IN THE HIGH COURT OF THE REPUBLIC OF SINGAPORE

[2019] SGHC 172

Originating Summons No 3 of 2019

Between

Singapore Medical Council

… *Appellant*

And

Dr Lim Lian Arn

… *Respondent*

JUDGMENT

[Professions] — [Medical profession and practice] — [Professional misconduct] — [Disciplinary threshold] — [Informed consent]

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Singapore Medical Council
v
Lim Lian Arn

[2019] SGHC 172

High Court — Originating Summons No 3 of 2019
Sundaresh Menon CJ, Andrew Phang Boon Leong JA and Judith Prakash JA
9 May 2019

24 July 2019 Judgment reserved.

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

Introduction

1 The medical profession is an esteemed one. Its members are called to heal. And those of us who avail of their services must, to a large extent, *entrust* ourselves to their care. It is not surprising then that the medical profession is carefully regulated such that its members may face sanctions for professional misconduct when they conduct themselves improperly. But it is not the case that every instance of a misstep by a medical practitioner will necessarily attract disciplinary sanctions under the Medical Registration Act (Cap 174, 2014 Rev Ed) ("the MRA"). The law has developed such that where a doctor does depart from acceptable standards of conduct, it remains necessary to establish that the departure in question is so egregious that it warrants disciplinary action. Doctors are human after all, and, like the rest of us, are susceptible to lapses, errors of judgment, poor record-keeping and failures of memory. It would pose an

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intolerable burden for each medical practitioner, and, indeed, for society, which invests in and depends on the establishment of a vibrant medical profession, if each and every one of these failures were visited with sanctions. This is why the law seeks to strike a balance between, on the one hand, providing for the imposition of appropriate sanctions in those cases where there has been a grave failure on the part of the medical practitioner with possibly severe consequences for the patient, and, on the other hand, providing a rich range of options for the counselling, education and rapid rehabilitation of those practitioners who have departed from the expected standards but not in a persistent or sufficiently serious way. The law has always recognised the need to strike this balance, but it is sometimes overlooked in practice, as it was in this case. The result has been an ill-judged prosecution, an unwise decision to plead guilty and an unfounded conviction. In short, there has been a miscarriage of justice, with dire consequences for the medical practitioner concerned.

2 The medical practitioner in this case is Dr Lim Lian Arn ("Dr Lim"), who, before the Disciplinary Tribunal ("the DT"), pleaded guilty to one charge of professional misconduct under s 53(1)(*d*) of the MRA for failing to obtain informed consent from his patient before administering a steroid injection to her left wrist (see [1] of the DT's grounds of decision in *Singapore Medical Council v Dr Lim Lian Arn* [2018] SMCDT 9 ("GD")). Because Dr Lim chose to plead guilty, and because the DT accepted that plea, the DT was left to consider the question of sentence. On this, the Singapore Medical Council ("the SMC"), which prosecuted the matter, sought a suspension for a period of five months, while Dr Lim urged the DT to either impose the maximum fine of $100,000 or, if the DT were minded to impose a suspension, limit this to the minimum period of three months. Having considered the matter, the DT imposed a fine of $100,000 together with a number of other commonly-made disciplinary orders.

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There followed a major outcry from the medical profession, many of whom thought the penalty was unreasonably high. Those protesting appeared to be concerned that the decision would set an unacceptable benchmark for other cases, notwithstanding the fact that the DT had in fact imposed the lesser of the sanctions that Dr Lim himself had sought. The thrust of the dissatisfaction appeared to be directed at the SMC, which bears a responsibility for regulating the medical profession and which, in prosecuting Dr Lim in that capacity, had sought an even harsher sanction.

3 On 15 February 2019, following that outcry, the Ministry of Health requested the SMC to review the appropriateness of the sentence and to determine any subsequent steps that should be taken. The SMC accordingly brought the present appeal under s 55(1) of the MRA for a review of the DT's decision by having the sentence reduced to a fine of not more than $20,000. In the course of the arguments, counsel for the SMC, Mr Chia Voon Jiet ("Mr Chia"), in response to a question that we posed to him, maintained that as far as the SMC was concerned, Dr Lim's conviction was sound; it was only the sanction imposed on him that the SMC was taking issue with. When we asked Dr Lim's counsel, Mr Eric Tin Keng Seng ("Mr Tin"), whether he had any view on the soundness of the conviction, he was of little assistance to us and seemed more concerned to explain why Dr Lim had been advised to plead guilty.

4 Having heard the parties, we are satisfied that there has been a miscarriage of justice and that Dr Lim's conviction must be set aside. Simply put, the undisputed facts do not support the charge. Taking the SMC's case at its highest, and even assuming that Dr Lim in fact did not obtain the patient's informed consent, given the undisputed facts found by the DT, this was a case involving a departure from the applicable standards of conduct that did not warrant disciplinary sanction under the MRA. We explain this conclusion in this

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judgment, in the course of which we will also take the opportunity to canvass the following points:

(a) the threshold to be met before misconduct may be found to constitute professional misconduct under the MRA;

(b) the importance of expert evidence in assessing the liability of the medical practitioner and the sentence to be imposed;

(c) the nature and extent of a medical practitioner's duty to obtain informed consent; and

(d) the question of defensive medicine.

5 Finally, we should add that much of the difficulty in this case stemmed from Dr Lim's decision to plead guilty and then to seek a fine of $100,000. While those were matters for Dr Lim to decide on, what this case demonstrates is that medical practitioners may occasionally elect not to contest proceedings despite having strong merits on their side. In such situations, it remains incumbent on courts and tribunals to closely scrutinise the facts and the evidence, and satisfy themselves both that the conviction is well-founded and that the sentence to be imposed is appropriate to the facts that are before them. That is what we have done. It should be made clear that this is not a response to the outcry from the medical community in the wake of the DT's decision. Courts are not susceptible to be moved by such extraneous opinions, however strongly and sincerely they may be held and expressed. We emphasise this point because it is the rule of law that we are subject to, not the rule of the crowd.

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The facts

6 We begin by recounting the relevant facts. These are mostly found in the GD, although in the course of this judgment, we will make reference to the record of proceedings where necessary.

The charge

7 The charge as set out in the amended notice of inquiry dated 10 May 2018 reads in material part as follows:

> That you, Dr Lim Lian Arn, a registered medical practitioner under the [MRA] are charged that on 27 October 2014, whilst practising at Alpha Joints & Orthopaedics Pte Ltd, Gleneagles Medical Centre, 6 Napier Road, #02-20, Singapore 258499, you had acted in breach of Guideline 4.2.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition) ("ECEG 2002") in that you failed to obtain informed consent from your patient … as would be expected from a reasonable and competent doctor in your position, in that you failed to advise the Patient of the risks and possible complications arising from the administration of 10mg of triamcinolone acetonide with 1% lignocaine in a total volume of 2ml ("H&L Injection"), before administering the H&L Injection into the Patient's left wrist:
>
> …
>
> and that in relation to the facts alleged, your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, and that you are thereby guilty of professional misconduct under section 53(1)(d) of the [MRA].
>
> [underlining, emphasis in bold and text in strikethrough in original omitted]

The facts relating to the charge

8 Dr Lim is a registered specialist in orthopaedic surgery. His practice is incorporated under the name Alpha Joints & Orthopaedics Pte Ltd ("the Clinic") at Gleneagles Medical Centre (GD at [3]). On 27 October 2014, the patient

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consulted Dr Lim at the Clinic about some pain in her left wrist. Dr Lim conducted a physical examination of the wrist and advised the patient to undergo a scan using Magnetic Resonance Imaging ("MRI"). This was done on the same day (GD at [7]–[8]).

9 On the following day, Dr Lim informed the patient of the results of the scan and offered her two treatment options (GD at [8]):

(a) bracing and oral medication; or

(b) an injection of 10mg of triamcinolone acetonide with 1% lignocaine in a total volume of 2ml ("H&L Injection") coupled with bracing and oral medication.

10 The only material difference between these two options appears to be the H&L Injection, which was part of the second option but not the first. The patient chose the latter option and Dr Lim administered the H&L Injection to her left wrist in the region of the Triangular Fibrocartilage Complex and Extensor Carpi Ulnaris ("the Injected Area"). The agreed statement of facts records that before administering the H&L Injection, Dr Lim did not advise the patient of the following matters (referred to at [9] of the GD as "the risks and possible complications that could arise from the H&L Injection"):

(a) post-injection flare, in particular, that:

(i) the patient might experience increased pain and inflammation in the Injected Area that could be worse than the pain and inflammation caused by the condition being treated;

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(ii) the onset of the post-injection flare was usually within two hours after the injection and would typically last for one to two days;

(b) the post-injection flare could be treated by rest, intermittent cold packs and analgesics;

(c) change in skin colour including depigmentation (loss of colour), hypopigmentation (lightening) and hyperpigmentation (darkening);

(d) skin atrophy (thinning);

(e) subcutaneous fat atrophy;

(f) local infection; and

(g) tendon rupture.

11 As it transpired, some of these risks and complications did manifest. The patient experienced swelling and pain in the Injected Area about two hours after the H&L Injection. Subsequently, she developed "paper-thin skin with discolo[u]ration, loss of fat and muscle tissues" [emphasis in original omitted] in the Injected Area (GD at [10]).

12 By way of a statutory declaration dated 11 January 2016, the patient filed a complaint against Dr Lim regarding his alleged failure to advise her on the possible complications arising from the H&L Injection.

The decision below

13 Dr Lim was prosecuted for his failure to obtain informed consent from the patient, and this was predicated on his conduct amounting to such serious

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negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. Dr Lim pleaded guilty to the charge as set out in the amended notice of inquiry and eventually admitted to the agreed statement of facts without any qualification. The DT accordingly found him guilty of professional misconduct under s 53(1)(*d*) of the MRA (GD at [12]).

14 As we mentioned at [2] above, before the DT, the SMC sought a five-month suspension (GD at [26]). Dr Lim, on the other hand, submitted that the maximum fine of $100,000 would be the most appropriate sentence. In the alternative, he submitted that if the DT were of the view that a period of suspension was necessary in the circumstances, the minimum suspension period of three months would be adequate (GD at [25]). The DT held that a suspension was not warranted (GD at [67]) and imposed a fine of $100,000 as well as a number of other commonly-made disciplinary orders (GD at [74] and [76]). In declining to order a suspension, the DT considered the following points:

(a) First, the risks and possible complications of the H&L Injection constituted material information that should have been explained to the patient. However, the DT also noted that there was no evidence that the patient would have taken a different course of action had such information been conveyed to her (GD at [48]). As a result, the DT concluded that the patient's autonomy had not been substantially undermined (GD at [50]–[51]).

(b) Second, this was not a case where Dr Lim had deliberately suppressed information or intentionally departed from ethical standards. Dr Lim's omission was an honest mistake and was described by the DT as "an isolated one-off incident, involving one patient" (GD at [49]). In

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this regard, the DT considered it relevant that Dr Lim produced redacted notes of consultations with other patients, which showed that he commonly did explain to and discuss with his patients the risks and complications of treatments such as the H&L Injection.

(c) Third, Dr Lim had informed the patient of the results of the MRI scan and had offered alternative treatment options. He had not offered the H&L Injection as the sole treatment; nor had he actively recommended this particular treatment (GD at [52]–[53]).

(d) Fourth, the harm that resulted fell within the recognised adverse effects of the H&L Injection, which Dr Lim should have informed the patient about. That said, the DT was of the view that the injection itself was an appropriate treatment for the patient (guided by the patient's symptoms and following proper investigations that had been done by Dr Lim) and it was minimally invasive. It was a commonly performed procedure in clinics that required no sedation or anaesthesia. While the patient did suffer some side effects and complications resulting from the H&L Injection, there was nothing to suggest that those side effects were permanent or debilitating. In essence, the harm was not *caused* by any medical misstep on Dr Lim's part. To that extent, Dr Lim's degree of culpability was "on the low end", and the harm that ensued was "limited in nature and extent" (GD at [54]–[57]).

(e) Fifth, Dr Lim's personal mitigating circumstances were strong. He had an unblemished record over a career spanning 29 years and had pleaded guilty at the earliest available opportunity. He had been co-operative with the investigations, and was genuinely remorseful. Dr Lim

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had also taken remedial steps to improve his consent-taking procedures and the documentation of such consent in his patient notes (GD at [58]).

15 Having considered these matters, the DT came to the conclusion that Dr Lim's conduct was not so egregious as to deserve a suspension (GD at [67]). Turning to the appropriate fine to be imposed, the DT took into account the following considerations:

(a) Dr Lim was a specialist in orthopaedic surgery and a senior doctor who had been in practice for close to 30 years. His seniority was regarded as an aggravating factor (GD at [69]).

(b) The risks and possible complications that could arise from the H&L Injection were properly to be regarded as material information that Dr Lim should have provided to the patient to enable her to make an informed choice. The complications which the patient experienced were the very complications that ought to have been conveyed to her (GD at [70]).

(c) Dr Lim was unlikely to re-offend and the need for specific deterrence was not thought to be strong. This was an isolated incident and an honest oversight on Dr Lim's part. Dr Lim had also shown genuine remorse, apologised to the patient and taken steps to improve his own practices for obtaining his patients' informed consent and documenting the same (GD at [71]).

(d) It was important to send a strong signal to the medical profession that the failure to obtain informed consent was a serious matter and to deter such failures (GD at [72]).

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16 In the circumstances, the DT agreed with the submission by Dr Lim's counsel that a fine of $100,000 would suffice and be appropriate (GD at [74]).

The grounds of appeal

17 The SMC, which had earlier sought a suspension of five months, now submits that the fine imposed by the DT was manifestly excessive and/or seriously or unduly disproportionate in quantum for two key reasons:

(a) First, having made certain findings in relation to Dr Lim's conduct and the mitigating factors that applied to him, the DT erred in its application of the relevant legal principles and sentencing precedents in determining the quantum of the fine that should then be imposed.

(b) Second, the DT's sentencing decision might have implications on the practice of medicine and the provision of healthcare services in Singapore. These implications were not raised before or considered by the DT, but are thought to be relevant in determining the appropriate sentence. We pause to note that these points plainly could and should have been considered by the SMC and its counsel before seeking the even harsher penalty of a substantial suspension before the DT.

18 Mr Chia further submitted that the SMC had also reviewed the sentence in the light of our decision in *Wong Meng Hang v Singapore Medical Council and other matters* [2019] 3 SLR 526, which was handed down shortly after the DT's determination on Dr Lim's case. According to Mr Chia, that decision is material to the sentencing analysis to be applied here. In all the circumstances, the SMC now seeks a reduction of the fine to not more than $20,000. Dr Lim agrees with the SMC's position on appeal and did not offer us anything else to speak of.

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19 At the hearing on 9 May 2019, we expressed concern about the very basis of Dr Lim's conviction. Mr Chia maintained that there was proper basis for the conviction. He submitted that Dr Lim had a duty to convey *all* the risks and possible complications listed out at [10] above, and that the expert report that accompanied the amended notice of inquiry supported this position. He also contended that Dr Lim's misconduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. In so contending, Mr Chia emphasised that the DT was a specialist tribunal and, thus, in convicting and sentencing Dr Lim, it must be taken to have deemed the facts to be sufficient for Dr Lim to be liable under the MRA. As for Mr Tin, as we have already noted, he did not seriously challenge the propriety of the conviction and reiterated the unremarkable position that Dr Lim did not object to a reduction of the fine.

20 Before we turn to the substantive analysis of the issues, it is appropriate to make some brief observations about this case. It seems to us that the case took the course that it did largely because of a series of missteps that were, in a sense, preventable. As we have already noted and will elaborate in due course, the DT found that Dr Lim's conduct was an honest one-off mistake. On the basis of the facts that he admitted, Dr Lim might have fallen short of the standards set out in the Singapore Medical Council Ethical Code and Ethical Guidelines (2002 edition) (hereinafter referred to the "ECEG (2002)"; the 2016 edition will be referred to as the "ECEG (2016)", and both editions collectively as the "ECEG"). But it seems to have escaped all the parties that such a breach does not *necessarily or inevitably* lead to the conclusion that Dr Lim was guilty of professional misconduct under s 53(1)(*d*) of the MRA. The Complaints Committee that was appointed to inquire into the patient's complaint had a range of options to deal with the complaint without referring the case to the DT.

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It did not, however, explore those options. And then, when the matter came before the DT, it appears that once Dr Lim made the decision to plead guilty, neither the respective parties' counsel nor the DT further considered the question of liability. Moreover, having made findings on the nature and extent of Dr Lim's infraction, the DT did not then re-assess the logic of its conclusions and consider whether the charge was made out; specifically, whether Dr Lim's conduct amounted to such serious negligence that it objectively portrayed an abuse of the privileges which accompany registration as a medical practitioner. Before us, it became evident that neither Mr Chia nor Mr Tin were alive to this critical point. In the circumstances, it is apposite to first reiterate what constitutes professional misconduct under the MRA.

The disciplinary procedure under the MRA

21 The disciplinary process under the MRA is typically initiated by a complaint of misconduct or impropriety on the part of the doctor. The complaint must be made or referred to the SMC in writing and be supported by such statutory declaration as the SMC may require: s 39(1) of the MRA. The matter, however, does not immediately proceed before a Disciplinary Tribunal; instead, a Complaints Committee first conducts an inquiry into the complaint. There are three possible outcomes at this stage:

(a) If the Complaints Committee is unanimously of the opinion that the complaint or information is frivolous, vexatious, misconceived or lacking in substance, it must dismiss the matter and give reasons for the dismissal (s 42(4)(*a*) of the MRA).

(b) If the Complaints Committee is unanimously of the opinion that no investigation is necessary, it must either issue a letter of advice to the

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medical practitioner or refer the matter for mediation (s 42(4)(*b*) of the MRA).

(c) In any other case, the Complaints Committee must direct one or more investigators to carry out an investigation and make a report to it under s 48 of the MRA (s 42(4)(*c*) of the MRA).

22 After investigations and upon due inquiry into the complaint, if the Complaints Committee is of the view that no formal inquiry by a Disciplinary Tribunal is necessary, the Complaints Committee has a range of options to address the complaint; these include issuing a letter of advice or warning to the medical practitioner or referring the matter for mediation: s 49(1) of the MRA. It is only if the Complaints Committee determines that a formal inquiry is necessary that it must then order that an inquiry be held by a Disciplinary Tribunal: s 49(2) of the MRA.

23 Once a Disciplinary Tribunal has been appointed, a notice of inquiry specifying, in the form of one or more charge(s) determined by the Complaints Committee, the matters which the Disciplinary Tribunal will inquire into is to be sent to the medical practitioner. The notice of inquiry must be accompanied by a copy of the report of any expert witness whose evidence the SMC intends to adduce at the inquiry: regs 27(1) and 27(2) of the Medical Registration Regulations 2010 (S 733/2010).

24 It will be noted from the foregoing description that there is a process of escalation, and that there are options available in the alternative to commencing disciplinary proceedings to address complaints. We will return to this observation later.

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Professional misconduct

Three-stage inquiry

25 Under the MRA, disciplinary sanctions may be imposed against a medical practitioner in the following situations:

> **53.**—(1) Where a registered medical practitioner is found by a Disciplinary Tribunal —
>
> (*a*) to have been convicted in Singapore or elsewhere of any offence involving fraud or dishonesty;
>
> (*b*) to have been convicted in Singapore or elsewhere of any offence implying a defect in character which makes him unfit for his profession;
>
> (*c*) to have been guilty of such improper act or conduct which, in the opinion of the Disciplinary Tribunal, brings disrepute to his profession;
>
> (*d*) to have been guilty of professional misconduct; or
>
> (*e*) to have failed to provide professional services of the quality which is reasonable to expect of him …

26 Dr Lim was charged under s 53(1)(*d*) of the MRA for professional misconduct. In *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*"), we discussed the scope of professional misconduct and observed that professional misconduct can be made out in at least two situations (at [37]):

> (a) first, where there is an *intentional, deliberate departure from standards* observed or approved by members of the profession of good repute and competency (commonly referred to as the "first limb of *Low Cze Hong*"); and
>
> (b) second, where there has been *such serious negligence* that it *objectively portrays an abuse of the privileges* which accompany

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registration as a medical practitioner (commonly referred to as the "second limb of *Low Cze Hong*").

27 The two limbs of *Low Cze Hong* in broad terms cover intentional breaches and negligent breaches respectively. We accept that these may not necessarily be exhaustive of the situations that may amount to professional misconduct. Indeed, we have on previous occasions expressed the view that professional misconduct would extend to grave breaches of other ethical obligations such as a breach of the obligation to charge a fair and reasonable fee for services rendered: *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086 at [51], citing *Lim Mey Lee Susan v Singapore Medical Council* [2013] 3 SLR 900 at [44]. However, it is unnecessary, in this decision, for us to definitively pronounce on what other situations might amount to professional misconduct because the present charge has explicitly been brought under the second limb of *Low Cze Hong*.

28 It will readily be appreciated that the test for professional misconduct as set out in either limb of *Low Cze Hong* requires the court or tribunal to engage in a three-stage inquiry. The first stage is to establish the relevant benchmark standard that is applicable to the doctor. The second is to establish whether there has been a departure from the applicable standard. It seems to us that the SMC, Dr Lim and the DT all stopped at this point without going on to the third stage, which is then to determine whether the departure in question was sufficiently egregious to amount to professional misconduct under the particular limb of *Low Cze Hong* set out in the case against the doctor. In cases prosecuted under the first limb, the question is whether the departure was an intentional and deliberate departure from the applicable standard; while in cases prosecuted under the second limb, the question is whether the negligent departure from the

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applicable standard was so serious that objectively, it portrays an abuse of the privileges of being registered as a medical practitioner.

29 Consistent with this three-stage inquiry, in *Ang Pek San Lawrence v Singapore Medical Council* [2015] 1 SLR 436 ("*Ang Pek San Lawrence*"), we said that a Disciplinary Tribunal would have to make the following findings before it may hold that the SMC has proved its charge against the allegedly errant doctor (at [39]):

(a) In relation to the first limb of *Low Cze Hong*:

(i) 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;

(ii) whether the applicable standard of conduct required the doctor to do something and, if so, at what point in time such duty crystallised; and

(iii) whether the doctor's conduct constituted an intentional and deliberate departure from the applicable standard of conduct.

(b) In relation to the second limb of *Low Cze Hong*:

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

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

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30 The underlying rationale for the three-stage inquiry is simple: not every departure from the acceptable standards of conduct would necessarily amount to professional misconduct. This is not surprising. As we observed to Mr Chia in the course of his submissions, there must be a threshold that separates relatively minor breaches and failures from the more serious ones that demand disciplinary action. Were it otherwise, doctors would find it impossible to practise in a reasonable way. For a medical practitioner to be charged and found liable under the MRA, the misconduct must be more than a mere technical breach of the relevant standards. It cannot be gainsaid that conduct (such as negligence) which might attract civil liability is different from conduct that results in disciplinary proceedings and sanctions; the latter is quasi-criminal in nature and is concerned with punishment and regulation, while the former is concerned with compensation rather than punishment and regulation in a formal sense. At the same time, even technical or minor breaches should be dealt with in an appropriate way. It is for this reason that the MRA provides an array of measures to address a patient's complaint and a doctor's misconduct without necessarily escalating the matter to a formal disciplinary inquiry: see [21]–[24] above.

31 A broadly similar approach is adopted in other jurisdictions as well. Thus, in New Zealand, for example, in *Martin v Director of Proceedings* [2010] NZAR 333 ("*Martin*"), the High Court of New Zealand recounted the development of a two-stage approach by the New Zealand courts and described it in the following terms (at [14]–[16]):

> 14 Under the 1995 Act [*ie*, the Medical Practitioners Act 1995 (NZ)] a two-step approach was taken to determining whether conduct constituted disgraceful conduct in a professional respect, professional misconduct or conduct unbecoming. This approach involved, first, an enquiry whether the practitioner had departed from acceptable professional standards and, secondly, whether the departure was such as to

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> justify a disciplinary sanction. This approach had its roots in *B v Medical Council* [[2005] 3 NZLR 810], where Elias J considered what conduct would justify a finding of either conduct unbecoming or professional misconduct under the 1968 Act [*ie*, the Medical Practitioners Act 1968 (NZ)]. Her statement that, to attract professional discipline the conduct would have to depart from acceptable professional standards to an extent significant enough to justify sanction for the purposes of protecting the public, has been approved and consistently adopted in relation to both the 1968 and 1995 Acts:
>
> > But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available … The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her obligations. …
>
> 15 In *McKenzie v Medical Practitioners Disciplinary Tribunal* [[2004] NZAR 47] Venning J, considering a charge of professional misconduct under the 1995 Act, slightly reformulated that approach as the distinct two-step process I have described. The Court of Appeal approved this two-step process in *F v Medical Practitioners Disciplinary Tribunal* [[2005] 3 NZLR 774].
>
> 16 In the present case, counsel were agreed that the two-step approach was still correct in the context of the HPCAA [*ie*, the Health Practitioners Competence Assurance Act 2003 (NZ)]. … I agree that the two-step process is still correct. …

32 The New Zealand approach first asks the question "whether the practitioner had departed from acceptable professional standards" before examining "whether the departure was such as to justify a disciplinary sanction". Although there are differences in the framing of the approach in *Martin*, it is not in substance different from the one that we have articulated above at [28].

33 At the hearing, Mr Tin explained that he had proceeded on the basis that a breach of a "basic principle" in the ECEG (2002) amounts to professional

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misconduct. He was mistaken. It will be evident from what we have said above that the question whether particular conduct does or does not cross the disciplinary threshold will commonly be a fact-sensitive one. In line with this, both editions of the ECEG make clear that a departure from the standards prescribed there does not itself lead to the conclusion that there has been professional misconduct. The introduction to the ECEG (2002) reads:

> This Ethical Code represents the fundamental tenets of conduct and behaviour expected of doctors practising in Singapore. The Ethical Guidelines elaborate on the application of the Code and are intended as a guide to all practitioners as to what [the] SMC regards as the minimum standards required of all practitioners in the discharge of their professional duties and responsibilities in the context of practice in Singapore. *It is the view of the SMC that serious disregard [of] or persistent failure to meet these standards can potentially lead to harm to patients or bring disrepute to the profession and consequently may lead to disciplinary proceedings.* [emphasis added]

34 While doctors are expected to adhere to the standards prescribed in the ECEG (2002), it is "*serious disregard* [of] or *persistent failure* to meet these standards … [that] may lead to disciplinary proceedings" [emphasis added]. Similarly, the ECEG (2016) reiterates the point as follows:

> The SMC takes the view that serious disregard of or persistent failure to meet the standards set out under the ECEG [(2016)] can potentially lead to harm to patients or bring disrepute to the profession with loss of confidence in the healthcare system and consequently may lead to disciplinary proceedings.

The disciplinary threshold under the second limb of Low Cze Hong

35 As we have noted already, the present case was prosecuted under the second limb of *Low Cze Hong*, and it is to this that we now turn. In *Ang Pek San Lawrence*, we said, in respect of the second limb of *Low Cze Hong*, that a Disciplinary Tribunal must find: (a) whether there was serious negligence on

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

36 The words that describe the threshold where a doctor's failure amounts to professional misconduct under this limb, namely, "objectively portrays an abuse of the privileges which accompany registration as a medical practitioner", can be traced to *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197, where the New South Wales Court of Appeal considered the statutory test of "misconduct in a professional respect" under the Medical Practitioners Act 1938 (NSW). The material portion of Kirby P's judgment merits reference (at 200–201):

> **"Misconduct" means more than mere negligence:**
>
> The words used in the statutory test ("misconduct in a professional respect") *plainly go beyond that negligence which would found a claim against a medical practitioner for damages* … On the other hand gross negligence might amount to relevant misconduct, particularly if accompanied by indifference to, or lack of concern for, the welfare of the patient … Departures from elementary and generally accepted standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant could amount to such professional misconduct … But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from acceptable standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner: cf *Allinson* [*v Council of Medical Education and Registration* [1894] 1 QB 750] (at 760–761). These are the approaches which have been taken in our courts. They have been taken in the courts of England where such misconduct is alleged. And they have similarly been taken in the courts of the United States. The entry in *Corpus Juris Secundum*, vol 58, (1948) at 818, reads:
>
> > "Both in law and in ordinary speech the term 'misconduct' usually implies an act done willfully with a wrong intention, and conveys the idea of intentional wrongdoing. The term implies fault beyond the error of judgment; a wrongful intention, and not a mere error of judgment; but it does not necessarily imply corruption or criminal intention, and, in the legal idea of

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> misconduct, an evil intention is not a necessary ingredient. The word is sufficiently comprehensive to include misfeasance as well as malfeasance, and as applied to professional people it includes unprofessional acts even though such acts are not inherently wrongful. Whether a particular course of conduct will be regarded as misconduct is to be determined from the nature of the conduct and not from its consequences."
>
> …
>
> *… Moral turpitude is not now required … But it is still necessary, in every case, to prove misconduct that goes beyond mere carelessness.*
>
> [emphasis added]

37 In the above passage, Kirby P was seeking to articulate the threshold of wrongdoing that must be shown before misconduct can be found and *disciplinary action* warranted. What is evident from this is that as a general rule, mere negligence or incompetence on the part of the doctor will not be enough. There has to be something more.

38 In our judgment, the critical inquiry is whether the conduct would be regarded as falling so far short of expectations as to warrant the imposition of sanctions. In broad terms, it will be relevant to consider the nature and extent of the misconduct, the gravity of the foreseeable consequences of the doctor's failure and the public interest in pursuing disciplinary action. This would depend on a multitude of overlapping considerations including the importance of the rule or standard that has been breached, the persistence of the breach and the relevance of the alleged misconduct to the welfare of the patient or to the harm caused to the doctor-patient relationship. Serious negligence portraying an abuse of the privileges which accompany registration as a medical practitioner would generally cover those cases where, on a consideration of all the circumstances, it becomes apparent that the doctor was simply indifferent to the patient's welfare or to his own professional duties, or where his actions entailed

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abusing the trust and confidence reposed in him by the patient. On the other hand, it would not typically cover one-off breaches of a formal or technical nature where no harm was intended or occasioned to the patient or where harm was not a foreseeable consequence; nor would it ordinarily cover isolated and honest mistakes that were not accompanied by any conduct which would suggest a dereliction of the doctor's professional duties. There are of course many shades of misconduct, but it would be neither practical nor desirable to be overly-prescriptive or definitive in this regard. The key point is that a determination that the disciplinary threshold has been crossed is not an exercise in the abstract. To use the words of Elias J in *B v Medical Council* [2005] 3 NZLR 810 at 811:

> … [T]he reasonableness of the standards applied must ultimately … [take] into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. …

A court or tribunal would typically expect to be guided by the available expert evidence in this context, a point to which we will return later.

39 To further illustrate the disciplinary threshold, it is helpful to refer briefly to some precedents of this court. In *Jen Shek Wei v Singapore Medical Council* [2018] 3 SLR 943, the patient discovered a pelvic mass during an MRI scan and was referred to the appellant, Dr Jen, who performed a transvaginal scan on the patient and found a lump in each of her ovaries. Without further evaluation or investigation, Dr Jen concluded that the pelvic mass was malignant and advised the patient to undergo surgical removal. The surgery was performed and it turned out that the mass was not malignant at all. The disciplinary threshold was crossed in that case because in deciding to recommend surgery without further tests, Dr Jen was found to have been

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indifferent to the patient's welfare. Dr Jen had proceeded on the basis that surgery was required and had advised the patient to undergo surgery without further evaluation when such further assessment was warranted in the circumstances: at [61]–[62].

40 Similarly, in *Chia Foong Lin v Singapore Medical Council* [2017] 5 SLR 334, we reiterated that the threshold to be crossed before misconduct may be found is a high one. Misconduct entails more than mere negligence. While *gross* negligence might amount to relevant misconduct, particularly if it is accompanied by indifference to, or lack of concern for, the welfare of the patient, mere errors of judgment and professional incompetence would generally be insufficient to support a finding of gross negligence: at [60]. In that case, the doctor concerned ("Dr Chia") failed to diagnose Incomplete Kawasaki Disease ("KD") affecting a one-year old patient despite the patient displaying symptoms of the condition and despite the availability of relatively straightforward and harmless exclusionary tests. Instead, she misdiagnosed the patient as having viral fever and persisted in this diagnosis over three separate occasions notwithstanding the potential danger to the infant patient. In upholding the Disciplinary Tribunal's decision to convict Dr Chia of professional misconduct, we said (at [61]–[62]):

> 61 … While we recognise that the line between an error of judgment and gross negligence could in certain circumstances be fine and that an error of judgment does not, *ipso facto*, constitute professional misconduct, it is the entire picture which will be determinative. In our view, and here we agree with the [Disciplinary Tribunal], the following circumstances were critical and justified the conclusion of the [Disciplinary Tribunal] that the line had been crossed in the present case:
>
> > (a) It is not disputed that the consequences of a delay or missed diagnosis of KD can be severe. Neither is it disputed that KD and Incomplete KD are not uncommon among infants. These are two vitally important factors.

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> (b) The [Disciplinary Tribunal] found that the Patient's fever "did not totally settle" when he was discharged on 1 March 2013. This means that the Patient presented persistent fever throughout the Relevant Period. Yet, despite the presence of at least two characteristics of classic KD and remittent fever, Dr Chia fixed her eyes on viral fever as the diagnosis and failed to conduct a holistic assessment of the Patient's condition.
>
> (c) As an "experienced paediatrician of 23 years' standing", Dr Chia was expected to be aware of the possibility of Incomplete KD. She was also expected to conduct the supportive tests to exclude the disease in view of the severe consequences a patient may face if she failed to do so in a timely manner.
>
> (d) Dr Chia had multiple opportunities to rule out KD by ordering supportive tests (on 28 February, 1 and 3 March 2013). Yet, she failed to do so. Also, she did not seek the advice of her colleagues who were present at [the hospital] during the Relevant Period. Instead, she acted without any advice or discussion with the parents of the Patient on KD, relying only on her "hunch". The failure to order supportive tests on 28 February 2013 might be a mere lapse of judgment. But, as the [Disciplinary Tribunal] noted, there were "at least three occasions of serious lapses on [Dr Chia's] part".

62 It may be argued that because KD tends to mimic characteristics of other sicknesses (such as viral fever), Dr Chia's failure to identify Incomplete KD as a possible diagnosis and to order supportive tests to rule it out could be construed as a mere error in judgment as opposed to gross negligence. While we accept that such a view could be taken as of 28 February, or even 1 March 2013, this could not be so as of 3 March 2013 when the Patient visited Dr Chia at her Clinic with red lips and having had fever for the past two nights. When the available tests to exclude KD are simple to undertake and when the consequences of no timely treatment of KD could be severe, it is not for a doctor to take chances with the well-being of a patient. If there was a need to take chances, that determination should be left for the patient (or his parents if the patient is an infant) to make on an informed basis. We struggle to understand why such exclusionary tests, which were not harmful to the Patient, were not undertaken, or why the parents of the Patient were not informed of their availability. It is here that Dr Chia badly faltered.

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41 This was a case where the misconduct was plainly avoidable, the consequences of the lapse were serious and the doctor's persistent failure to resort to readily available and relatively harmless exclusionary tests could be characterised as indifference to the patient's welfare and gross negligence.

The role of expert evidence

42 We turn to the subject of expert evidence, which plays a relevant and important role in establishing the standards applicable to the doctor, and also in determining whether any departure from those standards was sufficiently serious to amount to professional misconduct.

43 At the hearing, we pointed out to Mr Chia that there were serious inadequacies in the expert report that had been tendered in support of the charge. While the report *concluded* that Dr Lim should have advised the patient of the list of possible complications that could arise from the H&L Injection, no reasons at all were provided for the conclusion. As the Court of Appeal said in *Pacific Recreation Pte Ltd v S Y Technology Inc and another appeal* [2008] 2 SLR(R) 491, albeit in a different context, an expert cannot merely present his conclusion without also presenting the underlying evidence and the analytical process by which the conclusion is reached (at [85]):

> Whatever the case, it is clear that the expert cannot merely present his conclusion on what the foreign law is without also presenting the underlying evidence and the analytical process by which he reached his conclusion. For instance, in *The H156* [[1999] 2 SLR(R) 419] …, Selvam J quite rightly warned against "the expert deciding the issue by assuming the power of decision", saying:
>
> > The function of an expert on foreign law is to submit the propositions of foreign law as fact for the consideration of the court. The court will then make its own findings of what the foreign law is. Even though the expert may submit his conclusions, he must present the materials and the grounds he uses to make his conclusions. The

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> expert may not usurp the function of the court and present his finding. Further he cannot decide the issue by applying the law to the facts without setting out the law and the reasoning process.
>
> He denounced as a "pretended opinion" … the Norwegian lawyers' report which consisted of a single sentence: "The heads of damages are of a type recognised in Norwegian law" …

It is important that an expert demonstrate how a conclusion is reached. This is so that the court is in a position to consider whether the expert's reasoning is sound and, in turn, evaluate the worth of the opinion appropriately. An expert report that consists of conclusions only without any reasons supporting the conclusions offers no assistance, and it is the duty of counsel to ensure that the evidence proffered meets the minimum standards.

44 The material portion of the expert report in this case reads as follows:

> 17. A doctor shall provide adequate information to a patient so that he can make [an] informed choice about his medical management: see Guideline 4.2.4.1 of the ECEG 2002. The information should include details of his clinical condition, investigation results, and discussion of [the] treatment options available including [the] benefits, risks and possible complications of each option.
>
> 18. Before giving the H&L Injection, Dr Lim should have advised [the patient] of the possible complications that can arise from an H&L Injection which include:
>
> (a) post-injection flare (Cortisone flare), in particular, that:
>
> (i) [the patient] may experience increased pain and inflammation in the area injected that can be worse than the pain and inflammation caused by the condition being treated;
>
> (ii) the onset of the post-injection flare is usually within 2 hours after the injection and typically lasts for 1 to 2 days; and
>
> (iii) the post-injection flare can be treated by rest, intermittent cold packs and analgesics;

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> (b) change in skin colour including depigmentation (loss of colour), hypopigmentation (lightening) and hyperpigmentation (darkening);
>
> (c) skin atrophy (thinning);
>
> (d) subcutaneous fat atrophy;
>
> (e) local infection; and
>
> (f) tendon rupture.
>
> 19. In particular, the complications experienced by [the patient] as documented in her complaint dated 11 January 2016, namely:
>
> (a) "About two hours following the injection I experienced swelling in the area and pain so severe that I could not bear even the slightest touch"; and
>
> (b) "Later on, the adjacent area of the hand developed a paper-thin skin with discolo[u]ration, loss of fat and muscle tissues".
>
> are complications that should have been disclosed by Dr Lim.
>
> …
>
> 24. If Dr Lim had not advised [the patient] on the possible complications arising from the H&L Injection, [the patient] would still be able to consent (whether explicit or implied) to the injection. However, such consent would not be an informed consent.
>
> …
>
> 26. …
>
> …
>
> (b) If Dr Lim had not informed [the patient] about the possible complications arising from the H&L Injection as stated at paragraph 18 above, it is my view that Dr Lim had not fulfilled his responsibility to ensure that a patient under his care is adequately informed so that she is able to participate in decisions about her treatment. Dr Lim had not provided [the patient] with adequate information so that she can make an informed choice.

45 The expert report does not state *why* the specific list of possible complications spelt out in para 18 had to be disclosed to the patient or *why* Dr Lim was in this case under a positive duty to convey to the patient those risks

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and possible complications. The question of just what Dr Lim should have disclosed is likely to be impacted by such factors as the likelihood of the risk or complication eventuating and the severity of the potential injury that might follow (see [48]–[49] below on the duty to obtain informed consent). But none of this is even mentioned in the expert report. Such information would have been relevant not only to establish the standards expected of Dr Lim, but also to assess the extent to which Dr Lim had departed from those standards, as well as to assess, when it came to sentencing, the potential harm and culpability inherent in any misconduct as might be found.

46 Mr Chia eventually accepted that the expert report was wanting, but he submitted that notwithstanding the inadequacies therein, the DT was ultimately a "specialist tribunal" and, in applying its expertise, had assessed Dr Lim's misconduct to be sufficient to constitute professional misconduct. We are unable to accept this contention. Indeed, it is evident that neither the DT nor the respective parties' counsel even considered the adequacy of the expert report. In any event, while a specialist tribunal may bring its specialist knowledge and expertise to bear in assessing the evidence before it, it cannot supplement evidential gaps using its own knowledge: *A v A Professional Conduct Committee* [2018] NZHC 1623 at [17] and [19]. It remains the burden of the SMC to adduce sufficient and adequate evidence to prove the elements of the charge, and this simply was not done in this case.

Informed consent

47 We turn next to the question of informed consent. Dr Lim was charged with failing to obtain informed consent. This, in essence, was an assertion that Dr Lim had not conveyed certain material information to the patient before obtaining her consent to the administration of the H&L Injection. When we

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asked Mr Chia just what information the SMC said ought to have been disclosed, he replied that Dr Lim ought to have disclosed the *entire* list of risks and possible complications set out at [10] above. He contended that this was supported by para 18 of the expert report: see [44] above.

48 Leaving to one side our grave reservations about the expert report, we are troubled by the position taken on behalf of the SMC. It was made clear by the Court of Appeal in *Hii Chii Kok v Ooi Peng Jin London Lucien and another* [2017] 2 SLR 492 ("*Hii Chii Kok*") that a doctor is *not* under a duty to convey to his patient every conceivable risk. Whether information has to be disclosed depends on several factors. The first port of call is to ask if the information is relevant and material to the patient. This is to be assessed from the vantage point of the patient, having regard to the matters that he is reasonably likely to attach significance to in arriving at his decision. Second, the information must reasonably be in the possession of the doctor. Third, a doctor may be justified in withholding information in particular situations. Where information is justifiably withheld, a doctor would not have legal liability visited upon him.

49 On the question of relevance and materiality and how this bears on the question of disclosure, *Hii Chii Kok* addressed this very point at [140]–[143]:

> 140 … [I]t seems to us that what makes a risk sufficiently material to the reasonable patient will vary along the dimensions of likelihood and severity. It has been held in Canada, for instance, that a risk must be disclosed where it is *likely* to transpire, even if the outcome is a *slight* injury, or where the risk is *uncommon* (but not unknown) but it carries *serious* consequences, such as paralysis or death … It seems to us that such a matrix is a sensible tool for determining the materiality of risks so that remote risks with minor consequences will generally be deemed immaterial, while likely risks with severe consequences will almost certainly be risks that the reasonable patient is likely to attach significance to before deciding on the proposed treatment and should therefore be disclosed.

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> 141 One noteworthy logical consequence of the matrix-based analysis is that it is conceivable for even a very severe consequence to not require disclosure if its chances of occurring are so low that the possibility is not worth thinking about. That outcome is reasonable – after all, it has been pointed out that virtually every member of society routinely places himself in situations in which severe consequences including death are a remote but real possibility … To put it simply, there will be no need to state what even a layperson would be aware of without specifically being advised of it; nor to state that which would be regarded as so plainly unlikely that it would not concern the reasonable person. This is common sense.
>
> …
>
> 143 In the final analysis, as we have said, the question of whether the information is reasonably material is one that will have to be answered with a measure of common sense. The reasonable patient would not need or want to know and understand every iota of information before deciding on whether to undergo the proposed treatment. Indeed, it has been observed that indiscriminately bombarding the patient with information, in what has been colourfully described as an "information dump", tends to have the opposite effect of leaving the patient more confused and less able to make a proper decision. …
>
> [emphasis in original]

50 Ultimately, what has to be disclosed is largely a matter of common sense. In the present case, the information in question pertained to how the patient should make her choice between the two treatment options that she was presented with: see [9] above. If a patient consults a medical practitioner with a routine complaint that can be addressed by two or three relatively uncomplicated and equally valid treatment options, the information to be disclosed is that which the patient would need in order to be able to make a decision from among those options. This would then require consideration of the nature and likelihood of any adverse side effects or complications. In the absence of any expert evidence on the gravity and likelihood of any adverse side effects or complications of the H&L Injection, there was simply no evidentiary

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basis to form any view as to just what Dr Lim should have disclosed, why he should have done so, or how serious his failure to disclose was.

Defensive medicine

51 We turn finally to that part of Mr Chia's submissions where he contended that there was an "outcry" from the medical profession after the DT's decision was handed down, and that one of the adverse consequences mentioned in that context was that the decision could promote the practice of defensive medicine. Having regard to the ill-advised positions taken on behalf of the SMC, we make no comment on the medical profession's grievances in so far as they were directed at those positions. However, we note that there have in recent times been petitions organised by the medical profession to have adjudicated decisions reversed. The circumstances may vary, but what these cases tend to have in common is a protest at the perceived harshness of the penalties and warnings of the spectre of defensive medicine.

52 Taking the first point, fidelity to the rule of law demands that courts remain independent and not succumb to external pressures: see also Chan Sek Keong, "Securing and Maintaining the Independence of the Court in Judicial Proceedings" (2010) 22 SAcLJ 229 at para 36. Decisions are made within the confines of the case at hand and not under the sway of public opinion. Hence, we bluntly told Mr Chia that the "outcry" from the medical profession is irrelevant to us because our concern is solely with the merits of the present case.

53 On the issue of defensive medicine, it seems to us that there is a tendency to overuse the term even when it is not appropriate. "Defensive medicine" describes the situation where a doctor takes a certain course of action in order to *avoid legal liability* rather than to secure the patient's best interests. The two

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paradigm examples of defensive medicine are where a doctor prescribes unnecessary treatments to avoid the risk of later being faulted, and where a doctor refuses to recommend a potentially beneficial treatment because it is riskier or newer than other less effective treatments and therefore more likely to expose the doctor to future litigation: *Hii Chii Kok* at [84]. In the context of obtaining informed consent from a patient, it has been suggested that doctors are likely to overwhelm patients with a deluge of information on unlikely risks in order to protect themselves legally. With respect, it is a mistake to describe this as defensive medicine.

54 The reason for this is simple: giving too much information *will not avoid* legal liability. Underpinning the ethical obligation to obtain informed consent is the recognition that the patient has a right to *participate in decisions* about his or her treatment and medical management: see Guideline 4.2.2 of the ECEG (2002). Bombarding the patient with an "information dump" might have the effect of leaving the patient "more confused and *less able* to make a *proper decision*" [emphasis added]: *Hii Chii Kok* at [143]. The patient cannot meaningfully be said in such circumstances to be in a position to give informed consent, and the doctor would then have fallen short of his ethical obligation and may well be exposed to legal liability. In truth, the deployment of the term "defensive medicine" in the context of obtaining a patient's consent is often misplaced. Where it might apply is when a doctor withholds information about potentially beneficial treatment options because such options are more likely to give rise to legal liability; it would not typically apply to a situation where the doctor simply gives too much information.

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Our decision

55 In the light of these observations, we come to our decision, having considered the record of proceedings and the parties' submissions at the hearing. We are satisfied that the facts and the evidence do not support the charge against Dr Lim and, accordingly, set aside his conviction.

56 First, we entertain serious doubts as to whether Dr Lim did indeed fail to advise the patient of the risks and possible complications of the H&L Injection in the first place. It is common ground that Dr Lim offered the patient two treatment options: bracing and oral medication with the H&L Injection, and without the injection. It is also accepted that Dr Lim did not actively recommend the H&L Injection to the patient. The only difference between the two treatment options lay in whether the H&L Injection would be administered. Just on those facts, we very much doubt that the patient would have proceeded with the H&L Injection without any question or discussion at all as to its possible benefits and side effects. The injection was a steroid injection and there was a clearly more conservative alternative treatment that was available – namely, the option to have recourse to bracing and oral medication alone. In his written explanation dated 2 March 2016, Dr Lim stated that it was his usual practice to inform his patients about the possible complications that could arise from steroid injections. Specifically, he said:

> … With steroid injections, I usually tell my patients about the possible complications of infection, tendon rupture, non-efficacy, skin hypopigmentation and fat atrophy.

57 The impression which Dr Lim gave in his written explanation was that while he could not specifically recall whether he had informed the patient of the risks and possible complications that could arise from the H&L Injection, and while his clinic notes did not document any such discussion, it was his usual

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practice to discuss these matters before administering the injection. At the disciplinary inquiry, Dr Lim again indicated that he was unsure if he had actually failed to inform the patient of the risks and possible complications that might arise from the H&L Injection. This prompted the DT to check if Dr Lim was qualifying his plea, and it was only after several rounds of clarification with Dr Lim and Mr Tin, who was also Dr Lim's counsel in the proceedings below, that Dr Lim eventually accepted that he would plead guilty to the charge unconditionally.

58 At the hearing before us, Mr Tin explained that one of the difficulties which Dr Lim faced was that his clinic notes did not specifically record him discussing the risks and possible complications of the H&L Injection with the patient. However, we have said elsewhere that the existence of supporting clinic notes, while obviously desirable, is not determinative of the issue. Whether a fact is made out must be assessed on the *totality* of the evidence: *Lam Kwok Tai Leslie v Singapore Medical Council* [2017] 5 SLR 1168 at [37] and [46]. It is of course ideal that doctors keep an accurate record of each consultation as this would safeguard against difficulties of the present kind arising. But it should be noted that the H&L Injection is a routine one administered in a clinical setting, and this might well have accounted for why a detailed note of any discussion with the patient of the attendant risks and possible complications was not kept by Dr Lim.

59 Aside from this, it does not seem to ever have been explored how, if indeed there had been no discussion at all of these matters between Dr Lim and the patient, the patient decided between the two treatment options, which, as we have pointed out, were for the most part the same, save for the H&L Injection. Presented with these options, we find it implausible that the patient would have unthinkingly and unquestioningly picked the one with the steroid injection

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without having asked Dr Lim for his advice. With respect, Mr Tin ought to have pursued this line of inquiry with his client, especially since the latter maintained all along that he could not specifically recall whether or not he had provided the patient with information about the risks and possible complications that might arise from the H&L Injection.

60 Leaving this to one side, we are satisfied that based on the findings of the DT, the circumstances of this case do not meet the disciplinary threshold. In short, the facts do not support the charge that Dr Lim's conduct amounted to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner. We recount the key findings made by the DT (see [48]–[57] of the GD):

(a) There was nothing to suggest that the patient would have taken a different course of action had the risks and possible complications of the H&L Injection been conveyed to her.

(b) This was an isolated one-off incident involving one patient and was an honest omission on Dr Lim's part.

(c) The patient's autonomy to make an informed decision on her own treatment was not substantially undermined, given that there was nothing to suggest that she would not have undergone the H&L Injection if she had been informed of the risks and possible complications that could arise. We note in this regard that patient autonomy is the core concern that underlies the requirement to obtain a patient's informed consent.

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(d) Dr Lim had offered an alternative option of conservative treatment. He had not offered the H&L Injection as the sole treatment; nor had he actively recommended this particular treatment to the patient.

(e) The H&L Injection was an appropriate and reasonable treatment for the patient, and was clearly guided by the patient's symptoms following proper investigations done by Dr Lim. The injection was not a complicated or highly invasive procedure, or one that required sedation or anaesthesia, to be performed in an operating theatre. It was a minimally invasive procedure and commonly performed in a clinic.

(f) While the patient did suffer some side effects and complications resulting from the H&L Injection, there was nothing to suggest that the complications which she experienced were in any way permanent or debilitating; nor were they caused by any act or omission on Dr Lim's part. Instead, they were simply a consequence of the treatment. Dr Lim's degree of culpability was "on the low end" and the harm that ensued was "limited in nature and extent".

61 These findings quite clearly demonstrate that the present case was one involving a one-off failing committed in the course of a routine procedure with no material harm to the patient that could fairly be said to have been caused by Dr Lim. Having made these findings, the DT ought to have re-assessed the logic of its conclusions and asked itself whether the charge that Dr Lim had chosen to plead guilty to was in fact supported by the facts and the evidence.

62 In our judgment, there was nothing on these facts and the evidence to indicate that Dr Lim's conduct could be said to amount to such serious negligence as to portray an abuse of the privileges of being registered as a

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medical practitioner, or to fall so far short of expectations as to warrant the imposition of any sanction: see [38] above.

63 We add in any case that based on the findings of the DT, even if misconduct had been made out, the imposition of the maximum fine of $100,000 would have been wholly unwarranted given that, in the words of the DT (at [57] of the GD), "Dr Lim's degree of culpability is on the low end and the harm that [ensued] is limited in nature and extent". The DT fell into error by too readily accepting Dr Lim's submission that the maximum fine of $100,000 would be appropriate, which itself was made in response to the SMC's wholly unwarranted position that a suspension of five months was called for.

Conclusion

64 This case culminated in the appeal before us because of a series of avoidable missteps. Once the decision was made by Dr Lim to plead guilty, no one appeared to have considered the propriety of the conviction. Having examined the facts and the evidence before us, we hold that the charge is not made out and set aside Dr Lim's conviction as well as all the orders made below. As for costs, having regard to the role played by each party in bringing about this debacle, we order the parties to bear their own costs here and below.

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

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Chia Voon Jiet, Koh Choon Min and Charlene Wong (Drew & Napier LLC) for the appellant;
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