC's case on the applicable standard of conduct is that medical leave *had* to be given, with no allowance for light duties whatsoever. We arrived at this view of the SMC's case on the applicable standard primarily because, in the first instance at least, the SMC did not appear to suggest that it was departing from Dr Rajaratnam's evidence. Dr Rajaratnam's evidence, the SMC submits, shows that no benefit would result from assigning light duties to someone in the Patient's position, and that medical leave should therefore have been given. The SMC also submits that Dr Tan Soo Heong's evidence that light duties would have been appropriate should not be accepted. A similar position was taken by the SMC at the appeal hearing before us.

50 Dr Looi's position on the applicable standard of conduct, both below and before us, is that there was no fixed requirement for *only* medical leave to be given, and that light duties could be medically appropriate for someone in

the Patient's position as well. Unfortunately, the applicable standard was not identified with great precision by Dr Looi. But we understand this to be the submission given Dr Looi's support for evidence, including that of Dr Tan Soo Heong, indicating that the decision to issue light duties was appropriate in the case of the Patient.

(2) The expert evidence

(A) DR RAJARATNAM'S EVIDENCE

51 The SMC relies primarily on Dr Rajaratnam's evidence in support of its position that the applicable standard was for medical leave to be given at least until the Second Stage surgery, and that assigning light duties was inappropriate. For the inquiry, Dr Rajaratnam prepared an expert opinion on the care provided to the Patient by Dr Looi ("Dr Rajaratnam's Report"). In his report, Dr Rajaratnam set out his views on the appropriate medical leave that ought to have been given to the Patient as follows:

(a) He first explained what, in his view, light duties and medical leave entail:

(i) Medical leave is given when a patient requires time off from work to address his or her health and safety needs.

(ii) Light duties is a generic term and is open to interpretation. It has to be taken in the context of the patient's job description. The requirement is that the patient should not be engaged in activities at work that delay his recovery or put it at risk. Specifically, with regard to someone who has had a cut in the dominant hand that has been sutured, he would be unable to safely perform heavy work requiring the use of his hands.

During this period, he may be assigned light duties *if the work environment allows for it*. That is the case when he can perform duties not requiring the use of the injured hand.

(b) Broadly speaking, whether a patient requires medical leave after a First Stage surgery depends on the patient's working environment. If a patient's occupation does not require the use of his affected hand at all, he may be able to return to work without medical leave. For instance, office duties like answering phone calls with hands-free devices would be fine. However, such a situation was "very unlikely" in Dr Rajaratnam's view, as there would be "significant pain with discomfort" following the First Stage surgery. It would be difficult to return to manual work immediately after surgery as most people would require the use of their hands in handling basic activities at work.

(c) In deciding the number of days of medical leave that should be given to a patient, it was appropriate to consider the following:

(i) patient factors such as the patient's tolerance for pain, injury sustained, or emotional trauma suffered;

(ii) work environment factors such as the job description of the patient, the nature of his job and the availability of alternative jobs, *especially for the issuance of light duties*; and

(iii) the circumstances surrounding the procedure performed, such as the type of immobilisation, splinting and the amount of rest required.

(d) After a First Stage surgery, he would give medical leave for two to three weeks for the flap to set. During that time, the recipient finger

and the thumb would have to be splinted together, and it is therefore crucial that the fingers should rest. Any activity using the hand could put the surgery at risk, as the flap may detach.

(e) Dr Looi ought to have given medical leave to the Patient on 8 August 2011. Dr Rajaratnam reiterated that he would have given the Patient medical leave from the day of his injury to the day he would return for the Second Stage surgery, which would be 21 days later in his practice.

(f) Dr Rajaratnam further opined that Dr Looi's decision not to give medical leave, and to assign light duties instead, on 12 August 2011 was "grossly inappropriate". This was because, in respect of light duties in the marine industry, even if the Patient had been advised to stay and help out in the office instead, he would "most likely require the use of his hand for even the most basic of office functions". Further, even if the Patient did not use his hand for the light duties, the "exposure to dusty environment in travelling to the office is a potential risk for infection of the wound", despite the fact that the wound may be dressed. Further still, the Patient may, while engaging in those activities, "accidentally pull off the middle finger from the thumb". In his view, it was "not optimal" to allow the Patient to go back to a working environment so soon after the surgery had been performed.

52 At the inquiry, Dr Rajaratnam testified that he understood Dr Looi as having performed a "random pattern flap". It was therefore crucial for the flap not to be disturbed, or it would fail. He accepted that his report was based on the understanding that the random pattern thenar flap procedure had been performed on the Patient, although he maintained that his report would remain

applicable to any thenar flap. He also stated that since the 1990s he had not performed thenar flap surgeries as there were "better alternatives".

53 Dr Rajaratnam also reiterated the view expressed in his report that it was grossly inappropriate to give the Patient light duties as it would put the surgery at risk. This was especially given the Patient's occupation as a welder in a shipyard. By contrast, if the Patient were in another situation, where he uses "purely his brains to work and no physical labour, he doesn't have to drive, then it's possible he could have gone back to light duties". Even if the Patient said that his employer would arrange for him to do just light duties, there would be no purpose in his going back to work.

54 Dr Rajaratnam agreed that Ms Pang would have been correct to say, in her report, that the Patient could have done light duties as of 10 August 2011. He also accepted that an occupational therapist like Ms Pang would be best placed to decide on whether it would be suitable for someone like the Patient to return to light duties with the aim of rehabilitation. He did not fully agree, however, that light duties could replace occupational rehabilitation. As he put it, "going back to work to use broom doesn't necessarily mean you would reduce the stiffness in the other fingers", namely, the ring finger and middle finger.

(B) DR LOOI'S EVIDENCE

55 We turn next to the evidence given by Dr Looi in his own defence. Unsurprisingly, he took the position that light duties were appropriate. He explained his reasons as follows:

(a) He had performed the axial pattern thenar flap procedure on the Patient, and not the random pattern thenar flap. The key difference in the axial pattern flap procedure was that the flap was drawn closer to the finger, and therefore less stretching of the finger was required. The random pattern flap required the flap to be drawn at the base of the thumb, whereas the axial pattern flap allowed it to be drawn closer to the middle of the palm. The axial pattern flap procedure thus gave the Patient significantly more mobility in his other fingers, and also provided for better revascularisation from the finger to the flap. That said, he also accepted that it did not follow that an axial pattern flap surgery would mean that a patient could carry out light duties thereafter.

(b) After the surgery, he put an occlusive dressing over the wound. An occlusive dressing completely covers the wound such that it is not exposed to the external environment, and this helps keep it clean and prevent infection.

(c) Dr Looi stated that he was familiar with the working environment at a shipyard. He had asked the Hospital to organise safety talks at the worksite and medical talks to executives on hand surgery, so as to assist specialists at the Hospital when they had to make decisions on treatment plans for patients in such industrial cases. During those engagements, he would take the opportunity to walk around the area to better understand the working environment of the workers, and the light duty and medical protocol in such a workplace. In this regard, he made reference to a documented visit to the shipyard of PPL Shipyard Pte Ltd in October 2012. He also stated that he had made similar site visits even before the SMC's first letter to him in 2012.

(d) Dr Looi observed that the Patient was able to hold a pen and sign off on his discharge advice form after the First Stage surgery, despite the fact that it was his dominant hand that had been injured and operated on. He strongly disagreed with the allegation in the Charges that the Patient would be unable to use his right hand effectively for many activities of daily living. He asserted that after First Stage surgery patients could still feed themselves, "wipe themselves", and dress themselves. In this case, he noted that the Patient's pain score had generally been low, and he was conscious, alert and coherent the entire time. He also took into account his knowledge that the company (Tellus) had a system to assign recovering workers other duties, and would not send them back to their regular work. In particular, his understanding was that Tellus had in the past assigned injured patients to duties that did not "jeopardise their hand, such as in the office [and] in the guardhouse".

(e) In the circumstances, he did not think that the Patient should be denied the chance for early rehabilitation through light duties. Dr Rajaratnam's view that medical leave ought to follow for the two or three weeks until the Second Stage surgery neglected to consider that the Patient had responded well, that the surgery was performed well and with a good procedure which reduced tension, and that the Patient's workplace had facilities which could cater for injured workers on light duties. For instance, Dr Rajaratnam's view assumed that a patient would be in significant pain after a First Stage surgery, but the Patient's case shows that post the operation he actually only experienced mild pain (except for one episode on the night of the procedure).

(f) Dr Looi also disagreed with Dr Rajaratnam's assessment of the risk of flap detachment. First, the risk of pulling the finger out of the flap is low because the finger would be engaging the extensor mechanism, which is a weak mechanism (as compared to the flexor mechanism, which is engaged when one grasps something). Second, the risk of flap detachment must be balanced against the risk that immobilising the other fingers could give rise to a greater risk of circulation compromise and flap failure.

56 Finally, Dr Looi accepted in cross-examination that if Tellus had no facilities to cater for an injured worker who had been assigned light duties, he would have given full medical leave instead. He also accepted that performing light duties was not a substitute for occupational therapy.

(C) DR TAN SOO HEONG'S EVIDENCE

57 Dr Tan Soo Heong prepared a report for the inquiry, after considering the relevant medical records of the Patient from both the Hospital and SGH, and Dr Rajaratnam's Report.

58 He started his report by stating that there was no "standard duration" for medical leave or any protocol that mandated giving a minimum period of medical leave for illnesses and injuries. Instead, a number of factors had to be considered, including the nature of the illness or injury, the method of treatment, the recovery time needed, whether the patient needed hospitalisation, the nature of the patient's occupation, and the patient's personal circumstances and medical needs. Two different patients with the same condition may well be issued different periods of medical leave by the same doctor.

59 Dr Looi's post-operative management plan to give the Patient one day of medical leave followed by seven days of light duties, was "appropriate and acceptable". He reached this view based on the following factors:

(a) The Patient's records showed that he mostly experienced only "mild pain" after the First Stage surgery, contrary to Dr Rajaratnam's suggestion that a patient would typically experience "significant pain".

(b) Although the Patient's dominant hand was bandaged, he was still able to use it, and his lower limbs and left arm allowed him to ambulate. Even with his right hand bandaged, he managed to sign his discharge advice form the day after surgery, and was able to sign his consent form for the Second Stage surgery on 7 September 2011, as well as the Financial Counselling Form. As only the middle finger was bandaged, the other fingers were left free and still allowed him to write, hold objects, and to do light chores. These activities would not compromise his recovery.

(c) Contrary to Dr Rajaratnam's description, the thenar flap procedure was not a "complex reconstruction of the hand". Although skill is required to successfully perform it, it is a procedure which a trainee registrar is expected to be able to perform, and it took Dr Looi just 40 minutes. It is a purely "skin and subcutaneous tissue level of surgery" and the underlying tendons, nerves, bones and joints are not disturbed in any way.

(d) Although Dr Rajaratnam was right to say that there was a risk of flap detachment, there was also a risk of circulation compromise and flap failure if immobilisation were to be done incorrectly. In his view,

early mobilisation was very important for recovery. As a routine matter, therefore, he would not splint or immobilise fingers after the First Stage surgery.

(e) Although certain activities, such as climbing up a ladder or operating powered tools, would be detrimental to recovery, that did not mean that the Patient could not use the affected hand at all.

60 In general, patients can use their unaffected hand for activities of daily living immediately after the completion of First Stage surgery. They usually begin using the injured hand to assist in activities of daily living the day after the surgery. There is no special requirement for rest other than what is common for a minor day-surgery. Rehabilitation after the First Stage surgery includes joint mobilisation to move the unaffected fingers, and functional rehabilitation to optimise reintegration of the injured hand. The latter may be started the day after the First Stage surgery, once the flap has been assessed to be stable.

61 At the inquiry, Dr Tan Soo Heong reiterated his approval of Dr Looi's decision to certify the Patient as fit for light duties. He explained that as the Patient's other limbs were unaffected and he was ambulatory, he would start such a patient on some activities the next day. He disagreed with Dr Rajaratnam's view that medical leave for two to three weeks up till the Second Stage surgery ought to be given. Relying on an article studying various return-to-work times after fingertip amputations, he explained that there was no rule that the patient must have three weeks of medical leave.

(D) MS PANG'S EVIDENCE

62 Finally, we turn to consider Ms Pang's evidence. She has been an occupational therapist since 1992. She also prepared a report for the inquiry after sighting the Patient's medical records, Dr Looi's written explanation to the SMC and Dr Rajaratnam's Report. Although she did not hold herself out as an expert on hand injuries, her experience included about 50 patients who had undergone the thenar flap procedure.

63 She first explained the standard operating procedure for occupational therapists. Generally, they take instructions from the surgeons, and focus on increasing the patient's early return to function. For thenar flap cases, they would try to prevent tension on the flap. Occupational therapy for the hand would be categorised into mobilisation (moving the unaffected digits) and activity-based rehabilitation (encouraging re-training on specific activities).

64 With regard to the Patient specifically, she would have recommended a focus on early mobilisation of the unaffected digits so as to prevent stiffness in the affected hand. She would have recommended a home programme for active movement maybe three times a day, and for a patient to use the unaffected hand in daily activities as much as possible. Such a rehabilitation program should commence once the patient is medically stable, and after the pain has subsided. A patient may need about two days of rest after the operation but it would depend on the individual. In the Patient's case, he could have been encouraged to start on rehabilitation on 9 or 10 August 2011, but it is unlikely that there would be active rehabilitation at that point. It would be mainly gentle mobilisation.

65 As for the Patient returning to work on a light duties assignment, she was informed that the light duties available at the Patient's work place entailed changing security passes, desk jobs, sentry duties and sweeping the floor. In her view, the Patient would have been able to perform such duties even on 10 August 2011. He would not have been obstructed by his affected hand and could have managed those duties with his non-dominant hand. Further, from a rehabilitation perspective, going back to work under a light duties regime would have helped him prevent stiffness in his affected hand and also helped him to reintegrate into the workplace. Ultimately, she was of the view that assignment of light duties for the Patient on 10 August 2011, with a review on 12 August 2011, would not have affected his recovery.

(3) Our decision on the applicable standard

66 The Tribunal 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 second post-operative day. In particular, the Tribunal accepted the evidence that "sick leave ought to have been provided until the flap was divided", *ie*, the Second Stage surgery.

67 Having considered the record of proceedings, with respect, we are of the view that this conclusion by the Tribunal was arrived at against the weight of the evidence. It is apparent that the Tribunal's finding was based on a preference for Dr Rajaratnam's view that medical leave of two to three weeks should be given until the Second Stage surgery, and that certifying the Patient fit for light duties was grossly inappropriate. We do not agree, however, with the Tribunal's evaluation of Dr Rajaratnam's evidence. In our view, properly understood, Dr Rajaratnam's evidence was actually that, in principle, light duties *could* be

appropriate. To that extent, Dr Rajaratnam's evidence was *consistent* with the evidence given by Dr Looi, Dr Tan Soo Heong and Ms Pang that light duties could be medically appropriate for the Patient.

68 Starting with his report, Dr Rajaratnam stated that "[if] the patient's occupation does not require the use of his affected hand at all, then he may be able to return to work without medical leave". This was stated in response to the query whether medical leave is necessary for every patient who undergoes the First Stage surgery. Although he did go on to say that a return to work would be "very unlikely … as there will be significant pain with discomfort following surgery and it will be difficult for somebody to return to manual work immediately" (see above at [51(b)]), that is not an objection to light duties *in principle*. Read in totality, Dr Rajaratnam's evidence is that he accepts the possibility of light duties being appropriate, provided that the circumstances are suitable. The relevant circumstances would include, perhaps, non-manual work, simple tasks that can be done without the affected hand, and a lack of pain.

69 As for his evidence at the inquiry that giving the Patient light duties was grossly inappropriate and that he could see no purpose in sending the Patient back to work, this too has to be scrutinised to extract the *principle* that he was propounding. When Dr Rajaratnam was asked why he thought that giving the Patient light duties was grossly inappropriate he replied:

> A. Because he just had had a reconstructive procedure and his -- the treatment is still ongoing in terms of the surgical treatment, it's not completed yet. And I wouldn't want to risk the surgery that I have performed, until I at least have divided. Now we are taking [*sic*] in context of this patient, who's a welder in a shipyard. *If it's in another situation, where I am assured of the environment which he goes to, he uses his purely his brains to work and no physical labour, he doesn't have to drive, then it's possible he could have gone back to light*

> *duties*. So for -- *in context of this patient*, no, he should not have had light duties. He should have been given medical leave. I do not see any benefit for the patient to receive light duties.
>
> Q. Well, what if the patient tells you that, "I am a welder, my employer is going to arrange for me to do light duties, I think I can do light duties"?
>
> A. I still would not, because not just to cover myself, but I think I am *putting the patient under the risk, you know, for the flap to be detached or get infected*. And *I see no gain in him, because he's not going to be that useful in his work environment. I can't see the purpose* of him going back to work. He sustained an injury, quite a significant injury, in which he's lost the tip of his finger. He's had a reconstructive procedure, any logical mind says he needs time to rest. So, and I think the general practice among most surgeons would be to give them medical leave.
>
> [emphasis added]

70 On first glance, it would appear that Dr Rajaratnam gave two inconsistent answers regarding the suitability of light duties. In the first response above, he accepted that there *could* be a case in which light duties could be given – namely, where he is "assured of the environment", the patient uses "purely his brains to work", there is "no physical labour", and the patient "doesn't have to drive". On the other hand, in the second response above, he said that even if the patient had told him that his employer was going to arrange for him to do light duties, he would not certify the patient fit for light duties. The reason for this refusal was that he would be putting the patient at risk of having an infected flap or of it detaching, and that he did not envisage that the patient would gain from going back to work because the patient would not be useful in his work environment.

71 In our view, this is not so much an inconsistency as simply an indication of Dr Rajaratnam applying his principle – that light duties *could* be suitable in

the appropriate circumstances – to the particular context of the Patient, as he understood it to be. This is evidenced by his references to the "context of this patient", in particular, as a "welder in a shipyard". We are fortified in our view by Dr Rajaratnam's answers later on in the inquiry in relation to Ms Pang's opinion that the Patient could have returned to light duties on 10 August 2011:

> Q. Okay, going on to the next paragraph -- next part of Vicki Pang's evidence, opinion: "My opinion on the Patient returning to work on light duties. As mentioned above, *I am informed that the light duties available at the Patient's work place entails changing of security passes, desk jobs, sentry duties and sweeping of the floor. Based on this understanding of light duties available to the Patient*, I believe that the Patient would very likely be able to perform these light duties even on 10 August … The Patient did not have a bulky dressing on his affected hand and he would not have been obstructed on his affected hand. In addition, the Patient could also have managed these light duties with his non-dominant hand." Now pausing there, can I just refer you to Dr Tan Soo Heong's report, which is tab 1 of this bundle. Now Dr Tan has -- I think you have seen this, has at page 20 -- look at page 24 and 25.
>
> A. Yup.
>
> Q. Of the report. Dr Tan's evidence is that this patient here also had a Thenar Flap under the pedicle method on -- right?
>
> A. Yes.
>
> Q. And this was how the bandage was done and the patient can be seen to be holding a medicine bottle, at the bottom picture of 24 and 25, he seemed to be holding a broom and a pen on the lower picture. Okay. So having this picture in mind and what Vicki Pang states here –
>
> A. Yup.
>
> Q. -- would you agree that Vicki Pang is correct in saying that *this patient could have done light duties as of 10th August 2011*?
>
> A. *Yes*.
>
> [emphasis added]

When Dr Rajaratnam was given the *particulars* of the light duties assigned by Tellus, he accepted that the Patient could have done light duties as of 10 August 2011.

72 In our view therefore, the Tribunal erred in so far as they failed to distinguish between the principle that Dr Rajaratnam was propounding – that light duties *could* be appropriate in the right circumstances – and his application of that principle to the circumstances of the Patient's employment at Tellus as Dr Rajaratnam understood them. In truth, the principle that was borne out by Dr Rajaratnam's evidence was entirely consistent with the evidence given by the witnesses who testified on behalf of Dr Looi. As we have set out above, Dr Looi, Dr Tan Soo Heong and Ms Pang gave evidence that, in the right circumstances, light duties could be given to patients who had undergone the First Stage surgery.

73 If it had accepted that the standard did not prohibit the issuing of light duties, the next thing that the Tribunal would have had to determine was whether the Patient's circumstances were the "right circumstances" such that giving him light duties could be considered medically appropriate. In this regard, it appears to us that Dr Rajaratnam's opinion of what light duties would entail for the Patient was wrongly coloured by the fact that the Patient was a welder, so that he made erroneous assumptions as to the types of activities that the Patient would perform at his workplace if he were given light duties. For instance, Dr Rajaratnam stated in his report that "in respect of light duties *in the marine industry*, even if the [Patient] has been advised to stay and help out in the office instead, he will *most likely require the use of his hand for even the most basic of office functions*" [emphasis added]. That Dr Rajaratnam made such an assumption explains how he could have stated, on the one hand, that it

was possible the Patient could have gone back to light duties if he did no physical labour, and on the other hand, that there would be a risk of flap detachment or infection "in his work environment" as a welder. It also explains why, when Dr Rajaratnam was told expressly to consider *specific* activities as constituting light duties, he accepted that light duties would have been appropriate for the Patient.

74 It is of course true that a patient's occupation is a significant part of the overall circumstances that are relevant in determining whether light duties would be appropriate for that patient. However, a patient's occupation alone is not dispositive, and it would be a fallacy to allow that to dictate one's views as to what duties might be available for such a patient. A patient whose usual work was risky or took place in a dangerous environment may nonetheless be the beneficiary of arrangements at his workplace made to enable him to perform rehabilitative activities in a safe environment. That was in fact the case here, as will be seen below – the Patient had in fact performed only light duties.

75 In determining whether the Patient had the "right circumstances" that would have allowed light duties to be medically appropriate, the relevant inquiry is what circumstances the doctor was aware of regarding the Patient at the time he made the decision. Dr Looi's evidence was that he was aware of the general working conditions as well as the systems that a typical shipyard would have in place for workers sent back for light duties. He was also aware that Tellus, the Patient's employer, had systems in place to ensure that patients assigned light duties would be given simple duties, such as tasks in the office or guardhouse, that would not jeopardise their injuries. We note that the Tribunal accepted that Dr Looi "appeared to have some knowledge of the light duty arrangements at [Tellus] from past dealings", and we see no reason to upset that

finding. In our view, these constituted the "right circumstances" in which light duties could be medically appropriate, as they were consistent with the types of duties described as appropriate for the Patient by Ms Pang and even Dr Rajaratnam.

76 We emphasise at this point that what we have just found should be distinguished from two separate questions (which we address below). First, the question whether light duties were medically appropriate for the Patient given his circumstances is conceptually distinct from the question whether Dr Looi had satisfied his duty to establish that there were adequate conditions for rest and rehabilitation. Second, the question whether light duties were medically appropriate for the Patient is also distinct from the question whether the Patient *actually* and *eventually* performed such activities that were appropriate for rehabilitation.

77 We also note for completeness that Dr Rajaratnam's opinion on the proper medical leave that ought to be given to the Patient appeared to be based largely on the understanding that a random pattern thenar flap procedure had been performed on the Patient. The Tribunal took the view that the mere fact that an axial pattern thenar flap procedure had been performed on the Patient did not have "such a significant effect on post-operative management that permitted light duties from the second post-operative day". We agree with this view – indeed, on Dr Looi's own evidence, the type of procedure carried out was not in itself determinative of the proper medical leave to be given.

78 For the reasons given, we accept Dr Looi's submission that certifying the Patient fit for light duties was a medically appropriate course of action. In legal terms, the evidence therefore suggests that the applicable standard of

conduct was that a doctor could give the Patient either medical leave *or* light duties (starting from the second post-operative day). The SMC's case, to the extent that it submitted that the standard was that medical leave *alone* had to be given, to the exclusion of certifying the Patient fit for light duties, therefore fails.

79 Before turning to analyse the next issue, namely, whether Dr Looi departed from the applicable standard of conduct, we note that both parties advanced their cases below and on appeal on the basis that part of the applicable standard of conduct was that Dr Looi had to first ascertain whether there were adequate conditions for a patient's rest and rehabilitation before certifying that patient fit for light duties. Notably, this was the way in which the parties in *Kevin Yip* advanced their cases as well. We shall therefore proceed on the basis that this was part of the applicable standard of conduct, though we make some observations below (at [109]–[111]) on the case having been run in this manner.

Departure from the applicable standard of conduct

80 As mentioned above, the second of the elements that the SMC has to prove to establish the Charges is that Dr Looi had departed from the applicable standard of conduct. Here, the applicable standard of conduct was that a doctor examining a patient with the Patient's injuries and in his circumstances could either (a) prescribe him medical leave; or (b) if the doctor had first ascertained that there were adequate conditions for the Patient's rest and rehabilitation, certify him fit for light duties. In other words, the single applicable standard of conduct provided two possible courses of action for a doctor in Dr Looi's position. There is no difficulty with framing the applicable standard of conduct in this way. As this court observed in *Kevin Yip* (at [67]), framing an applicable standard of conduct in this manner is but recognition of the fact that there may,

depending on the circumstances, be two or more courses of action which are medically appropriate. All that is required is that the relationship between the two or more courses of action be defined clearly. In the present case, it is evident from the way we have framed the applicable standard of conduct that the courses of action that were open to Dr Looi were *alternative* courses of action. For the SMC to prove that Dr Looi had departed from this standard of conduct, it would have to show that the course adopted by Dr Looi did not satisfy the requirements of either limb of the applicable standard.

81 On the facts, it is evident that Dr Looi did not prescribe medical leave for the Patient. He did, however, prescribe light duties for the Patient and so the inquiry turns to whether he had first ascertained that there were adequate conditions for the Patient's rest and rehabilitation. The SMC could prove that Dr Looi had failed to meet the requisite standard in this respect by proving that Dr Looi had certified the Patient fit for light duties *without first ascertaining* that there were adequate conditions for the Patient's rest and rehabilitation.

82 With regard to the duty on the part of a doctor to establish adequate conditions for rest and rehabilitation vis-à-vis a patient, this court in *Wong Him Choon* made clear that a doctor is not entitled to rely on assumptions by reason of the doctor's past dealings with an employer (at [70] and [73]). We note in this respect, that the Tribunal found as a fact that Dr Looi had knowledge of light duty arrangements in Tellus. Dr Looi himself had provided evidence that he had treated about 20 patients from Tellus by the time he saw the Patient and he was familiar with the work environment and the light duties arrangements at Tellus. Clearly, the Tribunal accepted this evidence. In this regard, while we have no quarrel with the ruling in *Wong Him Choon* mentioned above, we would comment that the amount of investigation into the working environment and

availability of light duties that a doctor has to do in respect of any patient before him (both with the patient and with his employer's representative), would vary depending on the extent of *knowledge* he already has of the work environment and his experience of how in any particular workplace, light duties were implemented. We note that in *Wong Him Choon*, the doctor concerned had not *in fact* established the availability of light duties (at [73]). The position in this case is different.

83 The SMC's case against Dr Looi is precisely that Dr Looi had failed to *actually* ascertain that there were adequate conditions for rest and rehabilitation for the Patient, and that Dr Looi had instead merely operated on his assumptions from his previous interactions with Tellus. Dr Looi's case is he had knowledge of the light duties regime at Tellus and that he had actually discussed the possibility of light duties with the Tellus representative who accompanied the Patient on 7 August 2011, and therefore had not just relied on any assumptions from past experiences with Tellus.

84 The evidence in favour of Dr Looi's account was as follows:

(a) Ms Ho, a Senior Staff Nurse at the Hospital, who regularly assisted Dr Looi, gave evidence on Dr Looi's usual practice in the following terms:

> A … And also either before or after the surgery, Dr Looi will ask the safety officer regarding the patient's job scope or environment to make sure -- because he want to ensure that after the patient discharge from the hospital, his post-op management is well taken care of.
>
> Q … So can you tell us what is Dr Looi's standard procedure for post-op management? For consultation, for post-op review consultation?

> A Alright. Okay, subsequently when a patient who come back for a clinic review, nurses would open up his dressing and let Dr Looi see. … Either the nurses or Dr Looi himself will do a dressing for the patient. And during the process, Dr Looi will assess the workers, whether regarding his wound function, whether the patient warrant for a full MC or a light duties. Okay, if he thinks that the conditions warrant for a full MC, he will issue a full MC to the patient. If the condition doesn't warrant for a full MC, then he will ask the patients. If there is a communication problem with the patient, then we will speak together with the safety officer or some -- a person that who can translate. Okay, Dr Looi will ask them whether the company will treat him well, whether he is in a lot of pain, and then whether the company has any light duties for him? If light duty is given -- light duty certificate is issued to him, whether the company will still put him as light duty job or still heavy manual labour. … So if Dr Looi finally decide that this worker is warrant for light duties certificate, then he would try his best to ensure that the company is compliant with it and that, in what way is that, we will call up the company or if the next day, the patient can return, and then said that he can't cope with the light duty or he is in a lot of pain, then Dr Looi will issue a full MC to him. Or if on that day, Dr Looi is not present, the 24-hours walk-in doctor will call up Dr Looi to clarify whether to -- can he issue a full MC to the patient.

(b) Dr Looi's evidence was that he had discussed with Mr Chia, who was present at the Hospital after the First Stage surgery, the Patient's work environment and the possibilities for the Patient's early rehabilitation. His exact testimony was as follows:

> A … And therefore, so I told [the Patient] to watch out some of these, and then I went on to discuss the work environment with Jimmy. I asked Jimmy what sort of -- whether is it possible to rehab this patient early. … And I also asked -- I also talked to the safety supervisor to see if there is provisions for work and I operate – I have many experience with workers, injured workers from Tellus, and in my experience, the management, the supervisors and the safety officers, they generally care for their workers and they generally, if they are fit for mobilisation and light duty, they generally allocate them

> to positions of revocation or transitional work to allow them to go back. … so after all this was discussed, we then sent him back to the ward. So because [the Patient] responded so well, I then went on to write my probably [*sic*] post-operative plan …

85 Dr Looi's evidence that he spoke with Mr Chia at the Hospital on the day of the Patient's First Stage surgery was, however, contradicted by Mr Chia himself. Although Mr Chia explained that his role in Tellus entailed that on most occasions he was the one "bringing the injured to the hospital", the day of the accident, 7 August 2011, was his "off day". He was therefore only notified about the Patient's accident by a telephone call from his "safety coordinator", one Mr Mokasamy Panisivan ("Mr Mokasamy"), who accompanied the Patient to the Hospital. Mr Mokasamy had called initially to ask for authority to take the Patient to the Hospital when he was injured, and had called subsequently to obtain approval for the Hospital's proposal that the Patient be operated on.

86 The Tribunal noted this inconsistency, and concluded that Dr Looi had "erroneously recalled that [Mr Chia] had attended with the Patient on 7 August 2011 at [the Hospital]" (at [70] of the GD). Consequently, the Tribunal concluded that there was "no evidence that [Dr Looi] had made efforts to establish that there had been adequate conditions for rest and rehabilitation at the material time vis-à-vis the Patient" (at [78] of the GD).

87 In our view, however, that is not an accurate assessment of the evidence. Although we accept that Mr Chia's testimony appears to contradict Dr Looi's evidence that he discussed the availability of light duties for the Patient at Tellus, we do not think that this entirely undermines Dr Looi's evidence, in the broader sense, that he at least discussed the availability of light duties with *someone* from Tellus. We reach this view for three reasons. First, we have

uncontroverted evidence from Ms Ho as to Dr Looi's usual practice, which involved making checks with the patient, or the relevant accompanying safety officer in the case of injured employees, regarding the availability of light duties. Left unrebutted, we think that the benefit of doubt should be given to Dr Looi such that we can assume that he did make such checks in the present case. Second, on Mr Chia's own evidence, which is not contested by the SMC, Mr Chia was *usually* the one who took injured workers to the Hospital. Given that the material events occurred some six years before Dr Looi testified, Dr Looi's imperfect recall of the identity of the person he had discussions with regarding the Patient is not fatal to him. He may have got the wrong impression from a review of certain of the Hospital's documents for the Patient on 7 August 2011 as these, erroneously, name Mr Chia as the accompanying person. Third, Mr Chia did recall that Mr Mokasamy had accompanied the Patient when he was taken to the Hospital and had obtained permission for the Patient to be operated on. Mr Chia's evidence and the Hospital documents both indicate that the Patient was not in the Hospital alone. Mr Mokasamy was most likely the person Dr Looi spoke with after the surgery regarding light duties. Indeed, Dr Looi's evidence on having spoken about the need for light duties on 7 August 2011, was to some extent corroborated by Mr Chia's evidence as to the stringent efforts Tellus made subsequently to ensure that the Patient only did light duties (see [89] below].

88 Looked at in this light, we do not see how it could be said that there was "no evidence" that Dr Looi had made efforts to establish the availability of light duties. Instead, with Ms Ho's evidence, and Dr Looi's evidence of having spoken to someone not being entirely undermined, it seemed to us that there was in fact evidence to support the view that Dr Looi had made efforts to establish the availability of light duties for the Patient and did not simply assume

that previous arrangements would be made available to him. Contrary to the Tribunal's view, there was a stark absence of evidence suggesting that Dr Looi had *omitted* to establish the availability of light duties or that he operated on assumptions rather than actual knowledge. We are therefore satisfied that the SMC has not proven that Dr Looi departed from this *aspect* of the applicable standard of conduct.

Light duties were in fact carried out

89 For completeness, we should note that we are fortified in our views by our quite separate conclusion that light duties were *in fact* carried out by the Patient when he returned to his workplace at Tellus. On this point, the Tribunal was prepared to accept the evidence of Mr Chia and Mr Tay that the Patient had been on light duties which involved attending at the Health, Safety and Environment Department ("the HSE Department") during the period in question (GD at [76] and [78]). In particular, Mr Chia testified that he had let the Patient remain in the dormitory on 9 August 2011 over the National Day public holiday. On 10 August 2011, Mr Chia took the Patient to the HSE Department to record a statement on the accident. Thereafter, for five days, the Patient attended a rehabilitation programme which, as Mr Tay, the manager of the HSE Department at the time, testified, included classroom-based safety training (GD at [72]). Like the Tribunal, we can see no reason why this evidence should not be accepted.

90 At the appeal hearing, Ms Choo sought to challenge this finding by the Tribunal. Ms Choo relied principally on a document which, on the face of it, appeared to be an attendance sheet. In particular, the document indicated, among other things, that the Patient had worked on a vessel for eight hours on

10 August 2011, and 11 hours on 11 August 2011. Ms Choo submitted that the document showed that the Patient had not been doing light duties, but had in fact resumed work on vessels on 10 and 11 August 2011.

91 We do not accept this submission. At the inquiry, the document was put to Mr Chia and he explained that it was not for indicating the attendance of workers, but merely for "manpower cost allocation". Mr Chia explained that to ascertain a worker's attendance, one would have to look at the attendance sheets. Those attendance sheets were ultimately not before us or the Tribunal because, although Mr Chia was asked to produce them for the inquiry, he no longer had those documents under his control as he had left Tellus by the time of the inquiry. However, as Ms Choo frankly acknowledged at the hearing, the SMC had not sought to subpoena the production of those documents by Tellus.

92 Ultimately, it is for the SMC, as the prosecuting authority in cases like this, to ensure that it can prove its case. Even though it was not strictly an element of either of the Charges against Dr Looi that the Patient *in fact* had not carried out light duties, it nonetheless remained incumbent on the SMC to prove this fact, had it wished to assert it. If the SMC were to succeed on establishing the Charges, the SMC would undoubtedly seek to rely on the fact, if proven, that the Patient had not in fact carried out light duties as a factor to consider in terms of the harm or potential harm that might have been suffered as a result of Dr Looi's misconduct. If, as in this case, the SMC took the view that the Patient did not in fact attend at the HSE Department to carry out light duties, it was incumbent on the SMC to seek to obtain the relevant documents, such as the attendance sheets. This was, however, not done, and the SMC cannot, in our view, rely simply on a document that merely *suggested*, on its face, that the

Patient had worked on vessels. This is especially so given that Mr Chia had given unchallenged evidence that the document was not to be read as such.

93 We also note that the document indicated, among other things, that the Patient had spent eight hours on a vessel on 7 August 2011, *ie*, the day of the accident. Yet there is evidence in the record that the Patient was seen at the Hospital as early as 10.45am on 7 August 2011. As it is clear that the Patient was hospitalised thereafter until his discharge on 8 August 2011, to read the document as indicating that the Patient had performed eight hours of work on 7 August 2011 would therefore have required us to find that the Patient started work at the latest around 2.45am on 7 August 2011 and worked continuously until his accident on that day. In the absence of any evidence that Tellus employees had such working hours, or that the Patient specifically was working those hours on that day, we find it very difficult to construe the document relied upon by the SMC as proof of the Patient's actual activity at the shipyard on the days in question, and that he had in fact been doing his usual work after the First Stage surgery instead of performing light duties. It must also be remembered that Dr Looi reviewed the Patient on 12 August 2011 and the Patient did not say anything to Dr Looi then about having had to go back to normal duties.

Conclusion on the First Charge

94 For the reasons given above, we hold that Dr Looi's conviction on the First Charge should be set aside. In particular, the SMC failed to establish that the applicable standard of conduct required a doctor to issue medical leave as the *only* acceptable course of action. Instead, the standard that was proved showed that it was equally open to a doctor to certify the Patient fit for light duties, provided that the doctor ascertained that there were adequate conditions

for the patient's rest and rehabilitation before doing so. The SMC failed to establish that Dr Looi had departed from both limbs of the applicable standard of conduct. Although Dr Looi had not issued medical leave to the Patient, he had (a) issued light duties to the Patient; and (b) first ascertained that there were adequate conditions for the Patient's rest and rehabilitation. The Tribunal found that the Patient had *in fact* attended at the HSE Department and carried out light duties, and this finding cannot be impugned.

The Second Charge

95 We now turn to address the Second Charge. The focus of the inquiry into the Second Charge is whether, when Dr Looi saw the Patient again at the review on 12 August 2011, he departed from the applicable standard of conduct by certifying the Patient fit for light duties until 22 August 2011. Crucially, Dr Looi must be judged against the circumstances of the Patient *as he presented on 12 August 2011*. Having considered the record of proceedings and the submissions before us, we have concluded that Dr Looi's conviction on the Second Charge should also be set aside. We set out our reasons below.

The applicable standard of conduct

96 On the first element, namely the applicable standard of conduct, the starting point must, in our view, be that which applied to the First Charge, when Dr Looi developed his post-operative management plan on 7 August 2011. Given that some time had passed since the First Stage surgery, it would appear to us, at least in the absence of expert evidence to the contrary, that if light duties were medically appropriate on the second post-operative day, then they were *a fortiori* medically appropriate on the fifth post-operative day (*ie*, 12 August 2011). This follows simply from the inference that a patient's condition would

be expected to improve over time, such that the appropriateness or acceptability of an ostensibly less protective form of medical care, such as light duties, would increase over time. This inference is of course subject, as we have said, to expert evidence to the contrary, or to evidence that the patient's condition had *not* in fact improved over time but that, for some reason, it had deteriorated to the extent that light duties were no longer appropriate.

97 In the present case, the evidence suggests that the Patient's position had improved between 8 August 2011 and 12 August 2011. At the review on 12 August 2011, the Patient presented without "any abnormal signs" and did not appear unhappy. The wound and the dressing were in good condition, and Dr Looi personally changed the dressing for the Patient. The Patient was also moving his other fingers quite well. It was also, in our view, relevant that at the *later* review on 22 August 2011, the Patient again presented with no complaints. There were no signs of infection or bleeding, hence Dr Looi noted that the flap was viable. As such, he proceeded to fix a date for the Second Stage surgery. This evidence supported Dr Looi's view on 12 August 2011 that the Patient was recovering well and that light duties were still appropriate.

98 At the appeal hearing, Ms Choo sought to rely on two facts which, in her submission, indicated that the Patient was not in fact recovering as well as Dr Looi's evidence suggested. First, she pointed to the fact that when the Patient presented at SGH on 20 August 2011, he had complained of "pain over the stitch area", which suggested a risk of infection. Second, she referred to the fact that on the Patient's later review with Dr Looi on 22 August 2011, Dr Looi had attempted to give the Patient seven days of medical leave, but he could not satisfactorily explain why he attempted to do so. We do not accept Ms Choo's submission that either of these facts *proves* that the Patient's condition had,

by 12 August 2011, worsened such that the applicable standard of conduct *required* that only medical leave be given.

99 We first address the Patient's review with Dr Tan Chong Hun at SGH on 20 August 2011. In our view, Dr Tan Chong Hun's treatment and assessment of the Patient on 20 August 2011 do not show that the Patient's condition had substantially worsened by 20 August 2011. Such treatment and assessment therefore cannot establish that the Patient's condition had worsened *by 12 August 2011*, some eight days prior to the Patient presenting himself at SGH. We arrive at this conclusion primarily because Dr Tan Chong Hun himself was not certain that the Patient had an infection of the wound as of 20 August 2011. In his records, he noted that the Patient had no "discharge over wound", there was "no pus discharge", and the wound was "clean". The Patient was also "afebrile", *ie*, he was not feverish. Consequently, the *only* indication that there *might* have been an infection in the wound was that the wound was "slightly wet". At the inquiry, Dr Tan Chong Hun explained that all these notes meant that he could not conclusively decide, as of 20 August 2011 when he saw the Patient, whether there was an infection. Instead, he explained that the "chief complaint" by the Patient then was inadequate painkillers, which he addressed by prescribing three different kinds of painkillers.

100 We next address Ms Choo's reliance on the review on 22 August 2011 where Dr Looi offered, and the Patient refused, one week of medical leave. That this occurred is not disputed, and is in any event supported by the review note. Dr Looi's evidence as to why he offered the Patient one week of medical leave was, simply put, that he could not recall why he did so. Although he said that "there were some signs to tell me that he required a full MC", these were not documented. In our view, Dr Looi's evidence on this was quite clearly simply

rationalisation as to why he might have offered medical leave to the Patient. In the absence of any documentation, and Dr Looi's frank admission that he cannot definitively recall what prompted him to offer medical leave, it would be entirely speculative for this court to hold that the Patient must have been in a certain condition as of 22 August 2011 such that the applicable standard of conduct *required* that only medical leave be given.

101 Accordingly, we are satisfied that as of 12 August 2011, given the state of the Patient as borne out by the evidence, the applicable standard of conduct was not more onerous that that which was required of Dr Looi on 7 August 2011. Specifically, we are of the view that the applicable standard of conduct, for the Second Charge, was also that a doctor examining a patient with the Patient's injuries and in his circumstances could either prescribe him medical leave, or certify him fit for light duties if the doctor had first ascertained that there were adequate conditions for the Patient's rest and rehabilitation (see above at [80]).

Departure from the applicable standard of conduct

102 We adopt the same approach as that which we applied to the First Charge above. The inquiry therefore turns to whether Dr Looi had established that there were adequate conditions for the Patient's rest and rehabilitation before he certified the Patient fit for light duties on the second occasion.

103 We have found above (at [82]–[88]) in respect of the First Charge that Dr Looi had discussed the availability of light duties at Tellus with the person who was accompanying the Patient, before certifying the Patient fit for light duties. In our view, the evidence similarly shows that Dr Looi also discussed the availability of light duties at Tellus with the Patient and the accompanying

safety officer at the subsequent review on 12 August 2011. Dr Looi testified that he had spoken to the Patient directly on 12 August 2011 regarding the availability of light duties at Tellus, and the suitability of the light duties that the Patient had thus far been tasked with. Dr Looi also testified that he had spoken with Mr Chia at the review on 12 August 2011, and Mr Chia "affirmed that [the Patient] was given duties in the office" or in the guardhouse. Although, as the SMC pointed out, Mr Chia could not remember the review on 12 August 2011, we do not think that this undermines Dr Looi's evidence that he had discussed the availability of light duties at Tellus with the Patient and the accompanying safety officer (who he recalled as being Mr Chia), or Ms Ho's evidence as to Dr Looi's usual practice in relation to review sessions with patients.

104 In the final analysis, we can see no basis to find that Dr Looi omitted to discuss the availability of light duties at Tellus with either the Patient or the accompanying safety officer during the further review on 12 August 2011. The present case is unlike *Wong Him Choon* where the doctor had candidly admitted in his testimony at the inquiry that he had been prepared to operate on assumptions and had not specifically inquired into the availability of light duties at the patient's workplace (at [70]–[72]). It is also unlike *Kevin Yip* where the doctor's own evidence was that he was "wholly unaware that the Patient had not done any light duties at all after he was discharged" (at [79]). In the instant case, it is clear not only that the Patient had in fact carried out light duties after returning to his workplace and prior to the review on 12 August 2011, but Dr Looi also testified that he had followed up with the Patient regarding the duties that the Patient had been asked to do.

105 For the reasons above, we find that Dr Looi did not depart from the applicable standard of conduct on the review of 12 August 2011 in certifying the Patient fit for light duties.

The Alternative Charges

106 Having set aside Dr Looi's conviction on both of the Charges, we consider finally whether either of the Alternative Charges can be established instead. As mentioned earlier, the Alternative Charges were framed along the lines of the second limb of professional misconduct as set out in *Low Cze Hong*. The following findings would have to be made to make out a charge under the second limb of professional misconduct (*Kevin Yip* at [51]; *Wong Him Choon* at [49(b)]):

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

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

107 In *Wong Him Choon*, this court stated that serious negligence may be demonstrated by a lack of concern for a patient's interests. In the context of a charge alleging that a doctor had prescribed inadequate medical leave, serious negligence may be demonstrated by a doctor failing to follow the "very basic principle of obtaining a detailed history from a patient, especially in relation to the nature of his work, before issuing a medical certificate for light duty" [emphasis in original omitted] (at [87]).

108 The Tribunal, citing the passage in *Wong Him Choon* just referred to, took the view that it would have convicted Dr Looi on the Alternative Charges. The Tribunal's conclusion rests on its finding that Dr Looi had "failed to

consider the Patient's pain levels, let alone the existence and nature of light duty arrangements when he ordered the same" (GD at [91]). We do not agree with the Tribunal's decision on the Alternative Charges because, for the reasons set out above, we have found that the evidence does not support such a finding. In particular, we have found that Dr Looi had certified the Patient fit for light duties, which the evidence shows was a medically appropriate course of action in the circumstances, *and* Dr Looi had first ascertained that there were adequate conditions for light duties to be carried out, on both 7 August 2011 and 12 August 2011. In these circumstances, we do not see how Dr Looi be said to have been seriously negligent by disregarding the Patient's interests or by failing to obtain a detailed history from the Patient.

109 On a concluding note, it appears to us where the gravamen of a charge against a doctor is that he failed to establish that there were adequate conditions for a patient's rest and rehabilitation before certifying that patient fit for light duties, such misconduct may more appropriately be pursued by a charge framed along the lines of the second limb of professional misconduct as set out in *Low Cze Hong*, *ie*, in terms of serious negligence. Alternatively, a charge framed along the lines of the first limb of professional misconduct as set out in *Low Cze Hong* would also be appropriate *if* the applicable standard of conduct and the material allegation as identified in the charge is that the doctor ought to have made such checks, but failed to do so. By contrast, where the nub of the SMC's case is actually that the medical certification issued was inadequate, in type or in duration, then a charge framed along the lines of the Charges in this case appears to us to be appropriate.

110 Ultimately, the charges that are brought against a doctor must alert the doctor to the main thrust of the allegations against him. If, for instance, the

SMC's case is not that the giving of light duties *per se* is objectionable, and the true substance of the charge is that the doctor's alleged failure was in failing to make inquiries, then *that* should be reflected as the main allegation in the charge – either in the form of an allegation of serious negligence for failing to make such checks, or as a deliberate departure from the applicable standard of conduct which required that the doctor make such checks.

111 In our view, such an approach would have the added benefit of ensuring conceptual clarity in identifying the relevant applicable standard of conduct for charges framed in terms of the first limb of professional misconduct as set out in *Low Cze Hong*. For instance, it would avoid having to shoehorn a doctor's duty to ascertain the availability of light duties before certifying a patient fit for light duties into the ostensibly objective standard of "adequate medical leave". If, as in this case, the evidence shows that light duties were medically appropriate for a patient, it is difficult to see how a doctor's failure to ascertain the availability of light duties would result in the giving of such light duties being considered "inadequate medical leave". It would be neater, in our view, for the charges to reflect that while the doctor may well have arrived at the right result and had given "adequate medical leave", this result was nonetheless arrived at incorrectly (and fortuitously) because he failed in his duty to first ascertain that light duties were available. Although we have, for the purpose of this case, proceeded on the basis that the duty to ascertain the availability of light duties basis formed part of the applicable standard of conduct for what constitutes "adequate medical leave", that was because parties advanced their cases before the Tribunal and on appeal in that way. That need not invariably be the way cases are pursued in the future.

Conclusion

112 For the reasons set out above, Dr Looi's appeal in OS 12 is allowed. We therefore set aside Dr Looi's conviction on, and all orders made by the Tribunal in relation to, the Charges. In the circumstances, the question of sentence does not arise, and we thus dismiss the SMC's appeal in OS 11.

113 The parties shall file their written submissions on the costs of the cross-appeals and of the hearing before the Tribunal within 14 days of the date of this judgment. The submissions shall be limited to ten pages each.

Sundaresh Menon Chief Justice	Judith Prakash Judge of Appeal	Tay Yong Kwang Judge

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