SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR ABD HELD ON 12-15 MAY 2009 AND 6-8 JANUARY 2010

Disciplinary Committee:
Prof John Wong Eu Li (Chairman)
Dr Wong Yue Sie
Dr Tham Tat Yean
Ms Serene Wee (Lay Member)

Legal Assessor:
Mr Thean Lip Ping

Prosecution Counsel:
Mr Tan Chee Meng, SC
Ms Chang Man Ping
Ms Melanie Ho
Ms Emily Su
(WongPartnership LLP)

Defence Counsel:
Mr Cavinder Bull, SC
Ms Harleen Kaur
(Drew & Napier LLC)
Mr Charles Lin
(M/s Donaldson & Burkinshaw)

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. You, Dr ABD ("Dr ABD") are charged with 2 charges as set out in the Notice of Inquiry ("NOI") dated 12 August 2008. Briefly, they are as follows:

   (a) The first charge is that Dr ABD, on 6 December 2005 performed pre-cut sphincterotomy ("the Procedure") on one Mr P ("the Patient") for the purpose of removing a stone in the common bile duct, when Dr ABD knew or ought to have known that the Procedure was beyond the scope of his competence ("the Competence Charge"); and

   (b) The second charge is that Dr ABD, from 6 December 2005 to 8 December 2005, was in willful neglect of his duties and grossly mismanaged the post-operative treatment of the Patient ("the Mismanagement Charge").

2. The Committee has heard and considered:

   (a) the evidence given by Madam PW1 (the "Complainant") and Dr PW2 called on behalf of the Singapore Medical Council ("SMC");

   (b) the evidence of Dr ABD, Dr DW1, Dr DW2, Dr DW3, Dr DW4, and Professor DW5 called on behalf of Dr ABD, and

3. The Committee has heard and considered the respective submissions of the Prosecution and Dr ABD and also read their written submissions.

4. The Committee now turns to consider the evidence relating to the charges against Dr ABD.

5. With regard to the first charge, the Committee notes that while Dr ABD has been accredited to perform endoscopic retrograde cholangiopancreatograms ("ERCPs"), no clear guidelines exist as to what constitutes "competency" in performing pre-cut sphincterotomy. We note that Dr ABD had been trained and his technique had been supervised by Drs DW1 (between 1999-2001) and DW4 (in 2004), both senior accomplished endoscopists familiar with this technique. They both testified that he was competent to do this procedure on his own. Prior to 6 December 2005, Dr ABD had done 17 pre-cut sphincterotomies at Alexandra Hospital. The Committee accepts the evidence of both Dr DW1 and Dr DW4.

6. Therefore, on the first charge, the Committee finds that this charge has not been proven beyond reasonable doubt and the Committee acquits him of this charge.

7. However, the Committee feels obliged to add this. In the review of the first charge, the Committee had some concerns about the high number of pre-cut sphincterotomies (27%) Dr ABD performed to gain access to the common bile duct. Given the risks associated with this technique, and that other more experienced endoscopists reported a much lower incidence of using this technique, the Committee would advise Dr ABD to review his practice, and the frequency of use of this technique to gain access to the common bile duct.

8. The second charge is that during the period from 6 December 2005 to 8 December 2005, Dr ABD was in willful neglect of his duties and had grossly mismanaged the post-operative treatment of the Patient. So it is the period from 6 to 8 December 2005 that the Committee has to focus on. The Committee notes the following sequence of events:

(A) 6 December 2005

(i) 1500-1550 hours: Dr ABD was unsuccessful in cannulating the bile duct despite performing the pre-cut sphincterotomy. The Patient was kept nil-by-mouth post procedure, which was not Dr ABD's usual practice in previous cases. Dr ABD ordered that the Patient be observed and not be discharged.

(ii) 1710 hours: The Patient's abdomen felt distended; discomfort was noted, and tenderness was elicited on palpation.

(iii) 1745 hours: Two episodes of bilious vomiting were noted.

(iv) 1800 hours: The Patient was noted to be unwell with epigastric pain radiating to the back, and voluntary guarding detected. The Registrar on-call, Dr DW3's assessment was that of "?post ERCP complications". Dr ABD verbally instructed Dr DW3 to order blood tests and an erect chest X-ray.

(v) 1900 hours: The Patient complained of abdominal pain and intramuscular pethidine was administered.

(vi) 2150 hours: The results of the tests were received and Dr DW3 updated Dr ABD verbally.

(B) 7 December 2005

(i) 0440 hours: The Patient's abdomen was distended, and it was noted that the Patient was unable to pass urine and motion.

(ii) 0850 hours: The Patient was seen by Dr ABD for the first time post procedure.

(iii) Between 1700 – 1930 hours: A CT scan was ordered.

(iv) 2330 hours: The CT results were noted and the Patient was sent for emergency surgery by Dr ABD.

9. The evidence shows that on or after 1700 hours on 6 December 2005 to 0850 hours on 7 December 2005, the most senior doctor who attended to the Patient was the Registrar on-call, Dr DW3.

10. At 1800 hours or thereabouts on 6 December 2005, Dr DW3 made a call to Dr ABD and gave Dr ABD his assessment on the Patient's condition.

11. At 2150 hours, the chest x-ray was interpreted as not showing any air under the diaphragm. The blood tests were interpreted as being consistent with acute pancreatitis. Dr DW3 conveyed these results and discussed his assessment and management with Dr ABD verbally through the telephone.

12. In the view of the Committee, Dr ABD should have personally attended on the Patient and evaluated his condition on 6 December 2005 when notified that the Patient was unwell following a procedure done by him, especially as results of initial tests were available. Being the consultant in charge, and by virtue of his accreditation by the hospital to perform the procedure, he would be 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. Relying solely on the assessment of junior doctors, including one still in specialty training was not in the best interests of this Patient, and fell short of his professional duty to the Patient.

13. We accept that the timing of certain tests can vary between specialist doctors, but we are of the opinion that had Dr ABD, as a responsible, competent consultant surgeon seen the Patient earlier, would have considered ordering a CT scan earlier when the Patient's condition did not improve by the following day. After all, the chest x-ray did not reveal anything of consequence. The CT scan was the appropriate diagnostic test to be carried out as it would have revealed the perforation of the duodenum.

14. Dr ABD first saw the Patient post procedure at 0850 hours on the morning of 7 December 2005 – nearly 16 hours after the onset of symptoms. He was content with his diagnosis that the Patient had pancreatitis although he did not rule out perforation. It appears that another chest X-ray was ordered but not a CT scan. The Committee is of the view that a more timely CT scan would have been crucial in the management of the Patient.

15. In the Committee's opinion, a reasonably responsible doctor who has performed a procedure which was unsuccessful, and associated with known

risks of significant complications, has the responsibility to see the Patient in a timely fashion when the Patient had symptoms, signs, and tests consistent with such a complication. We note that Dr ABD was informed that the Patient was unwell 2 hours after the procedure, but did not examine the Patient until nearly 17 hours after the procedure. The Committee is of the opinion that had Dr ABD seen the Patient on the night of 6 December 2005, the appropriate definitive diagnostic test (i.e. CT scan) could have been ordered earlier. The CT scan was not ordered until 25 hours after the procedure.

16. Having looked at the totality of matters discussed above, the Committee is of the opinion that the failure of Dr ABD to personally assess his Patient on the night of 6 December 2005 when Dr ABD was aware that the Patient was unwell after the unsuccessful pre-cut sphincterotomy, and manage the situation appropriately between the onset of symptoms and signs post ERCP and the diagnosis of perforation amounts to willful neglect of Dr ABD's professional duties.

17. As a result, the Committee finds that the second charge has been proven beyond reasonable doubt.

18. Accordingly, the Committee finds you, Dr ABD, guilty of willful neglect of your professional duty to your Patient and therefore of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174).

SENTENCE

19. The Committee has carefully considered the points made in mitigation by your Counsel.

20. In light of all the circumstances, the Committee determines as follows:
    (a) that you be suspended from practice for a period of 6 months;
    (b) that you be censured;
    (c) that you give a written undertaking to the Medical Council that you will not engage in the conduct complained of or any similar conduct; and
    (d) that you pay 70% of the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the Council and the Legal Assessor.

21. The hearing is hereby concluded.

Dated this 8th day of January 2010.