SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR HUANG HSIANG SHUI MARTIN HELD ON 5 – 9 OCTOBER 2015 AND 28 OCTOBER 2015

Disciplinary Tribunal:
Mr Thean Lip Ping (Chairman)
Dr Joseph Sheares
A/Prof Anette Jacobsen
Dr Swah Teck Sin

Prosecution Counsel:
Mr Francis Goh
Ms Shazana Anuar
Mr Sui Yi Siong
(Harry Elias Partnership LLP)

Defence Counsel:
Mr Edwin Tong, SC
Mr Tham Hsu Hsien
Ms Koh En Ying
(Allen & Gledhill LLP)

DECISION OF THE DISCIPLINARY TRIBUNAL ON SENTENCING

(Note: Certain information may be redacted or anonymised to protect the identity of the parties.)

FACTUAL BACKGROUND

1 Dr Huang Hsiang Shui Martin ("**Dr Huang**") is a plastic surgeon in private practice. Since about 2000, he has been conducting his practice under the name of "The Cosmetic Surgery Clinic" ("**TCSC**"). The scope of his professional work encompasses cosmetic surgery of the face, breast, body and female genitals, non-surgical treatments for facial rejuvenation and enhancement, craniomaxillofacial surgery for facial trauma and facial deformities, paediatric plastic surgery, and reconstructive surgery for cleft lip and palate.

2 In September 2010, his friend, Dr A, a consultant dermatologist, of Clinic A, referred a patient to him, Ms P (the "**Patient**") in relation to treatment of a scar on the Patient's upper left medial (i.e. inner) thigh.

3 Dr A had earlier, on or about 18 January 2008, performed what she believed to be a routine excision biopsy of a naevus (i.e. a mole) on the Patient's upper left medial thigh. However, due to complications and associated treatment using steroid injections, the area involved developed a significant and visible contour deformity, namely a scar.

4 An appointment was made for 16 November 2010 for the Patient to consult Dr Huang. On that day, the Patient and her mother Mdm N went to TCSC to consult Dr Huang. The Patient was a minor, then aged 17 years. Dr Huang examined the scar and explained the option of carrying out a scar revision and contouring of the underlying fat on the Patent's left upper medial thigh (the "**Procedure**").

5 Mdm N and the Patient agreed to go ahead with the Procedure. Arrangements were made for the Procedure to be performed by Dr Huang at the Specialist Surgery & Laser Centre Pte Ltd ("**SSLC**") on 29 November 2010. On that day, the Patient went to the SSLC for the Procedure, accompanied by her sister and Mdm N. At the SSLC, they were attended to by a nurse, and as the Patient was a minor, Mdm N was asked to sign two forms, one of which is a consent form. The consent form states, among other things, that photographs may be taken as part of the Patient's confidential medical records.

6 Subsequently, just before the commencement of the Procedure, Mdm N and the Patient's sister left. The Patient was brought to the operating room where she was asked to remove all her clothing including her brassiere and her underwear, and was given a gown as well as an inner gown and a disposable underwear to wear. After that, Dr Huang came in and the nurse asked her to remove the gowns. She felt uncomfortable and asked to put on her brasserie. Dr Huang agreed and she put on her brassiere. Later, she was required to remove her disposable underwear and a

nurse approached her and assisted her by pulling down her underwear. A number of photographs ("**Pre-Procedure Photos**") were then taken of her standing with her back against the wall wearing only the brassiere, and she was completely nude downwards.

7 The Procedure was subsequently carried out and appeared to be successful.

8 After she came out of the operating room, she spoke to her mother on the telephone. She was very distressed and upset with respect to the taking of the Pre-Procedure Photos.

9 In consequence, in or around December 2010, Mdm N commenced civil proceedings on behalf of the Patient, who was a minor, in the High Court of Singapore against Dr Huang. However, the civil proceedings were ultimately settled on the first day of the trial.

COMPLAINT TO SMC

10 On 8 December 2011, Mdm N made a complaint to the Singapore Medical Council ("**SMC**") in respect of the taking of the Pre-Procedure Photos. Pursuant to the provisions of the Medical Registration Act (the "**Act**"), the complaint was referred to the Chairman of the Complaints Panel who appointed a Complaints Committee to inquire into the complaint. The Complaints Committee, in accordance with section 42(4)(c) of the Act, directed an investigation to be carried out under section 48 of the Act.

11 The investigation was carried out and the Complaints Committee after deliberation of the investigation report, on 22 March 2013, determined under section 49 of the Act that a formal inquiry is necessary and ordered that an inquiry be held by a

disciplinary tribunal. Pursuant to the order of the Complaints Committee, the SMC on or about on 28 February 2014 appointed a disciplinary tribunal consisting of Mr Thean Lip Ping ("**Mr Thean**") as Chairman, and A/Prof Anette Jacobsen, A/Prof Roy Joseph and Dr Joseph Sheares as Members. However, on 25 March 2014, Mr Thean resigned as Chairman on account of ill-health. Later, Mr Thean recovered from his illness and he was re-appointed as Chairman on 6 March 2015. In the meanwhile, Dr Swah Teck Sin was also appointed as a Member on 6 March 2015 in replacement of A/Prof Roy Joseph who resigned on account of conflict of interests. Accordingly, the disciplinary tribunal ("**DT**") (consisting of Mr Thean Lip Ping as Chairman, A/Prof Anette Jacobsen, Dr Joseph Sheares and Dr Swah Teck Sin as Members) was duly constituted on 6 March 2015 pursuant to the provisions of the Act.

NOTICE OF INQUIRY

12 Pursuant to Regulation 27 of the Medical Registration Regulations 2010, a Notice of Inquiry was issued by the solicitors for the SMC on 13 March 2015 which sets out two charges against Dr Huang. The two charges are as follows:

"*1. That you Dr Martin Huang Hsiang Shui (MCR No. M03901B) are charged that, on or about 29 November 2010, whilst practising as a registered medical practitioner at the MD Specialist Healthcare Pte Ltd, 290 Orchard Road #20-01 Paragon Singapore 238859, you failed to exercise due care in the management of your patient, namely one Ms P (the "Patient") whom you knew at the material time to be a minor aged 17 years and to be the daughter of the Complainant and had acted in breach of section 4.2.1 (Attitude towards patients) of the Singapore Medical Council Ethical Code and Ethical Guidelines ("SMC ECEG") by failing to treat the Patient with courtesy, consideration, compassion and respect and to protect her right to privacy and dignity during a pre-procedure review on the said date.*

Particulars

(i) *The Patient, together with the Complainant, had attended at the premises of The Cosmetic Surgery Clinic on or about 16 November 2010 for consultation ("the Consultation") in relation to scar revision and contouring of the underlying fat on the Patient's upper left medial thigh (the "Medical Procedure");*

(ii) *Following the Consultation, the Complainant and the Patient gave consent to proceed with the Medical Procedure which was scheduled for 29 November 2010 at the premises of the Specialist Surgery & Laser Centre ("the Centre");*

(iii) *On 29 November 2010, the Patient, together with the Complainant, attended at the Centre for Medical Procedure and the Complainant signed for and on behalf of the Patient, two forms which the clinic staff had advised to be consent forms for the Medical Procedure before the Patient underwent the pre-procedure review and the Medical Procedure without the Complainant;*

(iv) *The Patient was thereafter led to the operating room where the Medical Procedure was to be performed and was asked to remove all her clothing and inner garments and to change into disposable underwear which was provided by the clinic and was also given a medical gown and another garment to be used as an overcoat;*

(v) *Sometime thereafter, you had entered into the operating room and told the Patient to stand against one of the walls for photographs to be taken of the area where the Medical Procedure was to be performed and had informed one of the attending nurses, Nurse N1, to assist the Patient to remove her overcoat and medical gown which would leave the Patient wearing disposable underwear and no brassiere;*

(vi) When the Patient, who felt extremely uncomfortable and embarrassed at the prospect of having to be completely topless in the presence of the Clinic Staff and you, asked if she could wear her brassiere whilst the photographs were being taken, Nurse N1 checked with you and you told her that the Patient could put on her brassiere;

(vii) On your instructions, Nurse N1 then walked towards the Patient and started to roll down the Patient's disposable underwear in your presence, to which the Patient panicked and protested. In response, Nurse N1 simply told her that the underwear had to be removed without giving further explanation;

(viii) Despite the Patient's protests and clear discomfort, Nurse N1 suddenly pulled down the Patient's disposable underwear, thereby completely exposing her genitalia, causing the patient to be shocked and anxious and immediately reacting by using her hands to cover her genitalia; and

(ix) You then instructed the Patient to place her hands on her head while one Ms N2 proceeded to take lower body photographs (a total of 7 photographs) of the front and back areas of the Patient with her genitalia fully exposed;

and that in relation to the facts alleged you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap. 174) (2014 Rev. Ed.)."

"*2. That you Dr Martin Huang Hsiang Shui (MCR No. M03901B) are charged that, whilst being a registered medical practitioner at the MD Specialist Healthcare Pte Ltd, 290 Orchard Road #20-01 Paragon Singapore 238859, you failed to exercise due care in the management of your patient, namely one Ms P (the "Patient"), whom you knew at the material time to be a minor*

aged 17 years and to be the daughter of the Complainant and had acted in breach of sections 4.2.2 (Informed Consent) and 4.2.4.1 (Right to information) of the SMC ECEG by failing to inform and provide adequate information to the Patient in respect of the specific pre-procedure requirements such as to enable the Patient to make informed choices and participate in decisions in relation to the Patient's treatment.

Particulars

(i) The Patient, together with the Complainant, had attended at the premises of The Cosmetic Surgery Clinic on or about 16 November 2010 for consultation ("the Consultation") in relation to scar revision and contouring of the underlying fat on the Patient's upper left medial thigh (the "Medical Procedure");

(ii) Following the Consultation, the Complainant and the Patient gave consent to proceed with the Medical Procedure which was scheduled for 29 November 2010 at the premises of the Specialist Surgery & Laser Centre ("the Centre");

(iii) On 29 November 2010, the Patient, together with the Complainant, attended at the Centre for the Medical Procedure and the Complainant signed for and on behalf of the Patient, two forms which the clinic staff had advised to be consent forms for the Medical Procedure before the Patient underwent the pre-procedure review and the Medical Procedure without the Complainant;

(iv) The Patient was thereafter led to the operating room where the Medical Procedure was to be performed and was asked to remove all her clothing and inner garments and to change into disposable underwear which was provided by the clinic and was also given a medical gown and another garment to be used as an overcoat;

(v) *Sometime thereafter, you had entered into the operating room and told the Patient to stand against one of the walls for photographs to be taken of the area where the Medical Procedure was to be performed and had informed one of the attending nurses, Nurse N1, to assist the Patient to remove her overcoat and medical gown which would leave the Patient wearing disposable underwear and no brassiere;*

(vi) *When the Patient, who felt extremely uncomfortable and embarrassed at the prospect of having to be completely topless in the presence of the Clinic Staff and you, asked if she could wear her brassiere whilst the photographs were being taken, Nurse N1 checked with you and you told her that the Patient could put on her brassiere;*

(vii) *On your instructions, Nurse N1 then walked towards the Patient and started to roll down the Patient's disposable underwear in your presence, to which the Patient panicked and protested. In response, Nurse N1 simply told her that the underwear had to be removed without giving further explanation;*

(viii) *Despite the Patient's protests and clear discomfort, Nurse N1 suddenly pulled down the Patient's disposable underwear, thereby completely exposing her genitalia, causing the patient to be shocked and anxious and immediately reacting by using her hands to cover her genitalia;*

(ix) *You then instructed the Patient to place her hands on her head while one Ms N2 proceeded to take lower body photographs (a total of 7 photographs) of the front and back areas of the Patient with her genitalia fully exposed;*

(x) *You had failed to inform the Patient at any time during the Consultation and/or prior to the Medical Procedure that prior to carrying out the Medical Procedure, you required the Patient to have pre-operative photographs taken of her lower body with her genitalia exposed during a pre-procedure review;*

(xi) You had failed to explain to the Patient the need to have such lower body photographs taken and the specific reasons why photographs of the Patient's exposed genitalia were required; and

(xii) In consequence of the above-stated facts, the Patient was not in a position to participate in an informed decision-making process and did not therefore give informed consent in respect of the lower body photographs that were taken of her with genitalia exposed during the pre-procedure review;

and that in relation to the facts alleged you have been guilty of professional misconduct under Section 53(1)(d) of the Medical Registration Act (Cap.174) (2014 Rev. Ed.)."

PRE-INQUIRY CONFERENCE

13 Pursuant to Regulation 29(1) of the Medical Registration Regulations 2010, the DT held a Pre-Inquiry Conference ("**PIC**") on 13 April 2015, at which directions were given for the hearing of the inquiry to be held. It was there directed that the hearing be held in two tranches: the first tranche to be held from 5 to 9 October 2015, and the second tranche to be held from 26 to 28 October 2015.

FIRST TRANCHE OF HEARING

14 The hearing commenced on 5 October 2015 where the Patient and Mdm N gave evidence and they were cross-examined by counsel for Dr Huang. Thereafter, Dr PE, the expert for the Prosecution, gave evidence and he was cross-examined by counsel for Dr Huang. The Prosecution then closed its case.

15 The Defence was called and the Defence counsel opened the case for the Defence. At this stage, counsel for the Defence sought leave to call first one of the experts for the Defence, Dr DE, a senior consultant plastic and reconstructive surgeon, currently

practising at Clinic B, Singapore, and also at Hospital C in Perth, Western Australia. The DT was given to understand that Dr DE would be leaving for Australia the following day, and accordingly with the agreement of the Prosecution and the DT, he was called first to give evidence for the Defence.

16 Dr DE gave evidence for the Defence and was cross-examined by counsel for the Prosecution. He was also questioned by the DT. He concluded his evidence at the conclusion of the first tranche of the hearing on the 9 October 2015, and the hearing was adjourned. Prior to the adjournment, the DT was informed by counsel for the Prosecution that Dr Huang "*would be taking a certain course*" and that both counsel would "*work out the details*" and the Parties would inform the DT what the position would be prior to the commencement of the hearing at the second tranche.

SECOND TRANCHE OF HEARING

17 On 22 October 2015, the solicitors for the SMC informed the DT in writing that Dr Huang intended "*to take a certain course of action*" and requested that "*the sentencing and mitigation hearing*" be fixed for Wednesday, 28 October 2015 at 2.00 pm and that the hearing dates of 26 and 27 October 2015 (as previously fixed) be vacated. The solicitors for Dr Huang by a letter dated 23 October 2015 confirmed that they would be agreeable to the proposal suggested by the solicitors for the SMC. Accordingly, the DT directed that the dates 26 and 27 October 2015 be vacated and that the hearing take place on 28 October 2015.

18 At the hearing on 28 October 2015, the DT was informed that Dr Huang would be pleading guilty to the first charge and that Dr Huang had agreed that the second charge would be taken into consideration by the DT for the purposes of exercising the powers of the DT under section 53(2) of the Act. The Parties had also agreed on a Statement of Facts, which was tendered to the DT for consideration.

19 The first charge together with the particulars was read out to Dr Huang and Dr Huang pleaded guilty.

SUBMISSIONS ON SENTENCING AND MITIGATION

20 The counsel for the SMC made his submissions. He submitted that the appropriate sentence to be imposed on Dr Huang should be: (a) a fine of S$7,000; (b) a censure; (c) a written undertaking from Dr Huang that he will not repeat such conduct in the future; and (d) a written unreserved apology from Dr Huang to the Patient for the failure to treat her with courtesy, compassion, and respect during the taking of the Pre-Procedure Photos on 29 November 2010 and for the emotional distress that had caused her.

21 The counsel submitted that based on precedents on sentencing, both local disciplinary and foreign cases, a fine, censure and the letter of undertaking are the benchmark sentence for professional misconduct of this nature. He suggested that the aggravating factor in this case, namely, the deep emotional trauma inflicted on the Patient, required the imposition of a sanction beyond the bare minimum established by the sentencing precedents. He also suggested that no mitigating value should be given to Dr Huang's guilty plea which came after the close of the Prosecution case, and that the guilty plea was a tactical move to minimise the losses rather than a genuine expression of remorse.

22 Counsel cited two New Zealand cases in support of his contentions and a local precedent and submitted that guidance may be derived from these cases. He submitted that there is an aggravating factor in this case and the seriousness of the consequences on the Patient is a relevant sentencing consideration. He submitted that Dr Huang's actions were professionally discourteous at the very least, or

coercive at the very worst. Counsel submitted that the taking of the Pre-Procedure Photos in the operating room where the Patient was required to remove her underwear and appeared completely naked from waist downwards in front of strangers caused her deep emotional trauma and distress.

23 Counsel for the Respondent submitted that Dr Huang acted in good faith with the interest of the Patient at heart. The taking of the Pre-Procedure Photos, which was part of the management, was carried out in accordance with the appropriate and accepted medical practice. Counsel further submitted that Dr Huang had no intention of causing the Patient any distress or harm. His error was in failing to appreciate that the Patient required additional care and attention before taking the Pre-Procedure Photos. Dr Huang admitted that to meet the required standards, he could have treated the Patient with more courtesy, consideration, compassion and respect and could have done more to protect her right to privacy and dignity.

24 Counsel brought to the attention of the DT that Dr Huang took immediate steps to apologise to the Patient and her family on that very evening of 29 November 2010. Counsel also said that Dr Huang was deeply remorseful and regretted that he was not more comprehensive in the discussion with the Patient and Mdm N on 16 November 2010 and in particular in mentioning that the Pre-Procedure Photos would be taken of the Patient without her clothing on.

25 Lastly, counsel submitted that Dr Huang gave full cooperation to the inquiry by SMC and in particular to the Complaints Committee. Dr Huang provided all the documentation and explanations requested of him.

26 Counsel brought to the DT's attention mitigating factors: Dr Huang's contribution to the society and the medical community; his good character supported by testimonials

given by a fellow doctor, Dr DT, and two lady patients. It was also pointed out that Dr Huang has suffered enough: having been embroiled in the legal proceedings for close to 5 years. First, there were civil proceedings which were settled, and following the settlement, Mdm N lodged a complaint to the SMC. The complaint was made in December 2011 and there was long delay in the disciplinary proceedings which had been hanging over Dr Huang's head ever since.

DECISION ON SENTENCE

27 The DT duly considered the submissions of both counsel and having taken into account all the circumstances, determined as follows:

(a) that Dr Huang be fined in the sum of S$10,000;

(b) that Dr Huang be censured;

(c) that Dr Huang give a written undertaking to the SMC that he would abstain from the conduct complained of or any similar conduct.

The DT declined to make an order that Dr Huang give a letter of apology to the Patient as requested by the Prosecution.

28 On the question of costs, the DT ordered that Dr Huang pay 70% of the costs and expenses of and incidental to the proceedings, including the costs of the solicitors to the SMC.

GROUNDS OF DECISION ON SENTENCE

29 Dr Huang pleaded guilty to the first charge with the second charge taken into consideration for the purpose of the DT's determination of the sentence. The first charge concerns Dr Huang's failure to exercise due care in the management of the Patient, whom he knew at that time was a minor aged 17 years, in breach of section

4.2.1 of the Singapore Medical Council Ethical Code and Ethical Guidelines ("**Ethical Code and Ethical Guidelines**") by failing to treat the Patient with courtesy, consideration, compassion and respect and to protect her right to privacy and dignity during the time of the taking of Pre-Procedure Photos.

30 Section 4.2.1 of Ethical Code and Ethical Guidelines provides as follow:

> "*4.2.1 Attitude towards patients*
>
> *Patients shall be treated with courtesy, consideration, compassion and respect. They shall also be offered the right of privacy and dignity. It is recommended that a female chaperone be present where a male doctor examines a female patient. This will protect both the patient's right to privacy and dignity, as well as the doctor from complaints of molestation.*
>
> *On the other hand, a doctor is not obliged to allow himself to be subjected to abuse of any kind by patients or their relatives. Where such abuse occurs, provided that there is no need for self-defence against physical harm, doctors shall not retaliate, but end the engagement with the patient as quickly as possible, in a professional manner."*

31 Dr Huang had breached this provision of the Ethical Code and Ethical Guidelines. He certainly did not treat the Patient with the required courtesy, consideration, compassion and respect and did not take steps to protect her privacy and dignity in the operating room as expected of him at the material time before the Pre-Procedure Photos were taken. At the operating room, the Patient was asked to remove all her clothing including her brassiere and her underwear, and was given a gown as well as an inner gown and a disposable underwear to wear. After that, when Dr Huang came in, he asked the nurse to remove both the inner and the outer gowns. The Patient felt

uncomfortable and asked to put on her brassiere. Dr Huang agreed and she put on her brassiere. Later, she was required to remove her disposable underwear and a nurse approached her and assisted her by pulling down her underwear. Thereupon, the Patient appeared completely nude from waist downwards in front of strangers, and Dr Huang did not show any concern of the deep emotional trauma and distress she was having.

32 The DT is of the opinion that this breach is a serious offence which merits a sanction beyond the bare minimum set out in the sentencing precedents referred to the DT by the Parties. It seems to the DT that a clear message should be sent to the medical profession that treating a patient with courtesy, consideration, compassion and respect and offering the right of privacy and dignity is required of all medical practitioners. In the opinion of the DT, an adequate sanction is intended to deter similar misconduct and to uphold the trust and respect the society has for the medical profession. The DT expects that Dr Huang with his experience, reputation and high regard by his peers and patients to uphold a high standard of professional conduct and to set an example to other medical practitioners.

33 The DT was not persuaded by the two precedents produced by the Prosecution counsel of New Zealand cases to impose a fine of S$7,000. Such an amount in the context of the Act would have been just a “slap on the wrist”. In the opinion of the DT, it is in the public interest that a significant fine should be imposed on Dr Huang.

34 The DT was also not persuaded by counsel for the Respondent that no fine should be imposed for this breach of the Ethical Code and Ethical Guidelines, and that only a censure and a letter of undertaking from Dr Huang under sections 53(2)(f) and (g) respectively of the Act would suffice. Nor was the DT persuaded by the precedent in 2002 produced by counsel which has similarities with the case at hand and in which

a fine of S$2,000 was imposed. Such an amount is patently inadequate. Hence the DT determined that a fine of S$10,000 is the appropriate penalty.

35 In arriving at this amount, the DT took into account the relevant mitigating circumstances. First, Dr Huang pleaded guilty to the first charge, though it was slightly belated. But before that, the DT was given to understand that counsel for the Prosecution and the counsel for the Defence discussed the matter concerning Dr Huang pleading guilty. The DT did not believe that the belated plea of guilty to the first charge was a tactical ploy on the part of Dr Huang. Secondly, there was a long delay that had taken place in these proceedings. The complaint was made by Mdm N on 8 December 2011, and Dr Huang did not receive any notice of the complaint until 30 August 2012. It was not until 13 March 2015 that the Prosecution issued the Notice of Inquiry. As a result, this complaint had been hanging over Dr Huang's head for over 4 years. Such a delay was truly inordinate. Lastly, there were produced before the DT very strong testimonials in favour of Dr Huang. However, having considered all these mitigating circumstances, the DT was not disposed to imposing a fine of less than S$10,000.

36 Turning to the request by the Prosecution that the DT should order a letter of apology to be given by Dr Huang to the Patient, the DT declined to make such an order. First, the DT has serious doubts whether it has jurisdiction to make such an order. Secondly, assuming that it has jurisdiction to do so, the DT did not think it should make such an order. The Patient already had a similar remedy provided for her in the settlement of the civil case brought against Dr Huang in the High Court in Singapore.

37 On the question of costs, the DT in exercise of its discretion decided that only 70% of the costs and expenses of and incidental to the proceedings should be paid by Dr

Huang. The DT is of the opinion that this percentage of the costs and expenses is adequate and appropriate in all the circumstances of this case.

38 The DT orders that the Grounds of Decision be published.

Dated this 3rd day of December 2015.