Lim Mey Lee Susan
v
Singapore Medical Council

[2013] SGHC 122

High Court — Originating Summons No 780 of 2012
Andrew Phang Boon Leong JA, V K Rajah JA and Tan Lee Meng J
15 January 2013

Professions — Medical Profession and Practice — Professional Conduct — Disciplinary Proceedings — Medical Registration Act

28 June 2013 Judgment reserved.

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

Introduction

1 This is an appeal by the appellant ("the Appellant"), a registered medical practitioner, against her conviction by a Disciplinary Committee ("the DC") appointed by the respondent ("the Respondent"), the Singapore Medical Council, of 94 charges of professional misconduct under s 45(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("the Medical Registration Act"). As the Appellant's alleged professional misconduct occurred before the amendments made by the Medical Registration (Amendment) Act 2010 (Act 1 of 2010) ("the 2010 Amendment Act") came into effect, it is the Medical Registration Act as it stood prior to the 2010 Amendment Act ("the MRA") which applies to the disciplinary proceedings against the Appellant as well as

this appeal, and not the Medical Registration Act as it currently stands ("the current Medical Registration Act"). This appeal raises several related issues of fundamental importance. In particular, is there an *ethical* obligation on the part of all doctors who practise medicine in Singapore to charge a fair and reasonable fee for their services? If so, is such an obligation an inherent one, or must it first be embodied within published legislation or rules before it can be enforced? If such an ethical obligation exists, is it *inoperative in the face of a binding contract between a doctor and his or her patient* (assuming that the contract in question is not otherwise rendered invalid under the general principles of *contract law*)? These questions raise, in turn, an even more fundamental question – what does it mean to be a *professional*? More specifically, is a professional bound by *ethical* obligations which trump his or her *commercial* obligations and interests? If so, should a distinction be drawn between lawyers on the one hand and doctors on the other, given that for lawyers, the answer to the last-mentioned question is in the affirmative, whilst counsel for the Appellant has argued that the contrary should obtain for his client instead?

2 There are also numerous important issues of *application* as well. The issues referred to in the preceding paragraph do not operate in a vacuum. The charges against the Appellant relate, in the main, to fees of approximately $24m which the Appellant invoiced for services which she (and other doctors) provided to Pengiran Anak Hajah Damit Pg Pemancha Pg Anak Mohd Alam ("the Patient"), a member of the royal family of Brunei, over 110 treatment days from January to June 2007. In its decision dated 17 July 2012 ("the DC decision"), the DC ordered that the Appellant be suspended from practice for a period of three years, pay a financial penalty of $10,000 and be censured in writing. It further ordered the Appellant to undertake, on her return to practice,

not to charge her patients more than a fair and reasonable fee for her services. The DC also ordered the Appellant to pay the costs of the disciplinary proceedings. The present appeal relates, in the final analysis, to the Appellant's status as a professional doctor. That is why all the charges brought against her must – as the DC itself acknowledged – be proved by the Respondent beyond reasonable doubt (see the DC decision at [3.3.1]).

The factual background

The Appellant's treatment of the Patient beginning in 2001

3 The material facts, as summarised by the DC in its decision, are as follows. The Appellant's primary area of practice is general surgery, and she was at the material time registered as practising at Susan Lim Surgery Pte Ltd at Gleneagles Medical Centre. The Appellant is also the chairman and chief executive officer of a number of other clinics, including Group Surgical Practice Pte Ltd, Centre for Weight Management Pte Ltd, Centre for Cancer Surgery Pte Ltd and Centre for Breast Screening and Surgery Pte Ltd (which, together with Susan Lim Surgery Pte Ltd, shall hereinafter be collectively referred to as "the Appellant's clinics").

4 In or around 2001, the Appellant began treating the Patient for cancer of the left breast. The Appellant was the Patient's principal physician, and was responsible for the Patient's overall care as well as for the coordination of her treatment. For services rendered to the Patient in 2001, Susan Lim Surgery Pte Ltd issued invoices amounting to $671,827.80. The Appellant did not attend to the Patient in 2002 and 2003, and resumed her treatment of the Patient in 2004, providing medical services to the Patient during the following periods:

(a) from around May 2004 to August 2004, for which period the Appellant's clinics issued invoices amounting to $2,708,895;

(b) from around January 2005 to December 2005, for which period the Appellant's clinics issued invoices amounting to $3,790,237.50;

(c) from around January 2006 to November 2006, for which period the Appellant's clinics issued invoices amounting to $7,501,357.50; and

(d) from around January 2007 to June 2007, for which period the Appellant's clinics issued invoices amounting to $26,042,112.50 inclusive of Goods and Services Tax ("GST") (the sum is approximately $24m before GST).

The arrangement between the parties was that the Appellant's clinics would address their invoices to the High Commission of Brunei in Singapore, and the invoices would ultimately be approved and paid by the Bruneian government.

5 On 19 August 2007, the Patient passed away. For services rendered in 2007, to which the charges brought against the Appellant largely relate, the total quantum of the invoices issued by the Appellant's clinics amounted (as noted above) to approximately $24m. The services which the Appellant provided in 2007 concerned, in the main, palliative care and the coordination of the treatment of a patient in the advanced stages of breast cancer. As the DC observed in its decision, in 2007, the Appellant did not perform on the Patient any surgical procedures which would have required her to utilise her considerable surgical skills and expertise (see the DC decision at [2.2.4] and [5.1.4]). There is some dispute as to the number of days of treatment provided

in 2007. The Respondent asserts, and the DC in its decision accepted, that the Appellant's invoices for 2007 covered 110 treatment days from 15 January 2007 to 14 June 2007. However, the Appellant contends that invoices were issued in relation to 153 treatment days from 15 January 2007 to 16 July 2007, and included services which she and her staff provided to the Patient in Brunei in June 2007 and July 2007. We shall proceed on the basis that the Appellant's invoices covered 110 treatment days up to 14 June 2007, as the services provided by the Appellant and her medical team to the Patient after the latter's repatriation to Brunei in June 2007 are not the subject of any invoices. This conclusion is supported by the Appellant's own letter dated 12 November 2007 to the Permanent Secretary of the Ministry of Health of Brunei ("MOHB"), where she referred to "billings during the period of 110 days between 15 January to 14 June 2007".[1]

MOHB contacts the Ministry of Health of Singapore

6 In May 2007, the High Commission of Brunei in Singapore alerted MOHB to the magnitude of the Appellant's bills. On 18 July 2007, MOHB's Director-General of Medical Services, Dr Affendy bin Pehin Orang Kaya Saiful Mulok Dato Seri Paduka Haji Awang Abidin, met with the Director of Medical Services of the Ministry of Health of Singapore ("MOHS"), Prof K Satku ("Prof Satku"), to review the bills issued by the Appellant in 2007. Prof Satku invited MOHB to write in officially to MOHS so that MOHS could investigate the matter.

[1] Appellant's Core Bundle ("CB") at Vol II Part H, p 11.

7 On 20 July 2007, officials of MOHB met with Dr Lim Cheok Peng ("Dr C P Lim"), the chief executive officer of the Parkway Group (which operates Gleneagles Hospital, where one of the Appellant's clinics is located), and informed him that MOHB found the Appellant's bills excessive. Dr C P Lim conveyed the Bruneian government's dissatisfaction with the bills to the Appellant on the same day, and subsequently informed MOHB that he had spoken with the Appellant.

Invoices annulled, withdrawn or discounted

8 In a letter dated 1 August 2007, the Appellant informed the Permanent Secretary of MOHB that 43 invoices which she had issued in 2007 "should be disregarded"[2] and treated as "null and void".[3] The Appellant offered her apologies, explaining that her office was "not used to handling such bills over such a long period of time".[4] The Appellant further offered to reduce the amount set out in the remaining invoices by 25% and to withdraw another two invoices "as a gesture of goodwill".[5] This had the combined effect of reducing the Appellant's fees for services rendered to the Patient in 2007 to about $12.6m. The invoices which the Appellant chose to withdraw or annul mainly related to services provided by other doctors, radiotherapy services and the coordination of medical conferences with other specialists to discuss the Patient's treatment.

---

[2] CB at Vol II Part H, p 5.

[3] *Ibid*.

[4] *Ibid*.

[5] CB at Vol II Part H, p 6.

9 In a letter dated 18 August 2007, the Appellant apologised to the Minister of Health of Brunei for what she described as "inadvertent mistakes"[6] made by her office in respect of the invoices due to the complexity of the billings. On 27 August 2007, after the death of the Patient on 19 August 2007, MOHB responded to the Appellant restating its position that "[t]he Ministry of Health of Brunei finds the charges to be extremely high".[7] Also by a letter dated 27 August 2007, MOHB wrote to MOHS expressing its view that the Appellant's charges for the services rendered in 2007 were "unacceptable and extremely high".[8] In its letter to MOHS, MOHB referred to the Appellant's letter of 1 August 2007, asserting that notwithstanding the withdrawal of the 45 invoices and the 25% discount, MOHB still found the Appellant's charges "unacceptable".[9] The letter then proceeded to seek the intervention of MOHS in the matter.

10 By way of a letter dated 1 November 2007, the Appellant wrote to the Permanent Secretary of MOHB offering to travel to Brunei at her own expense for a meeting to "resolve this matter amicably to the approval and satisfaction of Ministry of Health, Brunei Darussalam".[10] The Appellant met with the Permanent Secretary of MOHB on 8 November 2007. The Appellant again excused her charges as mistakes on the part of her accountant, and offered this time to waive her and her medical team's professional fees from 15 January

---

[6] *Id*, p 8.

[7] *Id*, p 9.

[8] *Id*, p 7.

[9] *Ibid*.

[10] CB at Vol II Part H, p 10.

2007 to 14 June 2007 as a gesture of goodwill. She requested that MOHB reimburse her for the remaining sum of $3,248,791.29, which represented bills from third-party doctors and disbursements relating mainly to services provided during the period from 14 June 2007 to 16 July 2007 when the Patient was treated in Brunei. MOHB took no position on the offer and informed the Appellant that it would look into the matter further. Subsequently, the Appellant sent a letter dated 12 November 2007 to the Permanent Secretary of MOHB setting out the offer that she had made at the meeting.

MOHS's letter of complaint to the Respondent

11 Upon receipt of MOHB's 27 August 2007 letter seeking the intervention of MOHS, MOHS conducted its own investigations into the matter. By way of a letter of complaint dated 3 December 2007 ("the Complaint") to the chairman of the Respondent's Complaints Panel, MOHS expressed concerns that the Appellant "may have taken unfair advantage of her position as the principal physician to the Patient, and of the trust and confidence which had been reposed in her".[11] Based on its preliminary review of the documents obtained, MOHS identified the following issues of concern:

(a) whether the invoices issued by the Appellant for the period from January 2007 to June 2007 demonstrated a pattern of overcharging and/or improper billing, and whether the Appellant had overcharged the Patient prior to January 2007;

[11] *Id*, p 17.

(b) whether the Appellant had invoiced inappropriately for professional services which she did not render to the Patient, or which she carried out only with the assistance of other doctors; and

(c) whether there were conflicts of interest in view of the fact that the Appellant was the manager of all the clinics which had issued invoices for services rendered to the Patient.

In relation to the issues raised by MOHS, the DC observed that issues (b) and (c) above formed no part of the charges against the Appellant. Consequently, the DC proceeded on the assumption that all the *services* set out in the invoices were actually and reasonably rendered to the Patient. The Complaint concluded by stating that MOHS was referring the matter to the Respondent for a thorough investigation as to whether the Appellant's conduct in relation to the Patient amounted to professional misconduct.

The Complaints Committee and the first Disciplinary Committee

12 Pursuant to s 39(7) of the MRA, the chairman of the Respondent's Complaints Panel laid the Complaint before a Complaints Committee ("the CC"). Upon the CC's invitation, the Appellant provided her written explanation on the Complaint by way of two letters dated 4 February 2008 and 18 July 2008 respectively. On 17 November 2008, the CC ordered that a formal inquiry be held by a Disciplinary Committee pursuant to s 41 of the MRA. Pursuant to ss 41 and 42 of the MRA, the Respondent appointed a Disciplinary Committee ("the First DC") to inquire into the Complaint. The First DC comprised Assoc Prof Chin Jing Jih, Assoc Prof Ong Biauw Chi, Dr Wong Yue Sie and Ms Serene Wee. The legal assessor to the First DC was Mr Giam Chin Toon SC.

The Appellant meets with the Minister of Health of Brunei

13 In January 2009, the Appellant met with the Minister of Health of Brunei. The DC's findings in relation to what occurred in that meeting were based on a letter from MOHB to the High Commissioner of Singapore in Brunei dated 26 January 2010, which stated:[12]

> … During the meeting, [the Appellant] told us that she was prepared to withdraw all her invoices i.e. waive all her/team's fees and "*third party billings*" if the Ministry was prepared to issue a "*letter of good standing*". She briefly narrated to us some of the points she would like us to set out in this "*letter of good standing*", essentially stating to the effect that the Government of His Majesty the Sultan and Yang Di-Pertuan Of Brunei Darussalam will not pursue the matter any further and that Brunei Darussalam takes no issue with her bills. We did not accede to her request at the meeting. … [emphasis in original]

The Appellant disputes this version of events and denies that she had ever indicated that she would drop any claim for payment in return for a letter of good standing from MOHB. MOHB declined to drop the matter.

The proceedings before the First DC

14 On 20 July 2009, the Respondent issued to the Appellant a notice of inquiry containing 94 charges of professional misconduct under s 45(1)(*d*) of the MRA. The hearing before the First DC took place between 28 January 2010 and 8 April 2010. Thirteen witnesses for the Prosecution gave evidence before the First DC. At the close of the Prosecution's case, the Appellant made a submission of no case to answer. The First DC fixed a three-day hearing commencing on 29 July 2010 to receive oral submissions. On 29 July 2010,

---

[12] Respondent's Supplemental Core Bundle ("RSCB") at Vol I, p 59.

written submissions on the Appellant's "no case to answer" submission having been duly filed, the parties attended before the First DC to present their oral arguments on that submission. The chairman of the First DC informed the parties at the outset of the hearing (see the DC decision at [2.17.6]):

> We have read the written submission and I understand from my colleagues in the panel that we have no further questions to raise. Does either party have anything else to add or submit before we deliver our decision at this stage?

Counsel for the Appellant asked the First DC to proceed with its initial indication to hear oral arguments on the Appellant's "no case to answer" submission, which the First DC did. However, having presented his oral arguments, counsel for the Appellant applied for the First DC to recuse itself on the grounds that contrary to its earlier indication that it would hear oral arguments on the Appellant's "no case to answer" submission, the aforementioned statement by its chairman showed that it had prejudged that submission even before hearing the parties' oral arguments. As the Prosecution did not object to the application, the First DC recused itself.

The appointment of a fresh Disciplinary Committee and the judicial review proceedings

15 Upon the First DC's recusal, a fresh Disciplinary Committee – *viz*, the DC as defined above at [1] – was appointed on 14 September 2010, comprising Prof Tan Ser Kiat as the chairman, Prof C Rajasoorya, Dr Abraham Kochitty, Assoc Prof Koh Ming Choo Pearlie as the layperson and Mr Vinodh Coomaraswamy SC ("Mr Coomaraswamy") as the legal assessor.

16 On 17 December 2010, the Appellant filed Originating Summons No 1252 of 2010 ("OS 1252") in the High Court seeking, *inter alia*, leave to apply for:

> (a) a quashing order against the Respondent's decision to appoint a fresh Disciplinary Committee to hear the 94 charges against the Appellant on the grounds that such decision was: (i) illegal under the MRA; and (ii) tainted by actual or apparent bias on the part of the Respondent; and
>
> (b) a prohibiting order prohibiting the Respondent from appointing a fresh Disciplinary Committee to continue the disciplinary proceedings against the Appellant in respect of the 94 charges on the basis that such appointment would be unreasonable according to the principles laid down in the leading English Court of Appeal decision of *Associated Provincial Picture Houses, Limited v Wednesbury Corporation* [1948] 1 KB 223.

On 26 May 2011, the High Court dismissed the Appellant's application in OS 1252 (see *Lim Mey Lee Susan v Singapore Medical Council* [2011] 4 SLR 156). Dissatisfied with the High Court's decision, the Appellant appealed to the Court of Appeal. On 30 November 2011, the Court of Appeal dismissed the appeal (see *Lim Mey Lee Susan v Singapore Medical Council* [2012] 1 SLR 701 ("*Susan Lim (CA)*")).

The proceedings before the DC

17 At a pre-inquiry conference ("PIC") on 2 December 2011, the Appellant's counsel informed the DC that the Appellant's appeal to the Court

of Appeal against the High Court's decision in OS 1252 had been dismissed, and indicated that the Appellant was prepared to proceed with the disciplinary inquiry before the DC. The parties agreed that the DC should proceed with the inquiry not by hearing all the Prosecution's witnesses afresh, but by receiving the transcripts of the evidence given by the Prosecution's witnesses in the proceedings before the First DC and continuing the Defence's case from that point.

18 At a PIC on 16 January 2012, the legal assessor to the DC, Mr Coomaraswamy, informed the parties that the DC had taken note of the Appellant's decision to proceed on the basis of the evidence adduced before the First DC. He sought to ascertain whether the Appellant appreciated the full consequences of her decision, in that it: (a) deprived her current counsel of the opportunity to cross-examine the Prosecution's witnesses according to his case theory, as opposed to the case theory which had been advanced by his predecessor before the First DC; and (b) deprived her of the significant tactical advantage of cross-examining the Prosecution's witnesses for a second time. The Appellant's solicitors confirmed that the Appellant was aware of the consequences of her decision and, by a letter dated 19 January 2012, confirmed that the Appellant had decided to proceed on the basis of the transcripts of the evidence adduced before the First DC. The DC then confirmed the provisional decision which it had made at the PIC on 16 January 2012 to proceed with its inquiry into the 94 charges against the Appellant based on the evidence adduced by the Prosecution before the First DC.

19 By a letter dated 28 February 2012, the Appellant's counsel informed the DC that the Appellant was of the view that the evidence adduced by the

Prosecution had not established any of the charges against her, and further indicated that she did not intend to call any evidence in her defence and wished to proceed to tender closing submissions to the DC. The parties tendered their written closing submissions and appeared before the DC to present their oral closing submissions over three hearing days from 21 to 23 May 2012.

The charges against the Appellant

20 The DC, in its decision, grouped the 94 charges proferred against the Appellant into two broad categories based on the nature of the respective charges (see [1.2.1] of the DC decision). The first 83 charges (labelled "the Category I charges") were for allegedly invoicing the Patient medical fees that were far in excess of and disproportionate to the services rendered by the Appellant and her medical team. The remaining 11 charges ("the Category II charges") were for allegedly invoicing the Patient medical fees that were far in excess of and disproportionate to the services rendered *as well as* falsely representing that such fees had been invoiced by and/or would be payable to certain named doctors, when the Appellant knew or ought to have known that such representation was not true in so far as she had added a significant and undisclosed markup to the actual fees charged by those doctors.

21 In addition to the two broad categories described above, the DC also analysed the 94 charges in accordance with six further sub-categories based on the nature of the services set out in the invoices concerned (see [2.10.2] of the DC decision). We find it helpful to adopt this classification, which is set out below, in our own analysis:

(a) Charges 1 to 65 ("the Category A charges") relate to fees for services rendered by the Appellant and/or her medical team from 15 January 2007 to 13 June 2007. The Prosecution alleged that these fees were "far in excess of and disproportionate to what [the Appellant was] entitled to charge for the services [she] rendered".[13]

(b) Charges 66 and 67 ("the Category B charges") relate to services rendered by two of the Appellant's employees, Dr Kum Cheng Kiong ("Dr Kum") and Dr Lam Foong Lian ("Dr Lam"). Charge 66 relates to fees for services rendered by Dr Kum and Dr Lam from 19 April 2007 to 14 June 2007 (which fees currently remain unpaid), while Charge 67 relates to fees for services rendered by these two doctors from 10 May 2006 to 20 May 2006 (which fees have already been paid). These two charges allege that the fees which the Appellant invoiced for the services of Dr Kum and Dr Lam, on top of the fees already separately invoiced for the Appellant's services during periods similar to the periods covered by these charges, were "inappropriate and far in excess of and disproportionate to the services … rendered".[14]

(c) Charges 68 to 73 ("the Category C charges") are in respect of fees which the Appellant invoiced for "radiotherapy facilities & staff"[15] [capital letters in original omitted] for the period from 5 February 2007 to 4 May 2007. The Prosecution alleged that these fees were "far in

---

[13] Amended CB at Vol II Part F, (*inter alia*) p 5.

[14] *Id*, p 232 and Amended CB at Vol II Part G, p 5.

[15] Amended CB at Vol II Part G, (*inter alia*) p 20.

excess of and disproportionate to what [the Appellant was] entitled to charge for the services [she] rendered".[16]

(d) Charges 74 to 76 and 84 to 94 ("the Category D charges") relate to treatment rendered by third-party specialists, Prof Lee Chuen Neng ("Prof Lee"), Dr Wong Sin Yew ("Dr Wong"), Dr Whang Hwee Yong ("Dr Whang"), Dr Chin Kin Wuu ("Dr Chin)", Dr Koo Chee Choong ("Dr Koo"), Dr Khor Tong Hong ("Dr Khor"), Dr Tanny Chan ("Dr T Chan") and Dr Chan Tiong Beng ("Dr T B Chan"), as part of the team of specialists coordinated by the Appellant. Charges 74 to 76, 84, 85, 87 and 93 relate to invoices issued before 2007 (which invoices have already been paid), while the rest of the Category D charges relate to invoices issued in 2007 (which invoices are currently still unpaid). Charges 74 to 76 allege that the fees which the Appellant invoiced for services that she rendered together with certain of the aforementioned third-party doctors were "far in excess of and disproportionate to what [the Appellant was] entitled to charge for the services [she] rendered".[17] Charges 84 to 94 (which also constitute the Category II charges (see above at [20])) allege that the Appellant falsely represented to the Patient or the Patient's representatives that the fees invoiced by the Appellant in the invoices concerned "had been charged by and/or would be payable to"[18] the relevant third-party doctors, *and* that "in any event such fees were far in excess of and

---

[16] *Id*, (*inter alia*) p 18.

[17] *Id*, (*inter alia*) p 55.

[18] *Id*, (*inter alia*) p 103.

disproportionate to what [the Appellant was] entitled to charge for the services [she] rendered".[19]

(e) Charges 77 and 78 ("the Category E charges") are in respect of fees invoiced by the Appellant for the cancellation of her scheduled attendance at overseas conferences in February 2007 and May 2007 in order to attend to the Patient. The charges allege that these fees were "inappropriate and far in excess of and disproportionate to the cancellation in question".[20]

(f) Charges 79 to 83 ("the Category F charges") are in relation to fees invoiced by the Appellant for coordinating and attending specialist clinical management conferences with an overseas oncology specialist, Prof Ian Smith ("Prof Smith"), and other specialists to review and discuss the Patient's treatment. Charges 79 and 80 relate to invoices issued for services rendered in 2007 (which invoices currently remain unpaid), while Charges 81 to 83 relate to invoices issued before 2007 (which invoices have already been paid). The charges allege that the Appellant's fees were "inappropriate and far in excess of and disproportionate to the services [the Appellant] rendered"[21] in coordinating and attending the aforesaid clinical management conferences.

---

[19] *Ibid*.

[20] Amended CB at Vol II Part G, pp 79 and 82.

[21] *Id*, (*inter alia*) p 86.

The decision of the DC

22 In convicting the Appellant of all the 94 charges of professional misconduct, the DC made the following unanimous findings:

(a) The Appellant, like all medical practitioners in Singapore, was subject to an ethical obligation to charge a fair and reasonable fee for her services, such obligation being an intrinsic aspect of the medical profession. The extent to which a medical practitioner could be said to have breached this obligation and to have misconducted himself or herself professionally must be based on the judgment of his or her peers, taking into account objective criteria drawn from all the circumstances of the case, including: (i) the nature of the services rendered and the time spent by the medical practitioner in rendering them; (ii) any specific demands made by the patient of the medical practitioner; (iii) any special relationship of trust and confidence between the medical practitioner and the patient; (iv) the medical practitioner's special training, skills and expertise; (v) the medical practitioner's professional standing and seniority; (vi) the fees generally invoiced for comparable services by other medical practitioners of similar skill and standing; (vii) the opportunity costs of rendering the services in question; and (viii) the circumstances of urgency under which the services were rendered.

(b) The aforesaid ethical obligation bound the Appellant whether or not there was any fee agreement between her and the Patient. The objective of an ethical obligation limiting doctors' fees was to safeguard the interests of the patient, the public and the medical profession, and that objective remained operative even if there was an

agreement (binding as a matter of contract law) between a doctor and his or her patient on fees.

(c) In any event, there was no fee agreement between the Appellant and the Patient on the facts.

(d) In respect of all the 94 charges, the Appellant had breached her ethical obligation to charge fairly and reasonably for her services. Her breaches amounted to professional misconduct because they constituted intentional, deliberate departures from the standards observed or approved by members of the medical profession of good repute and competency. In this regard, the DC found as follows:

(i) In respect of the Category A charges, the Appellant's role was mainly to provide palliative care to the Patient and coordinate treatment by other specialists, and her fees were excessive and disproportionate to the services which she provided.

(ii) In respect of the Category B charges, given that the Appellant had already issued invoices totalling $16,485,500 (before the 25% discount offered in the Appellant's 1 August 2007 letter to MOHB ("before discount")) for services provided by her and her medical team during periods similar to the periods covered by those charges, the additional and separate charges for the services of her employees, Dr Kum and Dr Lam, were grossly excessive.

(iii) In respect of the Category C charges, the Appellant's fees were grossly disproportionate to the services rendered,

which essentially amounted to accompanying the Patient to radiotherapy sessions that were in fact administered by Dr Khor, a third-party radiation oncologist. The excessiveness of the Appellant's fees was evident from comparisons with the fees of the attending radiation oncologist (*viz*, Dr Khor) as well as with the bill rendered by Mount Elizabeth Hospital's Radiotherapy Department for the use of its facilities.

(iv) In respect of the Category D charges, the Appellant's fees for services rendered or procedures carried out by certain third-party specialists were excessive, especially in view of the Appellant's undisclosed markup of many times the amount of the fees actually invoiced by the relevant third-party specialists.

(v) In respect of the Category E charges, the amounts billed for the cancellation of the Appellant's scheduled attendances at overseas conferences were wholly excessive and disproportionate to the cancellations in question. The DC noted that there was no evidence of the costs and expenses which the Appellant had incurred or the basis for the fees invoiced. Moreover, the DC also noted that the above-mentioned cancellation fees were imposed in addition to separate fees of $450,000 (see Charge 77) and $158,000 (see Charge 78) for services actually rendered by the Appellant and her medical team on the dates concerned.

(vi) In respect of the Category F charges, the Appellant's fees for organising and attending specialist clinical management conferences to review the Patient's treatment were

grossly excessive and inappropriate, especially in view of what was invoiced by the other doctors involved in the treatment of the Patient.

(e) In respect of the Category II charges (which form part of the Category D charges), the DC found that the Appellant additionally falsely represented in the relevant invoices that the invoiced fees had been charged to the Appellant or would be payable by her to the third-party doctors identified in those invoices. A reasonable reader of the relevant invoices would have formed the impression that the fees set out in those invoices were the fees charged by the named third-party doctors without any markup. The Appellant's breaches in respect of the Category II charges amounted to professional misconduct because they constituted intentional, deliberate departures from the standards observed or approved by members of the medical profession of good repute and competency.

23 On finding the Appellant guilty of all 94 charges, the DC ordered that the Appellant: (a) be suspended from practice for a period of three years; (b) pay the maximum financial penalty of $10,000; (c) be censured in writing; (d) undertake, on her return to practice, not to charge her patients more than a fair and reasonable fee for her services; and (e) pay the costs of the disciplinary proceedings, including the proceedings before the First DC. The DC cited the egregiousness of the Appellant's overcharging and the systematic pattern of breaches over a sustained period of time as reasons why a censure and a financial penalty were insufficient. The DC indicated (at [7.5.3] of its decision) that it would have been minded to order the removal of the Appellant's name from the register of medical practitioners pursuant to

s 45(2)(*a*) of the MRA in addition to a financial penalty, but for what it described as the Appellant's "exceptional care to the Patient" (at [7.5.3.b] of the DC decision) and her contributions to the community in Singapore as an eminent physician. Instead, it ordered (*inter alia*) the maximum suspension of three years to be imposed. At [7.5.4] of its decision, the DC stated:

> Only a suspension of the maximum three years will lead the public and the profession to understand that this degree of egregious overcharging is something which the profession feels is at the highest end of the spectrum of professional misconduct which falls just short of calling for erasure.

The issues before this court

24 Counsel for the Appellant, Mr Lee Eng Beng SC ("Mr Lee"), helpfully framed the issues before this court as follows:

(a) Is there an objective ethical limit on medical fees in private health care that operates outside contractual and market forces ("Issue 1")?

(b) If the answer to Issue 1 is in the affirmative, should the Appellant be bound by the ethical obligation to limit her fees when such obligation had not been published at the material time ("Issue 2")?

(c) Assuming that there was, at the material time, an ethical obligation on the part of the Appellant to charge fair and reasonable fees for the services rendered to the Patient, was there sufficient evidence making out the 94 charges against her of professional misconduct in the form of overcharging the Patient ("Issue 3")?

(d) Was there sufficient evidence making out the Category II charges inasmuch as these charges alleged that the Appellant had falsely represented in the invoices concerned that the fees charged therein were the fees invoiced by third-party doctors, when she had in fact added a significant and undisclosed markup to the actual fees of those third-party doctors ("Issue 4")?

We pause to note – parenthetically – that whilst the issues were framed slightly differently in the Appellant's written case, both sets of issues were in fact the same in *substance*. Indeed, we were of the view that the issues as framed above were clearer.

25 To the above, we would add a fifth issue: if one or more of the charges against the Appellant is made out, what ought to be the appropriate sanction ("Issue 5")?

26 We would also observe that Mr Lee framed Issue 1 quite narrowly. In our view, that particular issue ought to be addressed – in the first instance at least – in a more *general* manner. We therefore reframe Issue 1 in the following terms, *viz*, whether there is an ethical obligation on the part of *all* doctors who practise medicine in Singapore – *over and above* contractual and market forces (for example, any existing agreement on fees between the doctor concerned and his or her patient) – to charge a fair and reasonable fee for their services (an "ethical obligation to charge a fair and reasonable fee"). If the answer to this question is in the affirmative, then the fact that the present proceedings relate to *private* health care would be rendered a moot point.

27 Let us now turn to consider each of these issues *seriatim*, beginning with Issue 1.

Issue 1

Overview

28 As Mr Lee correctly observed, Issue 1 is the most important and fundamental one in the context of the present proceedings. As we have already alluded to above, this issue ought – in the first instance at least – to be considered in a more general manner than that formulated by Mr Lee. To recapitulate, we are of the view that we ought to consider, first, whether there is, on the part of *all* doctors who practise medicine in Singapore, an ethical obligation to charge a fair and reasonable fee for their services. The DC answered this question in *the affirmative* (see the DC decision at [1.3.2.a]). We agree with the DC and now proceed to set out our reasons as to why such an ethical obligation ought to – and does in fact – exist. We would further note that the analysis which follows will also address the various points raised by Mr Lee in both their general as well as specific contexts.

What is a "profession"?

General

29 We commence our analysis at the most fundamental level simply because it is imperative; this level of analysis constitutes the foundational source from which other important conclusions flow. The key question in this regard is: what is a "profession"?

30 *The Oxford English Dictionary* (Clarendon Press, 2nd Ed, 1989) ("*OED*") defines (at vol XII, pp 572–573) a "profession", *inter alia*, as follows:

> … [A] *public declaration*; a business or profession that one *publicly avows* …
>
> …
>
> The occupation which one *professes* to be *skilled in* and to follow. … A vocation in which a *professed knowledge* of some department of learning or science is used in its *application* to *the affairs of others* or in the practice of an art founded upon it. …
>
> …
>
> [emphasis added]

31 In the light of the literal language of the term "profession" as well as the definition just considered, it is significant, in our view, that in both the legal as well as the medical professions, each person admitted to practice makes *a public declaration* just prior to embarking on his or her career. Before considering the role of ethics in the medical profession, we shall first consider the position in the legal profession in order to shed light on the various essential characteristics of professions *generally*.

The legal profession

32 When admitted as an advocate and solicitor of the Supreme Court, each lawyer makes the following declaration (see r 30 of, read with the First Schedule to, the Legal Profession (Admission) Rules 2011 (GN No S 244/2011) ("the Legal Profession (Admission) Rules")):

> I, A.B., do solemnly and sincerely declare (and swear) that I will truly and honestly conduct myself in the practice of an advocate and solicitor according to the best of my knowledge and ability and according to law.
>
> (So help me God.)

33 As the Court of Three Judges observed in *Narindar Singh Kang v Law Society of Singapore* [2007] 4 SLR(R) 641 ("*Narindar Singh Kang*") at [50],

the above declaration (which was, at that time, set out in s 24 of the Legal Profession Act (Cap 161, 2001 Rev Ed)):

> … is a solemn declaration which, though outwardly simple, is pregnant with meaning. It is a declaration by the lawyer concerned that he or she will not only exercise his or her professional knowledge and skills to the best of his or her ability as well as according to law, but (and more importantly) that such knowledge and skills will be exercised "truly and honestly". This signifies a duty not merely to oneself and to one's client, but also to the court and to the attainment of justice and fairness generally. …

34 In *Narindar Singh Kang*, the court also cited (at [50]) the following observations by Prof Jeffrey Pinsler in *Ethics and Professional Responsibility: A Code for the Advocate and Solicitor* (Academy Publishing, 2007) ("*Ethics and Professional Responsibility*"):

> Prof Jeffrey Pinsler, in his seminal work, *Ethics and Professional Responsibility: A Code for the Advocate and Solicitor* (Academy Publishing, 2007), also aptly observes thus (at paras 01-108–01-109):
>
> > The oath binds the person taking it for the entire length of his career, although the number of disciplinary actions taken against advocates and solicitors may indicate that it has too often been honoured in the breach. Three phrases ring out: "truly and honestly conduct myself"; "according to the best of my knowledge and ability"; and "according to law".
> >
> > Referring to the oath that they had just taken, the Chief Justice, in his address to newly admitted advocates and solicitors on 20 May 2006, said:
> >
> > > Bear in mind always that a lawyer's first and foremost duty is to uphold the principles of honesty, integrity and professionalism. This is reflected in the oath that you have just taken this morning … .

35 The declaration set out in the Legal Profession (Admission) Rules is an important one for a number of reasons. Indeed, it embodies the essence of at

least two main characteristics of a profession (here, the legal profession). First, it refers to the special professional *knowledge* and *ability* required of every lawyer. Secondly (and perhaps more importantly), it emphasises the commitment by a lawyer to conduct himself or herself in the spirit of *truth and honesty* – a commitment which is necessarily one that is *ethical* in nature. This commitment may – and, in fact, has been – embodied in regulations. However, it must never be forgotten that such regulations are grounded in an *ethical* source rooted in the truth and honesty which are the vital (albeit intangible) *values* that undergird the very practice of law itself. In this regard, the following observations by the Court of Three Judges in *Law Society of Singapore v Rasif David* [2008] 2 SLR(R) 955 at [49] and [52], in that part of the judgment aptly entitled "Coda: The signal importance of values in the legal profession", may also be usefully noted:

> 49 … [A]s highlighted by the then Second Minister for Law, Prof S Jayakumar, during the second reading of the Legal Profession (Amendment) Bill 1986 (Bill 20 of 1986) (see *Singapore Parliamentary Debates, Official Report* (22 September 1986) vol 48 at col 670):
>
> > [The legal profession is] very important to the functioning of society. …
> >
> > … [M]embers of the public have no choice really but to place their problems, their difficulties, their fortunes, their liberties and, in some cases, even their lives in the hands and the trust of lawyers.
> >
> > So the legal profession, not surprisingly, is described as an "honourable" profession. …
> >
> > It is important, therefore, that the public have the utmost confidence in the ethical standards, financial and personal integrity of lawyers.
>
> ***Indeed, in the final analysis, a lawyer's professional conduct should flow not from fear of punishment under statutory enactments such as s 85(2) of the [Legal Profession Act (Cap 161, 2001 Rev Ed)], but, instead, from the innate desire to uphold the moral, ethical and***

> ***professional standards which lie at the heart of the legal profession. Statutory enactments only provide the obvious starting point against which a lawyer must measure his conduct.***
>
> …
>
> 52 There are ***certain values*** which are ***universal and time-honoured, including, in particular, the values of honour, integrity and honesty. Such values are an integral part not only of life in general, but also of the legal profession in particular. No profession – not least the legal profession – can exist (let alone thrive) without them. Indeed, no life worth living can be lived without adhering to these values. In his keynote address at the inaugural Singapore Legal Forum organised by the United Kingdom Singapore Law Students Society in 2007*** (available at <http://app.supremecourt.gov.sg/default.aspx?pgid=2061&printFriendly=true> (accessed 25 January 2008)), ***the learned Chan Sek Keong CJ aptly quoted the following observation by Earl Warren, a former Chief Justice of the US Supreme Court: "in civilised life, law floats on a sea of ethics". Devoid of the integral values outlined above, the legal profession would be no more than an empty shell, shorn of moral fibre. Its legitimacy and standing in the eyes of the public would be diminished and, beyond a certain point, would even be forfeit.*** This would be a tragedy in the light of the ideals which the legal profession embodies – the chief of which are to ensure that justice is achieved in each individual case by the objective application of general rules and principles (which are themselves, by definition, also objective), and (wherever possible) to lay down general principles that would aid in the resolution of future cases as well.
>
> [emphasis added in bold italics]

36 The ethical obligations owed by a lawyer to his or her client are not one-sided by any means. As noted above, a lawyer possesses *special expertise* which is brought to bear for his or her client and for which he or she must be *properly remunerated*. However, the idea that a lawyer can, *inter alia*, charge his or her client in an *excessive* fashion *contradicts* the spirit of truth and honesty to which we have already referred. The duty of truth and honesty owed by a lawyer to his or her client contains a corresponding *ethical*

obligation not to take advantage of the client (whether monetarily or otherwise). Indeed, the same may be said with regard to the special expertise of a lawyer inasmuch as the lawyer, being in a superior position in relation to the client (which is why his or her expertise and advice are being sought in the first place), is under an *ethical obligation not* to take advantage of the client. All this serves to *distinguish* a *profession* from other vocations. As Lord Hugh P MacMillan aptly observed in a speech, "Law and History", delivered at the Jubilee Meeting of the Scottish Law Agents Society in October 1934 (see Lord MacMillan, *Law and Other Things* (Cambridge University Press, 1937) pp 118–134 at p 127, also cited by Prof Pinsler in *Ethics and Professional Responsibility* at para 01-003):

> … *The difference between a trade and a profession is that the trader frankly carries on his business primarily for the sake of pecuniary profit while the members of a profession profess an art, their skill in which they no doubt place at the public service for remuneration, adequate or inadequate, but which is truly an end in itself.* The professional man finds his highest rewards in his sense of his mastery of his subject, in the absorbing interest of the pursuit of knowledge for its own sake, and in the contribution which, by reason of his attainments, he can make *to the promotion of the general welfare.* … [emphasis added]

37 In a similar vein, V K Rajah J (as he then was), in *Wong Keng Leong Rayney v Law Society of Singapore* [2006] 4 SLR(R) 934 (affirmed by the Court of Appeal in *Wong Keng Leong Rayney v Law Society of Singapore* [2007] 4 SLR(R) 377), observed as follows (at [84]–[85]):

> 84 The ***rules of ethics***, as articulated in the [Legal Profession Act (Cap 161, 2001 Rev Ed)], its subsidiary legislation and the Law Society Practice Directions ***and conventions*** (collectively "ethical rules"), should not be perceived as an external and inconvenient imposition of values on the legal profession but rather ***as an embodiment of the moral compass and aspirations of the profession. It must also be recognised that ethical rules only delineate***

> ***minimal standards and duties which solicitors must observe.*** There is much left unsaid that must be implicitly understood and observed with intelligent flexibility. Unstinting compliance with all ethical rules and practices is in the enlightened self-interest of the profession. ***Without such observance and effective enforcement of ethical rules, the glue that binds and distinguishes advocates and solicitors as professionals as opposed to merely self-serving businessmen will soon dissolve. A solicitor is most certainly not merely a businessman or client proxy. He is an officer of the court charged with the unique responsibility of upholding the legal system and the quality of justice***; see my observations in *Public Trustee v By Products Traders Pte Ltd* ("the *By Products* case") [2005] 3 SLR(R) 449 at [26]–[36].
>
> 85 ***A failure by significant numbers of the legal profession to abide by and observe these ethical standards would eventually drive the entire profession down the slippery slope of ignominy. Systemic ethical corruption will fray and ultimately destroy the moral fibre of the profession.*** In a race to the bottom, legal practices will expend more and more valuable time and resources competing with and out-foxing each other for business rather than focusing their efforts on effectively delivering premier services to clients and appropriately discharging their wider obligations to the community. While legal practices are necessarily run as profit-making businesses, this does not, and cannot, mean that ethical constraints should be perceived as inconveniences to be either accepted and [*sic*] ignored at will. Solicitors who take their obligations and roles seriously should not be disadvantaged by the less scrupulous who do not.
>
> [original emphasis in underlined bold italics; emphasis added in bold italics]

38 An excellent summary of the legal profession – embodying as well as confirming the analyses set out above – may be found in the following passage in the introductory chapter to Part I of *Ethics and the Legal Profession* (Michael Davis & Frederick A Elliston eds) (Prometheus Books, 1986) at pp 24–25:

> According to the *lawyers'* conception, a certain number of persons *constitute a profession if, and only if, (1)* they are all

> engaged in the *same learned art*, *(2)* that engagement is more or less full-time, *(3)* the art itself is ***helpful to others in some important way***, *(4)* the persons so engaged *form an organization governing how they practice their art*, ***and*** *(5) the governance so imposed* ***is primarily for the public good rather than for the good of those so organized***. …
>
> The members of a profession must [practise] an "art." … The art must be "learned," that is, one depending heavily on books. …
>
> But even "book learning" is not enough to make an art a profession. The art must be one that a person can practice more or less full-time, otherwise the art could only have amateur practitioners. … ***The art must also be helpful to others in an important way. Thus medicine can be a profession <u>because it cures the sick</u>***. …
>
> Those engaged in a learned art must, according to this conception, be organized as well. Without organization, practitioners of even the most learned and helpful art would not be a profession but simply so many individuals practicing the same art. …
>
> To practice a profession is, it is often said, ***<u>not to pursue a "mere money-making calling</u>."*** *To organize* as a profession is ***<u>to undertake more than serving oneself</u>***. ***There must, in addition (or instead), be <u>a commitment to the good of others – clients, patients, parishioners, or the like – even when carrying out that commitment does not benefit those who practice the art. The members of some professions must, for example, be ready to help those who cannot afford to pay. A lawyer who, though working full-time, never accepted payment, would be no less a member of the profession than one who usually exacted high fees</u>***. To organize as a profession is to impose upon the members a discipline they would not otherwise be subject to. Professional organizations may maintain such discipline by informal peer pressure; by promulgating an express "code of ethics"; by limiting who may join the organization; and by censuring, suspending, or expelling members whose conduct is "unprofessional." ***<u>To be a member of a profession is to declare oneself to be someone of whom more than ordinary good conduct may properly be expected</u>.***
>
> [emphasis added in italics, bold italics and underlined bold italics]

The medical profession

39 Turning to *the medical profession*, the idea that the practice of medicine is, above all, a calling of the highest order is a historical cornerstone of the medical profession. It can be traced through the millennia – through countless doctors who have taken, in one form or another, a version of what has oft been hailed as one of the world's first *ethical* codes, the Hippocratic Oath (and see also, in this regard, the *general* definition of a "profession" in the *OED* referred to above at [30]). In Singapore, this oath currently takes the form of the Singapore Medical Council Physician's Pledge (presently found in the Second Schedule to, read with reg 16(2) of, the Medical Registration Regulations 2010 (GN No S 733/2010)), which is taken by every doctor upon being admitted as a fully registered medical practitioner and which reads as follows:

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

40 This pledge is *even more explicit* in its reference to *ethical* obligations and values than the corresponding declaration taken by lawyers (pursuant to r 30 of, read with the First Schedule to, the Legal Profession (Admission)

Rules (reproduced above at [32])). In our view, this pledge constitutes no mere rhetoric. Instead, it embodies – as the summary with regard to the *legal* profession set out above (at [38]) underscores – a calling that seeks, amongst other obligations, to be *helpful to others in an important way* (here, by curing the sick) and goes *beyond* mere money-making and the advancement of self-serving interests.

41 Indeed, the proposition that the spirit of public service and the existence of *ethical* obligations underpin all professional practice applies with equal (and, arguably, even greater) force to medical practitioners, whom we collectively entrust with our health, our well-being and, in certain instances, our lives. In this respect, the medical profession occupies a unique societal position of both great privilege and commensurate responsibility. In this regard, the following observations by the then Governor of the Straits Settlements, Sir John Anderson, in his speech on the occasion of the formal opening of the very first medical school in Singapore on 28 September 1905 are particularly apposite (published in *The Straits Times* of 29 September 1905 (available at <http://newspapers.nl.sg/Digitised/Article/straitstimes19050929-1.2.47.aspx> (accessed 24 June 2013)), also quoted (in part) in *Transforming Lives: NUS Celebrates 100 Years of University Education in Singapore* (Singapore University Press Pte Ltd, 2005) at p 11):

> … What I want you to remember is that the course of study you are about to enter upon is ***not merely*** *a course of study which is* ***intended to enable you to earn a living***, but … a passport to *membership of* ***a very great profession****, a profession* ***in many instances*** *of* ***unselfish devotion and splendid achievement****, a profession with very* ***lofty ideals*** *and one which calls for* ***all the best qualities****, mental* ***and moral****, which a man can give.* It demands not only freshness and vigour of body, but steadiness and skill in hand and eye. *It wants infinite patience* ***and keenest sympathy****, and to all*

> *these qualities there has to be added* ***unfaltering courage****. …*
> [emphasis added in italics and bold italics]

As also articulated by this court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*") at [36]:

> … The importance of maintaining the highest level of professionalism and ethical conduct has been duly acknowledged by the [Singapore Medical Council] in the Introduction section of the [Singapore Medical Council] Ethical Code (at p 1):
>
> > The medical profession has always been held in the highest esteem by the public, who look to their doctors for the relief of suffering and ailments. In modern medical practice, ***patients and society at large expect doctors to be responsible both to individual patients' needs as well as to the needs of the larger community. Much trust is therefore endowed upon doctors to do their best by both.*** *This trust is contingent on the profession maintaining the highest standards of professional practice and conduct.*
> >
> > …
>
> [original emphasis in italics; emphasis added in bold italics]

42 We would like to emphasise, in the circumstances, that fostering a culture of ethics and striving to achieve the ideals embodied within the practice of medicine as a whole represent the only *meaningful* way to approach the questions that matter in this profession. It is with this in mind that we now turn to Issue 1 proper, namely, whether there exists, on the part of all doctors who practise medicine in Singapore, an ethical obligation to charge a fair and reasonable fee for their services. In our view, any engagement with this issue must take place in the full context of the professional status of doctors *and* the unique situation which they occupy in society, coupled with the ethical considerations which necessarily attach to both these weighty positions (and which are embodied in the pledge reproduced above at [39]).

Is there an ethical obligation to charge a fair and reasonable fee on the part of all doctors practising medicine in Singapore?

43 Given the fact that *ethical* obligations are an integral part of professions in general and the medical profession in particular, are all doctors who practise medicine in Singapore under an ethical obligation to charge a fair and reasonable fee for their services? As we have already indicated above (at [28]), we would answer this question in the affirmative.

44 As counsel for the Respondent, Mr Alvin Yeo SC ("Mr Yeo"), quite correctly pointed out, the bedrock of the relationship between a professional and his or her client is *trust and confidence* (see also, to like effect, the DC decision at [4.5.2] as well as generally above at [32]–[42]). We also agree with Mr Yeo that in this regard, there can be no distinction between doctors on the one hand and lawyers on the other. This proposition – *viz*, that the relationship between a professional and his or her client is founded on trust and confidence – is so basic as to underpin every professional relationship and, indeed, applies with arguably greater force to medical practitioners, given the particular vulnerability of those who seek out medical services and the high stakes involved in many medical decisions. The especial vulnerability of patients and their dependence on health care professionals are heightened by the reality that information is (in the nature of things) distributed unequally in the medical setting, with a doctor invariably possessing far more information than his or her patient regarding the medical options and services available, where they may be found and how they should be priced. In such a setting, it is imperative to ensure that the sanctity of the trust and confidence reposed by a patient in his or her medical practitioner is safeguarded to the fullest extent possible. Put simply, given a doctor's specialised knowledge and training coupled with his or her duty to utilise these skills both to heal the patient and to look after the

latter's welfare generally (with conscience and dignity, as embodied in the pledge set out above at [39]), any action on the part of a doctor which results in the taking advantage of his or her patient's vulnerability (and this includes overcharging) would be *a contradiction in terms* and, indeed, would represent *an unacceptable conflict of interest*. It is therefore clear, in our view, that every doctor is under an ethical obligation to charge a fair and reasonable fee for services rendered to his or her patient. The corollary of this is that overcharging would constitute an abuse of the trust and confidence placed by a patient in his or her doctor, and this would (in turn) constitute conduct that is dishonourable to the doctor as a person as well as in his or her profession, *ie*, it would constitute *professional misconduct* within the meaning of s 45(1)(*d*) of the MRA.

Overcharging in the legal profession

45 Indeed, it has been clearly established that gross overcharging by *a lawyer* constitutes professional misconduct (notwithstanding the presence of a fee arrangement or an agreement between the lawyer and his or her client).

46 In *Law Society of Singapore v Andre Ravindran Saravanapavan Arul* [2011] 4 SLR 1184 ("*Arul*"), it was observed thus (at [31]):

> Rule 2(2)(*c*) of the LP(PC)R [the Legal Profession (Professional Conduct) Rules (Cap 161, R 1, 2000 Rev Ed)] provides that every advocate and solicitor is obliged to "act in the best interests of his client and to charge fairly for work done". What is a "fair" charge depends very much on all the circumstances of the case, including the standing of the lawyer concerned, the nature of the legal work, the time spent on the work, *etc*. Different lawyers will have different opinions about their professional worth. Similarly, different clients will have different opinions on the professional worth of the same lawyer. As a general concept, a fair charge is merely a general guide to a lawyer not to grossly overcharge his client to the extent that it will "affect the integrity of the profession" (see

> r 38 of the LP(PC)R …). ***The corollary of the integrity of the legal profession being undermined is that the entire profession will be brought into disrepute. Gross overcharging will create a reaction or perception from the public that lawyers are merciless parasites, and that will produce a stain on the noble nature of legal services.*** [emphasis added in bold italics]

Whether the ethical obligation not to overcharge is inherent in the legal profession

47 Mr Lee argued, on behalf of the Appellant, that the legal position with regard to overcharging by lawyers is distinguishable from that in respect of overcharging by doctors. In particular, he submitted that decisions such as the one considered in the preceding paragraph are not authority for the proposition that the rule against overcharging is inherent in a lawyer's professional status because the legal profession is governed by express statutory provisions. Rule 38 of the Legal Profession (Professional Conduct) Rules (Cap 161, R 1, 2010 Rev Ed) ("the LP(PC)R"), for example, states expressly that an advocate and solicitor shall not render a bill which amounts to "such gross overcharging that will affect the integrity of the profession". There is, Mr Lee argued, currently no equivalent rule governing the conduct of doctors in this regard.

48 In response to the above argument, Mr Yeo argued, on behalf of the Respondent, that the cases of *Re Han Ngiap Juan* [1993] 1 SLR(R) 135 ("*Han Ngiap Juan*") and *Re Lau Liat Meng* [1992] 2 SLR(R) 186 ("*Lau Liat Meng*"), both of which held that lawyers who grossly overcharged their clients could be found guilty of professional misconduct, were decided *before* the earliest version of r 38 of the LP(PC)R was promulgated in 1998. More importantly, perhaps, it bears reiterating that these decisions express in clear terms the proposition that lawyers who charge exorbitant fees lay themselves open to

disciplinary action *for having abused the trust and confidence reposed in them by their clients*.

49 Mr Lee also argued that apart from the LP(PC)R, the rule against lawyers overcharging their clients has been in statutory form since at least 1934 (see chs V and VI of the Advocates and Solicitors Ordinance 1934 (SS Ord No 32 of 1934)). With respect, this assertion is flawed. Mr Lee appears to be referring, in this regard, to the rule prohibiting lawyers from entering into fee agreements which are unfair or unreasonable (presently encapsulated in s 113 of the Legal Profession Act (Cap 161, 2009 Rev Ed)). This rule ("the s 113 LPA rule") permits the court to cancel an unfair and/or unreasonable fee agreement. However, as the Respondent points out (correctly, in our view), the unfairness and/or unreasonableness of a fee agreement could arise from factors other than the quantum of the fees concerned, for example, where the agreement was not fully explained to the client. Further, the s 113 LPA rule also presupposes that there is a fee agreement in place, an element which the DC found the Appellant had not proved. Hence, the s 113 LPA rule *cannot* be considered a *general* rule of conduct proscribing lawyers from overcharging for their professional services.

50 We note that Mr Lee also referred to the Legal Profession Act (Cap 161, 1990 Rev Ed), the statutory regime which applied to *Lau Liat Meng* and *Han Ngiap Juan*. He additionally referred to the Sixth Schedule to the Legal Profession (Solicitors' Remuneration) Order 1974 (GN No S 205/1974) ("the Solicitors' Remuneration Order 1974"), the provision governing solicitors' remuneration at the time *Lau Liat Meng* and *Han Ngiap Juan* were decided. This Schedule states that "[n]on-contentious work for which no provision is made by means of a scale or fixed sum shall be such sum as is fair

and reasonable having regard to all the circumstances of the case". Despite the presence of this particular Schedule, we are of the view that the tenor of the language utilised in *Lau Liat Meng* and *Han Ngiap Juan* indicates that the ethical duty not to overcharge is *inherent* in the legal profession and *does not* derive its source from statute or regulations (as a matter of fact, neither decision referred to the Sixth Schedule to the Solicitors' Remuneration Order 1974). On the contrary, it appears that the situation is the *converse*: the relevant statutory provisions and regulations merely make explicit what is an obviously logical and commonsensical ethical obligation, given the relationship of trust and confidence between a lawyer and his or her client. In *Han Ngiap Juan*, the court emphasised the *right* of a client to trust that any bill rendered by his or her lawyer was fair and reasonable, whilst in *Lau Liat Meng*, it emphasised (at [20]) that "the legal profession as an honourable profession is given the duty and responsibility to regulate itself, a responsibility made all the heavier in view of the trust necessarily placed by lay persons overwhelmed by the intricacies of the law". This underscores the important fact that in both of these decisions, the proscription against overcharging was considered to be *a general and inherent* one in the legal profession.

51 Mr Lee nevertheless sought to distinguish the factual matrix in *Lau Liat Meng* from that in the present appeal, arguing that the former was a case of dishonesty and attempted deception, whereas the present case related to the mere quantum of fees. With respect, Mr Lee appeared to be arguing that there could be no finding of overcharging (or no finding of grossly improper conduct giving rise to disciplinary proceedings) in the absence of additional factors such as dishonesty or a clear and distinct finding of abuse of trust or relationship. However, it is clear from the case law just cited that the presence

of such additional factors is unnecessary, and that overcharging can – in and of itself – constitute professional misconduct. As already emphasised, gross overcharging on the part of a lawyer constitutes (in and of itself) a clear abuse of the trust and confidence reposed by the client in the lawyer and brings the legal profession into disrepute in the eyes of the public. Put simply, such conduct is dishonourable and is the very antithesis of the ideal of public service, which is the hallmark of what it means to be a professional. If, in fact, overcharging also encompasses elements of dishonesty or fraud, it would simply be an *a fortiori* case which calls for *even stricter sanctions* to be imposed on the lawyer concerned.

The ethical obligation not to overcharge in the context of the medical profession

52 Although we have dealt with the Appellant's specific submissions in some detail, they are, with respect, not only unmeritorious, but also completely ignore the foundational proposition (already emphasised above) to the effect that there are ethical obligations which professionals must observe *regardless* of their respective professions. More specifically, the charging of fees is common to *all* professions, and there must therefore be – even in the absence of express statutory provisions or regulations – an ethical obligation on the part of a professional, *over and above contractual and market forces*, to charge his or her client only a fair and reasonable fee for services rendered. As already explained above, a professional possesses special expertise and learning which clients or patients (in a natural position of vulnerability) depend upon, reposing (in the process) trust and confidence in the professional concerned. Hence, an ethical obligation to charge a fair and reasonable fee for services rendered is necessary, lest there be an abuse of the trust and confidence reposed by the client in the professional concerned (regardless of:

(a) whether the latter is a lawyer, a doctor or, indeed, any other professional; and (b) whether the services concerned are provided in a public or a private context). This is logical, commonsensical and flows from *first principles*. Express statutory provisions or regulations in this regard merely restate this. We have also explained that the rationale for this ethical obligation to charge fairly and reasonably applies with paramount force to medical professionals, given the immeasurable trust and confidence bestowed on them both by their patients and by the community at large.

53 It should also be noted – in a closely related vein – that what constitutes a fair and reasonable fee for services rendered would depend not only on the relevant facts (see also the helpful criteria laid down by the DC above at [22(a)] and below at [72]), but also on the views of experts in the particular field of practice concerned. Mr Lee argued that the situations which could potentially arise in the medical context were so varied that it would be impossible for a view to be given as to what would be a fair and reasonable fee to charge in a particular case. We cannot accept this argument. The difficulty in expressing a view does not necessarily entail that no view whatsoever can be given. If such reasoning is taken to its logical conclusion, there would, *ex hypothesi*, be no objective standards to guide doctors in setting their fees. This would theoretically mean that doctors can charge whatever they like. Indeed, we would observe parenthetically that such logic would also apply, by parity of reasoning, to all other professions. This surely cannot be the case. Even given differences in factors such as the seniority and expertise of the doctor concerned as well as the location of his or her clinic, it must at the very least be possible for the experts concerned to opine on the possible range of fees which would be considered fair and reasonable in a particular set of circumstances. In a related vein, we also note the following observations by

the Competition Commission of Singapore in its Statement of Decision in *Re Singapore Medical Association – Guidelines on Fees* [2010] SGCCS 6 (at [28] and [146]), which, whilst made in a somewhat different context, nevertheless demonstrate the viability of arriving at fair and reasonable fees for medical services through improved pricing transparency:

> 28. *To improve pricing transparency*, [the Ministry of Health] has also *undertaken various measures in disseminating price information of medical services*, such as:
>
> i) requiring all private medical clinics to display their common charges as indicated by the Guidelines under the Private Hospitals and Medical Clinics Act (1980) & Regulations (1991), thereby increasing pricing transparency for consultations;
>
> ii) publishing individual hospital bill sizes on the [Ministry of Health's] website and requiring hospitals to provide financial counselling to patients, thereby increasing price transparency before admissions to hospitals; and
>
> iii) requiring medical bills given to patients to be itemised as indicated by the Guidelines under the Private Hospitals and Medical Clinics Act (1980) & Regulations (1991).
>
> …
>
> 146. [The Competition Commission of Singapore] recognises that there are valid reasons why market forces alone may not lead to efficient outcomes in the medical services sector. However, [the Competition Commission of Singapore's] view is that the [Singapore Medical Association's Guidelines on Fees] did not contribute towards achieving better outcomes, and [were] instead anti-competitive. *On the other hand, the restructured hospitals' direct involvement in Hospital Care and the government's efforts to improve pricing transparency are more effective, unrestrictive and unbiased ways to deal with the issues of information asymmetry, over-charging and optimal consumption of healthcare services. [The Singapore Medical Association] can consider contributing to this by encouraging its members in the private sector to support greater transparency in healthcare charges by publishing their actual fees for their services, broken down or itemised in a meaningful way. It can*

> *also support [the Singapore Medical Council] in the peer review disciplinary hearings.*
>
> [emphasis added]

This approach achieves what is, in our view, a practical balance between the proscription of overcharging on the one hand and the need to ensure appropriate remuneration for doctors' services on the other hand.

54 Returning to considerations of general principle, we also note that Mr Lee appeared to concede on behalf of the Appellant that a doctor was under an ethical obligation to charge a fair and reasonable fee for services rendered. In the Appellant's written case, for example, it is stated thus:[22]

> Nothing in the Appellant's Case is intended to suggest that a medical practitioner is entitled to charge unfair or unreasonable fees. The issue for the Court is what is an unreasonable fee and upon what legal basis are a doctor's fees to be determined as unreasonable?

However, this concession appears to be more apparent than real, for in the very next paragraph of that same written case, it is stated as follows:[23]

> It is stressed however that there is nothing wrong with a patient agreeing to pay large sums for medical services. The essential rationale of a free market in the provision of medical services is that patients are entitled to seek exceptional, onerous or luxurious services from their medical practitioner at a price that both doctor and patient consider to be appropriate. In such circumstances even if the sums are large no disrepute to the profession is occasioned. Professional misconduct in relation to the charging of fees only arises where there is unethical conduct associated with the fees such as dishonesty, fraud or abuse of position.

---

[22] Appellant's Case at para 5.

[23] *Id*, para 6.

55 Indeed, the seemingly ambiguous nature of the Appellant's arguments in this regard is neatly encapsulated in the following submission at a later part of the Appellant's written case:[24]

> This of course does not mean that a doctor is entitled to charge unfair or unreasonable fees. All it means is that the question of what amounts to a fair and reasonable fee is to be determined by the law of contract; the wishes of the patient; the cost base of the doctor; the nature of the services required; and in all the circumstances of the case. This necessarily means that there is no immutable upper limit to any fees according to the existence of an intrinsic ethical cap. A doctor is free to arrive at a lawful agreement as to the level of fees to be charged with her patient as long as the agreement is arms-length and involves no impropriety or abuse of relationship.

56 In our view, the *substance* of the Appellant's case is that a doctor does *not* have any ethical obligation to charge a fair and reasonable fee for services rendered, although the quantum or size of the fee concerned might be a *factor* in ascertaining whether or not (when taken into account together with *all other relevant factors*) the doctor concerned is guilty of professional misconduct in the form of overcharging. We have already explained that this approach is flawed, not least because it erodes the relationship of immense trust and confidence that exists between a doctor and his or her patient. It is, however, understandable why the Appellant has adopted such an approach. For one, it paves the way for the further (and closely related) argument that where there is a valid and binding agreement between a doctor and his or her patient: (a) the mere quantum of the fee which the parties agreed on cannot (in the absence of other factors) give rise to a breach of any ethical obligation; and (b) on the

[24] *Id*, para 94.

contrary, such an agreement is enforceable by the doctor concerned. This would be an appropriate juncture to deal with this last-mentioned argument.

Is a doctor's ethical obligation to charge a fair and reasonable fee superseded by a valid agreement between the doctor and his or her patient?

57 Mr Lee also argued, on behalf of the Appellant, that there had in any event been a valid and binding agreement between the Appellant and the Patient for the fees invoiced. This agreement, he added, was not vitiated under the general principles of contract law. In the circumstances (so the argument went), the ethical obligation to charge a fair and reasonable fee for services rendered did not apply to the Appellant. Put simply, such an ethical obligation (assuming that it existed) had been *superseded* by this agreement. Reduced even further, Mr Lee's argument was that in a situation such as this, contractual (or commercial) obligations trumped ethical obligations.

58 Before proceeding to analyse the aforesaid argument, we would observe that this argument cannot be mounted if there was *no fee agreement* between the Appellant and the Patient in the first place. This was, in fact (as mentioned above at [22(c)]), the finding of the DC, which analysed this issue in some detail after having heard the relevant testimony (see the DC decision at [4.7.1]–[4.7.11]). We see no reason to interfere with the DC's finding, which is based on a considered view of the relevant evidence as well as on coherent reasoning (see also the role of this court in an appeal against the order of a Disciplinary Committee under the MRA/a Disciplinary Tribunal under the current Medical Registration Act (set out below at [77])). It is true, as Mr Lee sought to argue, that the DC only found that there had been no "overarching" fee agreement (see the DC decision at [4.7.11]). However, it is

also clear on the available evidence that there was (contrary to Mr Lee's submission) *no series of individual fee agreements* either.

59 Be that as it may, even assuming that an agreement was entered into between the Appellant and the Patient, the Appellant's argument (see above at [57]) to the effect that contractual or commercial obligations trump ethical obligations *cannot* be accepted.

60 One of the Appellant's key submissions in this regard is that the court ought to be concerned not with the *resulting terms* of an agreement between a doctor and his or her patient as such, but rather, with the *manner* in which the agreement was entered into. In particular (so the argument runs), the court need only concern itself with whether or not the doctor concerned is guilty of conduct that falls foul of the principles of contract law (for example, by making a misrepresentation which the patient relies upon in entering into the agreement, or by exerting duress or undue influence on the patient to enter into the agreement). In short, the Appellant's argument centres on the *procedural* fairness (or unfairness) in entering into an agreement, as opposed to the *substantive* fairness (or unfairness) of the actual terms of the agreement itself. This is akin to the approach adopted by the Judicial Committee of the Privy Council towards the broader doctrine of unconscionability in contract law in its decision (in an appeal from the New Zealand Court of Appeal) in *Thomas Bruce Hart v Joseph O'Connor and Others* [1985] AC 1000 ("*Hart*"). Quite apart from the fact that – in the Singapore context at least – the broader doctrine of unconscionability is in a state of flux (see, for example, the Singapore Court of Appeal decisions of *Sandar Aung v Parkway Hospitals Singapore Pte Ltd (trading as Mount Elizabeth Hospital) and another* [2007] 2 SLR(R) 891 at [39] and *Chua Chian Ya v Music & Movements (S) Pte Ltd*

(formerly trading as M & M Music Publishing) [2010] 1 SLR 607 at [17]–[24], as well as the Singapore High Court decision of *Wellmix Organics (International) Pte Ltd v Lau Yu Man* [2006] 2 SLR(R) 117 at [72]; although *cf* the Singapore High Court decision of *E C Investment Holding Pte Ltd v Ridout Residence Pte Ltd and another (Orion Oil Ltd and another, interveners)* [2011] 2 SLR 232 at [62]–[67]), the analogy with *Hart* is, with respect, fundamentally flawed. This is because ethical obligations are, *ex hypothesi*, not only *procedural*, but also *substantive* in nature. In other words, in the *ethical* context, it is entirely permissible (and indeed appropriate) for the court (or a Disciplinary Committee under the MRA/a Disciplinary Tribunal under the current Medical Registration Act, as the case may be) to examine the *substantive fairness* of the terms of an agreement between a doctor and his or her patient (here, as to the fees invoiced). The point of the inquiry would, of course, be to ensure that the fees invoiced are fair and reasonable, with a finding to the contrary meaning that the doctor concerned has abused the relationship of trust and confidence which (as emphasised above) constitutes the foundation or bedrock of all relationships between professionals and their clients.

61 Indeed, in the context of the legal profession, the Court of Three Judges, in the recent decision of *Law Society of Singapore v Ang Chin Peng and another* [2013] 1 SLR 946 ("*Ang Chin Peng*"), made the following salient observations (at [34]–[35], [41]–[42] and [46]–[50]):

> 34 The existence of [ss 109(5) and 109(6) of the Legal Profession Act (Cap 161, 2009 Rev Ed) ("the LPA")] is most significant as they envisage that an agreement by a Solicitor with his client as to fees is not final (and cannot be final) and is always subject to review by the court ***to ensure that the fees to be paid by the client [are] always fair or reasonable relative to the work done***. ***Of course such a fee agreement can also be set aside on some other***

general grounds relating to contract. The rationale behind s 109(6) is clear – it is only the Solicitor, and not the client, who fully appreciates the nature and extent of the work to be undertaken on the matter. The Solicitor thus enjoys an advantage and it would be unfair to the client to be straitjacketed, without any available recourse, to the fee agreement. Understandably therefore, this provision permits the client to have the agreement reviewed by an independent person, *ie*, the taxing officer of the court. In every instance, the Solicitor must satisfy the test of fairness or reasonableness of the amount charged in relation to the services rendered.

35 We would further add that ***even under common law***, a Solicitor is ***expected to charge fairly***. …

…

41 … [W]e ***cannot see how*** the Respondents' arguments that they were given *carte blanche*, ***by virtue of the fee agreements, to render a bill grossly disproportionate to the time spent on the matter, can be sustained***. At para 30 of their written submissions, the Respondents argued that "the charges against the Respondents have nothing to do with whether the agreements on costs were 'unfair or unreasonable'". Taking the argument one step further they contended that the [Disciplinary Tribunal] had exceeded its mandate and erred in law in determining whether the fee agreements were fair and reasonable (also at para 30 of the Respondent[s'] written submissions), as only the High Court can decide whether the agreements on costs were "fair and reasonable" pursuant to an application under s 109(5) of the LPA.

42 ***This shows a basic misconception on the part of the Respondents that just because they had the oral agreements, the fees they billed pursuant to those agreements cannot be wrong.*** …

…

46 We have earlier (at [32] above) referred to r 2(2)(*c*) of the [LP(PC)R] which states that a Solicitor has an obligation "to act in the best interests of his client and to charge fairly for work done". What is a "fair" charge must necessarily depend on all the circumstances of the case. Paragraph 2 of the Legal Profession (Solicitors' Remuneration) Order (Cap 161, O 1, 2010 Rev Ed) sets out the criteria for fairness and reasonableness in charging for non-contentious work. ***The***

following circumstances, in particular, are germane to deciding what is "fair and reasonable":

(a) the importance of the matter to the client;

(b) the skill, labour, specialised knowledge and responsibility involved on the part of the Solicitor;

(c) the complexity of the matter and the difficulty or novelty of the question raised;

(d) where money or property is involved, the amount or value thereof;

(e) the time expended by the Solicitor;

(f) the number and importance of the documents prepared or perused, without regard to length; and

(g) the place where, and the circumstances under which, the services or business or any part thereof are rendered or transacted.

47 ***It will, accordingly, be appreciated that in construing whether fees charged for a non-contentious matter [are] fair and reasonable, factors such as the complexity of the matter; time expended; number and importance of documents prepared or perused,* etc*, must all be taken into consideration.***

…

48 In the earlier case of *Law Society v Low Yong* Sen [2009] 1 SLR(R) 802 ("*Low Yong Sen*") at [38], the court said that the test of overcharging is an objective one, "having regard to the nature of the work done (contentious or otherwise) and any prior agreement between the parties". ***The presence of a fee agreement does not end the inquiry: it is but one factor, together with the nature of work done, that ought to be taken into consideration in determining whether there is overcharging.***

49 In support of their argument that a *laissez-faire* approach should be adopted, "in that if there is a fee agreement and the bill was rendered in accordance with it then in general there cannot be overcharging," the Respondents also relied on the following dicta in the case involving the medical profession of *Lim Mey Lee Susan v Singapore Medical Council* [2012] 1 SLR 701 ("*Susan Lim*") at [55] to show that there could be no misconduct:

> Be that as it may, it is necessary that *we correct any suggestion that in* Arul*, the court of 3 Judges decided that an allegation of overcharging for professional services should, in law, be viewed as a commercial dispute and not as a matter of professional ethics*. In the general context of professional services, if the service provider and the client agree on the fee payable for the services to be rendered, and if the services are rendered in accordance with the terms of the agreement, no issue of overcharging would normally arise, however high the fee may seem to another client or another service provider in the same profession. *But, as held by the court of 3 Judges in* Arul*, overcharging can still arise even where there is a fee agreement if the service provider pads his bill or does unnecessary work of a kind not specified in his fee agreement with his client. Overcharging for professional services simply means either charging, in respect of services rendered, an amount beyond what is reasonably chargeable for those kinds of services, or charging for unnecessary services or services not rendered at all.* In the last-mentioned instance, overcharging might even amount to dishonesty and/or cheating. Whether or not overcharging in a particular profession crosses the threshold of acceptable professional conduct into the realm of punishable professional misconduct is a matter for the relevant professional body to decide in the first instance, and, if there is an appeal, ultimately by a court of law, on the facts of each case. The decision of the court of 3 Judges in *Arul* is not an authority for the proposition that professionals are entitled to overcharge their clients. It actually affirms the law to the contrary. [emphasis added]

50 In our opinion, the Respondents' reliance on this passage in *Susan Lim* is misplaced. Indeed, *Susan Lim* proves the case against them. ***Overcharging can still occur even if there is a prior agreement on fees***, and as the court stated there "overcharging for professional services simply means either charging, in respect of services rendered, an amount beyond what is reasonably chargeable for those kinds of services, or charging for unnecessary services or services not rendered at all".

[original emphasis in italics; emphasis added in bold italics]

Whilst the court in *Ang Chin Peng* was dealing with an express statutory provision, the general principles expressed therein buttress the conclusion which we have arrived at in the context of the present proceedings.

62 Most importantly, perhaps, there are decisions of this court which endorse this particular ethical obligation (to charge only a fair and reasonable fee for services rendered) in the context of *the practice of medicine* itself. In *Low Chai Ling v Singapore Medical Council* [2013] 1 SLR 83, for example, this court stated (at [66]) that "it can be confidently said that *no professional should overcharge or be allowed to overcharge*" [emphasis added]. And in *Low Cze Hong*, this court held (at [88]) as follows:

> … *The basic premise underpinning the doctor and patient relationship is that all medical practitioners will infallibly discharge their duties in the time-honoured and immaculate traditions of this singularly noble profession. Unfortunately, this is not always the reality.* Regrettably, and indeed reprehensibly, a few doctors abuse what should be an inviolable relationship when they prescribe unnecessary treatment and/or ***overcharge***. … [emphasis added in italics and bold italics]

63 The Appellant's argument that there is no ethical limit to the fees which a doctor can charge was also considered (albeit by way of *obiter dicta*) by the Court of Appeal in the context of the judicial review proceedings which the Appellant brought against the appointment of the DC (see above at [16]). Again, we would like to draw attention to the court's observations in *Susan Lim (CA)* (at [55]) (quoted in the extract from *Ang Chin Peng* above at [61]), where the court emphasised that overcharging should *not* be viewed as a merely commercial matter and *could* amount to punishable professional misconduct in certain circumstances (as decided by the relevant professional body in the first instance and by a court of law in the event of an appeal).

64 Returning to considerations of general principle, it is clear that as a *professional*, a doctor cannot rely solely on the morals of the marketplace. As a member of an honourable profession which is rooted in the ideal of public service, a doctor has *higher ethical obligations* which are founded on a relationship of trust and confidence for the reasons set out in detail above (see, especially, above at [39]–[44]). Viewed in this light, such ethical obligations necessarily trump contractual or commercial obligations where there is a conflict between the two. However, as Mr Yeo correctly observed, this does not mean that contractual obligations are irrelevant. Indeed, depending on the particular factual matrix, there will often (but not always) be an overlap between ethical obligations and contractual obligations. But, one thing is clear: ethical obligations are fundamental and both *characterise* as well as *justify* the special status of a "profession" that is conferred on the medical profession. Hence, such ethical obligations must – in a situation where they are in conflict with contractual or commercial obligations – prevail over the latter.

Issue 2

65 We turn now to the next issue, Issue 2, which is whether the Appellant should be bound by a doctor's ethical obligation to charge a fair and reasonable fee for services rendered when such obligation had not been published in any legislation or ethical code at the material time. This particular issue has, in fact, already been dealt with during the course of our analysis of Issue 1. It will be recalled that we concluded that the ethical obligation to charge a fair and reasonable fee for services rendered is an *inherent* one in all professions, and that any express statutory provisions or regulations merely state in explicit terms an obligation which has existed all along. It follows, therefore, that Issue 2 must be resolved in the Respondent's favour.

66 We would add that the Appellant's arguments to the contrary are, in any event, not supported by the relevant legal material.

67 For example, professional misconduct pursuant to s 45(1)(*d*) of the MRA, by its very nature, can take a myriad of forms – of which overcharging is one. Indeed, in *Low Cze Hong*, where this court reviewed comprehensively (at [20]–[37]) the scope of "professional misconduct" in the context of s 45(1)(*d*), it was observed (at [27]) that:

> … the replacement of the old term "infamous conduct" [as judicially defined in *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750] with the new term "professional misconduct" by Parliament was not merely a change in linguistic semantics but rather one of real substance. The new term "professional misconduct" plainly embraces a ***wider scope of conduct for which disciplinary action can be taken*** by the [Singapore Medical Council]. … [emphasis added in bold italics]

The court proceeded to state as follows (at [37]):

> … In summary, we accept Kirby P's suggestion in [*Pillai v Messiter (No 2)* (1989) 16 NSWLR 197 at 200] that professional misconduct can be made out in at least two situations: first, ***where there is an intentional, deliberate departure from standards observed or approved by members of the profession of good repute and competency***; and second, where there has been such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner … [emphasis added in bold italics]

The DC rightly noted that it was only the first limb of this quotation which was relevant to the disciplinary proceedings against the Appellant (see the DC decision at [4.1.3]).

68 In a related vein, the Singapore Medical Council Ethical Code and Ethical Guidelines ("the ECEG") is also applicable to our inquiry. The ECEG

represents the fundamental tenets of conduct and behaviour expected of doctors practising medicine in Singapore, although it expressly professes not to be an exhaustive code. Although there is no provision in the ECEG which refers precisely to an ethical obligation to charge a fair and reasonable fee for services rendered, the ECEG nevertheless contains relevant provisions which, on their terms, support the existence of such an obligation. In particular, it is important for the honour and integrity of the medical profession that doctors charge fairly and reasonably, lest the profession become or be seen as one that is motivated by mere personal gain or financial considerations. In this regard, para 3 of the ECEG provides as follows:

> Patients and the public must be able to trust doctors implicitly with their lives and well being. To justify this trust, doctors have to maintain a good standard of care, conduct and behaviour. The [Singapore Medical Council] prescribes an ethical code which doctors are expected to uphold. These principles are applicable to a wide variety of circumstances and situations. Adherence to this Code will enable society to have trust and confidence in the profession.
>
> …
>
> In general, a doctor is expected to:
>
> …
>
> - Maintain a professional relationship with patients and their relatives and *not abuse this relationship through inappropriate personal relationships or for personal gain.*
>
> …
>
> [emphasis added]

69 Reference may also be made to paras 4.2.5.2 and 4.6.1 of the ECEG, which read as follows:

> *4.2.5.2 Abuse of trust*
>
> The doctor may become a friend of the patient's family and enjoy the trust and confidence of family members. Such trust must not be abused in any way for the doctor's personal gain and the confidence between the patient, his family and the doctor shall be preserved.
>
> …
>
> 4.6.1 Disclosure of interest
>
> …
>
> A doctor shall not let financial considerations imposed by his own practice, investments or financial arrangements influence the objectivity of his clinical judgement in the treatment of his patients.
>
> [italics and underlining in original]

70 We further emphasise that the ethical rule that a doctor must charge a fair and reasonable fee for his or her services is not only one that is rooted in logic, common sense, justice and fairness, but is also one that will *not* be enforced *unreasonably*. As the DC itself pertinently observed (see the DC decision at [4.5.5]):

> Given the very serious consequence of having been found by one's peers to have breached this obligation [to charge a fair and reasonable fee for services rendered] and to have committed professional misconduct by having done so, it is no doubt the case that *one's peers will be slow to find a breach or to find professional misconduct in marginal cases*. [emphasis added]

Issue 3

Overview

71 Having established that the Appellant was, at the material time, under an ethical obligation to charge only a fair and reasonable fee for the services rendered to the Patient, we turn now to the relevant facts in order to ascertain

whether the fees invoiced by the Appellant were in fact fair and reasonable. It will be recalled that the first 83 charges against the Appellant (*ie*, the Category I charges) contain allegations of overcharging *simpliciter*. The remaining 11 charges (*ie*, the Category II charges) allege that the Appellant overcharged for the relevant services *and* that she falsely represented in her invoices that the fees set out therein were the fees levied by third-party doctors, when she had in fact added a significant and undisclosed markup to the actual fees of those third-party doctors. In this section, we shall examine all 94 charges of overcharging (including the Category II charges). The false representation aspect of the Category II charges will be dealt with under the next issue (*viz*, Issue 4). As we have already noted, the DC found the Appellant guilty of all 94 charges.

Our analysis

The relevant context

72 As we have explained (above at [53]), what constitutes a fair and reasonable fee for services rendered in any given situation would depend not only on the relevant facts, but also on the views of experts in the particular field of practice concerned. In this regard, the following observations by the DC are helpful (see the DC decision at [4.5.6]–[4.5.7], also referred to above at [22(a)]):

> 4.5.6 We accept the Prosecution's submission that the level at which a practitioner can be said to have breached this obligation [to charge a fair and reasonable fee for services rendered] and to have misconducted herself professionally arising from that breach must be *based on the judgment of her peers, taking into account certain objective criteria.* These objective criteria will be drawn from all the circumstances of the case and will obviously include: (a) the nature of the medical and other services rendered and the time spent by the practitioner in rendering them; (b) any specific demands made

> by the patient of the doctor; (c) any special relationship of trust and confidence between the practitioner and the patient; (d) the practitioner's special training, skills and expertise; (e) the practitioner's professional standing and seniority; (f) the fees generally charged for comparable services by other doctors of similar training, skills, expertise, standing and seniority; (g) any opportunities which the doctor had to forgo as a result of rendering the services in question; and (h) the circumstances of urgency under which the services are rendered.
>
> 4.5.7 We do not, however, accept that the affluence of the patient is an objective criterion which can legitimately be taken into account in setting or assessing what is a fair and reasonable fee. It is ethically legitimate, and indeed something to be encouraged, for a doctor to charge an indigent patient a fee which is less than a fair and reasonable fee, or even to waive a fee, simply because the patient is indigent. It is not ethically legitimate for a doctor to charge a rich patient more than a fair and reasonable fee simply because that patient is rich.
>
> [emphasis added]

73 The following observations in *Han Ngiap Juan* (at [34]) might also be usefully noted:

> Obviously not every case of overcharging will constitute grossly improper conduct. Inevitably there will be some diversity of opinion as to what would or would not be correct in each case, and where the line ought to be drawn. The passages quoted from [*Lau Liat Meng*] … indicate clearly that ***the extent to which a client is overcharged is a very strong factor*** against an advocate and solicitor accused of overcharging amounting to grossly improper conduct under s 83(2)(*b*) of the Legal Profession Act [(Cap 161, 1990 Rev Ed)], and ***this must be so whether or not there is any allegation of dishonesty or deceit. In our view, while this may not be a conclusive factor, it is a very material one, and the more a client is overcharged, the harder it will be for the advocate and solicitor concerned to persuade the court that the explanation he gives does justify the overcharge. In short, a really egregious overcharge is not to be vindicated merely by asserting the lack of dishonesty or deceit, when the reason given in explanation of such an overcharge is patently insupportable***. [emphasis added in bold italics]

74 A constant refrain by the Appellant is that the DC's findings of guilt in respect of all the 94 charges against her were not supported by the evidence. In particular, the Appellant argued that the DC relied upon expert evidence which had no underlying basis, and that such evidence consisted of mere assertions without any supporting pricing exercise or market research. With respect, this argument, whilst attractive superficially, fails to take into account the *context* which the Respondent's experts were commenting on. As the DC noted (see the DC decision at [5.1.4]–[5.1.5]), during the material period, the Appellant was not treating the Patient in her specific field of specialisation, *ie*, as a general surgeon. The Patient was then in the terminal stages of cancer and her treatment was basically *palliative* in nature. Hence, the Appellant was not (in the main at least) rendering any *primary* treatment to the Patient as such, but was instead coordinating treatment rendered by other specialists. That was the context in which the Appellant's charges were rendered. In the circumstances, we see no reason why the Respondent's experts would be unable to assess whether the Appellant had in fact engaged in overcharging which amounted to professional misconduct. Indeed, the fairness and reasonableness of many of the Appellant's charges (such as charges for specific procedures as well as ward or intensive care unit ("ICU") charges) could be objectively ascertained. In fairness to the Respondent's experts, they were cognisant of the Appellant's efforts and abilities as well as the sacrifices she had to make in rendering services to the Patient, and factored all these into their assessment of the fairness and reasonableness of the Appellant's fees.

Our approach

75 Mr Lee argued, additionally, that the safety of the Appellant's convictions was vitiated by the fact that the DC: (a) did not consider each and

every one of the 94 charges against the Appellant; and (b) did not make specific findings of fact as to what fee would have been fair and reasonable in respect of each charge. The latter argument is wholly unmeritorious and ought therefore to be rejected forthwith. It is not necessary (nor, indeed, necessarily helpful) for the DC to determine the precise dollar value of the services which the Appellant provided. The role of the DC was simply to decide on the fairness and reasonableness of the Appellant's fees based on its analysis of the evidence. The former argument, on the other hand, appears attractive at first blush inasmuch as it asserts that the DC did not literally refer to each and every charge in its decision.

76 In so far as this last-mentioned argument is concerned, it bears emphasising that the court looks more at the *substance* than the *form* of a decision. The DC was clearly of the view that it had, in arriving at its decision, scrutinised *all* the charges against the Appellant. As the detailed reasoning in its decision applied to all the charges, the DC clearly considered it unnecessary to refer to and set out its specific reasoning in relation to each charge. This appears to us to have been an excellent approach, if only to avoid a prolix rendition of the DC's decision which would have served to tax the reader's patience and risked confusing both the initiated and, *a fortiori*, the uninitiated reader.

77 That said, in view of the argument made by Mr Lee, we have undertaken a detailed examination of all the 94 charges against the Appellant. In doing so, we bore in mind the role of this court in the context of the present proceedings, which role was reiterated in *Gan Keng Seng Eric v Singapore Medical Council* [2011] 1 SLR 745 as follows (at [20]–[21]):

20 The role of the High Court in an appeal of this nature is set out in s 46(8) of the [MRA] which provides:

> **Orders of Disciplinary Committee**
>
> **46.**— …
>
> …
>
> (8) In any appeal to the High Court against an order referred to in subsection (6), the High Court shall accept as final and conclusive any finding of the Disciplinary Committee relating to any issue of medical ethics or standards of professional conduct unless such finding is in the opinion of the High Court unsafe, unreasonable or contrary to the evidence.

21 The High Court in *Low Cze Hong v Singapore Medical Council* [2008] 3 SLR(R) 612 ("*Low Cze Hong*"), at [39], held that in considering an appeal, a court would be slow to interfere with the findings of the Disciplinary Committee unless the grounds in s 46(8) of the [MRA] are satisfied. However, the court also noted (at [42]) that it would not give undue deference to the views of the Disciplinary Committee in a way which would effectively render nugatory the appellate powers granted by s 46(7) of the [MRA]. Similarly, in the recent case of *Gobinathan Devathasan v Singapore Medical Council* [2010] 2 SLR 926 ("*Gobinathan*"), at [28], the High Court noted that it would ordinarily not be easy to displace a finding or an order of a Disciplinary Committee and that the court will only interfere if the Disciplinary Committee's finding is "unsafe, unreasonable or contrary to the evidence". The High Court further added (at [29]) that:

> We are mindful that the Disciplinary Committee has the benefit, which we do not have, of hearing oral evidence on both sides; and it is a specialist tribunal with its own professional expertise and understands what the medical profession expects of its members. Nevertheless, decisions of Disciplinary Committees must be reasonably reached in accordance with the evidence presented. In other words, while we would accord an appropriate degree of respect to a Disciplinary Committee's decision, we will not defer to that decision if it is not in accordance with law and/or the established facts …

Having scrutinised all the 94 charges against the Appellant, we are of the view that the DC did indeed examine all the charges and arrived at the correct

decision in convicting the Appellant of every charge. As noted above (at [21]), the charges were analysed by the DC under (*inter alia*) six sub-categories based on the nature of the relevant services set out in the invoices concerned. This, in itself, strongly suggests that the DC did in fact consider *all* the charges against the Appellant, albeit in an organised fashion under the aforementioned sub-categories. We also note that the Respondent had in fact placed a detailed rendition of each charge before the DC.[25] We are accordingly of the view that it was unnecessary for the DC to literally set out its decision on each and every one of the 94 charges.

78 Like the DC, we do not think that it is necessary to lengthen this judgment unnecessarily and (worse still) thereby detract from its general readability. We note that a dogmatic insistence on a mechanistic review of each and every charge against the Appellant would not only be needlessly repetitious, but would also tend to obfuscate rather than illuminate. However, in deference to Mr Lee's argument on this point, we shall nevertheless attempt to explain our analysis with respect to each and every charge (bearing in mind, of course, the need to avoid unnecessary prolixity). For the purposes of clarity, a schedule of all the 94 charges against the Appellant (divided into the six sub-categories set out above at [21]), together with the corresponding invoiced amounts and the particulars of the medical services rendered, is annexed to this judgment (see Annexes A to F respectively for each of the sub-categories of charges). It might be helpful for the reader to refer to these annexes whilst perusing our analysis of the various charges.

---

[25] RSCB at Vol II, pp 229–261.

Two unmeritorious arguments by the Appellant

79 Before commencing with our analysis of the charges, we shall briefly mention two arguments made by the Appellant which we consider to be wholly without merit. The first argument is that the DC erred in not asking any questions of the legal assessor, Mr Coomaraswamy. We find this argument utterly unmeritorious and therefore propose to say no more about it. The second unmeritorious argument by the Appellant is that when a doctor presents an invoice, he or she is not "charging" the patient concerned a fee because the invoice is nothing more than a request for payment of the fee stated therein. We do not find this argument persuasive in the least for the reasons given by the DC (see the DC decision at [4.8.1]–[4.8.4]).

80 Let us turn now to the actual invoices rendered by the Appellant in the context of the charges against her.

The Category A charges

81 The Category A charges, which are (as mentioned above at [21(a)]) the first 65 charges, relate to fees for services rendered by the Appellant and/or her medical team from 15 January 2007 to 13 June 2007.

82 Before proceeding with our detailed analysis, we wish to make certain points regarding the general context of the Appellant's fees. First, it is pertinent to note that many of the procedures described in the Appellant's invoices were in fact performed by *third parties*, with the Appellant serving a primarily coordinative function as the Patient's principal physician. In particular, the DC perceptively observed that during the material period, the Appellant did not perform any *surgical* procedures, which, in addition to being

the Appellant's area of expertise, would generally command higher fees than the palliative care and coordinative services which were the services actually provided by the Appellant to the Patient (see the DC decision at [5.1.4]–[5.1.5] and also above at [74]):

> 5.1.4 In addition, we note that Dr Lim [the Appellant] *performed no surgical procedure in this period which would have engaged her considerable professional expertise and surgical skills. Dr Lim's role in this period* ***was mainly providing palliative care, coordinating treatment by other specialists, and giving comfort and reassurance to the Patient, who was in the terminal stages of cancer and nearing the end of her life.*** *Professor Soo [Khee Chee] and Dr Hong [Ga Sze] cited examples of complex surgical procedures which would justify the levying of higher medical fees. They both estimated the cost of surgical procedures that could take up to 10 hours as being in the region of about $30,000.* ***In contrast, Dr Lim charged fees of up to $450,000 per day for services which did not involve a comparable level of complexity and demands on Dr Lim's expertise as a surgical procedure.*** *As an example, the invoices levied in Charge 1, which in aggregate amount to $397,600, was for one day's worth of services which [was] wholly disproportionate to the amount billed and not involving any form of surgical procedure.*
>
> 5.1.5 The ***same analysis*** applies for ***each of the remaining*** Charges no. 2 to 65 as set out in Volume 1 of the Prosecution's Bundle of Invoices and amplified in Schedule 1 to the Prosecution's Closing Submissions.
>
> [emphasis added in italics and bold italics]

83 Our analysis of the Category A charges, which we shall expound on presently, followed two concurrent and overlapping limbs of inquiry.

84 The first limb of our inquiry entailed grouping the Category A charges generally according to treatment dates, whereupon we examined the amounts invoiced by the Appellant for given sets of services on various treatment days. In order to minimise confusion, we have referred to the invoices and the charges in chronological order wherever possible. We have also analysed the

Category A charges according to the description of the services that the Appellant herself set out in her invoices, thereby assuming that all the *services* enumerated in the invoices were actually and reasonably provided. The purpose of this exercise, of course, is to give the reader an idea of the type, complexity and extent of the services provided in order to determine whether the Appellant's fees were indeed fair and reasonable. We also considered these fees in the light of the expert evidence before us.

85 The second limb of our inquiry was to undertake an internal comparison of the various invoices issued by the Appellant. In other words, we identified various patterns and inconsistencies in the Appellant's invoicing behaviour which demonstrated that the invoices were issued in an unsystematic, arbitrary and, ultimately, opportunistic manner.

86 Due to the large number of charges faced by the Appellant and the multitude of services rendered on most treatment days, we have dealt with most of the charges with a view towards identifying key trends in the Appellant's fees and flagging out the more obvious inconsistencies in her invoicing behaviour. As a result of our inquiry, we were able to conclude unequivocally that the Appellant's fees were grossly excessive and vastly disproportionate to the services actually provided.

(1) Charges 1 to 6 (for the period 15–20 January 2007)

87 On 15 January 2007, the Patient was evacuated to Singapore and admitted to Gleneagles Hospital in a state of respiratory distress. Charge 1 (which is cited as an example in the DC decision) relates to the invoices levied by the Appellant amounting to *$397,600* ($76,950 after the 25% discount offered by the Appellant in her letter to MOHB dated 1 August 2007 ("after

discount") and her withdrawal of one of the invoices concerned) for services provided on 15 January 2007 itself. In using Charge 1 as an illustration, we note that this particular charge is striking as it represents one of the larger amounts invoiced by the Appellant for a single day's services. However, we are nonetheless of the view that this charge demonstrates much that is unsatisfactory in the Appellant's invoicing conduct. The Appellant's fees for this single day of treatment were contained in four different invoices (see Annex A for the details):

(a) In the first invoice, the Appellant charged $295,000 (before discount)[26] for (*inter alia*) the emergency admission of the Patient for respiratory distress, together with an urgent chest x-ray and an assessment by a team of specialists (the Appellant subsequently offered to withdraw this invoice by way of her 1 August 2007 letter to MOHB).

(b) Via a second invoice, the Appellant charged $75,800 for "Inpatient Review and Close Monitoring"[27] of the Patient on the night of 15 January 2007 as well as for "Post-pleurodesis procedure"[28] and "Close monitoring of intravenous drips with fluid replacement".[29]

---

[26] Unless otherwise indicated, the amounts referred to in this judgment represent the Appellant's invoiced fees *before* any discount or withdrawal of the invoice(s) concerned.

[27] Amended CB at Vol II Part F, p 8.

[28] *Ibid*.

[29] *Ibid*.

(c) By yet another invoice, the Appellant charged $11,300 for "Intensive Nursing Care",[30] including (*inter alia*) "Emergency Insertion of right and left chest tubes nursing procedures (after hours)"[31] and "Nursing *accompaniment* for radiological and haematological investigations"[32] [emphasis added].

(d) By way of a final invoice, the Appellant charged another $15,500 for "Daily Hospitalisation Intensive Care, Respiratory and Vital Parameters Monitoring".[33]

What is immediately apparent from the above invoices is not only the excessiveness of the fees set out therein, but also the somewhat opaque manner in which they were issued. We make two brief observations in this particular regard. First, for these unexceptional (albeit necessary) services, the Appellant saw fit to charge a grand total of $397,600. As emphasised by the DC (see above at [74] and [82]), these fees were not in respect of any surgical procedures conducted by the Appellant, but were essentially for stabilising the Patient's condition and coordinating her treatment. We note that by way of the first invoice, the Appellant effectively charged *a premium of $295,000* for, in the main, dealing with the Patient's emergency admission on 15 January 2007 and coordinating her assessment by a team of specialists (the Appellant's consciousness of the inappropriateness of the fee is perhaps reflected in her subsequent offer to withdraw (*inter alia*) this particular invoice via her

---

[30] Amended CB at Vol II Part F, p 10.

[31] *Ibid*.

[32] *Ibid*.

[33] Amended CB at Vol II Part F, p 12.

1 August 2007 letter to MOHB). Moreover, the Appellant saw fit to charge *additional* and sizeable fees for: (a) services rendered on the same night (*ie*, the night of 15 January 2007); (b) nursing care; as well as (c) general intensive care and monitoring. This leads us to our second point, which is that the Appellant's overcharging was, in our view, partially enabled (or at least facilitated) by her practice of issuing multiple invoices for services rendered over a single day. Whilst there is nothing wrong *per se* with issuing multiple invoices for a single day's treatment, we note that such a practice makes it difficult for anyone reading the invoices to ascertain at a single glance the aggregate amount charged for a particular day's services.

88 For each of the following three days of hospitalisation (*viz*, 16 to 18 January 2007, and relating to Charges 2 to 4 respectively), the Appellant invoiced an aggregate amount of between *$96,100* and *$98,500* for each day. This aggregate amount consisted of the following fees:

(a) $75,800 each day for, *inter alia*, inpatient review, management of bilateral pleurodesis and drainage of pleural effusion;

(b) $15,500 each day for hospitalisation intensive care coupled with respiratory and vital parameters monitoring; and

(c) between $4,800 and $7,200 each day for "Intensive Nursing Care"[34] (depending on the actual nursing services provided on each given day (see further below at [91])).

[34] *Id*, (*inter alia*) p 17.

89 In respect of 19 January 2007 (*vis-à-vis* Charge 5), over and above charging for the services mentioned in the preceding paragraph (*ie*, $75,800 for (*inter alia*) inpatient review, management of bilateral pleurodesis and drainage of pleural effusion, $15,500 for hospitalisation intensive care coupled with respiratory and vital parameters monitoring and $11,300 for "Intensive Nursing Care"),[35] the Appellant invoiced an *additional $125,800* for, *inter alia*, "Review & Assessment of Porta cath with imaging perform [*sic*] in ward … Difficult cannulation and change of porta cath needle (from size ¾ inch to 1 inch) under ultrasound guidance [and] Flushing of Port-a-cath with Hep Saline",[36] as well as a *further $68,500* for "Porta cath cannulation for chemotherapy treatment",[37] resulting in a total aggregate fee of *$296,900* ($222,675 after discount) for all the services rendered on 19 January 2007. We take pains to emphasise that far from being major medical procedures, the two last-mentioned sets of services relating to port-a-cath procedures (which ostensibly merited an additional charge of *$194,300*) were in effect basic preparatory services necessary for a patient undergoing chemotherapy.

90 On 20 January 2007 (*vis-à-vis* Charge 6), the Patient was discharged and relocated to a hotel at her insistence. For this treatment day, the Appellant issued two invoices, which collectively set out an aggregate fee of *$48,500* ($36,375 after discount). This aggregate fee comprised: (a) $15,500 for hospitalisation intensive care coupled with respiratory and vital parameters monitoring; (b) $25,800 for an evening home consultation-cum-specialist

---

[35] *Id*, p 38.

[36] *Id*, p 36.

[37] *Ibid.*

examination (likewise coupled with respiratory and vital parameters monitoring); and (c) $7,200 for "Intensive Nursing Care".[38] We note that for this particular day, the Appellant chose to invoice for both a *home* consultation *and* an entire day's fees in respect of *hospitalisation* intensive care.

91 Before considering the next group of charges, we would like to highlight some concerns in respect of the Appellant's fees for "Intensive Nursing Care".[39] In respect of Charge 3 (*vis-à-vis* 17 January 2007), the Appellant charged $4,800 for "Intensive Nursing Care",[40] including "Ambulatory support, SAO2 Monitoring[,] Management of bilateral pleural drains and change of bottles".[41] However, on two other days, the Appellant charged $7,200 for essentially the same nursing services, with the addition of either "Accompaniment for CT Simulation by Dr Lam"[42] (see Charge 2 *vis-à-vis* 16 January 2007) or "Nursing accompaniment for whole body PET Scan procedures"[43] (see Charge 4 *vis-à-vis* 18 January 2007). We find it difficult to accept that nursing accompaniment for scans conducted by third parties warranted an *extra charge* of *$2,400*. In respect of Charge 5, we note that the Appellant charged $11,300 for (*inter alia*) "Management of bilateral pleural drains and … Nursing protocol for bilateral pleurodesis with tetracycline"[44] as well as nursing accompaniment to chemotherapy. In this regard, the expert

---

[38] Amended CB at Vol II Part F, p 44.

[39] *Id*, (*inter alia*) p 33.

[40] *Id*, p 24.

[41] *Ibid*.

[42] Amended CB at Vol II Part F, p 17.

[43] *Id*, p 31.

[44] *Id*, p 38.

opinion of Prof Soo Khee Chee ("Prof Soo"), an oncologist, in cross-examination to the effect that nursing charges of $11,000 a day were "somewhat excessive"[45] is, in our view, of no mean significance.

(2) Charges 7 to 15 (for the period 21 January 2007–9 March 2007)

92 Upon her discharge from Gleneagles Hospital on 20 January 2007, the Patient remained in Singapore until her repatriation to Brunei on 9 March 2007. With the exception of a few days of emergency hospitalisation, the Patient spent most of this period in a hotel, during which time the Appellant provided her with outpatient medical services. During the period of five days from 21 to 25 January 2007 (see Charges 7 to 11), the Appellant levied a daily aggregate charge of *$29,600* ($22,200 after discount), which comprised:

(a) $25,800 for each day's home consultation, specialist examination and respiratory and vital parameters monitoring; and

(b) $3,800 for each day's "Specialised nursing, ambulatory support & nursing care".[46]

93 On 26 January 2007 (the subject of Charge 12), the Patient was admitted again to Gleneagles Hospital upon encountering breathing difficulties. For this particular day, the Appellant charged a total of *$332,600* ($249,450 after discount), comprising: (a) $25,800 for a home consultation (coupled with a specialist examination and respiratory and vital parameters monitoring); (b) $295,000 for (*inter alia*) urgent hospital admission, inpatient

[45] CB at Vol II Part B, p 182.

[46] Amended CB at Vol II Part F, (*inter alia*) p 49.

review and 24-hour monitoring as well as management of respiratory dyspnoea by a team of specialists; and (c) $11,800 for "Intensive Nursing Care".[47] The Patient was subsequently discharged, and during the three-day period from 2 to 4 February 2007 (the subject of Charge 13), the Appellant continued to charge $25,800 each day for "Daily Home Consultations and respiratory management",[48] amounting to an aggregate charge of *$77,400* ($58,050 after discount) for those three days.

94 From 5 February 2007 to 9 March 2007, the Patient underwent 25 *radiotherapy sessions* conducted by Dr Khor, the attending radiation oncologist. Apart from charging the Patient $875,000 for "radiotherapy facilities & staff"[49] [capital letters in original omitted] in respect of these radiotherapy sessions (this is the subject of Charges 68 and 69, and will be dealt with below under the Category C charges), the Appellant additionally charged the Patient an aggregate of $625,000, or *$25,000 per session*, for what she termed "Radiotherapy – Daily Administration, Entry into Radiation Chamber for patient checks"[50] (this is the subject of Charges 14 and 15). As noted by the DC (at [5.3.4]–[5.3.5] of its decision):

> 5.3.4 The radiation therapy referred to was carried out at the hospital for an hour on each of the days stated in the invoices. The invoices rendered by Dr Lim [the Appellant] essentially reflect her charges for the services that Dr Lim and her staff provided by ***accompanying the Patient to the hospital and providing support***. The actual mapping of tumour

---

[47] *Id*, p 75.

[48] *Id*, p 78.

[49] Amended CB at Vol II Part G, pp 20 and 25.

[50] Amended CB at Vol II Part F, pp 81 and 84.

> boundaries and administration of radiotherapy was carried out by Dr Khor.
>
> 5.3.5 Dr Lim explains that the work done by her and her team at these sessions were as follows:
>
> > "[Dr Lim] and her team would enter the radiation chamber with the Patient. [Dr Lim] and her team would ***undress and prepare the Patient, lift her onto the table, position her, leave the radiation room during the radiotherapy, watch her from the window to the room, return into the room thereafter, help the Patient up, dress the Patient and escort her out of the room***, and back to her car."
>
> [emphasis added in bold italics]

The DC also noted Prof Soo's evidence (at [5.3.6] of its decision) that the task of positioning the Patient was the proper responsibility of the actual attending radiation oncologist, Dr Khor, and not the Appellant, as it had a direct bearing on the safety of the Patient. Finally, we note that Dr Khor charged $300 for each radiotherapy session which he conducted. In comparison to this, the Appellant's fee of *$25,000 per session* for, essentially, accompanying the Patient and positioning her during these sessions is undeniably excessive in the extreme.

95 In relation to Charge 15, we would further note that the Appellant *additionally* charged *$260,000* for pre-transfusion blood investigations done on 6 March 2007 and blood transfusion and electrolyte albumin replacement carried out on 7 March 2007. The Appellant subsequently offered to withdraw the invoice for this sum via her 1 August 2007 letter to MOHB.

(3) Charges 16 to 36 (for the period 10 April 2007–9 May 2007)

96 On 10 April 2007, the Patient returned to Singapore and was admitted to Gleneagles Hospital, where she remained hospitalised until her final

journey back to Brunei on 14 June 2007. For greater ease in dealing with the charges relating to this period, we have divided our analysis of these charges into two parts, namely, the charges covering the period 10 April 2007–9 May 2007 and the charges covering the period 10 May 2007–13 June 2007. In this part, we shall examine Charges 16 to 36, which are the charges covering the first-mentioned period of 10 April 2007 to 9 May 2007.

97 For services rendered on 10 April 2007 (see Charge 16), the day on which the Patient was admitted to Gleneagles Hospital, the Appellant charged a total of *$119,750* ($89,813 after discount), comprising $25,500 for a one-month post-radiotherapy review, $16,800 for flushing a port-a-cath with medications, $28,800 for difficult cannulation and change of a port-a-cath needle under ultrasound guidance, $38,600 for surface mapping on abdominal wall tumours, $8,500 for radiological investigations on the thorax and $1,550 for blood investigations. We would like to draw particular attention to the $16,800 fee for flushing a port-a-cath with medications. The DC summarised Prof Soo's expert evidence in respect of flushing a port-a-cath as follows (see the DC decision at [4.11.8.f]):

> A similar service is done at [National Cancer Centre] by a nurse and the charge is about $50.00. Even if performed by a doctor, a reasonable charge would be $200.00.

We note that the Appellant's fee for this simple procedure was *over 80 times* what Prof Soo considered to be a reasonable fee for a *doctor* carrying out a similar procedure. Even taking into account the Appellant's special skill and standing as a renowned surgeon, this clearly represented overcharging of the most extreme (and, indeed, astonishing) proportions.

98 Following the Patient's admission to Gleneagles Hospital on 10 April 2007, the Appellant charged the following fees for what she described as "*Radiotherapy* – Daily Administration, Entry into Radiation Chamber for patient checks"[51] [emphasis added] during the period from 11 April 2007 to 4 May 2007:

> (a) an aggregate of $224,000, or *$28,000 per session*, for eight sessions of radiotherapy of the lower abdomen and the left side of the neck (see Charges 17 to 22); and
>
> (b) an aggregate of $480,000, or *$48,000 per session*, for ten sessions of radiotherapy of the brain and the spine (see Charges 23, 27 and 29 to 31).

As already noted, these charges were essentially for *escorting the Patient and positioning her* during radiotherapy sessions conducted by the third-party radiation oncologist, Dr Khor. In respect of these fees, we make the same observations as we did above (at [94]) *vis-à-vis* Charges 14 and 15, *ie*, these fees are grossly excessive and bear no rational relation to the services actually provided (*ie*, accompanying and positioning the Patient during the hour-long radiotherapy sessions). We also note that the Appellant charged approximately double the amount in respect of radiotherapy of the brain and the spine ($48,000 per session) in comparison to radiotherapy of the lower abdomen and the left side of the neck ($28,000 per session). No explanation has been given for this wide disparity, and this is yet another instance of the haphazard and seemingly arbitrary nature of the Appellant's charges. Finally, we note that the

---

[51] *Id*, (*inter alia*) p 90.

Appellant additionally invoiced an aggregate of $730,000 for "radiotherapy facilities & staff"[52] [capital letters in original omitted] in respect of the *same* 18 sessions of radiotherapy during this period, *ie*, the period from 11 April 2007 to 4 May 2007 (this is the subject of Charges 70 to 73, which will be dealt with below under the Category C charges).

99 For the overlapping period of 16 April 2007 to 9 May 2007, the Appellant's fees fluctuated between *$65,000 and $210,000* for each day of inpatient intensive monitoring and care,[53] with the day-to-day variations being ostensibly due to differences in the services provided. The indiscriminate nature of the Appellant's invoicing during this period is demonstrated as follows:

(a) In respect of Charge 18, the Appellant charged *$105,500* for, *inter alia*, "Specialist evaluation for sudden weakness of leg",[54] "Urgent Admission to Ward",[55] "Urgent radiological investigations"[56] and "Emergency insertion of PICC line".[57]

(b) In respect of Charges 19 to 25, 27, 30 and 36, the Appellant charged *$65,000* per day for "Intensive Monitoring, Respiratory and Vital Parameters Monitoring".[58] (For Charges 27, 30 and 36, the

---

[52] Amended CB at Vol II Part G, (*inter alia*) p 30.

[53] Amended CB at Vol II Part F, (*inter alia*) p 99.

[54] *Id*, p 93.

[55] *Ibid*.

[56] *Ibid*.

[57] *Ibid*.

[58] Amended CB at Vol II Part F, (*inter alia*) p 99.

$65,000 fee also covered physiotherapy services provided by the Appellant as well as, in the case of Charge 30, the transfusion of blood products.)

(c) In respect of Charges 31 and 34, the Appellant charged *$75,000* per day for essentially the same services (primarily, "24-hrs Intensive Monitoring, Respiratory and Vital Parameters Monitoring"[59] and physiotherapy services), except that in the case of Charge 31, a rectal examination was also performed, and in the case of Charge 34, "Manual evacuation of faeces"[60] was also done. This *$10,000 increase* from her earlier charge of $65,000 for what was in essence inpatient intensive monitoring and care (either with or without physiotherapy) is otherwise unexplained.

(d) In respect of Charge 26, the Appellant charged *$150,000* for, *inter alia*, 24-hour intensive monitoring, "Removal/change of catheter and TPN line",[61] monitoring the Patient during a visit from her family and "Re-insertion of IDC".[62] The apparent markup for these simple services (in essence, removing and re-inserting the Patient's feeding tubes and catheter) is clearly unjustifiable.

(e) In respect of Charge 28, which relates to services rendered on a public holiday (*viz*, 1 May 2007), the Appellant charged *$210,000* for

---

[59] *Id*, pp 153 and 159.

[60] *Id*, p 159.

[61] *Id*, p 134.

[62] *Ibid*.

24-hour intensive monitoring (coupled with respiratory and vital parameters monitoring as well as total parenteral nutrition ("TPN")), physiotherapy, "Passive mobilisation",[63] standing exercises and the transportation of a massage chair to the Patient's ward, followed by its subsequent removal at the Patient's request. Again, taking her previous daily charge of $65,000 for, in essence, inpatient intensive monitoring and care (coupled with physiotherapy on some days) as a basis for comparison, the Appellant appeared to be charging an *extra $145,000* for *transporting-cum-removing a massage chair* and overseeing the Patient's "Passive mobilisation [and] Standing exercises",[64] and/or for working on a public holiday.

(f) In respect of Charge 29, the Appellant charged *$110,000* for services comprising, primarily, 24-hour intensive monitoring (including respiratory and vital parameters monitoring as well as TPN), physiotherapy, "Urinary sphincter Management Protocol"[65] and "Coordination of ENT specialist and late night visit"[66] upon the Patient's sudden complaint of ear pain. For managing this complaint, the Appellant presumably saw fit to charge an *extra $45,000* (as compared to the previous fee of $65,000 for (in essence) inpatient intensive monitoring and care, coupled with, in some instances, physiotherapy).

---

[63] Amended CB at Vol II Part F, p 141.

[64] *Ibid*.

[65] Amended CB at Vol II Part F, p 145.

[66] *Ibid*.

(g) In respect of Charges 32 and 33, the Appellant suddenly increased her charges for services consisting primarily of "24-hrs Intensive Monitoring",[67] physiotherapy and "Urinary sphincter Management Protocol"[68] to *$120,000*. This appears to have been because the two treatment days in question were on a weekend, and/or because of "extra" services provided on those two days (namely, attending to the Patient's sudden respiratory distress at 10.00pm in the case of Charge 32 and carrying out "manual evacuation of stools"[69] in the case of Charge 33).

(h) In respect of Charge 35, the Appellant charged *$120,000* for, essentially, 24-hour intensive monitoring, physiotherapy, urinary sphincter management, "ENT mobilis[ation]"[70] following the Patient's complaint of difficulty in swallowing and the administration of medications and a blood transfusion.

100 It is to be noted that the above fees were only in respect of, essentially, inpatient intensive monitoring and care. For the same period, the Appellant additionally charged for procedures carried out from day to day. For example:

(a) In respect of Charge 21, the Appellant additionally charged *$42,000* for managing a "CT Scan of Head at 6.30 pm at Radiology

---

[67] Amended CB at Vol II Part F, pp 155 and 157.

[68] *Ibid*.

[69] Amended CB at Vol II Part F, p 157.

[70] *Id*, p 161.

Department (After Hours)"[71] (presumably performed by a third party) upon the Patient's sudden weakness/giddiness, and *$87,000* for arranging for and assisting in a lumbar puncture procedure performed in the ward under sedation by Dr Tang Kok Foo, resulting in an aggregate fee of *$228,000* ($166,500 after discount) for a single day's services when taken together with fees for "Radiotherapy – Daily Administration, Entry into Radiation Chamber for patient checks"[72] ($28,000), hospitalisation intensive monitoring coupled with respiratory and vital parameters monitoring ($65,000) and TPN support ($6,000).

(b) In respect of Charge 22, the Appellant (apart from invoicing fees of $28,000 for "Radiotherapy – Daily Administration, Entry into Radiation Chamber for patient checks",[73] $65,000 for hospitalisation intensive monitoring coupled with respiratory and vital parameters monitoring and $6,000 for TPN support) additionally charged $158,000 for being the surgeon in attendance for an "urgent MRI Spine performed in Radiology Department",[74] as well as $130,000 for "Planning/Mapping for urgent neuro-radiotherapy to brain and spine [and] [m]oulding between 5 pm–7 pm (after hours)",[75] bringing the aggregate charge for that day to *$387,000* ($285,750 after discount).

---

[71] *Id*, p 110.

[72] *Id*, p 108.

[73] *Id*, p 114.

[74] *Id*, p 116.

[75] *Id*, p 117.

101 In addition to the above charges, the Appellant also issued an invoice for $90,000 (or $6,000 per day) for 15 days of TPN support or intravenous feeding (see Charges 18 to 27). Perhaps conscious of the manifest excessiveness of this fee, the Appellant subsequently offered to withdraw the invoice for this fee pursuant to her letter of 1 August 2007 to MOHB.

(4) Charges 37 to 65 (for the period 10 May 2007–13 June 2007)

102 During the final month of the Patient's hospitalisation in Singapore, the Appellant's charges for inpatient intensive monitoring and care soared to about *$250,000 to $450,000 per day*. It is difficult to discern a trend in the Appellant's charges, with the only reasonable explanation for such difficulty being the arbitrariness of the Appellant's charges themselves. We shall, nevertheless, attempt to give an outline of what was charged during this period:

(a) In respect of Charges 41, 42, 47, 48, 51, 53, 56 to 59 and 63, the Appellant charged *$250,000* per day ($187,500 after discount) for "24-hrs Critical Care Monitoring in Intensive Care Unit"[76] and "Clinic and OT cancellations/rescheduling".[77] On a typical day, such "Critical Care Monitoring"[78] comprised, in the main, respiratory and cardiovascular monitoring, "GI/Abdominal/fecal evacuation",[79] enteral and parenteral feeding, sacral skin necrosis toilet and dressings,

---

[76] *Id*, (*inter alia*) p 177.

[77] *Ibid*.

[78] *Ibid*.

[79] *Ibid*.

"Arterial Line Management/Porta cath/PICC/Peripherals",[80] catheter management, reverse barrier nursing, sepsis protocol, four-hourly blood gas monitoring and full blood investigations, with tracheostomy management included as well where Charges 51, 53, 56 to 59 and 63 were concerned. In respect of Charges 53 and 56, left and right pleurodesis respectively were also performed. It is to be emphasised, once again, that these services did not include any major surgical procedures, but were in fact typical services and procedures associated with palliative care.

(b) In respect of Charges 49, 50, 52, 54, 55, 60 to 62, 64 and 65, the Appellant charged *$280,000* per day ($210,000 after discount) for essentially the same services as those listed above in sub-para (a). The only discernible differences are that: (i) in respect of Charges 49, 50, 52, 54, 55, 61 and 62, the services were provided on either weekends or public holidays; and (ii) in respect of Charges 50, 54, 60, 64 and 65, additional services were provided, such as right pleurodesis and left pleural tap (see Charge 50), left pleurodesis (see Charge 54), "Trial mobilisation to General Ward … and emergency transportation back to ICU"[81] at night upon the Patient's respiratory distress (see Charge 60), "Trial run preparation for air evacuation back to Brunei"[82] (see Charge 64) and ultrasound of the liver/bladder, removal of a left chest tube and right pleurodesis (see Charge 65). No explanation is given for

---

[80] *Ibid*.

[81] Amended CB at Vol II Part F, p 221.

[82] *Id*, p 229.

the increase of $30,000 from the $250,000 daily charge described in the preceding sub-paragraph. We surmise that the increase can only be attributed to the fact that the work was done on either weekends or public holidays, and/or to the fact that "extra" services were provided (which services were, it should be noted, fairly routine ones). Again, we note the Appellant's apparent proclivity for inflating her fees at every opportunity without any underlying justification or any attempt at consistency.

(c) In respect of Charges 37 to 39 and 45, the Appellant charged *$450,000* each day ($337,500 after discount) for 24-hour intensive monitoring as well as emergency management and/or procedures. For example, in respect of Charge 37, the Appellant's services included, *inter alia*, urgent management of bone marrow suppression, urgent management of arrhythmia and respiratory distress, urgent transfer of the Patient to the ICU and mobilisation of a team of doctors to stabilise the Patient. In respect of Charge 38, the Appellant charged $450,000 for intensive monitoring of respiratory distress, including (*inter alia*) intensive chest physiotherapy, ventolin nebuliser treatment, urgent resuscitation with 10 *l*/min of oxygen, a two-dimension echocardiogram and loculated left pleural effusion drainage done in the ward. In respect of Charge 39, the same amount (*ie*, $450,000) was charged for, *inter alia*, urgent admission of the Patient to the ICU, resuscitation and haemodynamic/fluid management, bronchoscopy under sedation and bronchial lavage. In respect of Charge 45, the Appellant charged $450,000 for, *inter alia*, critical care monitoring in

the ICU, "Early reverse sedation",[83] "Muscle stimulation protocols",[84] "Physiotherapy in semi-recumbent position"[85] and three sessions of intensive chest physiotherapy.

(d) In respect of Charge 43, the Appellant charged an aggregate of *$660,000* ($495,000 after discount) for *a single day's* services, comprising: (i) $310,000 for, *inter alia*, 24-hour critical care monitoring in the ICU, a conference of specialists and *preparation* for tracheostomy; and (ii) $350,000 for the actual "Percutaneous Tracheostomy (*Minimally* Invasive Technique)"[86] [emphasis added] performed on the Patient in her ward under sedation (with a surgical team on standby from 4.00pm to 6.00pm) and "Post-procedure monitoring".[87]

(e) In respect of Charge 44, the Appellant charged *$350,000* ($262,500 after discount) for, *inter alia*, 24-hour critical care monitoring in the ICU and "1st POD – tracheostomy".[88]

103 We now come to Charge 40, which provides yet another instance of the Appellant's overcharging being facilitated by her practice of issuing multiple invoices for each treatment period. For services provided over the

---

[83] *Id*, p 187.

[84] *Ibid*.

[85] *Ibid*.

[86] Amended CB at Vol II Part F, p 182.

[87] *Ibid*.

[88] Amended CB at Vol II Part F, p 185.

course of three days from 13 to 15 May 2007, the Appellant issued invoices amounting to a total of *$1,270,000* ($712,500 after discount and after the withdrawal of the invoice described below in sub-para (c)) as follows:

(a) an invoice for *$450,000* in respect of 24-hour critical care monitoring in the ICU on 13 May 2007 (a Sunday);

(b) two invoices, each for *$250,000*, in respect of 24-hour critical care monitoring in the ICU on 14 May 2007 and 15 May 2007 respectively; and

(c) yet another invoice for *$320,000* for "continuous Team Management"[89] in respect of 24-hour critical care monitoring in the ICU during the same three-day period (*ie*, 13–15 May 2007), pleurodesis of the left lung with 500 mg of tetracycline, pleural effusion management, pre- and post-procedure monitoring and sedation for pain relief.

The Appellant offered to withdraw the last-mentioned invoice by way of her 1 August 2007 letter to MOHB, perhaps conscious of the irregularity of billing $320,000 for the relevant procedures *on top of* the $950,000 which she had already billed for inpatient intensive monitoring and care during the same three days. This was similarly the case in relation to Charge 46, which was also in respect of inpatient intensive monitoring and care provided over a three-day period (*viz*, 21–23 May 2007). For that period, the Appellant issued four invoices amounting to *$1,070,000* ($562,500 after discount and after the

[89] *Id*, p 173.

withdrawal of the invoice for $320,000 described below in point (b)) in total, *viz*: (a) three invoices, each for *$250,000*, for three days of critical care monitoring from 21 to 23 May 2007; as well as (b) another invoice for *$320,000* for "continuous Team Management"[90] in respect of 24-hour critical care monitoring in the ICU, pleurodesis of the right lung with tetracycline, pre- and post-procedure monitoring and sedation for pain relief over the same three-day period. Again, the Appellant offered to withdraw the last-mentioned invoice for $320,000 in her letter to MOHB dated 1 August 2007.

(5) Summary of our findings on the Category A charges

104 As can be seen, the Appellant's professional fees for inpatient intensive monitoring and care during the final period of the Patient's hospitalisation (*ie*, the period from 10 May 2007 to 13 June 2007) varied, often completely arbitrarily, from $250,000 to $450,000 per day. At this juncture, it is instructive to reiterate the DC's comments (at [5.1.4] of its decision):

> Professor Soo and Dr Hong [Ga Sze] cited examples of complex surgical procedures which would justify the levying of higher medical fees. ***They both estimated the cost of surgical procedures that could take up to 10 hours as being in the region of $30,000.*** In contrast, [the Appellant] charged fees of up to $450,000 per day for services which did not involve a comparable level of complexity and demands on [her] expertise as a surgical procedure. [emphasis added in bold italics]

In respect of the Appellant's practice of billing for 24-hour critical care monitoring in the ICU, the DC summarised Prof Soo's evidence as follows (see the DC decision at [4.11.8.d]):

---

[90] *Id*, p 190.

> Doctors are generally expected to be readily available to their patients. It is not standard practice in Singapore for a doctor to bill a patient for 24 hours. ***A reasonable charge for a specialist to consult a patient in ICU would be around $1,000. It is improper to charge a patient the full 24 hours***. [emphasis added in bold italics]

In other words, whilst the Appellant is a surgeon of considerable skill and standing, it was unreasonable for her to charge, in respect of 24-hour critical care monitoring in the ICU, an hourly rate commensurate with what she might have commanded for performing a complex surgery and, moreover, for her to charge for all 24 hours of her time.

105 In such circumstances, the Appellant's invoiced fees of *up to $450,000 per day* for inpatient intensive monitoring and care were grossly excessive and disproportionate to the (essentially palliative and coordinative) services which she and her medical team actually provided to the Patient. Moreover, in the course of the above analysis, we have also demonstrated that the Appellant's invoices were rendered in an overwhelmingly unsystematic, arbitrary and, ultimately, opportunistic manner, further buttressing our finding that the Appellant's fees were in fact excessive and bore no relation to the services actually provided. By way of a final example, we have, in our above analysis, traced the manner in which the Appellant's fees rose (dramatically) over a mere six-month period. Looking *only* at the Appellant's daily fees with respect to *inpatient intensive monitoring and care*, these started in the range of $96,100 to $98,500 in January 2007 (see above at [88]), rose to between $65,000 to $210,000 in April 2007 and early May 2007 (see above at [99]) and finally climaxed towards the end at between $250,000 to $450,000 in around mid-May 2007 and June 2007 (see above at [102]). Whilst this general upward trend could be explained in part by the Patient's deteriorating condition and the rising climate of emergency, it remains a fact that the Appellant's fees

were (on any objective view) grossly excessive and unreasonable, and became even more excessive as the year progressed.

106 We also further highlight that the charges just considered in this section (*ie*, the Category A charges) are only in respect of fees for services rendered by the Appellant and/or her medical team relating primarily to either inpatient or outpatient care. In addition to the above-mentioned fees, the Appellant additionally charged fees for the services of two of her employees, Dr Kum and Dr Lam (see the Category B charges), fees for "radiotherapy facilities & staff"[91] [capital letters in original omitted] (see the Category C charges), fees for treatment rendered by third-party doctors (see the Category D charges), conference cancellation fees (see the Category E charges) as well as fees for organising and attending specialist clinical management conferences with an overseas oncology specialist, Prof Smith, and other specialists (see the Category F charges), often in relation to the same treatment days as the ones just considered. Consequently, the Appellant's fees in respect of many of the treatment days are much higher than those evidenced by the Category A charges.

107 It is clear from the above analysis that the DC's conclusions are supported in the fullest measure possible by the available evidence. We reiterate three (related) points. Firstly, the Appellant argued before this court that the DC had not given detailed consideration to the individual invoices concerned in respect of (*inter alia*) the Category A charges. As we have just shown by our analysis, this argument is wholly unfounded. Secondly, the

---

[91] Amended CB at Vol II Part G, (*inter alia*) p 20.

above analysis is wholly consistent with the expert evidence, which was rightly accepted by the DC, and establishes the fact that the fees which are the subject of the Category A charges are excessive. Finally, it does not lie in the Appellant's mouth to state that the invoices in question were inaccurately issued (see also above at [9]–[10]) as the responsibility lay upon her to verify the amounts set out in each invoice (especially as these amounts were substantial sums in their own right). These general observations would, in fact, apply to the other charges as well. Let us turn now to consider the Category B charges.

The Category B charges

108 As mentioned above (at [21(b)]), the Category B charges comprise Charges 66 and 67, which (in turn) concern services rendered by two of the Appellant's employees, Dr Kum and Dr Lam, for the periods 19 April 2007–14 June 2007 (*vis-à-vis* Charge 66) and 10–20 May 2006 (*vis-à-vis* Charge 67).

109 The following reasons set out by the DC for its decision to convict the Appellant of these two charges are, in our view, clear and comprehensive, and we endorse them accordingly (see the DC decision at [5.2.1]–[5.2.7]):

> 5.2.1 Charges 66 and 67 are in relation to fees for services rendered by Dr Lim [the Appellant] as well as employees of SLS [Susan Lim Surgery Pte Ltd], Dr Kum and Dr Lam. Dr Kum is a general surgeon while Dr Lam is a general practitioner. Charge 66 relates to services rendered from 19 April 2007 to 14 June 2007 while Charge 67 relates to services rendered from 10 May 2006 to 20 May 2006.
>
> 5.2.2 In Charge 66, the aggregate fees for Dr Kum and Dr Lam were $222,500. For the same period, Dr Lim issued bills through SLS, [Group Surgical Practice Pte Ltd] and [Centre for Weight Management Pte Ltd] in the amount of $14,157,000, which bore similar descriptions of services

rendered. Even taking into account the discount of 25% given by Dr Lim, the total fees still amount to $10,122,750.

5.2.3 In light of the fact that Dr Lim had already issued invoices totalling $14,157,000 for the services she and her staff provided, we find beyond reasonable doubt that the additional and separate charge of $222,500 is grossly excessive. Even taking into account the reduction offered by Dr Lim by her letter to the MOHB dated 1 August 2007, the fees of $166,875 were nevertheless inappropriate, far in excess of and disproportionate to the servcies [*sic*] rendered to the Patient.

5.2.4 The same reasons apply to Charge 67 which relate to a 9-day period in May 2006 (10, 11, 13, and 15 to 20 May 2006).

5.2.5 Further, we note that the invoices for Dr Kum and Dr Lam contained descriptions ("Professional Fees – Dr Lam Foong Lian" and "Professional Fees for Dr Kum Cheng Kiong") which were the same words used by Dr Lim for invoices rendered in relation to services provided by other doctors who were not her employees. An objective reader of these invoices would not have appreciated that Dr Kum and Dr Lam were in fact employees of Dr Lim.

5.2.6 Having considered all the evidence, and for these reasons, we find beyond reasonable doubt that the Further Aggregate Fees, as defined in Charges 66 and 67, were not a fair or reasonable charge for the services rendered and were in fact far in excess of and disproportionate to the services rendered. We are further of the view that this is professional misconduct in that it was an intentional, deliberate departure from the standards observed or approved by members of the medical profession of good repute and competency relating to charging for services. This is our finding whether or not there was a Fee Agreement.

5.2.7 Accordingly, we find that in respect of the Category B charges, Dr Lim is guilty of professional misconduct under section 45(1)(d) of the MRA.

The Category C charges

110 As already mentioned above (at [21(c)]), the Category C charges comprise Charges 68 to 73 and relate to fees totalling *$1,605,000* which the Appellant invoiced for "radiotherapy facilities & staff"[92] [capital letters in original omitted] during the period from 5 February 2007 to 4 May 2007. In this respect, the Appellant charged:

(a) an aggregate of $875,000 (the subject of Charges 68 and 69) for radiotherapy facilities and staff for 25 days of radiotherapy treatment to the right chest wall and tomotherapy treatment (*ie*, a *daily rate of $35,000*);

(b) an aggregate of $280,000 (the subject of Charges 70 and 71) for radiotherapy facilities and staff for eight days of radiotherapy treatment to the lower abdomen and the left side of the neck and tomotherapy treatment (*ie*, a *daily rate of $35,000*); and

(c) an aggregate of $450,000 (the subject of Charges 72 and 73) for radiotherapy facilities and staff for ten days of radiotherapy treatment to the brain and the spine and tomotherapy treatment (*ie*, a *daily rate of $45,000*).

Tellingly, the Appellant offered to withdraw all the above invoices by way of her letter of 1 August 2007 to MOHB, perhaps because of what these invoices (as will be elucidated in the next paragraph) entailed.

---

[92] *Ibid.*

111 As noted in our discussion of the Category A charges (see above at [94] and [98]), the Appellant had already charged a total of $1,329,000 (before discount) for her personal services in the form of, essentially, accompanying and positioning the Patient during the aforesaid radiotherapy sessions (this is the subject of Charges 14, 15, 17 to 23, 27 and 29 to 31). The actual radiotherapy sessions were conducted by the third-party radiation oncologist, Dr Khor. By way of the invoices forming the subject of the Category C charges, which we are now examining, the Appellant charged another $1,605,000 for "radiotherapy facilities & staff"[93] [capital letters in original omitted] in respect of the same 43 radiotherapy sessions. Apart from the extraordinary size of the fees invoiced in absolute terms, the Appellant's fees were also extremely excessive compared with *objective benchmarks*, such as the actual cost of the radiotherapy facilities utilised and the fees invoiced by the actual attending radiation oncologist, Dr Khor. We note the DC's comments in this respect (see the DC decision at [5.3.3]):

> Taking the invoices in February 2007 (Charge No. 68) and March 2007 (Charge No. 69) as examples, [the Appellant] rendered an invoice for "*Radiotherapy Facilities and Staff*" for $630,000 and $245,000 respectively. For the period from 5 February 2007 to 9 March 2007, Dr Khor Tong Hong, the attending Radiation Oncologist at Mount Elizabeth Radiotherapy Centre who administered Radiotherapy to the Patient ***over 24 occasions*** rendered an invoice of ***$7,200***. Mount Elizabeth Radiotherapy Centre rendered a bill for ***$33,358.40*** (before GST) for the ***entire duration of 5 February 2007 to 9 March 2007*** for the use of its facilities. In comparison, [the Appellant] billed the Patient fees ranging from $35,000 to $45,000 per day for "radiotherapy facilities and staff". [original emphasis in italics; emphasis added in bold italics]

---

[93] *Ibid.*

112 We note the apparent arbitrariness of the Appellant's charges with reference to one final example. For instance, in so far as Charges 68 to 71 are concerned, the daily fee invoiced for radiotherapy facilities and staff was *$35,000*, whilst in so far as Charges 72 and 73 are concerned, the daily fee invoiced was *$45,000*, the only difference being that the last-mentioned daily fee (of $45,000) was in respect of radiotherapy treatment to the brain and the spine (as opposed to radiotherapy treatment to the right chest wall (*vis-à-vis* Charges 68 and 69) and the lower abdomen and the left side of the neck (*vis-à-vis* Charges 70 and 71)). This is but another demonstration of the fact that the Appellant was simply charging whatever she liked in amounts that were truly unconscionable and which therefore constituted serious professional misconduct.

The Category D charges

113 As mentioned above (at [21(d)]), the Category D charges comprise Charges 74 to 76 as well as Charges 84 to 94, which (in turn) relate to invoices issued by the Appellant for services rendered by third-party doctors. It is important to note that Charges 84 to 94 (which are also the Category II charges) involve, additionally, allegations of false representations made by the Appellant. For the purposes of the present analysis, this last-mentioned set of charges (*ie*, Charges 84 to 94) will also be discussed in this part of our judgment, albeit only from the limited perspective of alleged overcharging; the false representation aspect of these charges will be discussed later under Issue 4 (see below at [132]–[135]).

114 Before we begin analysing the Category D charges, we think it necessary to briefly address the withdrawal of certain invoices by the Appellant via her 1 August 2007 letter to MOHB. The Category D charges

include both: (a) charges relating to invoices issued for services rendered in 2007 (see Charges 86, 88 to 92 and 94); and (b) charges relating to invoices issued for services rendered before 2007 (see Charges 74 to 76, 84, 85, 87 and 93), which invoices were paid by the Bruneian government sometime before August 2007. By way of her letter to MOHB dated 1 August 2007, the Appellant offered to withdraw her fees with respect to the former group of invoices, *ie*, invoices for services rendered in 2007. No discount or withdrawal was offered for the pre-2007 invoices, of course, as they had already been paid as at August 2007. Again, as will be demonstrated in the following paragraphs, we observe that the Appellant's offers to withdraw some of her invoices tended to relate to fees which appeared more difficult to justify.

115 In so far as Charges 74 to 76 are concerned, the DC observed as follows (see the DC decision at [5.4.3]–[5.4.4]):

> 5.4.3 Charge No. 74 concerns [the Appellant's] bill for $78,600 for services carried out jointly with Professor Lee [Chuen Neng]. Professor Lee, who reviewed the Patient and conducted the procedure, charged $945 for his services (which Gleneagles Hospital billed on his behalf). [The Appellant's] fee of $77,655 is not a fair and reasonable fee for the services rendered and is grossly excessive and wholly disproportionate to the services rendered.
>
> 5.4.4 The same analysis applies for Charges No. 75 and 76 which concern services carried out jointly with Dr Wong Sin Yew and Dr Whang Hwee Yong respectively.

116 In respect of Charge 74, the Appellant invoiced *$78,600* for a "Review and assessment for pleural tap"[94] and an "Inpatient Chest Tap"[95] purportedly

---

[94] Amended CB at Vol II Part G, p 56.

[95] *Ibid.*

carried out by Prof Lee, a cardiothoracic surgeon, and herself. The observations of the DC quoted in the preceding paragraph make it clear beyond reasonable doubt that the amount which the Appellant invoiced was clearly excessive, both in relation to the services provided and also (most tellingly) when viewed against the amount which was in fact invoiced by the doctor who *actually performed the procedure concerned*. Indeed, examining the invoices under Charges 75 and 76, the same pattern – as pointed out by the DC – is clear.

117 In so far as Charge 75 is concerned, the Appellant invoiced a fee of *$93,500* for a "Joint Consultation"[96] and "Joint Review"[97] purportedly carried out on, respectively, 24 and 30 May 2005 by her and Dr Wong, an infectious diseases physician. Dr Wong reviewed the Patient and invoiced a fee of *$500* for the services rendered. It should also be noted that the Appellant's invoiced fee of $93,500 was *in addition to* fees which the Appellant had *separately* invoiced in the sum of *$106,300* for services rendered on 24 May 2005.

118 Likewise, in so far as Charge 76 is concerned, the Appellant invoiced $211,000 for "urgent intravenous therapy for tumour of spine"[98] [capital letters in original omitted] carried out from 1 to 3 June 2004. In comparison, Dr Whang (the oncologist who actually carried out the treatment concerned) invoiced a fee of *$400*. It should also be noted that the Appellant's invoice for $211,000 was *in addition to* fees which the Appellant had *separately* invoiced

---

[96] Amended CB at Vol II Part G, p 64.

[97] *Ibid*.

[98] Amended CB at Vol II Part G, p 75.

in the sums of $25,800 for services rendered on 1 June 2004 and *$280,000* for services rendered during the overlapping period of 1 to 10 June 2004.

119 A similar analysis applies to the issue of alleged overcharging in relation to Charges 84 to 94.

120 Charges 84 to 86 relate to invoices purportedly issued by the Appellant for "professional fees for Dr Chin Kin Wuu"[99] [capital letters in original omitted]. In so far as these three charges are concerned, Dr Chin (the anaesthetist who performed the procedures concerned) invoiced fees of *$71,500* (*vis-à-vis* Charge 84), *$40,000* (*vis-à-vis* Charge 85) and *$2,120,000* (*vis-à-vis* Charge 86) respectively, whereas the Appellant invoiced fees of *$589,100*, *$155,000* and *$3,992,900* respectively instead. The Appellant offered (via her 1 August 2007 letter to MOHB) to withdraw her invoices with respect to the last-mentioned fee of $3,992,900, which related to services provided in 2007. Again, having reference to the fees of the third-party specialist who actually provided the primary services to the Patient, the Appellant's fees were undeniably excessive.

121 Charges 87 to 90 relate to invoices purportedly issued by the Appellant for "professional fees for Dr Koo Chee Choong"[100] [capital letters in original omitted]. In so far as these charges are concerned, Dr Koo (the cardiologist who performed the procedures concerned) invoiced fees of *$4,258.50* (*vis-à-vis* Charge 87), *$27,600* (*vis-à-vis* Charge 88), *$3,100* (*vis-à-vis* Charge 89) and *$1,270* (*vis-à-vis* Charge 90) respectively, whereas the Appellant invoiced

---

[99] *Id*, (*inter alia*) p 105.

[100] *Id*, (*inter alia*) p 222.

fees of *$32,150*, *$259,200*, *$47,100* and *$21,600* respectively instead. The Appellant offered in her 1 August 2007 letter to MOHB to withdraw the invoices which were the subject matter of Charges 88 to 90 (these invoices related to services rendered in 2007).

122 Charge 91 relates to invoices purportedly issued by the Appellant for "professional fees for Dr Khor Tong Hong"[101] [capital letters in original omitted]. Dr Khor (the radiation oncologist who performed the procedures concerned) and Mount Elizabeth Hospital (invoicing on behalf of Dr Khor) invoiced fees of *$19,050* and *$35,043.40* respectively, whereas the Appellant invoiced an aggregate fee of *$235,300* instead. In her letter to MOHB dated 1 August 2007, the Appellant offered to withdraw all the invoices under this particular charge.

123 Charge 92 relates to an invoice for *$25,500* purportedly issued by the Appellant for "professional fees for Dr Tanny Chan"[102] [capital letters in original omitted]. Dr T Chan (the gynaecologist who performed the procedure concerned) *did not render any invoice*. The Appellant offered (via her 1 August 2007 letter to MOHB) to withdraw the relevant invoice under this particular charge.

124 Charges 93 and 94 relate to invoices purportedly issued by the Appellant for "professional fees for Dr Chan Tiong Beng"[103] [capital letters in original omitted]. In so far as these charges are concerned, Dr T B Chan (the

---

[101] *Id*, (*inter alia*) p 245.

[102] *Id*, p 255.

[103] *Id*, (*inter alia*) p 258.

respiratory physician who performed the procedures concerned) invoiced fees of *$9,553.70* (*vis-à-vis* Charge 93) and *$3,000* (*vis-à-vis* Charge 94) respectively, whereas the Appellant invoiced fees of *$401,900* and *$285,100* respectively instead. In her letter to MOHB dated 1 August 2007, the Appellant offered to withdraw the latter invoice for $285,100, which related to services rendered in 2007.

125 A recurrent pattern observed in the above charges is that the Appellant's invoiced fees were often *many multiples* of the amounts invoiced by the third-party specialist concerned. In the circumstances, it is clear, in our view, that there had indeed been excessive overcharging by the Appellant with regard to the Category D charges.

The Category E charges

126 As already mentioned above (at [21(e)]), the Category E charges (*viz,* Charges 77 and 78) are in respect of the fees invoiced by the Appellant for the cancellation of her scheduled attendance at overseas conferences in February 2007 and May 2007 in order to attend to the Patient.

127 In this regard, we fully endorse the conclusion arrived at by the DC for the detailed reasons which it gave as follows (see the DC decision at [5.5.4]–[5.5.5]):

> 5.5.4 We note that:
>
> a. these cancellation charges are imposed in addition to [the Appellant's] charges of $450,000 (Charge 77) and $158,000 (Charge 78) for services rendered.
>
> b. We have no evidence of the costs and expenses which she incurred for the conferences, nor of the basis for the fees charged.

> 5.5.5 In both these charges, we find beyond reasonable doubt that the amounts billed are not fair or reasonable and are wholly excessive and disproportionate to the cancellation in question. While a practitioner can in principle bill a patient a reasonable amount for out-of-pocket and other reasonable costs of such cancellations, the amount that has been billed by [the Appellant] in the present case far exceeds what could conceivably be appropriate.
>
> [underlining in original]

The Category F charges

128 As also mentioned above (at [21(f)]), the Category F charges (*viz*, Charges 79 to 83) are in relation to the fees invoiced by the Appellant for coordinating and attending specialist clinical management conferences with an overseas oncology specialist, Prof Smith, and other specialists to review and discuss the Patient's treatment.

129 Once again, we agree with the conclusion arrived at by the DC for the detailed reasons which it gave as follows (see the DC decision at [5.6.2]–[5.6.4]):

> 5.6.2 Taking Charge No. 79 as an example, Professor Ian Smith charged £45,000 for this conference. Professor Smith, an eminent oncologist with an impeccable international reputation, had to travel to Singapore for 3 to 4 days to see the Patient. This necessarily meant that he was unable to see any of his other patients during this period, no matter how long or how short Professor Smith's actual consultation with the Patient was while in Singapore. Bearing in mind that Professor Smith, an internationally-eminent oncologist who was brought in for consultation on the Patient's treatment, charged only £45,000, Dr Lim's [the Appellant's] invoiced fee of $560,000 is grossly excessive. Dr Lim did not have to bear a similar opportunity cost for this same period. We note also that Dr Khor Tong Hong also attended this conference and charged $1,200 for this attendance.
>
> 5.6.3 Another example is Charge 81, which relates to Dr Lim's invoice for $560,000. These were Dr Lim's fees for attending and coordinating a specialist conference with

> Professor Ian Smith. There were other doctors who also attended this conference: Professor John Wong, Dr Khor Tong Hong, Dr Chan Tiong Beng and Dr Chin Kin Wuu. For attending this conference, Dr Chan charged the sum of $500. Dr Chin charged a total of $12,000 for attending the conference, as well as for close monitoring of the Patient at Royal Plaza on Scotts Hotel from 20 to 22 May 2006. Dr Lim charged $560,000 for attending and co-ordinating the conference, as well as an additional $31,000 for each of Dr Chan's, Dr Chin's, Professor Wong's and Dr Khor's attendance.
>
> 5.6.4 On the evidence before us, we find that Dr Lim's fees were not fair or reasonable and were far in excess of what she was ethically entitled to charge. Some indication of this is what was charged by the other doctors who were also involved in the treatment of the Patient. We find beyond reasonable doubt that the level of fees billed by Dr Lim in this category are grossly excessive and inappropriate.

130 The same analysis applies to Charges 80, 82 and 83, where the Appellant invoiced fees of $320,000, $380,000 and $180,000 respectively for coordinating and attending specialist clinical management conferences to discuss the Patient's treatment. The Appellant offered (in her letter to MOHB dated 1 August 2007) to withdraw the first-mentioned invoice for $320,000.

Our ruling on Issue 3

131 Throughout our analysis of Issue 3, we have drawn attention to various instances where the Appellant either offered to withdraw certain invoices or discounted the fee concerned by way of her letter of 1 August 2007 to MOHB. Looked at in the round, were all these instances to be taken into account, the total fee invoiced by the Appellant would have fallen from approximately $24m to approximately $12.6m. However, as the Respondent has maintained, even this latter amount constituted gross or excessive overcharging on the part of the Appellant. Without pronouncing on the *bona fides* of the Appellant in effecting the withdrawals of the aforesaid invoices and offering the relevant

discounts (*cf*, in this regard, the DC decision at [7.3.3.d.(iii)(1)]), we agree with the Respondent that even an aggregate fee of $12.6m constituted gross overcharging by the Appellant. When pressed to state a figure which *the Respondent* thought was reasonable, Mr Yeo stated a figure of *approximately $2m*. This figure is consistent with that suggested by one of the experts, Prof Soo (see also the DC decision at [4.11.8.b], where this figure is noted by the DC as well). We also note in this regard that another expert, Dr Tan Yew Oo, was of the view that a fee of between $10,000 to $15,000 per day would be "a very generous formula"[104] (see also the DC decision at [4.11.9.a], where this figure is noted by the DC as well). Based on this last-mentioned set of figures (and assuming a maximum fee of $15,000 per day for 110 days of treatment), the aggregate fee that the Appellant ought reasonably to have invoiced would be in the region of $1,650,000. We further note that another expert, Dr Hong Ga Sze, was of the view that it would be difficult to justify – even with special circumstances – a fee of beyond $1,000 to $2,000 per day (see also the DC decision at [4.11.10.d], where this figure is noted by the DC as well). Returning to the present analysis, it is clear that even if we allow some upward leeway in favour of the Appellant, an aggregate fee of $12.6m (let alone one of $24m) would still be *several times* what she ought to have invoiced the Patient for her services, even taking into account certain costs which the Appellant had to incur.

Issue 4

132 We turn now to consider the Category II charges, *viz*, the 11 charges alleging (in addition to overcharging) *false representations* on the part of the

[104] CB at Vol II Part C, p 23.

Appellant. These comprise Charges 84 to 94, which have already been analysed under Issue 3 in the context of the allegations of overcharging (see generally above at [119]–[124]). We now consider the same charges in relation to the false representations allegedly made by the Appellant.

133 In this regard, we note the following reasons set out by the DC in arriving at its decision that the Appellant had in fact made the false representations alleged (see the DC decision at [5.4.7]–[5.4.13]):

> 5.4.7 In respect of Charges No. 84 to 94, it is alleged that Dr Lim [the Appellant] falsely represented to the Patient and/or the Patient's representatives that these invoices represented fees due to the Third-Party Doctors. In particular:
>
> a. Charges No. 84, 85 and 86 relate to services provided by Dr Chin Kin Wuu, the anaesthetist;
>
> b. Charges No. 87, 88, 89 and 90 relate to services provided by Dr Koo Chee Choong, the cardiologist;
>
> c. Charge No. 91 relates to services provided by Dr Khor Tong Hong;
>
> d. Charge No. 92 relates to services provided by Dr Tanny Chan; and
>
> e. Charges No. 93 and 94 relate to services provided by Dr Chan Tiong Beng.
>
> 5.4.8 Taking Charge 84 as an example, Dr Lim issued invoices which were captioned ***"Emergency Admission for Respiratory Distress/Dyspnoea – Professional Fees for Dr Chin Kin Wuu"*** and which totalled $589,100 for 7 treatment days between 15 May and 24 May 2006, Dr Chin charged fees of $71,500. ***A reasonable reader of this invoice would have formed the impression that the charges comprised in the invoice were "for Dr Chin Kin Wuu", i.e. comprising fees charged by the third-party doctor in question, without mark-up. Dr Lim accepts that her invoices could have given this impression. This invoice, like all the others in Charges 84 to 94, was carefully worded and was detailed. We find that these invoices were drafted in order to be read in the way in which an ordinary reader would naturally read them.***

> 5.4.9 Similarly for each of the other charges, Dr Lim issued invoices which read "Professional Fees for Dr …". In none of these invoices was there any express or implied reference to any input by Dr Lim herself, for example by reference to a "combined consultation" with the doctor in question. ***In each of these cases, there was a significant undisclosed mark-up of fees which we find unjustifiable on the facts and evidence before us***.
>
> 5.4.10 ***It was argued on behalf of Dr Lim that it was not possible to say that a false representation had been made without evidence from the recipient of the representation that she had been misled by it. We do not accept this submission. A representation is made if it is communicated to someone other than the maker of the representation. It is not in dispute that that occurred. A representation is false if it is untrue in point of fact. Dr Lim's invoices made false representations***.
>
> 5.4.11 We find that the Prosecution has proved beyond reasonable doubt that Dr Lim falsely represented that the invoices rendered in each of Charges No. 84 to 94 were in respect of sums due to the third-party doctor identified therein, which was untrue. Further, the mark-up of fees by Dr Lim in each of these invoices was unjustifiably high and amounts on the facts of the case to a breach of the ethical obligation to charge a fee which is fair and reasonable.
>
> 5.4.12 We are further of the view that this is professional misconduct in that it was an intentional, deliberate departure from the standards observed or approved by members of the medical profession of good repute and competency relating to charging for services. This is our finding whether or not there was a Fee Agreement.
>
> 5.4.13 Accordingly, we find that Dr Lim is guilty of professional misconduct under section 45(1)(d) of the MRA for Charges No. 84 to 94.
>
> [emphasis added in bold italics]

134 The reasoning of the DC as set out in the preceding paragraph is clear and persuasive, and we endorse it accordingly. Indeed, there is no need, in our view, to belabour the point as the specific charge considered by the DC (*viz*, Charge 84) is *representative of* how the Appellant made her representations *vis-à-vis* the invoices which were the subject of the other charges alleging

false representations (*viz*, Charges 85 to 94). The language of each of the invoices concerned was plain, and a reasonable reader thereof would have understood the invoiced fee to have been the actual fee charged by the third-party doctor concerned without any markup. The Appellant's argument to the effect that there was no evidence that anyone had been misled by the false representations is, as the DC also held, a rather ineffectual one. Indeed, this is *a fortiori* the case in a situation (such as the one here) which is concerned with *professional ethics*.

135 In the circumstances, we have no hesitation in concluding that the decision of the DC on Issue 4 was clearly correct.

Summary of our findings on liability

136 Without seeking to detract in any way from the detailed analysis set out above, we think it appropriate to set out the following brief summary of our findings on liability (*viz*, Issue 1 to Issue 4) before we turn to consider the appropriate sanction to impose on the Appellant (*ie*, Issue 5):

(a) We began by answering the key question as to the meaning of a "profession". In the context of the medical profession, we found that given a doctor's specialised knowledge and training (and his or her corresponding duty to utilise these skills with conscience and dignity in the patient's best interests), there arises an ethical obligation on the part of a doctor not to take advantage of his or her patient (whether monetarily or otherwise), *which obligation operates over and above contractual and market forces*. In the circumstances, excessive overcharging would be a breach of this ethical obligation. There is therefore an objective ethical limit on medical fees in both private and

public health care that operates outside contractual and market forces, and Issue 1 (as reframed by us above at [26]) was answered in the affirmative. A doctor's ethical obligation to charge a fair and reasonable fee for services rendered is *not* superseded by a valid agreement between the doctor and his or her patient. Unlike the present approach in the law of contract, in the context of disciplinary proceedings against a medical practitioner, ethical obligations are not only procedural but also substantive in nature, and it is therefore entirely permissible (and indeed appropriate) for the court (or a Disciplinary Committee under the MRA/a Disciplinary Tribunal under the current Medical Registration Act, as the case may be) to examine the substantive fairness and reasonableness of the terms of an agreement between a doctor and his or her patient (here, of the fees invoiced). In any event, there was *no* fee agreement between the Appellant and the Patient on the facts.

(b) In so far as Issue 2 is concerned, as a doctor's ethical obligation to charge a fair and reasonable fee for services rendered is an *inherent* one which relevant express statutory provisions or regulations (should such be promulgated in future) merely restate in explicit terms, it follows that the Appellant was bound by that obligation even though it had not been published at the material time.

(c) In so far as Issue 3 is concerned, there was clearly sufficient evidence making out all the 94 charges against the Appellant of professional misconduct in the form of overcharging. In particular, the DC did, in our view, examine all the charges and arrived at the correct decision in convicting the Appellant of every charge. It was clear

(having regard, *inter alia*, to the relevant expert evidence) that the fees charged by the Appellant were, on any objective view, grossly excessive and unreasonable. It was also clear, from an internal comparison of the various invoices issued by the Appellant, that the invoices were issued in an unsystematic, arbitrary and, ultimately, opportunistic manner.

(d) In so far as Issue 4 is concerned, there was clearly sufficient evidence making out the 11 charges of professional misconduct (*ie*, Charges 84 to 94) which alleged that the Appellant had (in addition to overcharging) falsely represented in the relevant invoices that the fees charged therein were the actual fees invoiced by third-party doctors, when she had in fact added a significant and undisclosed markup to the actual fees of those third-party doctors. In particular, the reasoning of the DC was clear and persuasive, and we therefore endorsed it accordingly.

We turn now to the final issue, Issue 5. Having found that all the charges against the Appellant are made out, what ought to be the appropriate sanction?

Issue 5

137 In the light of our analysis above, this is clearly one of the most serious cases (if not the most serious case so far) of overcharging in the medical profession in the local context. Indeed, in finding unanimously that the Appellant was guilty of professional misconduct in respect of all the 94 charges proffered against her, the DC observed thus (see the DC decision at [6.1.2]):

> This DC adds that it views [the Appellant's] professional misconduct as being particularly serious. The fees charged by [the Appellant] are ***unconscionable***, whether viewed *per diem* ***or*** viewed holistically, whether viewed without the discount she offered or with the discount and after giving her the benefit of every doubt for the nature, scope and quality of her services. ***When a practitioner, particularly one of [the Appellant's] experience and seniority, breaches so egregiously her ethical obligation to limit the fees she charges for her services to a fair and reasonable fee, it inevitably has a deeply corrosive effect on the relationship of trust and confidence that must subsist between the medical profession and the public.*** [emphasis added in bold italics]

In a similar vein, the DC also observed, when considering the appropriate sanction to administer to the Appellant (see the DC decision at [7.5.1.b]–[7.5.1.c]):

> b. For the reasons given above and based on the expert evidence before this DC, Dr Lim [the Appellant] *breached by the widest and clearest margin* her ethical obligation to charge fees which were fair and reasonable. The fees charged by Dr Lim were *many multiples* of what the expert evidence showed would have been a fair and reasonable fee. This is why we have found that Dr Lim's breach was not marginal but was egregious and warrants a finding of professional misconduct
>
> c. It may be true that none of Dr Lim's patients have complained about her fees, making Dr Lim's invoicing practices in respect of the Patient an isolated case. However, the evidence before this DC in relation to the Patient shows *a systematic pattern* over a sustained period of time of charging fees which were *far in excess of and disproportionate to the services she rendered to the Patient*. In that sense, the breaches were not isolated incidents.
>
> [emphasis added]

138 In the circumstances, it is not surprising that the DC meted out the severe sanction which it did. The issue that now arises is whether there is any reason in principle for this court to interfere with the DC's sentence (bearing in mind this court's role in the present context (see above at [77])).

139 The Appellant has maintained throughout that she was justified in invoicing the fees which she did, particularly in the light of the fact that there was (so she argued) no ethical obligation to charge a fair and reasonable fee for services rendered and, *a fortiori*, because there had been an *agreement* entitling her, contractually, to charge the fees which she had invoiced. As we have seen, *contrary* to the Appellant's argument, all doctors who practise medicine in Singapore are under an ethical obligation to charge a fair and reasonable fee for services rendered. This obligation (as can be seen from the way we have delineated it above at [26]) operates *over and above* contractual and market forces, and thus cannot be superseded by an agreement between a doctor and his or her patient. In any event, we agreed with the DC that there was no fee agreement between the Appellant and the Patient on the facts of this case to begin with. We can well understand the Appellant arguing vigorously along the lines just stated. However, the fact remains that as a result of such an approach, there has been really no remorse shown by the Appellant at all.

140 We further note that the Appellant, in her written case, also argued that it was unfair to punish her for breaching an unpublished rule. We have rejected the arguments in this particular regard and therefore can accord them no significance at all.

141 The Appellant additionally argued in her written case that she had never pressed for payment of the fees which she had invoiced, and that she had also offered to either withdraw or substantially discount some of the invoices issued. However, leaving aside the *bona fides* (or otherwise) on the part of the Appellant in so offering (and *cf*, in this regard, the DC decision at [7.3.3.d.(iii)(1)]), the fact remains that the Appellant has – as we have just

noted – steadfastly maintained that she was right in principle in invoicing those fees in the first place. This suggests that the actions which the Appellant took in terms of either withdrawing or discounting some of the invoiced fees were by way of a concession at best.

142 Given the grave nature of the professional misconduct in this case, we affirm the sentence meted out by the DC on the Appellant. In doing so, we are (as was the DC (see the DC decision at [7.5.3])) fully cognisant of the fact that the Appellant: (a) did not (in the context of the charges relevant to Issue 4) deliberately falsify the invoices concerned; (b) displayed exceptional care to the Patient; and (c) is an exceptionally skilled doctor who has brought credit to Singapore (as demonstrated, *inter alia*, by the various testimonials produced on her behalf). Indeed, the DC proceeded to observe that because of these factors, it did not think it appropriate to remove the Appellant's name from the register of medical practitioners. We agree. However, none of the above factors excuses the Appellant from the consequences of the grave nature of her professional misconduct. Indeed, the quantum of the fees which the Appellant invoiced was so far beyond the pale that even if we had the option of imposing the maximum financial penalty of $100,000 now set out in s 53(2)(*e*) of the current Medical Registration Act (see the amendments made by s 26 of the 2010 Amendment Act), which option is not open to us as the disciplinary proceedings against the Appellant and this appeal are governed by the MRA as defined above at [1] (*ie*, the Medical Registration Act as it stood prior to the 2010 Amendment Act), we doubt whether the imposition of such a penalty would be sufficient (in the egregious circumstances of this particular case) to warrant a reduction in the period of suspension imposed by the DC (here, of three years).

Conclusion

143 For the reasons set out above, we dismiss this appeal with costs. If the parties are unable to agree on the date of commencement of the Appellant's suspension, they are at liberty to apply to this court for directions.

Andrew Phang Boon Leong	V K Rajah	Tan Lee Meng
Judge of Appeal	Judge of Appeal	Judge

Lee Eng Beng SC, Paul Tan, Elizabeth Wu and Amy Seow (Rajah & Tann LLP) for the appellant;
Alvin Yeo SC, Ho Pei Shien Melanie, Lim Wei Lee, Sim Mei Ling, Jolyn Francisca de Roza and Liu Xueyuan Alvis (WongPartnership LLP) for the respondent.

Annex A: The Category A charges[105]

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
1	15-Jan-07	4	1. Urgent admission of the Patient on 15-Jan-07 for respiratory distress; urgent chest x-ray; physical examination and assessment by the Appellant; urgent management of dyspnoea;[106] assessment and management by a team of specialists.	295,000^[107]	397,600	76,950	^The Appellant offered to withdraw the invoice for this sum (Invoice SLS/INV/2007/0004).

[105] To assist the lay reader, definitions and explanations of some of the medical terms utilised in this judgment are furnished in these Annexes. Unless otherwise indicated, these definitions and explanations are derived from *Stedman's Medical Dictionary*, a leading medical dictionary in the English language, and which is available online at <http://www.medilexicon.com/medicaldictionary.php> (Lippincott Williams & Wilkins, 2006) (accessed 24 June 2013).

[106] The term "dyspnea" (the American English spelling of "dyspnoea") is defined (*inter alia*) as "[s]hortness of breath, a subjective difficulty or distress in breathing, usually associated with disease of the heart or lungs".

[107] All the figures furnished in these Annexes are the invoiced amounts *before* GST.

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			2. (Night) Inpatient review and close monitoring; post-pleurodesis[108] procedure; close monitoring of intravenous drips with fluid replacement.	75,800			
			3. Intensive nursing care – ambulatory support; SaO2[109] monitoring; emergency insertion of chest tubes nursing procedures (after office hours); nursing accompaniment for radiological and haematological investigations; respiratory monitoring; dressings; under water seal of chest tubes.	11,300			
			4. Hospitalisation intensive care; respiratory and vital parameters monitoring.	15,500			

[108] The term "pleurodesis" is defined as "[t]he creation of a fibrous adhesion between the visceral and parietal layers of the pleura, thus obliterating the pleural cavity; it is performed surgically by abrading the pleura or by inserting a sterile irritant into the pleural space, and applied as treatment in cases of malignant pleural effusion, recurrent spontaneous pneumothorax, and chylothorax". The term "pleura" is defined as "[t]he serous membrane enveloping the lungs and lining the walls of the pulmonary cavities".

[109] MediLexicon International Ltd's *Medical Abbreviations Dictionary* (available online at <http://www.medilexicon.com/medicalabbreviations.php> (hereinafter referred to as "*Medical Abbreviations*") (accessed 24 June 2013)) defines "SaO2" as "Arterial Oxygen Concentration".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
2	16-Jan-07	3	1. Inpatient review and close monitoring; management of bilateral pleurodesis and drainage of pleural effusion;[110] close monitoring of intravenous drips with fluid replacement.	75,800	98,500	73,875	
			2. Intensive nursing care – ambulatory support; SaO2 monitoring; management of bilateral pleural drains and change of bottles; nursing accompaniment for CT simulation by Dr Lam.	7,200			
			3. Hospitalisation intensive care; respiratory and vital parameters monitoring.	15,500			
3	17-Jan-07	3	1. Inpatient review and close monitoring; management of bilateral pleurodesis and drainage of pleural effusion; close monitoring of intravenous drips with fluid replacement.	75,800	96,100	72,075	
			2. Intensive nursing care – ambulatory support; SaO2 monitoring; management of bilateral pleural drains and change of bottles.	4,800			

[110] The term "pleural effusion" is defined (*inter alia*) as "[i]ncreased fluid in the pleural space". It can cause shortness of breath by compression of the lung(s) and/or increased intrathoracic pressure, resulting in (among other things) increased work in breathing.

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			3. Hospitalisation intensive care; respiratory and vital parameters monitoring.	15,500			
4	18-Jan-07	3	1. Inpatient review and close monitoring; accompaniment for PET scan at Mount Elizabeth Hospital; management of bilateral pleurodesis and drainage of pleural effusion; close monitoring of intravenous drips with fluid replacement.	75,800	98,500	73,875	
			2. Intensive nursing care – ambulatory support; SaO2 monitoring; nursing accompaniment for whole body PET scan procedures; management of bilateral pleural drains and change of bottles.	7,200			
			3. Hospitalisation intensive care; respiratory and vital parameters monitoring.	15,500			

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
5	19-Jan-07	3	1. (a) Inpatient review and close monitoring; management of bilateral pleurodesis and drainage of pleural effusion; removal of bilateral chest tubes ($75,800). (b) Review and assessment of port-a-cath[111] with imaging; colour ultrasound study of tube connections of port-a-cath to internal jugular vein; difficult cannulation[112] and change of port-a-cath needle under ultrasound guidance; flushing of port-a-cath with Hep Saline ($125,800). (c) Port-a-cath cannulation for chemotherapy treatment ($68,500).	270,100	296,900	222,675	

[111] The term "Port (medical)" is described in Wikipedia as follows (see <http://en.wikipedia.org/wiki/Port_(medical)> (accessed 24 June 2013)): "[A] **port** (or **portacath**) is a small medical appliance that is installed beneath the skin. A catheter connects the port to a vein. Under the skin, the port has a septum through which drugs can be injected and blood samples can be drawn many times, … The term **portacath** is a portmanteau of "portal" and "catheter". *Port-a-Cath is a brand name of Smiths Medical*; others include Eco Port, Clip-a-Port, SmartPort, Microport [*etc*] .... The term **totally implantable venous access system** (**TIVAS**) is also used." [original emphasis in bold; emphasis added in italics] Smiths Medical describes its Port-A-Cath Implantable Venous Access Systems as a device "[d]esigned to permit repeated access to the venous system for the parenteral delivery of medications, fluids, and nutritional solutions and for the sampling of venous blood" (see <http://www.smiths-medical.com/catalog/implantable-ports/port-cath-implantable-venous.html> (accessed 24 June 2013)).

[112] The term "cannulation" is defined as the "[i]nsertion of a cannula". The term "cannula" is defined as "[a] tube that can be inserted into a cavity, usually by means of a trocar filling its lumen; after insertion of the cannula, the trocar is withdrawn and the cannula remains as a channel for the transport of fluid or passage of instruments". The term "trocar" is defined as "[a]n instrument for withdrawing fluid from a cavity, or for use in paracentesis. It consists of a metal tube (cannula) into which fits an obturator with a sharp three-cornered tip, which is withdrawn after the instrument has been pushed into the cavity; the name trocar is usually applied to the obturator alone, the entire instrument being designated trocar and cannula".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			2. Intensive nursing care – ambulatory support; SaO2 monitoring; management of bilateral pleural drains and change of bottles; bilateral pleurodesis with tetracycline;[113] post-procedure observation and monitoring; accompaniment to chemotherapy at National University Hospital by nursing staff.	11,300			
			3. Hospitalisation intensive care; respiratory and vital parameters monitoring.	15,500			
6	20-Jan-07 Saturday	2	1. Intensive nursing care – ambulatory support; SaO2 monitoring; post-chemotherapy care; accompaniment of the Patient back to hotel.	7,200	48,500	36,375	
			2. (a) Hospitalisation intensive care; respiratory and vital parameters monitoring ($15,500). (b) (Evening) Home consultation; specialist examination; respiratory and vital parameters monitoring ($25,800).	41,300			
7	21-Jan-07	2	1. Specialised nursing; ambulatory support; nursing care.	3,800	29,600	22,200	

[113] The term "tetracycline" is defined (*inter alia*) as "[a] broad spectrum antibiotic (a naphthacene derivative), the parent of oxytetracycline".

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
	Sunday		2. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800			
8	22-Jan-07	2	1. Specialised nursing; ambulatory support; nursing care.	3,800	29,600	22,200	
			2. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800			
9	23-Jan-07	2	1. Specialised nursing; ambulatory support; nursing care.	3,800	29,600	22,200	
			2. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800			
10	24-Jan-07	2	1. Specialised nursing; ambulatory support; nursing care.	3,800	29,600	22,200	
			2. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800			
11	25-Jan-07	2	1. Specialised nursing; ambulatory support; nursing care.	3,800	29,600	22,200	
			2. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800			
12	26-Jan-07	3	1. Home consultation; specialist examination; respiratory and vital parameters monitoring.	25,800	332,600	249,450	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			2. Emergency house call (10.00am); urgent hospital admission; mobilisation of nursing staff, administration staff and specialists; inpatient review and 24-hour monitoring (including post-procedure re-assessment of respiratory status, inpatient SaO2 monitoring and change of medications); urgent management of respiratory dyspnoea by a team of specialists.	295,000			
			3. Intensive nursing care – ambulatory support; SaO2 monitoring; accompaniment of the Patient to Gleneagles Hospital for urgent direct admission for respiratory distress; close monitoring of respiratory status.	11,800			
13	2 to 4-Feb-07 (3 days) Friday to Sunday	1	Coordinating surgeon in-charge for specialist management of breast cancer – daily home consultation and respiratory management ($25,800 x 3 days).	77,400	77,400	58,050	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
14	5 to 10-Feb-07; 12 to 16-Feb-07; 21 to 24-Feb-07; 26 to 28-Feb-07 (18 days)	1	Principal surgeon in attendance during radiotherapy – daily administration; entry into radiation chamber for patient checks ($25,000 x 18 days).	450,000	450,000	337,500	
15	1 to 2-Mar-07; 5 to 9-Mar-07 (7 days)	2	1. Principal surgeon in attendance during radiotherapy – daily administration; entry into radiation chamber for patient checks ($25,000 x 7 days).	175,000	435,000	131,250	[#]The Appellant offered to withdraw the invoice for this sum (Invoice GSP/INV/2007/0039).
			2. (a) Pre-transfusion blood investigations on 6-Mar-07. (b) Blood transfusion and electrolyte albumin replacement on 7-Mar-07 (the Appellant's clinic was blocked for this procedure); continuous close monitoring during transfusion; clinical examination during and after transfusion.	260,000[#]			

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
16	10-Apr-07	1	(a) One-month post-radiotherapy review; assessment of port-a-cath with imaging ($25,500). (b) Flushing of port-a-cath with medications ($16,800). (c) Difficult cannulation and change of port-a-cath needle under ultrasound guidance ($28,800). (d) Surface mapping on anterior abdominal wall tumours ($38,600). (e) Radiological investigations on thorax ($8,500). (f) Blood investigations ($1,550).	119,750	119,750	89,813	
17	11 to 13-Apr-07 (3 days)	1	Principal surgeon in attendance during radiotherapy (lower abdomen and left side of the neck) – daily administration; entry into radiation chamber for patient checks ($28,000 x 3 days).	84,000	84,000	63,000	

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
18	16-Apr-07	2	1. (a) Principal surgeon in attendance during radiotherapy (lower abdomen and left side of neck) – daily administration; entry into radiation chamber for patient checks ($28,000). (b) Specialist evaluation for sudden weakness of leg and inability to walk; urgent admission to ward; urgent radiological investigations; emergency insertion of PICC line[114] done under x-ray guidance for intravenous access; 24-hour monitoring (ECG, heart rate and blood pressure); cancellation of clinic for urgent attendance ($105,500).	133,500	139,500	100,125	*****The Appellant offered to withdraw Invoice CWN/INV/ 2007/0001 for the sum of $90,000 *vis-à-vis* 15 days of TPN support from 16 to 30-Apr-07 (the subject of Charges 18 to 27).
			2. TPN[115] support.	6,000*****			
19	17-Apr-07	3	1. TPN support.	6,000*****	99,000	69,750	
			2. Principal surgeon in attendance during radiotherapy (lower abdomen and left side of neck) – daily administration; entry into radiation chamber for patient checks.	28,000			

[114] The term "PICC line" is defined as an "acronym for peripherally inserted central catheter; a long-term type that is inserted peripherally".

[115] The term "total parenteral nutrition" is defined as "nutrition maintained entirely by central intravenous injection or other nongastrointestinal route".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			3. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring.	65,000			
20	18-Apr-07	3	1. TPN support.	6,000*	99,000	69,750	
			2. Principal surgeon in attendance during radiotherapy (lower abdomen and left side of neck) – daily administration; entry into radiation chamber for patient checks.	28,000			
			3. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring.	65,000			
21	19-Apr-07	4	1. TPN support.	6,000*	228,000	166,500	
			2. Principal surgeon in attendance during radiotherapy (lower abdomen and left side of neck) – daily administration; entry into radiation chamber for patient checks.	28,000			
			3. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring.	65,000			

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			4. (a) Specialist management of CT scan (head) after office hours upon the Patient's sudden weakness and giddiness ($42,000). (b) Urgent arrangement for and assistance at lumbar puncture[116] procedure performed under sedation in the ward by Dr Tang Kok Foo ($87,000).	129,000			
22	20-Apr-07	5	1. TPN support.	6,000*****	387,000	285,750	
			2. Principal surgeon in attendance during radiotherapy (lower abdomen and left side of neck) – daily administration; entry into radiation chamber for patient checks.	28,000			
			3. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring.	65,000			
			4. Surgeon in attendance for urgent MRI (spine) performed under sedation between 10.00am and 12.00 noon; clinic cancellation due to procedure.	158,000			

[116] The term "lumbar puncture" is defined as "a puncture into the subarachnoid space of the lumbar region to obtain spinal fluid for diagnostic or therapeutic purposes".

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
			5. Planning/mapping for urgent neuro-radiotherapy to brain and spine; moulding between 5.00pm and 7.00pm (after office hours).	130,000			
23	21-Apr-07; 23 to 27-Apr-07 (6 days)	3	1. TPN support ($6,000 x 6 days).	36,000*	649,000	459,750	
			2. Principal surgeon in attendance during radiotherapy (brain and spine) – daily administration; entry into radiation chamber for patient checks ($48,000 x 6 days).	288,000			
			3. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring; coordination of treatment ($65,000 x 5 days).	325,000			
24	22-Apr-07 Sunday	2	1. TPN support.	6,000*	71,000	48,750	
			2. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring; coordination of treatment.	65,000			
25	28-Apr-07 Saturday	2	1. TPN support.	6,000*	71,000	48,750	
			2. Hospitalisation intensive monitoring; respiratory and vital parameters monitoring; coordination of treatment.	65,000			
26	29-Apr-07	2	1. TPN support.	6,000*	156,000	112,500	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			2. 24-hour intensive bedside monitoring; respiratory and vital parameters monitoring; removal/change of catheter and TPN line; close monitoring of the Patient during family visit; re-insertion of IDC.[117]	150,000			
27	30-Apr-07	3	1. TPN support.	6,000*	119,000	84,750	
			2. Principal surgeon in attendance during radiotherapy (brain and spine) – daily administration; entry into radiation chamber for patient checks.	48,000			
			3. 24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs and neurological assessment); passive mobilisation; urinary sphincter[118] management.	65,000			

[117] "IDC" is the acronym for (*inter alia*) "indwelling catheter" (see *Medical Abbreviations*), which is (in turn) defined as "a catheter left in place in the bladder, usually a balloon catheter".

[118] The term "sphincter" is defined as "[a] muscle that encircles a duct, tube, or orifice in such a way that its contraction constricts the lumen or orifice".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
28	1-May-07 Public holiday	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs and neurological assessment); passive mobilisation; standing exercises; transportation of massage chair to the ward and subsequent removal at the Patient's request.	210,000	210,000	157,500	
29	2-May-07	2	1. Principal surgeon in attendance during radiotherapy (brain and spine) – daily administration; entry into radiation chamber for patient checks.	48,000	158,000	118,500	
			2. 24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs and neurological assessment); passive mobilisation; urinary sphincter management; standing exercises; urgent attendance to the Patient's sudden complaint of ear pain at 1.00am; coordination of late night visit by ENT specialist.	110,000			
30	3-May-07	2	1. Principal surgeon in attendance during radiotherapy (brain and spine) – daily administration; entry into radiation chamber for patient checks.	48,000	113,000	84,750	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
			2. 24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs and neurological assessment); passive mobilisation; urinary sphincter management; standing exercises; transfusion of blood products.	65,000			
31	4-May-07	2	1. Principal surgeon in attendance during radiotherapy (brain and spine) – daily administration; entry into radiation chamber for patient checks.	48,000	123,000	92,250	
			2. 24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs and neurological assessment); passive mobilisation; urinary sphincter management; standing exercises; outdoor physical treatment; per rectal examination/medications.	75,000			
32	5-May-07 Saturday	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; TPN; physiotherapy (electrode stimulation to muscles of both lower limbs); passive mobilisation; urinary sphincter management; standing exercises; general morbidity exercises; urgent recall upon the Patient's sudden respiratory distress at 10.00pm.	120,000	120,000	90,000	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
33	6-May-07 Sunday	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; physiotherapy (electrode stimulation to muscles of both lower limbs); passive mobilisation; urinary sphincter management; standing exercises; manual evacuation of stools due to faecal incontinence.	120,000	120,000	90,000	
34	7-May-07	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; physiotherapy (electrode stimulation to muscles of both lower limbs); passive mobilisation; urinary sphincter management; standing exercises, outdoor physical treatment; manual evacuation of stools.	75,000	75,000	56,250	
35	8-May-07	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; physiotherapy (electrode stimulation to muscles of both lower limbs); passive mobilisation; urinary sphincter management; standing exercises; mobility exercises; urgent ENT mobilisation following the Patient's complaint of swallowing difficulties; administration of medications; administration and close monitoring of blood transfusion.	120,000	120,000	90,000	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
36	9-May-07	1	(a) 24-hour intensive monitoring; respiratory and vital parameters monitoring; physiotherapy (electrode stimulation to muscles of both lower limbs); passive mobilisation; urinary sphincter management; standing exercises ($65,000). (b) Urgent scheduling (due to the Patient's sudden impending collapse); insertion of PICC line for TPN done after office hours under image intensifier; treatment for septicaemic shock; blood transfusion/platelet transfusion; change of urine catheter; treatment for hypovolemia;[119] urgent re-commencement of TPN ($280,000).	345,000	345,000	258,750	

[119] The term "hypovolemia" is defined as "[a] decreased amount of blood in the body".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
37	10-May-07	1	24-hour intensive monitoring; respiratory and vital parameters monitoring; urgent management of bone marrow suppression, arrhythmia and respiratory distress (at 4.00pm); urgent transfer of the Patient to ICU (at 8.00pm); mobilisation of a team of doctors to stabilise the Patient; intensive fluid support; diagnosis of pulmonary oedema/[120]pneumonia; administration of ventolin nebuliser; continuous haemodynamic and respiratory monitoring until 1.00am.	450,000	450,000	337,500	

[120] The term "pulmonary edema" (the American English spelling of "pulmonary oedema") is defined as "edema of lungs usually resulting from mitral stenosis or left ventricular failure". The term "edema" is defined (*inter alia*) as "[a]n accumulation of an excessive amount of watery fluid in cells or intercellular tissues".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
38	11-May-07	1	Intensive monitoring of respiratory distress; hourly fluid management; continuous bedside review and monitoring for cardiac, respiratory and electrolytes status/CVP[121] resuscitation; adjustment of TPN; intensive chest physiotherapy and ventolin nebuliser treatment for bronchospasm; emergency mobilisation of ICU team; urgent resuscitation with 10 *l*/min of oxygen (portable x-ray done); two-dimensional echocardiogram; mobilisation of radiology staff for urgent procedure (loculated left pleural effusion drainage done in the ward at 5.30pm).	450,000	450,000	337,500	
39	12-May-07 Saturday	1	Intensive monitoring of respiratory distress; urgent admission to ICU; intubation, ventilation and sedation; resuscitation and haemodynamic/fluid management; continuous respiratory monitoring; bronchoscopy under sedation; bronchial lavage for culture and sensitivity; clinic cancellation/rescheduling.	450,000	450,000	337,500	

[121] The term "CVP" is defined as the "[a]bbreviation for central venous pressure". The term "central venous pressure" is (in turn) defined as "the pressure of the blood within the venous system in the superior and inferior vena cava cephalad to the diaphragm, normally between 4–10 cm of water; it is depressed in circulatory shock and deficiencies of circulating blood volume and increased with cardiac failure and congestion of the venous circulation". The term "venous" is defined as "[r]elating to a vein or to the veins".

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
40	13 to 15-May-07 (3 days)	4	1. 24-hour critical care monitoring in ICU from 13 to 15-May-07; continuous team management; pleurodesis of left lung with 500 mg of tetracycline; pleural effusion management; pre- and post-procedure monitoring; sedation for pain relief.	320,000[@]	1,270,000	712,500	[@]The Appellant offered to withdraw the invoice for this sum (Invoice GSP/INV/2007/0064).
			2. 24-hour critical care monitoring in ICU (Sunday 13-May-07).	450,000			
			3. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling (14-May-07).	250,000			
			4. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling (15-May-07).	250,000			
41	16-May-07	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
42	17-May-07	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
43	18-May-07	2	1. Percutaneous tracheostomy[122] (minimally invasive technique) performed under sedation; surgical team (comprising the Appellant, Dr Winston Jong, Dr Chin, Dr Kum and Dr T B Chan) on standby from 4.00pm to 6.00pm; post-procedure monitoring.	350,000	660,000	495,000	
			2. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling; conference of specialists; preparation for percutaneous tracheostomy (minimally invasive technique); cardiovascular resuscitation and haemodynamic support with blood and blood products.	310,000			
44	19-May-07 Saturday	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling; 1st POD[123] – tracheostomy (the Patient awoke from a coma after one week); intensive continuous support and monitoring.	350,000	350,000	262,500	

[122] The term "tracheostomy" is defined as "[a]n operation to make an opening into the trachea". The term "trachea" is defined (*inter alia*) as "[t]he air tube extending from the larynx into the thorax to the level of the fifth or sixth thoracic vertebra where it bifurcates into the right and left bronchi".

[123] The term "POD" is defined (*inter alia*) as "Postoperative day" (see *Medical Abbreviations*).

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
45	20-May-07 Sunday	1	24-hour critical care monitoring in ICU; on standby from 7.30am; early reverse sedation; propping up the Patient in bed; strict reverse barrier nursing; tracheostomy dressings and adjustment of settings; muscle stimulation; physiotherapy in semi-recumbent position; intensive chest physiotherapy (3 sessions).	450,000	450,000	337,500	
46	21 to 23-May-07 (3 days)	4	1. 24-hour critical care monitoring in ICU from 21 to 23-May-07 (3 days); continuous team management; pleurodesis of right lung with 500 mg of tetracycline; pleural effusion management; pre- and post-procedure monitoring; sedation for pain relief.	320,000[+]	1,070,000	562,500	[+]The Appellant offered to withdraw the invoice for this sum (Invoice GSP/INV/2007/0068).
			2. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling (21-May-07).	250,000			
			3. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling (22-May-07).	250,000			
			4. 24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling (23-May-07).	250,000			
47	24-May-07	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
48	25-May-07	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
49	26-May-07 Saturday	1	24-hour critical care monitoring in ICU; clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	
50	27-May-07 Sunday	1	24-hour critical care monitoring in ICU (including right pleurodesis and left pleural tap).	280,000	280,000	210,000	
51	30-May-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
52	31-May-07 Public holiday	1	24-hour critical care monitoring in ICU (including tracheostomy management).	280,000	280,000	210,000	
53	1-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management and left pleurodesis); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
54	2-Jun-07 Saturday	1	24-hour critical care monitoring in ICU (including tracheostomy management and left pleurodesis); clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	
55	3-Jun-07 Sunday	1	24-hour critical care monitoring in ICU (including tracheostomy management).	280,000	280,000	210,000	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
56	4-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management and right pleurodesis); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
57	5-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
58	6-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
59	7-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
60	8-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); trial mobilisation to general ward; emergency transportation back to ICU at night upon the Patient's respiratory distress; clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
61	9-Jun-07 Saturday	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	
62	10-Jun-07 Sunday	1	24-hour critical care monitoring in ICU (including tracheostomy management).	280,000	280,000	210,000	
63	11-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); clinic and OT cancellation/rescheduling.	250,000	250,000	187,500	
64	12-Jun-07	1	24-hour critical care monitoring in ICU (including tracheostomy management); trial run preparation for air evacuation back to Brunei; clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	
65	13-Jun-07	1	24-hour critical care monitoring in ICU (including change of tracheostomy to Portex Size 7 in preparation for travel, ultrasound of liver/bladder, removal of left chest tube and right pleurodesis); clinic and OT cancellation/rescheduling.	280,000	280,000	210,000	

Annex B: The Category B charges

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
66	19-Apr-07 to 14-Jun-07 (Dr Kum) 7-May-07 to 14-Jun-07 (Dr Lam)	2	1. Services provided by Dr Kum (specialist ICU surgeon) from 19-Apr-07 to 14-Jun-07 relating to the general upper and lower gastrointestinal management of the Patient. 2. Services provided by Dr Lam (resident medical officer) from 7-May-07 to 14-Jun-07 relating to the Patient's ICU admission for ARDS,[124] sepsis and critical care management.	140,000^ 82,500^	222,500	166,875	^These invoices were in addition to invoices amounting to $14,547,000 ($10,122,750 after discount and after the Appellant's withdrawal of some of the invoices) separately issued by the Appellant for services rendered during the similar period of 16-Apr-07 to 14-Jun-07.

[124] "ARDS" is the abbreviation for (*inter alia*) acute respiratory distress syndrome, also known as adult respiratory distress syndrome (see *Medical Abbreviations*), which is (in turn) defined as "acute lung injury from a variety of causes".

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
67	10, 11, 13 and 15 to 20-May-06 (Dr Kum) 11, 13 and 15 to 20-May-06 (Dr Lam)	3	1. Services provided by Dr Kum on 10 and 11-May-06: (a) Cancellation of late afternoon surgery; short notice mobilisation out of office hours for flight to Brunei (at 4.00pm); assembly of equipment/medications ($28,000). (b) Emergency assessment of the Patient in Brunei (at 8.00am); respiratory and cardiovascular examination; medical accompaniment on flight from Brunei to Singapore; monitoring of vital parameters ($50,000). (c) Emergency transportation and medical accompaniment to Gleneagles Hospital; summary of medical parameters; handover to receiving team ($28,000). (d) Loss of surgical income ($80,000).	186,000[#]	254,300	No discount.	[#]These invoices (which have all been paid) were in addition to invoices amounting to $1,938,500 separately issued by the Appellant for services rendered during the similar period of 10, 11, 13 and 15 to 21-May-06.
			2. Services provided by Dr Kum on 13 and 15 to 20-May-06: (a) Specialist general surgical evaluation and handover to receiving team on 13-May-06 ($8,000). (b) Inpatient consultation from 15 to 20-May-06 ($3,800 x 6 days).	30,800[#]			

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
			3. Services provided by Dr Lam on 11, 13 and 15 to 20-May-06: (a) Medical management; respiratory management; haematology; medications ($2,500 x 8 days). (b) Pleurodesis pharmalogical dilution of tetracycline medicines ($3,500 x 5 sessions).	37,500[#]			

Annex C: The Category C charges

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
68	5 to 10-Feb-07; 12 to 16-Feb-07; 21 to 24-Feb-07; 26 to 28-Feb-07 (18 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to right chest wall; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	630,000^	630,000	0^	^The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0003).
69	1 and 2-Mar-07; 5 to 9-Mar-07 (7 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to right chest wall; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	245,000[#]	245,000	0[#]	[#]The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0004).

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
70	11 to 13-Apr-07 (3 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to lower abdomen and left side of neck; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	105,000*****	105,000	0*****	*****The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0006).
71	16 to 20-Apr-07 (5 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to lower abdomen and left side of neck; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	175,000[@]	175,000	0[@]	[@]The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0007).
72	21-Apr-07; 23 to 27-Apr-07 (6 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to brain and spine; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	270,000[+]	270,000	0[+]	[+]The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0008).

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
73	30-Apr-07; 2 to 4-May-07 (4 days)	1	Radiotherapy facilities and staff – for radiotherapy treatment to brain and spine; tomotherapy treatment (including equipment, chamber and facilities); monitoring in chamber by medical and radiation team to assess the Patient's positioning and respiratory status; services of in-house physician, nursing staff and radiation oncologist.	180,000[∞]	180,000	0[∞]	[∞]The Appellant offered to withdraw the invoice for this sum (Invoice CCS/INV/2007/0009).

Annex D: The Category D charges

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
74	22-Mar-05	1	Review and assessment for pleural tap by the Appellant, Prof Lee (cardiothoracic surgeon) and a medical team; inpatient pleural tap carried out by the Appellant and Prof Lee.	78,600^	78,600	No discount	^This invoice has already been paid. ^Prof Lee, who reviewed the Patient and conducted the procedure, charged $945 for his services.
75	24 and 30-May-05 (2 days)	1	(a) Joint consultation on 24-May-05 by the Appellant and Dr Wong (infectious diseases physician) – assessment and treatment of lung infection; assessment of pleurodesis; sputum and culture studies ($55,000). (b) Joint review on 30-May-05 by the Appellant and Dr Wong for lung infection; haematological investigations; pre-pleural effusion chemotherapy; chest x-ray ($38,500).	93,500[#]	93,500	No discount	[#]This invoice (which has already been paid) was in addition to an invoice for $106,300 separately issued by the Appellant for services rendered on 24-May-05. [#]Dr Wong, who reviewed the Patient, charged $500 for his services.

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
76	1 to 3-Jun-04 (3 days)	1	Treatment regime by Dr Whang (oncologist) – urgent intravenous therapy for tumour of spine: (a) First intravenous treatment given over an hour on 1-Jun-04 by specialised staff nurse and monitored by the Appellant ($63,000). (b) Second intravenous treatment given over an hour on 2-Jun-04 (public holiday) by specialised staff nurse and monitored by the Appellant ($85,000). (c) Third intravenous treatment given over an hour on 3-Jun-04 by specialised staff nurse and monitored by the Appellant ($63,000).	211,000*****	211,000	No discount	*****This invoice (which has already been paid) was in addition to invoices for a total of $305,800 separately issued by the Appellant for services rendered during the overlapping period of 1 to 10-Jun-04. *****Dr Whang, who reviewed the Patient on 1 and 2-Jun-04, charged $400 for her services.
84	15, 17 to 21 and 24-May-06 (6 days)	3	Professional fees for Dr Chin (anaesthetist).	589,100[@]	598,100	No discount	[@]This invoice (which has already been paid) is also the subject of a false representation charge. [@]Dr Chin charged $71,500 for his services during the similar period of 15 to 22 and 24-May-06.
85	10 and 11-May-06 (2 days)	1	Professional fees for Dr Chin (anaesthetist), including emergency assessment of the Patient in Brunei (at 8.00am), medical accompaniment on flight from Brunei to Singapore, summary of medical parameters, handover to receiving team and loss of anaesthetic income.	155,000[+]	155,000	No discount	[+]This invoice (which has already been paid) is also the subject of a false representation charge. [+]Dr Chin charged $40,000 for his services during the same period.

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
86	15-Jan-07 to 13-Jun-07	23	Professional fees for Dr Chin (anaesthetist).	3,992,900[∞]	3,992,900	0[∞]	[∞]The Appellant offered to withdraw all these 23 invoices, which were also the subject of a false representation charge. [∞]Dr Chin charged $2,120,000 (at a daily rate of $20,000) for his services during the similar period of 15-Jan-07 to 14-Jun-07.
87	11 and 15 to 20-May-06 (7 days)	1	Professional fees for Dr Koo (cardiologist).	32,150[β]	32,150	No discount	[β]This invoice (which has already been paid) is also the subject of a false representation charge. [β]Dr Koo charged $4,258.50 for his services during the same period.
88	19-Apr-07 to 14-Jun-07 (54 days)	1	Professional fees for Dr Koo (cardiologist).	259,200[Σ]	259,200	0[Σ]	[Σ]The Appellant offered to withdraw this invoice, which is also the subject of a false representation charge. [Σ]Dr Koo charged $27,600 for his services during the same period.

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
89	25 to 30-Jan-07 (6 days)	1	Professional fees for Dr Koo (cardiologist).	47,100[%]	47,100	0[%]	[%]The Appellant offered to withdraw this invoice, which is also the subject of a false representation charge. [%]Dr Koo charged $3,100 for his services during the similar period of 26 to 30-Jan-07.
90	12 and 23-Feb-07 (2 days)	1	Professional fees for Dr Koo (cardiologist).	21,600[§]	21,600	0[§]	[§]The Appellant offered to withdraw this invoice, which is also the subject of a false representation charge. [§]Dr Koo charged $1,270 for his services during the similar period of 13 and 26-Feb-07.

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
91	15, 16 and 26-Jan-07; 10 and 21-Apr-07 (5 days)	3	Professional fees for Dr Khor (radiation oncologist).	235,300[π]	235,300	0[π]	[π]The Appellant offered to withdraw these three invoices, which are also the subject of a false representation charge. [π]Dr Khor charged $19,050 for his services during the similar period of 16-Jan-07 to 4-May-07, while Mount Elizabeth Hospital charged (on behalf of Dr Khor) $35,043.40 for the similar period of 16-Jan-07 to 9-Mar-07.
92	19 and 20-Jan-07 (2 days)	1	Professional fees for Dr T Chan (gynaecologist).	25,500[μ]	25,500	0[μ]	[μ]The Appellant offered to withdraw this invoice, which is also the subject of a false representation charge. [μ]Dr T Chan did not render any invoices for her services.

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
93	11, 13 and 15 to 21-May-06 (9 days)	1	Professional fees for Dr T B Chan (respiratory physician).	401,900˜	401,900	No discount	˜This invoice, which is also the subject of a false representation charge, has already been paid. ˜Dr T B Chan charged $9,553.70 for his services during the same period.
94	15 to 19-Jan-07 (5 days)	1	Professional fees for Dr T B Chan (respiratory physician).	285,100Ω	285,100	0 Ω	ΩThe Appellant offered to withdraw this invoice, which is also the subject of a false representation charge. ΩDr T B Chan charged $3,000 for his services during the same period.

Annex E: The Category E charges

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
77	Feb-07	1	Short notice cancellation of flight to and conference in New York (pre-registered) to accommodate the Patient's urgent radiotherapy treatment regime.	78,000^	78,000	58,500	^This cancellation fee was in addition to a fee of $450,000 (before discount)/$337,500 (after discount) charged for the daily administration of radiotherapy sessions over 18 days in February 2007.
78	2-May-07	1	Emergency cancellation of flight to and conference booking in France (first representative for Singapore for non-invasive surgical technology).	180,000#	180,000	135,000	#This cancellation fee was in addition to a fee of $158,000 (before discount)/$118,500 (after discount) charged for, *inter alia*, 24-hour intensive monitoring and the administration of radiotherapy sessions on 2-May-07.

Annex F: The Category F charges

Charge	Treatment date(s)	No of invoices	Description of services according to the Appellant's invoices (separated by invoice)	Invoiced Amount ($)	Total Amount ($)	After Discount ($)	Comments
79	26 to 30-Jan-07 (5 days)	1	Attending and co-ordinating emergency specialist clinical management conference with Prof Smith and other specialists, including: (a) short notice mobilisation of Prof Smith and logistics; (b) pre-arrival case discussion with Prof Smith; (c) coordination of oncology review at short notice; (d) mobilisation; (e) briefing and case summaries with specialists in attendance; (f) compilation of case reports; (g) detailed analysis of chemotherapy regimes; (h) specialists' conference consultation at Gleneagles Hospital (at 5.00pm); (h) post-examination round-table discussions; (i) radiotherapy mappings; (j) summaries; and (h) formulation of treatment plan with all specialists.	560,000^	560,000	0^	^The Appellant offered to withdraw the invoice for this sum (Invoice SLS/INV/2007/0007). ^Prof Smith charged £45,000 for his services rendered during the similar period from 26 to 29-Jan-07, including loss of income due to his trip to Singapore.

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
80	19 to 21-Apr-07 (3 days)	1	Attending and co-ordinating emergency specialist clinical management conference with Prof Smith and other specialists, including: (a) short notice mobilisation of Prof Smith and logistics; (b) pre-arrival case discussion with Prof Smith; (c) coordination of oncology review at short notice; (d) mobilisation; (e) briefing and case summaries with specialists in attendance (f) compilation of case reports; (g) detailed analysis of chemotherapy regimes; (h) specialists' conference consultation at Gleneagles Hospital (at 5.30pm); (i) post-examination round-table discussions; (j) radiotherapy mappings; (h) summaries; and (i) formulation of treatment plan with all specialists.	320,000[#]	320,000	0[#]	[#]The Appellant offered to withdraw the invoice for this sum (Invoice SLS/INV/2007/0021). [#]Prof Smith charged £45,000 for his services from 19 to 21-Apr-07, including loss of income due to his trip to Singapore.

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
81	19 to 21-May-06 (3 days)	1	Attending and co-ordinating emergency specialist clinical management conference with Prof Smith and other specialists, including: (a) short notice mobilisation of Prof Smith and logistics; (b) pre-arrival case discussion with Prof Smith; (c) coordination of oncology review at short notice; (d) mobilisation; (e) briefing and case summaries with specialists in attendance; (f) patient review and preparation for clinical examination by specialists in a hotel on Sunday 21-May-06 (at 5.00pm); (g) review of CT scans and other imaging; (h) post-examination round-table discussions; (i) summaries; (j) formulation of treatment plan with all specialists; and (k) post-conference review of the Patient and administration of first chemotherapy medications (Venorolbine) in a hotel at 6.30pm.	560,000*****	560,000	No discount	*****This invoice has already been paid.

Charge	**Treatment date(s)**	**No of invoices**	**Description of services according to the Appellant's invoices (separated by invoice)**	**Invoiced Amount ($)**	**Total Amount ($)**	**After Discount ($)**	**Comments**
82	19 to 20-Apr-06 (2 days)	1	Attending and co-ordinating urgent specialist clinical management conference with Prof Smith and other specialists, including: (a) medical coordination of specialists' schedules; (b) compilation of case reports; (c) detailed analysis of chemotherapy regimes; (d) cancellation of overseas meeting (Geneva); (e) cancellation of patient appointments and OT listings; (f) specialists' conference consultation at Mount Elizabeth Hospital (at 5.00pm); (g) specialist review both pre- and post-consultation in Brunei; (h) formulation of treatment strategy plan; and (i) scheduling of medications and follow-up.	380,000[@]	380,000	No discount	[@]This invoice has already been paid.
83	9-Apr-05	1	Attending and co-ordinating specialist clinical management conference consultation with Prof Smith and other specialists, including: (a) cancellation of mid-morning clinic; (b) picking up Prof Smith from the airport; (c) specialists' conference consultation at Gleneagles Hospital (at 4.00pm); (d) specialists' review (evening); and (e) formulation of treatment strategy plan.	180,000[+]	180,000	No discount	[+]This invoice has already been paid.