IN THE REPUBLIC OF SINGAPORE

SINGAPORE MEDICAL COUNCIL DISCIPLINARY TRIBUNAL

[2018] SMCDT 6

Between

Singapore Medical Council

And

Dr Ganesh Ramalingam

… Respondent

GROUNDS OF DECISION

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension

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Singapore Medical Council
v
Dr Ganesh Ramalingam

[2018] SMCDT 6

Disciplinary Tribunal — DT Inquiry No. 6 of 2018
Dr Joseph Sheares (Chairman), Prof K Satkunanatham and Mr Tan Boon Heng (Legal Service Officer)
15 May 2018

Administrative Law — Disciplinary Tribunals

Medical Profession and Practice — Professional Conduct — Suspension

17 May 2018

GROUNDS OF DECISION

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

A. INTRODUCTION

1. In this inquiry into the acts of professional misconduct of the medical practitioner, the only issue before the Disciplinary Tribunal ("**DT**") was the appropriate *length* of the suspension to be imposed on the registered medical practitioner.

2. The medical practitioner in question, Dr Ganesh Ramalingam ("**Dr Ganesh**"), pleaded guilty to three charges of professional misconduct under section 53(1)(*d*) of the Medical Registration Act, Cap.174 ("**MRA**") for a failure to:

(a) obtain informed consent, in breach of Guideline 4.2.2 of the 2002 edition of the Singapore Medical Council ("**SMC**") Ethical Code and Ethical Guidelines ("**2002 ECEG**");

(b) keep proper medical records in respect of the treatment and care of the Patient, in breach of Guideline 4.1.2 of the 2002 ECEG; and

(c) undertake an adequate clinical assessment and evaluation of the Patient before offering a gastroscopy and colonoscopy to the Patient, in breach of Guideline 4.1.1.1 of the 2002 ECEG.

3. Having taken into consideration all the circumstances of the case, the DT imposed, among others, a **seven (7) month** suspension term on Dr Ganesh. We now set out the circumstances leading to, and the reasons for, the DT's decision.

B. THE AGREED STATEMENT OF FACTS

4. Dr Ganesh was a General Surgeon with PanAsia Surgery Pte Ltd. As a medical practitioner registered under the MRA, Dr Ganesh was required to adhere to the 2002 ECEG in force at the material time. Dr Ganesh knew and/or understood that, under the 2002 ECEG, he was obliged and/or required, among others, to:

(a) ensure that a patient under his care is adequately informed about: (i) her medical condition and options for treatment so that she is able to participate in decisions about her treatment; and (ii) if a procedure needs to be performed, the benefits, risks and possible complications of the procedure and any alternatives available to her (per Guideline 4.2.2 of the 2002 ECEG);

(b) keep clear, accurate, legible and sufficiently detailed medical records (per Guideline 4.1.2 of the 2002 ECEG); and

(c) provide medical care only after an adequate assessment of the patient's condition through good history taking and appropriate clinical examination (per Guideline 4.1.1.1 of the 2002 ECEG).

The Complaint

5. On or about 27 January 2015, the SMC received a complaint (the "**Complaint**") from one Mr C ("**Mr C**"), the husband of one of Dr Ganesh's former patients, one Mdm P ("**Patient**"). In the Complaint, Mr C raised, among others, the issue that Dr Ganesh had performed: (a) a gastroscopy; (b) a colonoscopy; and (c) a biopsy (collectively, the "**Procedures**") on the Patient at Parkway East Hospital at 321 Joo Chiat Place, Singapore 427990 (the "**Hospital**"), *without* informing the Patient adequately about the Procedures before performing the Procedures on the Patient.

The Inquiry by the Complaints Committee

6. The SMC subsequently appointed a Complaints Committee ("**CC**") and the Complaint was laid before the CC. Dr Ganesh sent a letter of explanation to the CC dated 10 July 2015 ("**Letter of Explanation**"), in which he admitted that he had omitted to make a record of his conversation with Mr C and the Patient.

7. After considering, among others, Dr Ganesh's Letter of Explanation, the CC decided to refer Dr Ganesh to a DT for possible professional misconduct pursuant to section 53(1)(*d*) of the MRA.

The Charges

8. Pursuant to Regulation 27 of the Medical Registration Regulations 2010 (Cap. 174), the SMC preferred three (3) charges against Dr Ganesh. The three (3) charges were as follows:

1ST CHARGE (AMENDED)

1. That you, DR GANESH RAMALINGAM, are charged that you, on or about 22 April 2014, whilst practising as a general surgeon at the PanAsia Surgery Group at 319 Joo Chiat Place #04-03, Parkway East Medical Centre, Singapore 427989 ("Clinic"), failed to obtain the required informed consent of one P ("Patient") before performing (i) a gastroscopy; (ii) a colonoscopy; and (iii) a biopsy (collectively, the

"Procedures") on the Patient at Parkway East Hospital at 321 Joo Chiat Place, Singapore 427990 ("Hospital"), in breach of Guideline 4.2.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines 2002 ("2002 ECEG"), to wit :-

Particulars

Prior to performing the Procedures, you failed to adequately inform the Patient of:

(a) the reasons for the Procedures (including what the Procedures entailed); and

(b) the alternative treatments available to the Patient (including but not limited to the use of oral antibiotics with observation, without the need for the Procedures),

and your aforesaid conduct amounts to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

2ND CHARGE

2. That you, DR GANESH RAMALINGAM are charged that you, on or about 22 April 2014, whilst practising as a general surgeon at the Clinic, failed to keep proper medical records in respect of the treatment and care of the Patient, in breach of Guideline 4.1.2 of the 2002 ECEG, to wit:

Particulars

You failed to keep medical records which accurately and sufficiently set out:

(a) the Patient's clinical details and investigation results (including but not limited to characterisation of the symptoms of diarrhoea and rectal bleeding, and the indications for the Procedures); and

(b) your advice and explanation to the Patient prior to the Procedures, if any,

and your aforesaid conduct constitutes an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

3RD CHARGE

3. That you, DR GANESH RAMALINGAM, are charged that you, on or around 22 April 2014, whilst practising as a general surgeon at the Clinic, failed to undertake an adequate clinical assessment and evaluation of the Patient before offering a gastroscopy and colonoscopy to the Patient, in breach of Guideline 4.1.1.1 of the 2002 ECEG, to wit:

Particulars

You failed to obtain the following necessary information to make a diagnosis of the Patient and to determine a proper course of treatment for her:

(a) the nature, frequency and history of previous episodes, of the Patient's diarrhoea and/or rectal bleeding; and

(b) the Patient's travel history and family history of bowel disorders,

and your aforesaid conduct constitutes an intentional, deliberate departure from the standards observed or approved by members of the profession of good repute and competency, and that in relation to the facts alleged you are guilty of professional misconduct under section 53(1)(*d*) of the Medical Registration Act (Cap. 174).

Facts relating to the Charges

9. On or about 22 April 2014, the Patient attended at the Clinic to consult Dr Ganesh on her rectal bleeding and abdominal discomfort. During the consultation, Dr Ganesh advised the Patient to undergo a gastroscopy and a colonoscopy to be performed by him,

without undertaking an adequate clinical assessment and evaluation of the Patient, in breach of Guideline 4.1.1.1 of the 2002 ECEG.

10. In accordance with Guideline 4.1.1.1 of the 2002 ECEG, it was agreed that Dr Ganesh ought to have obtained, among others, the following information required for a proper diagnosis of the Patient's condition and/or to determine a proper course of treatment for her:

(a) the nature, frequency and history of previous episodes of the Patient's diarrhoea and/or rectal bleeding; and

(b) the Patient's travel history and family history of bowel disorders.

11. Dr Ganesh, however, failed to obtain the above information from the Patient. Relying on Dr Ganesh's advice, the Patient agreed to undergo the colonoscopy and gastroscopy at the Hospital later the same day at about 5:30pm. Prior to performing the Procedures, Dr Ganesh ought to have, among others, adequately informed the Patient of:

(a) the reasons and indications for the Procedures (including what the Procedures entailed); and

(b) the alternative treatments available to the Patient (including but not limited to the use of oral antibiotics with observation, without the need for the Procedures).

12. During the consultation, Dr Ganesh also failed to adequately inform the Patient of: (a) the reasons and indications for the Procedures, and (b) any alternatives to the Procedures available to her. In breach of Guideline 4.2.2 of the 2002 ECEG, Dr Ganesh failed to obtain the required informed consent of the Patient before performing the Procedures on her. After the Patient underwent the Procedures on 22 April 2014, she suffered a perforation of her colon, and had to undergo corrective surgery via laparotomy. The corrective surgery was successful, but the Patient had a colostomy for two months thereafter. She also suffered two long scars as a result of the laparotomy and colostomy.

13. Further, in breach of Guideline 4.1.2 of the 2002 ECEG, Dr Ganesh failed to keep proper medical records in respect of the treatment and care of the Patient that accurately and sufficiently set out:

(a) the Patient's clinical details and investigation results, including but not limited to:

(i) further characterisation of the diarrhoea (such as its recurrence and/or progression);
(ii) further characterisation of the rectal bleeding (such as the nature of the blood and its relation to the diarrhoea);
(iii) the Patient's associated symptoms and travel history; and
(iv) his findings on physical examination of the Patient;

(b) the indications and justifications for the Procedures; and

(c) his advice and explanation to the Patient prior to the Procedures, if any.

The agreed acts of professional misconduct

14. It was agreed that Dr Ganesh's failure to obtain the informed consent of the Patient before performing the Procedures on her would amount to such serious negligence that it objectively portrays an abuse of the privileges which accompany registration as a medical practitioner.

15. Dr Ganesh's failure to: (a) keep proper medical records in respect of the treatment and care of the Patient; and (b) undertake an adequate clinical assessment and evaluation of the Patient before offering a gastroscopy and colonoscopy to her, constitute intentional, deliberate departures from the standards observed or approved by members of the profession of good repute and competency.

C. PLEA OF GUILT

16. At the inquiry before the DT on 15 May 2018, Dr Ganesh admitted, without qualification, to the facts set out in the Agreed Statement of Facts ("**ASOF**") tendered by the SMC and pleaded guilty to the three charges of professional misconduct.

D. SUBMISSION ON SENTENCING BY COUNSEL FOR SMC

17. Counsel for the SMC, Mr Edmond Kronenburg, submitted that taking into consideration the circumstances surrounding Dr Ganesh's misconduct as well as the relevant sentencing precedents, the SMC was of the view that the appropriate starting point is a suspension of 12 months. He informed the DT that misconduct involving a doctor's failure to obtain informed consent would generally attract a term of suspension. Further, having regard to the aggravating factors in this case i.e. Dr Ganesh's seniority and standing in the medical profession and the severe harm suffered by the Patient, a suspension sentence would be more so warranted on the facts of the present case given the serious nature of the misconduct involved.

18. Notwithstanding the aggravating factors highlighted above, Counsel for the SMC said that the SMC noted Dr Ganesh's early indication of his intention to take a certain course of action in relation to the Charges against him in November 2017, not long after the first Pre-Inquiry Conference on 9 October 2017. While the SMC is of the view that there is sufficient basis / evidence to make out the Charges against him, credit ought to be given to Dr Ganesh's early plea of guilt which contributed to significant savings in respect of the time and costs of this Disciplinary Inquiry. In the present case, a plea of guilt also helped to avoid the Patient having to testify and re-live her traumatic experience.

19. Counsel for the SMC further submitted that the SMC was not opposed to the DT adjusting the SMC's proposed sentence of a 12-month suspension to account for Dr Ganesh's early plea of guilt. In this regard, Counsel for the SMC submitted that a final sentence of 8 to 10 months' suspension would not be inappropriate.

E. MITIGATION BY COUNSEL FOR THE RESPONDENT

20. In mitigation, Counsel for the Respondent, Ms Mak Wei Munn, submitted the following:

(a) **Early plea of guilt**. Dr Ganesh was quick to fully acknowledge that the history obtained from as well as the advice provided to the Patient during the consultation on 22 April 2014 were inadequate. He also accepted that the documentation in this case was lacking and has not offered any excuses for his shortcoming. Following receipt of the Notice of Inquiry on 27 August 2017 and the Pre-Inquiry Conference on 9 October 2017, Dr Ganesh informed the DT on 23 November 2017 that he was intending to take a certain course of action, subject to an agreement being reached with the SMC on the ASOF. Between 8 December 2017 and 13 February 2018, Dr Ganesh fully co-operated with the SMC by providing timely input and responses, so that the ASOF could be expeditiously agreed upon notwithstanding the end of year public holidays and the Lunar New Year break. Dr Ganesh's conduct demonstrated a recognition and willingness to accept that, on this one occasion, he had fallen short of the standards expected of him. Dr Ganesh's timeous plea of guilt has saved the SMC time and resources that would otherwise have to be expended on a full Disciplinary Inquiry.

(b) **No antecedents**. Prior to Dr Ganesh's conviction of the present three charges, Dr Ganesh had an unblemished record with the SMC over 21 years of practice (16 years in government service and five years in private practice). The present conviction will be a permanent blot in Dr Ganesh's otherwise unblemished record, a stigma that he would have to carry for the rest of his career.

(c) **Prompt response to complication**. Dr Ganesh's response to the complication in this case demonstrated candour, honesty, and a desire to act in the best interests of the Patient. Upon being informed of the CT scan findings that suggested perforation of the bowel, Dr Ganesh took immediate

steps to deal with the complication. Dr Ganesh rushed to the hospital to review the CT scan films. He immediately contacted a senior colleague to discuss the findings and further management. Dr DW ("**Dr DW**") was asked to participate in the management for no other purpose than to ensure that the Patient's best interests were met.

(d) **Impact of complaint and proceedings**. Dr Ganesh has spent the past four years in anxiety and distress, after the complication materialised on 24 April 2014 and following receipt of the Notice of Complaint on 3 June 2015 and the Notice of Inquiry on 28 August 2017 (i.e. 2 years, 2 months and 26 days later). This has clouded his life and practice. Dr Ganesh and his wife recently started a family. They had hoped to be able to embrace this new season of life with the hope and promise ordinarily associated with welcoming a newborn baby. The weight of the proceedings and the recognition of misconduct have had the effect of a significant period of extra-curial punishment.

(e) **Active steps voluntarily taken to improve clinical care and medical practice**. To demonstrate his determination not to repeat the mistakes, Dr Ganesh has voluntarily taken active steps to improve his clinical care and medical practice. In doing so, Dr Ganesh has acknowledged his shortcomings and shown a commitment to improve in order to provide the best care to his patients. The steps taken include:

(1) <u>Use of Pamphlets and Visual Aids when obtaining informed consent</u>. Utilising teaching aids such as pamphlets and information sheets to better explain treatment options. The pamphlets are given to patients after their consultation with Dr Ganesh. Clinic assistants have also been trained to go through the pamphlets with the patients and ensure that they have no further questions before they leave the clinic. If patients have further queries, they would be directed back to the consultation room for further discussion with Dr Ganesh. This reduces the risks of error or failure in handwritten documentation.

(2) Ensuring sufficient elapse of time for the signing of the consent form. Effort is made to ensure that patients are given as much time as they request to review the consent forms before signing them. Dr Ganesh will reiterate the nature, risks and complications, and alternatives of the treatment options before the patients sign the consent forms (i.e. advice is given thrice). Even after patients sign the consent forms, they are informed that they have the liberty to cancel the procedure if they decide not to proceed.

(3) Ensuring patients' records are properly and accurately captured. During consultations, Dr Ganesh contemporaneously documents the discussion with his patients. The case notes are typed into the 'Clinic Assist' system. At the end of each day, Dr Ganesh would double check the 'Clinic Assist' system to ensure that all the patients' records are properly and accurately captured.

(4) Instituting a 24-hour hotline. Dr Ganesh has also set up a 24-hour hotline on which patients can contact him personally if they have any queries or doubts regarding their procedure or medical condition.

21. At the hearing, Counsel for the Respondent submitted that a short suspension of between three to six months (if necessary, a financial penalty) coupled with a censure and undertaking and an order for payment of costs would be appropriate in the present case considering that:

(a) the seriousness of the offences and moral culpability in Dr Ganesh's case is lower when compared against the facts in the precedent cases referred to in the Respondent's submission; and

(b) there is a low risk of Dr Ganesh re-offending as he has already taken active steps to improve his clinical care and medical practice after setting up his own practice.

F. THE DISCIPINARY TRIBUNAL'S ANALYSIS

Bewildering conduct of a senior and experienced medical professional

22. The entire conduct of Dr Ganesh, when the Patient attended at the Clinic on 22 April 2014 to consult him on her rectal bleeding and abdominal discomfort, was puzzling to say the least. At the consultation, Dr Ganesh failed to obtain sufficient medical history from the Patient in the consultation room. There was no adequate clinical assessment and evaluation of the Patient before he offered a gastroscopy and colonoscopy to the Patient. Dr Ganesh only rushed to have the Procedures (which were *not* emergency surgical procedures) carried out the same afternoon ***(within four hours after the consultation)***. We wish to stress that this conduct of Dr Ganesh was entirely inexplicable. In the first place, there was no urgency to conduct these Procedures on the Patient. Under those circumstances, Dr Ganesh could hardly avail himself the opportunity to obtain informed consent from the Patient. The Patient would also not have had the time to properly deliberate her earlier decision to undergo surgery and/or to seek a second medical opinion. By so doing, Dr Ganesh would have deprived himself of the possibility to re-evaluate the Patient and/or remedy any errors he could have made in his earlier diagnosis.

Exacerbated by Procedures that went awry

23. As fate would have it, and unfortunate for Dr Ganesh, after the Patient underwent the Procedures on 22 April 2014, she suffered a perforation of her colon, and had to undergo corrective surgery via laparotomy. The corrective surgery was successful, but the Patient had a colostomy for two months thereafter. She also suffered two long scars as a result of the laparotomy and colostomy. If the outcome of the Procedures had been uneventful, it would not have precipitated this Complaint.

SMC's Call for a Longer Suspension Sentence

24. Bearing in mind the bewildering conduct of Dr Ganesh in his management of the Patient at the material time, we agree with Counsel for the SMC's call for a longer suspension term (rather than a term of not more than six months as submitted by Counsel for the Respondent) for the following reasons:

(a) **Dr Ganesh has been convicted of three charges**. These charges relate to both the medical treatment / advice given to his Patient (i.e. the Amended 1st Charge and 3rd Charge) as well as his professional obligations as a physician (i.e. the 2nd Charge). Taken together, Dr Ganesh's overall misconduct is of a serious nature.

(b) **The Patient's lack of information severely undermined her autonomy to make the proper medical decision as to the treatment suitable for her.** In relation to the Amended 1st Charge, Dr Ganesh's failure to obtain informed consent is especially egregious – he had failed to provide critical information necessary for the Patient to make a proper medical decision. The Patient was not even aware of the nature of the surgery she was asked to undergo, including what the Procedures entailed and more importantly, was not presented with any alternative treatment options (including but not limited to the use of oral antibiotics with observation).

(c) **Dr Ganesh compounded his misconduct by failing to keep any medical records** (i.e. the 2nd Charge) relating to what had taken place in his consultation room – this is unlike the situation in other cases where the misconduct only involved a doctor's failure to keep complete / legible records, had missing, misleading or vague information. Dr Ganesh's abject failure to keep ***any*** records at all not only makes it extremely difficult to ascertain exactly what he had told the Patient (if at all), this failure effectively removed any chance for someone else (or himself) to remedy the deficiency in the informed consent process, viz. a subsequent reader would not know what was said (or not said) and would not be in a position to correct any errors.

On sentencing for the failure to obtain informed consent

25. The Court of Three Judges ("**C3J**") in *Lam Kwok Tai Leslie v SMC* [2017] 5 SLR 1168 at paragraph 90 had laid down the following factors that a DT ought to consider in sentencing doctors for their failure to obtain informed consent:

"(a) the materiality of the information that was not explained to the patient, namely, whether there is evidence that the patient would have taken a different course of action had such information been conveyed;

(b) the extent to which the patient's autonomy to make an informed decision on his own treatment was undermined as a result of the doctor's failure to convey or explain the necessary information; and

(c) the possibility of harm and, where applicable, the materiality of the harm which resulted from the doctor's failure to explain the necessary information. This follows from the court's observation in Yong Thiam Look Peter v Singapore Medical Council [2017] 4 SLR 66 (at [12]) that when harm ensues in a case where the harm does not form an element of the charge, the causation of such harm would be a "seriously aggravating" factor; on the other hand, the absence of such harm would "generally be a neutral consideration without any mitigating value."

26. Based on the aforesaid factors, we agree with the submission of the Counsel for the SMC that Dr Ganesh's misconduct vis-à-vis the lack of informed consent from the Patient is particularly egregious in that:

(a) he had failed to explain to the Patient material information, i.e. the reasons and indications for the Procedures (including what the Procedures entailed) and the alternative treatments available;

(b) the Patient's autonomy to make an informed decision on her treatment was seriously curtailed (especially because she did not know that alternative non-invasive treatments were in fact available); and

(c) significant harm resulted from Dr Ganesh's misconduct.

On sentencing for a failure to maintain proper medical records

27. In *Yong Thiam Look Peter v SMC* [2017] 4 SLR 66 ("**Dr Yong Thiam Look Peter**"), the C3J also reasoned that maintaining proper medical records forms the basis of good patient management and of sound communications pertaining to the care of the patient, such that doctors are also able to ensure that the care of patients can be safely

taken over by another doctor should the need arise. The C3J further noted the significant public health consideration in the need to keep detailed medical records, as such records enable effective reviews of cases where problems have ensued, and ensure that remedial or preventive measures can be developed. In fact, where a doctor practises in a group medical practice (as Dr Ganesh did at the material time in PanAsia Surgery), the need to maintain proper medical records is particularly crucial as the possibility of another doctor taking over management of the Patient is generally even higher, and his failure to do so would warrant a suitably firm deterrent sentence. In the case of Dr Ganesh, it was more so aggravating because no record was maintained vis scanty and/or illegible record.

On sentencing for a failure to properly make the diagnosis and recommended treatment

28. Flowing from the lack of proper and clear medical records in *Dr Yong Thiam Look Peter*, concerns were also raised over the basis upon which the respondent doctor could properly make the diagnosis and recommended treatment when he had only recorded his conclusions on the patient's diagnosis / condition without recording his *basis* for the same. In the same vein, Dr Ganesh likewise breached Guideline 4.1.1.1 of the 2002 ECEG when he failed to obtain information on (i) the nature, frequency and history of previous episodes of the Patient's diarrhoea and/or rectal bleeding; and (ii) the Patient's travel history and family history of bowel disorders, prior to advising the Patient on the proper course of treatment for her. This was Dr Ganesh's failure to undertake an adequate clinical assessment and evaluation of the Patient before offering a gastroscopy and colonoscopy to the Patient.

The cumulative effect of a failure to: (i) obtain informed consent; (ii) keeping proper medical records; and (iii) undertake an adequate clinical assessment and evaluation of the Patient before Procedures

29. The DT agrees with the submission of the Counsel for the SMC that in order to fulfil the primary sentencing objective of general deterrence as well as to uphold important public policy concerns, the sentence imposed by the DT needs to send a strong signal to the public that the medical profession does not (and will not) condone a doctor's failure to respect a patient's autonomy in deciding for himself/herself the appropriate treatment he/she should receive. Where the physician breaches the requirement to obtain

informed consent, as seen in the past decisions of the C3J and DT, the respondent doctor can expect to be suspended.

30. In preparation for this decision, we surveyed the sentencing precedents both from the C3J as well as from previous DTs (and equivalent) on the penalties for failure to obtain informed consent. Recent decisions from the C3J include: (a) *Jen Shek Wei v SMC* [2018] 3 SLR 943 ("**Dr Jen Shek Wei**"); and (b) *Dr Yong Thiam Look Peter*. Recent DTs' (and equivalent) decisions include: (a) *Dr Chan Heang Kng Calvin* (2017); (b) *Dr Looi Kok Poh* (2014); (c) *Dr Wong Yoke Meng #1* (2011); and (d) *Dr ABK* (2010). The C3J dealt with the charges of failure to obtain informed consent in both *Dr Yong Thiam Look Peter* as well as *Dr Jen Shek Wei*. In both cases, the C3J had imposed a suspension sentence among others.

31. The DT had observed in *Dr Chan Heang Kng Calvin* (2017) that the appropriate penalty for *"the Respondent's professional misconduct for the combination of breaches should be a term of suspension rather than a fine, even if it were a high fine of up to $100,000. Taken as a whole, the Respondent's acts were simply unacceptable and inconsistent with upholding high standards of the medical profession."* ***Taking into consideration: (a) the nature, and range, of the acts of professional misconduct admitted to by Dr Ganesh; (b) the harm caused to the Patient; and (c) the seniority and experience of Dr Ganesh, and the respect and standing he earned from the medical profession, we are compelled to conclude that an appropriate term of suspension is necessary in the circumstances.***

32. Since both Counsel for the SMC and Counsel for the Respondent agreed that a term of suspension is appropriate, ***the only issue before us is the length of the suspension to be imposed.*** Counsel for the SMC submitted that a 12-month suspension would be appropriate while Counsel for the Respondent reasoned at the hearing that a short suspension of not more than six months would be fair.

Determining a suitable starting point for the length of suspension

33. In determining the appropriate starting point of the length of suspension to impose against Dr Ganesh, we further narrowed down to two recent judgments of the C3J to be

examined more closely. In this respect, we had consciously excluded from consideration the not-so-recent decisions as the C3J had observed on more than one occasion that those sentences should be re-calibrated. Bearing this in mind, we identified the following recent judgments of the C3J: (a) *Dr Yong Thiam Look Peter*; and (b) *Dr Jen Shek Wei.*

(i) The Case of *Dr Yong Thiam Look Peter*

34. In *Dr Yong Thiam Look Peter*, the respondent doctor pleaded guilty to two charges of professional misconduct pursuant to section 53(1)(*d*) of the MRA, and one charge of failing to provide *professional* services of a quality which is reasonable to expect of him pursuant to section 53(1)(*e*) of the MRA, in respect of: (a) his failure to obtain informed consent of the patient, by failing to explain to the patient the nature and/or the benefits, risks and possible consequences of a trigger finger release surgery to be performed on the patient's left middle finger; (b) his failure to record what he had advised and explained to the patient (if any), the patient's response to the advice and/or explanation (if any), and/or the history, his physical findings and assessment of the patient; and (c) his performance of the trigger finger release surgery at the consultation table at his clinic, when the said procedure should have been undertaken in a procedure room or operating theatre.

35. The respondent doctor in *Dr Yong Thiam Look Peter* was sentenced to a suspension of six months with a fine of $10,000. He then appealed to the C3J against the sentence imposed. The C3J unanimously dismissed the appeal and observed that the six-month suspension *"may be said, if anything, to have been lenient"*. The respondent doctor in that case also had antecedents. He was not a first offender. The C3J, however, made no adjustments to the sentence as it was the respondent's (and not the SMC's) appeal against the DT's decision.

36. In the course of its judgment, the C3J also rejected the argument that the absence of harm to the patient in the case was a mitigating factor. The C3J held that where physiological harm to the patient was not an element of the offence, the absence of such harm would generally be a neutral consideration without any mitigating value. However, where harm was not an element of the charge, if harm did ensue to the patient, this *"would be a seriously aggravating factor"*. Finally, the C3J reiterated the need to *"re-calibrate"*

the sentences in previous precedents, as they have done so in their decisions in *Singapore Medical Council v Kwan Kah Yee* [2015] 5 SLR 201 and *Singapore Medical Council v Wong Him Choon* [2016] 4 SLR 1086.

37. We must categorically state that unlike the patient in the case of *Dr Yong Thiam Look Peter*, the Patient in our present case suffered significant harm as a result of the acts of Dr Ganesh's professional misconduct. The patient in the case of *Dr Yong Thiam Look Peter* did not suffer any physiological harm. However, in our present case, the Patient as a result of the Procedures suffered a perforation of her colon, had to undergo corrective surgery via a laparotomy (another serious and traumatic surgical procedure), and took months to recover from this ordeal. Throughout the recovery period, she endured significant physical pain and suffering. The Patient also has two long scars as a result of the laparotomy and colostomy, and continues to suffer from the lingering psychological impact as a result of the complications from the Procedures. As noted also by the C3J in *Dr Yong Thiam Look Peter*, the absence of harm is not necessarily a mitigating factor but if the Patient suffers harm, it is an aggravating factor. It therefore bears repeating that if we were to draw guidance from the decision in *Dr Yong Thiam Look Peter*, the appropriate starting point of the length of suspension for Dr Ganesh must be higher than six months of suspension taking into consideration the significant harm suffered by the Patient as well as the need for an upward calibration of the sentence in *Dr Yong Thiam Look Peter*.

(ii) The Case of *Dr Jen Shek Wei*

38. Turning now to the case of *Dr Jen Shek Wei,* the respondent doctor claimed trial to (and was found guilty of) two charges of professional misconduct pursuant to section 53(1)(*d*) of the MRA in respect of: (a) advising the patient to undergo surgery to remove a pelvic mass, without carrying out further evaluation and investigation of the patient's condition when such assessment was indicated; and (b) failing to obtain the required informed consent of the patient, by failing to adequately explain to the patient the nature, risks and possible consequences of a left oophorectomy, the consequences of the removal of the patient's left ovary, and obtain specific consent from the patient to remove the patient's left ovary and record such consent.

39. The respondent doctor in *Dr Jen Shek Wei* appealed to the C3J against his conviction and the sentence imposed by the DT. In the course of the C3J's review of the case, the C3J noted, among others, the following factors: (a) there was a lack of care in the manner that the respondent doctor had addressed the patient's condition, which called for a sufficiently deterrent sentence; (b) the respondent doctor was not remorseful, when he sought to disclaim responsibility for ensuring that the patient understood the nature of a left oophorectomy; (c) the term of suspension imposed by the DT was "on the low side", and that the C3J would have imposed a suspension of twice the length of time, i.e. 16 months; and (d) there was inordinate delay in the prosecution of the matter which warranted the halving of the term of suspension to be imposed. Accordingly, the C3J upheld the DT's conviction of the respondent doctor, and the DT's orders that the respondent doctor be suspended for a period of eight months and pay a penalty of S$10,000 with the Usual Orders. Of relevance to the present case is the C3J's observation that a global 16-month suspension would have been appropriate on the facts of the case, had there been no delay in the investigation / prosecution of the case.

40. As for the case of *Dr Jen Shek Wei*, the C3J said that it would have imposed a suspension of twice the length of time, i.e. 16 months had there not been an inordinate delay in the prosecution of the matter which warranted the halving of the term of suspension to be imposed i.e. a suspension of eight months. While there were significant similarities in the charges framed against Dr Ganesh and Dr Jen Shek Wei, we are of the view that the gravity of Dr Ganesh's professional misconduct is less severe than Dr Jen's (in particular, the greater harm caused to his patient by Dr Jen compared to the harm caused by Dr Ganesh). The breaches of Dr Ganesh were definitely not as egregious since in *Dr Jen Shek Wei's* case, the Patient had lost her ovary *against* her will and the respondent doctor therein was convicted only after a full trial. In the case of Dr Ganesh, he had elected to plead guilty shortly after the first Pre-Inquiry Conference. In addition, the harm suffered by the Patient in the present case is arguably not as drastic comparatively speaking. Taking guidance from the C3J that the starting point for the suspension of *Dr Jen Shek Wei* should have been 16 months, we do not think that the starting point for Dr Ganesh should be anywhere near to a 16-month suspension.

41. We note the seriousness of the three distinct charges admitted to by Dr Ganesh and its cumulative effect on the overall management and treatment of the Patient. Taking

guidance from the C3J in the cases of *Dr Yong Thiam Look Peter* and *Dr Jen Shek Wei*, for the reasons given above, we were satisfied that an appropriate starting point was a suspension substantially higher than six months but significantly lower than 16 months. Considering all the relevant sentencing factors, we were in agreement with the submission of the SMC i.e. to consider a 12-month suspension as a suitable starting point.

Calibrating an appropriate length of suspension taking into consideration the mitigation

42. Having determined that a suitable starting point is a suspension of 12 months for Dr Ganesh, we next turn our attention to calibrate an appropriate sentence taking into consideration the significant mitigating factors.

Early Plea of Guilt

43. We noted the SMC's submission that credit ought to be given to Dr Ganesh's early plea of guilt which contributed to significant savings in respect of the time and costs of this inquiry. In the present case, a plea of guilt also helped to avoid the Patient having to testify and re-live her traumatic experience. It was therefore added by Counsel for the SMC that the SMC does not oppose to the DT adjusting the SMC's proposed sentence of a 12-month suspension to account for Dr Ganesh's early plea of guilt. For this reason, the SMC submitted that a suspension of 8 to 10 months would not be inappropriate. We note this even handed submission on the appropriate sentence by the SMC.

Credit to the Respondent's Submission Acknowledging that a Suspension is Expected

44. Besides choosing to plead guilty at the earliest opportunity thus saving cost and time and not subjecting the Patient to further inconvenience by contesting the charges through a full trial, we must give credit to Dr Ganesh and his Counsel for taking a *"not-so-unrealistic"* stance in their submission on the appropriate sanctions. In the written mitigation, Counsel for the Respondent had submitted that *"a short suspension of less than 6 months coupled with a censure and undertaking and an order for payment of costs would be appropriate in the present case"*. At the hearing, Counsel for the Respondent did revise its sentencing submission from one that is "less than six months" to one that is "three to six months and, if necessary, a financial penalty".

45. Leaving aside the length of the appropriate suspension, the fact that Dr Ganesh and his Counsel had acknowledged that the appropriate penalty would include a suspension in this case deserves to be commended. To us, this is a manifestation of Dr Ganesh's true remorse for not attempting to downplay his acts of professional misconduct which had led to the harm and grief caused to both the Patient and the medical profession. Indeed, such a posture is not often seen at the DT hearings. Sadly, it is not uncommon that respondent doctors would often urge the DT to impose only fines arguing that their breaches were not as serious as the SMC would make them out to be. In this regard, we wish to give credit to Dr Ganesh where credit is due.

Low Risk of Re-Offending

46. In Dr Ganesh's mitigation, we also acknowledged that he had since taken concerted steps to improve his Protocols for Informed Consent paying heed to patient autonomy in decision-making, and documentation of clinic notes; all of which would indicate he is less likely to re-offend in these areas.

G. IN SUMMARY

47. In calibrating the appropriate sanctions against Dr Ganesh, we have placed an emphasis on the following:

(a) The three charges faced by Dr Ganesh were serious charges of professional misconduct considering the: (i) nature of the breaches; (ii) circumstances in which they were committed; (iii) harm caused to the Patient; and (iv) seniority and experience of Dr Ganesh, and the respect and standing he earned from the medical profession. We are in full agreement with the Counsel for the SMC that we must uphold the high standards expected of every medical practitioner. All these led us to conclude that the sanctions against Dr Ganesh must include an appropriate term of suspension. In this regard, we agreed with the submissions of the Counsel for the SMC that the appropriate starting point would be a 12-month suspension.

(b) We then considered Dr Ganesh's mitigating factors and to what extent they would cumulatively result in a reduction of the starting point of a 12-month suspension:

(1) In arriving at an appropriate length of suspension, we noted Dr Ganesh's early plea of guilt i.e. avoidance of a full trial.

(2) In addition, we were heartened that Dr Ganesh acknowledged that a suspension was what he could reasonably expect in the circumstances. It is much too common in DT hearings that the respondent doctor would submit that a financial penalty would be sufficient and appropriate to penalise him for his breaches instead of suspension. However, in the present case, Dr Ganesh had acknowledged that a term of suspension was warranted for the charges that he had pleaded guilty to. In our opinion, this was yet another objective indicator of genuine remorse which should go towards mitigating the sentence.

(3) Finally, we agree with the Counsel for the Respondent that there is a low risk of Dr Ganesh re-offending as he had already taken active steps to improve his clinical care and medical practice after setting up his own practice.

(c) In view of Dr Ganesh's early plea of guilt, Counsel for the SMC had submitted that a suspension of 8 to 10 months instead of 12 months can be considered. Taking into consideration Dr Ganesh's early plea of guilt and the other mitigating factors set out in (b) above, we felt that it would be just and fair to reduce the suspension sentence to seven months from the starting point of a 12-month suspension bearing in mind the cumulative effect of his mitigation.

H. ORDERS BY THE DT

48. For reasons given in this Grounds of Decision, the DT accordingly ordered that the Respondent:

(a) be suspended for a period of **seven (7) months**;

(b) be censured;

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

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

I. PUBLICATION OF GROUNDS OF DECISION

49. We also order that the Grounds of Decision be published.

50. The hearing is hereby concluded.

Dr Joseph Sheares Chairman	Prof K Satkunanatham	Mr Tan Boon Heng Legal Service Officer

Mr Edmund Kronenburg, Mr Kevin Ho and Ms Liew Wei Lin (M/s Braddell Brothers LLP)
for Singapore Medical Council; and
Ms Mak Wei Munn and Ms Christine Tee (M/s Allen and Gledhill LLP)
for the Respondent.