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PRESS RELEASE

DISCIPLINARY INQUIRY FOR DR ERIC GAN KENG SENG

1. The Disciplinary Committee ("**DC**") of the Singapore Medical Council ("**SMC**") held a disciplinary inquiry in May 2009 and January 2010 for Dr Gan Keng Seng Eric ("**Dr Gan**"), a registered medical practitioner and a specialist in general surgery. At the material time, Dr Gan was a Consultant in the Department of Surgery at Alexandra Hospital ("**AH**").

2. Dr Gan faced two charges of professional misconduct under section 45(1)(d) of the Medical Registration Act ("**MRA**") in relation to the management of one of his patients ("**the Patient**"). At the conclusion of the disciplinary inquiry, the DC acquitted Dr Gan on the first charge and convicted him on the second charge.

3. Taking all the circumstances into consideration, including Dr Gan's mitigation plea, the DC ordered that Dr Gan be suspended from practice for a period of 6 months. Dr Gan was also censured and ordered to give a written undertaking to the SMC that he would not engage in the conduct complained of or any similar conduct. Dr Gan was also ordered to pay 70% of the costs and expenses arising from the disciplinary inquiry incurred by SMC, including the costs of solicitors and the Legal Assessor.

4. Dr Gan appealed to the Court of Three Judges in respect of the conviction on the second charge and against the sentence ordered against him. The appeal was heard on 29 April 2010 and the Court of Three Judges delivered its decision on 1 November 2010. The Court dismissed Dr Gan's appeal on both conviction and sentence, with costs.

Charges:

5. The first charge involved the issue of whether Dr Gan was competent to perform pre-cut sphincterotomy ("**the Procedure**"), a surgical procedure, on the Patient for the purpose of removing a stone in the common bile duct. The second charge involved the issue of whether Dr Gan was in wilful neglect of his duties and had grossly mismanaged the post-operative treatment of the Patient. Dr Gan contested both charges at the SMC's disciplinary inquiry.

6. In relation to the first charge, the DC noted that whilst Dr Gan had been accredited to perform endoscopic retrograde cholangiopancreatograms ("**ERCP**"), no clear guidelines existed as to what constituted "competency" in performing the Procedure. Dr Gan had been trained, and his technique had been supervised, by senior accomplished endoscopists familiar with the Procedure, and they had testified that he was competent to perform the Procedure. Prior to performing the Procedure on the Patient, Dr Gan had performed 17 such procedures at AH. On this basis, the DC was unable to conclude beyond a reasonable doubt, that Dr Gan was not competent to perform the Procedure on the Patient.

7. However, the DC emphasised that in the review of the first charge, they had some concerns about the high number of procedures (27%) out of the total number of ERCPs Dr Gan performed in order to gain access to the common bile duct. Given the risks associated with the Procedure, and that other more experienced endoscopists reported a much lower incidence of using the Procedure, the DC advised Dr Gan to review his practice, and the frequency of use of the Procedure in order to gain access to the common bile duct.

8. The second charge alleged that Dr Gan failed to carry out the appropriate clinical investigation by way of a CT scan on the Patient's abdomen and pelvis within reasonable time in order to ascertain whether there was perforation of the duodenum, which was a known risk of the Procedure. This is despite the Patient's medical history of the failed Procedure, and his clinical conditions of persistent and severe epigastric pain, bilious vomiting and abdominal distension and tenderness, which started in the first few hours after the Procedure.

9. The evidence showed that Dr Gan first saw the Patient post-surgery nearly 16 hours after the onset of symptoms, even though he was informed that the Patient was unwell 2 hours after the Procedure. The DC noted that during this period, the most senior doctor who attended to the Patient was the Registrar on-call.

10. The DC was of the view that Dr Gan should have personally attended to the Patient and evaluated his condition when notified that the Patient was unwell following the Procedure Dr Gan performed, especially as results of initial tests were available. Being the consultant-in-charge, and by virtue of his accreditation by AH to perform the Procedure, he would have been in the best position to holistically evaluate all available information and adapt management decisions according to the clinical picture, especially as the Patient's condition evolved. The DC emphasised that relying solely on the assessment of junior doctors, including one still in specialty training, was not in the best interests of the Patient, and found that Dr Gan's conduct fell short of his professional duty to the Patient.

11. In the DC's opinion, a reasonably responsible doctor who had performed a procedure which was unsuccessful, and associated with known risks of significant complications, had the responsibility to see the Patient in a timely fashion when the Patient had symptoms, signs and tests consistent with such a complication.

12. Further, the DC was of the opinion that had Dr Gan, as a responsible, competent consultant surgeon, seen the Patient earlier (the same night after the surgery), he would have considered ordering a CT scan earlier when the Patient's condition did not improve the following day. The CT scan was the appropriate definitive diagnostic test to be carried out as it would have revealed perforation of the duodenum. However, Dr Gan did not see the Patient until 16 hours after the surgery. Although the Patient exhibited symptoms consistent with perforation (which Dr Gan did not rule out), he remained with his diagnosis of pancreatitis. He did not order a CT scan until 25 hours after the Procedure. The DC was of the view that a more timely CT scan would have been crucial in the management of the Patient.

13. Having considered the totality of the matters, the DC was of the opinion that Dr Gan's failure to personally assess the Patient on the night of the surgery when he was aware that the Patient was unwell after the unsuccessful Procedure, and manage the situation appropriately between the onset of symptoms and signs post-ERCP and the diagnosis of perforation amounted to wilful neglect of Dr Gan's professional duties. As a result,

the DC found, beyond reasonable doubt, that Dr Gan had grossly mismanaged the post-operative treatment of the Patient.

Decision of the Court of Appeal:-

14. On appeal, Dr Gan's counsel raised several grounds, including:
    a) That the DC went beyond the scope of the second charge;
    b) The DC's findings that had Dr Gan personally seen the Patient in the evening of 6 December 2005, he would have considered ordering a CT scan earlier is flawed and not supported by evidence; and
    c) The DC's criticism of the fact that Dr Gan did not personally attend to the patient on the night of 6 December 2005 is misplaced.

15. The Court disagreed with the various grounds raised by Dr Gan in his appeal. In particular, the Court held that even though Dr Gan's failure to attend to the Patient on the night of 6 December 2005 was not specifically set out in the Charge nor in the particulars furnished, Dr Gan's entire conduct in relation to the care of the Patient was necessarily put in issue when he was charged with willful neglect of his duties and gross mismanagement in the post-operative treatment of the Patient. The Court found that the Charge, as amplified by the particulars, clearly required the DC to consider the entire conduct of Dr Gan from the time the failed Procedures ceased until he performed the operation in the wee hours of 8 December 2005 to mend the duodenal perforation discovered through the CT scan which was eventually ordered. Dr Gan's failure to attend to the patient in the evening of 6 December 2005 was certainly a circumstance which the DC was entitled to take into account in its overall assessment as to whether there was gross neglect or mismanagement on Dr Gan's part.

16. In trying to justify his failure to attend to the patient during the evening of 6 December 2005, Dr Gan sought to rely on the fact that he was in communication with an on-call Registrar. In its decision, the DC did not think that this was an appropriate case for Dr Gan to arrive at a clinical assessment based merely on the input of the on-call Registrar. The Court agreed entirely with the DC's finding on this point. The Court recognised that under Guideline 4.1.1.4 of the SMC's Ethical Code and Ethical Guidelines ("SMC's ECEG") that the doctor in charge could delegate to another doctor or nurse, the task of providing treatment or care to a patient. However, in this case, the issue was the clinical assessment of the condition of a patient. In order to make the right assessment, much would necessarily depend on the skill and experience of the doctor. Indeed, the

Court highlighted Guideline 4.1.1.5 of SMC's ECEG, where it is stated that a doctor should make necessary and timely visits. He should also make timely investigations.

17. The Court further held that in view of this grave consequence if a duodenal perforation is not attended to with due dispatch, a consequence which Dr Gan said he well knew, the Court affirmed the DC's decision to have found Dr Gan guilty of gross neglect or mismanagement in failing to see the Patient in a more timely fashion, which would have led to a more timely CT scan and the discovery of the duodenal perforation in the Patient.

18. On the appeal against sentence, the Court found that the suspension of 6 months was not out of line with the previous cases and it was not manifestly excessive. As such, the sentence ordered by the DC is to stand.

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