**SINGAPORE MEDICAL COUNCIL DISCIPLINARY COMMITTEE INQUIRY FOR DR GAN KENG SENG ERIC HELD ON 11 FEBRUARY 2015**

**Disciplinary Committee:**
Prof Lee Eng Hin - Chairman
Prof Rathi Mahendran
A/Prof Pang Weng Sun
Ms Heidi Tan - Layperson

**Legal Assessor:**
Mr Thio Shen Yi, SC
(TSMP Law Corporation)

**Counsel for the SMC:**
Ms Aw Wen Ni
Ms Tricia How
(M/s WongPartnership LLP)

**Counsel for the Respondent:**
Mr Edwin Tong, SC
Ms Mak Wei Munn
Ms Koh En Ying
(M/s Allen & Gledhill LLP)

## DECISION OF THE DISCIPLINARY COMMITTEE

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

## Introduction

1. The Respondent, Dr Eric Gan Keng Seng ("**Dr Gan**"), is a qualified and registered medical practitioner under the Medical Registration Act (Cap. 174) (2004 Ed.) ("**the Act**"). Dr Gan is a specialist in general surgery with an interest in surgical oncology. Dr Gan is in private practice at Mount Elizabeth Novena Specialist Centre / Mount Elizabeth Novena Hospital. He had more than 20 years of experience at the material time. Dr Gan faced charges of professional misconduct under section 45(1)(d) of the Act.

2. On 16 May 2009, Mr P (the "**Patient**") was referred by Dr FW to Dr Gan for treatment of his recurrent varicose veins. The Patient first consulted with Dr Gan on 18 May 2009. The Patient had two further pre-surgery consultations with Dr Gan on 23 May 2009 and 13 June 2009.

3. At one or more of these pre-surgery consultations, Dr Gan and the Patient discussed the option of having the less invasive Endovenous Laser Treatment (the "**EVLT procedure**") as a treatment for his right leg. (Stab avulsions for both legs had also

been discussed.) Consequently, on 15 July 2009, the EVLT procedure was performed on the Patient's right long saphenous vein, together with stab avulsions of the varicosities in both of his calves (the "**Surgery**").

4. Nerve injury is a possible risk and complication of the Surgery. Dr Gan did not properly explain to the Patient at the pre-surgery consultations the possible risks and complications associated with the Surgery, specifically, the risk of nerve injury. As such, the Patient underwent the Surgery without fully understanding the possible risks and complications associated with the Surgery.

5. Dr Gan was not competent to perform the EVLT procedure and required the services of one Dr PW ("**Dr PW**") to perform the EVLT procedure on the Patient. During the pre-surgery consultations, Dr Gan did not inform the Patient that he was not competent to perform the EVLT; nor did Dr Gan inform the Patient that another doctor would perform parts of the Surgery, including the EVLT procedure.

6. During the Surgery, Dr Gan performed the stab avulsions of the varicosities in the Patient's right calf. Dr PW performed the EVLT procedure for the Patient's right long saphenous vein and the stab avulsions of the varicosities in the Patient's left calf.

7. In the circumstances, Dr Gan failed to provide adequate information to the Patient which would allow the Patient to make an informed choice about his medical management.

**The Notice of Inquiry**

8. A Notice of Inquiry dated 9 June 2014 was served on Dr Gan setting out the 3 charges as follows:

> "*Notice is hereby given to you that in consequence of a complaint made against you to the Medical Council an Inquiry is to be held by the Disciplinary Committee into the following charges against you:*
>
> 1. *That you **Dr ERIC GAN KENG SENG** are charged that on or about 15 July 2009, you did cause the Endovenous Laser Treatment (the "**EVLT procedure**") to be performed on the right long saphenous vein of one P (the "**Patient**") together with stab avulsions of the varicosities in both calves of the Patient (collectively, the "**Surgery**"), without explaining to him the possible risks and complications involved in the Surgery, and thereby failed to obtain the informed consent of the Patient for the Surgery that was performed on him.*

***Particulars***

(a) *The Patient was referred to you by his company doctor, Dr FW of XX Clinic & Surgery, for treatment of his recurrent varicose veins.*

(b) *The Patient first consulted you on 18 May 2009. The Patient had two further pre-surgery consultations with you on 23 May 2009 and 13 June 2009.*

(c) *At one or more of the pre-surgery consultations, you discussed the option of the Surgery for the treatment of his varicose veins with the Patient. In particular, on or about 13 June 2009, you informed the Patient that whilst the EVLT procedure was suitable for his right leg, the conventional method (high ligation and stripping) would be more suitable for his left leg.*

(d) *The Surgery was fixed for 15 July 2009.*

(e) *Nerve injury is a possible risk and complication of the Surgery.*

(f) *During the Patient's pre-surgery consultations with you, you did not explain, or did not sufficiently explain, to the Patient the possible risks and complications associated with the Surgery, in particular, the risk of nerve injury. You had only informed the Patient of the risk of bruising.*

(g) *The Patient underwent the Surgery without knowledge of the possible risks and complications with the Surgery.*

(h) *Paragraph 4.2.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines states that:-*

> *"**4.2.2 Informed Consent***
> *It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complication of the procedure and any alternatives available to him. If the patient is a minor, or of diminished ability to give consent, this information shall be explained to his parent, guardian or person responsible for him for the purpose of his consent on behalf of the patient."*

*and that in relation to the facts alleged, you are guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174) (2004 Rev Ed) (the "**MRA**")*("**the First Charge**")

2. *That you **Dr ERIC GAN KENG SENG** are charged that on or about 15 July 2009, you did cause the EVLT procedure to be performed on the right long saphenous vein of the Patient, without informing the Patient*

*that one Dr PW ("**Dr PW**") will be performing the EVLT procedure, and thereby failed to provide adequate information to the Patient which would allow the Patient to make an informed choice about his medical management.*

***Particulars***

*(a) The Patient was referred to you by his company doctor, Dr FW of XX Clinic & Surgery, for treatment of his recurrent varicose veins.*

*(b) The Patient had three pre-surgery consultations with you on 18 May 2009, 23 May 2009 and 13 June 2009.*

*(c) At one or more of the pre-surgery consultation, you discussed the option of the Surgery for the treatment of his varicose veins with the Patient. In particular, on or about 13 June 2009, you informed the Patient that whilst the EVLT procedure was suitable for his right leg, the conventional method (high ligation and stripping) would be more suitable for his left leg.*

*(d) The Surgery was fixed for 15 July 2009.*

*(e) During the Patient's pre-surgery consultations with you, you failed to inform the Patient that the EVLT procedure would not be performed by you, but would be performed by another doctor, Dr PW.*

*(f) The EVLT procedure was performed by Dr PW on 15 July 2009.*

*(g) The Patient underwent the Surgery without knowledge that it would be and was performed by Dr PW.*

*(h) Paragraph 4.2.4.1 of the Singapore Medical Council Ethical Code and Ethical Guidelines states that:-*

*"**4.2.4.1***
*A doctor shall provide adequate information to a patient so that he can make informed choices about his further medical management. A doctor shall provide information to the best of his ability, communicate clearly and in a language that is understood by the patient…."*

*and that in relation to the facts alleged, you are guilty of professional misconduct under section 45(1)(d) of the MRA.* ("**the Second Charge**")

*3. That you **Dr ERIC GAN KENG SENG** are charged that during the period from on or about 18 may 2009 to on or about 22 January 2010, you did misrepresent and mislead the Patient into believing that you*

*had the proper knowledge, skill and qualification to advise on and perform the EVLT procedure on the Patient when you did not.*

***Particulars***

*(a) The Patient was referred to you by his company doctor, Dr FW of XX Clinic & Surgery, for treatment of his recurrent varicose veins.*

*(b) The Patient had three pre-surgery consultations with you on 18 May 2009, 23 May 2009 and 13 June 2009 and six post-surgery reviews with you on 20 July 2009, 21 July 2009, 27 July 2009, 8 August 2009, 22 August 2009 and 22 September 2009.*

*(c) During the Patient's pre-surgery consultations, you advised the Patient on the EVLT procedure. At no point in time did you inform the Patient that you had to engage another doctor to perform or assist you in the EVLT procedure, or that you did not have the proper knowledge, skill and qualification to advise on and perform the EVLT procedure. Accordingly, the Patient was misled into believing that you had the proper knowledge, skill and qualification to advise on and perform the EVLT procedure.*

*(d) The Surgery took place on 15 July 2009, and the EVLT procedure was performed by Dr PW.*

*(e) During the Patient's post-surgery reviews, you continued to advise the Patient on the EVLT procedure. At no point in time did you inform the Patient that you had to engage another doctor to perform or assist you in the EVLT procedure, or that Dr PW performed the EVLT procedure or that you did not have the proper knowledge, skill and qualification to advise on and perform the EVLT procedure. Accordingly, the Patient was* [sic] *continued to be misled into believing that you had the proper knowledge, skill and qualification to advise on and perform the EVLT procedure.*

*(f) Paragraph 4.4.1 and 4.4.2 of the Singapore Medical Council Ethical Code and Ethical Guidelines states that:-*

*"**4.4.1 General principles***
*Both members of the profession and the public require information about doctors who they can refer patients to or seek consultation from. Patients seeking such information are entitled to protection from misleading information, as they are particularly prone to persuasive influence. Information provided must not exploit patients' vulnerability, ill-founded fear for their future health or lack of medical knowledge.*

***4.4.2 Standard required of information***

*In general, doctors may provide information about their qualifications, areas of practice, practice arrangements and contact details. Such information, where permitted, shall have the following standards:*

*a. Factual*
*b. Accurate*
*c. Verifiable*
*d. No extravagant claims*
*e. Not misleading*
*f. Not sensational*
*g. Not persuasive*
*h. Not laudatory*
*i. Not comparative*
*j. Not disparaging."*

*and that in relation to the facts alleged, you are guilty of professional misconduct under section 45(1)(d) of the MRA.*
("**the Third Charge**")

9. Dr Gan pleaded guilty to the First and Second Charges. The SMC withdrew the Third Charge. Therefore, what remains is for these Grounds of Decision to set out the Disciplinary Committee's determination of sentence.

**Sentencing and Mitigation**

10. Counsel for the SMC suggested that the following sentence for Dr Gan would be appropriate in the circumstances:

(a) Dr Gan be suspended from practice for 9 months;

(b) Dr Gan be censured;

(c) Dr Gan to provide a written undertaking to the SMC to abstain in future from the conduct complained of in the First and Second Charges; and

(d) Costs be paid by Dr Gan.

11. The SMC argued that the failures to obtain informed consent and to provide adequate information are serious forms of professional misconduct which justify Dr Gan's suspension from practice.

12. On the other hand, counsel for Dr Gan suggested that a fine of $5,000.00 and costs (which were to be moderated and fixed) was a more appropriate sentence. Counsel for Dr Gan also submitted that censure was inappropriate in Dr Gan's case.

13. After having considered the parties' respective submissions on sentencing and mitigation, and taking into account the totality of Dr Gan's conduct, the Disciplinary Committee makes the following orders as to sentence:

    (a) That Dr Gan be fined **$5,000.00**;

    (b) That Dr Gan be censured;

    (c) That Dr Gan give a written undertaking to the SMC to abstain in future from the conduct complained of in the First and Second Charges, or any similar conduct;

    (d) That Dr Gan pay costs of or incidental to these proceedings, including costs of SMC's solicitors and the Legal Assessor, to be taxed or agreed, except that such costs shall exclude costs related to or connected with the withdrawn Third Charge.

14. The Disciplinary Committee's reasons for the above sentence are set out in the paragraphs below.

15. From the outset, we made it clear that the failure to obtain informed consent from a patient through the failure of providing adequate information is a clear breach of a duty owed by the doctor to his patient. The above sentence reinforces the high ethical standards required of doctors and is commensurate with the level of trust and esteem that society reposes in the medical profession.

16. Under the First Charge, the failure to give the Patient information (that would have enabled the Patient to have given informed consent) was in respect of the risk of nerve damage. We note that both of the SMC's experts, Dr PE1 and Dr PE2 agreed that the possibility of nerve injury associated with the Surgery should have been made aware to the Patient. Dr PE2 described the risk of the nerve injury as being "*numbness*". Dr PE1 described the extent of the risk of saphenous nerve injury (which usually manifests as "*transient numbness*") in the medial calf to be up to 7%.[1] He added that the numbness is rarely permanent.

17. In our view, the magnitude of the sentence must also take into consideration the fact that Dr Gan's mistake of not informing the Patient of the risk must be seen in the context of the treatment as a whole. The Patient came to Dr Gan specifically asking about the EVLT procedure. Dr Gan's medical management of the Patient spanned several consultations. Dr Gan did not immediately advise the EVLT procedure or other surgery, choosing rather to recommend non-invasive and conservative treatments such as compression stockings. In addition, Dr Gan did provide the Patient with *some* but not adequate, information about the EVLT procedure. We have no basis to conclude that Dr Gan deliberately suppressed information or that Dr Gan was trying to push the Patient into doing a certain procedure.

[1] Expert report of Dr PE1, dated 5 February 2014, paragraph 6.

18. Concerning the Second Charge, we take note of the fact that Dr Gan had mentioned to the Patient, albeit inadequately, that he would require a colleague to assist him should an EVLT procedure be performed. While Dr Gan failed to provide adequate information as to the identity of this colleague, and the scope and nature of the colleague's role in the Surgery, we do not have reasons to conclude that Dr Gan was deliberately suppressing this information from the Patient. It was suggested to us by Counsel for SMC that Dr Gan had intentionally concealed Dr PW's role in the Surgery from the Patient because he was concerned he would lose the doctor-patient relationship with the Patient in the event that the Patient insisted on Dr PW performing the entire Surgery. In our view, there was no real basis for this suggestion. Dr Gan's mistake in this regard was more of the nature of an oversight and was not intentional. Dr Gan's overall behaviour was certainly not consistent with that of a doctor intent on trying to maximise profit from the situation. For the sake of completeness, we add that while Dr PW was introduced to the Patient by Dr Gan on the day of the Surgery itself, in our view, this introduction was a case of 'too little, too late'.

19. We are not of the view that Dr Gan's mistake deserves a suspension from practice. Most sentencing precedents concerning the lack of informed consent deem a fine without suspension as appropriate. In the sentencing precedents cited, suspension is appropriate in egregious cases of a doctor failing to provide informed consent. Factors such as the forgery of a patient's consent or the deliberate suppression of key information from a patient, would be sufficient to render a doctor's conduct as egregious. We have already concluded that Dr Gan made an honest mistake and we do not consider his conduct to have been egregious in this regard.

**Sentencing Precedents**

20. In *Low Cze Hong v SMC* [2008] 3 SLR(R) 612 ("***Low***"), the doctor was found guilty under a charge of failing to inform a patient of treatment options available to the patient, as well as failing to explain the risks of the treatment to the patient. Dr Low's sentence was a fine of $7,000.00, censure, to give a written undertaking to abstain from similar conduct in the future, and to pay costs. No suspension was imposed. While Dr Low's fine was higher than the $5,000.00 fine we have ordered Dr Gan to pay, it should be borne in mind that Dr Low was also guilty of a second charge. This second charge related to Dr Low's recommendation to the patient which he was found to have known, or ought to have known, was not an appropriate treatment. In addition, Dr Low applied a treatment without a proper trial of the relevant medication and, in the course of rejecting other forms of therapy, failed to consult with the patient's primary doctor who had been treating the patient for 10 years before the patient saw Dr Low. We regard *Low's* case to be more culpable than Dr Gan's case, especially considering that the EVLT procedure was not alleged to have been an inappropriate treatment for the Patient, whereas Dr Low failed to advise other appropriate alternative treatments.

21. In the 2011 case of *Dr Koh Gim Hwee*, the doctor was found to be guilty of having failed to adequately inform the patient about her medical condition and options for

treatment, as well as the risks, complications and benefits associated with the treatment (a birthing method) that was recommended. Dr Koh was fined $10,000, censured, ordered to give a written undertaking to abstain from similar conduct in the future, and to pay costs. No suspension was imposed. This case is again relatively more culpable than Dr Gan's case when it is considered that Dr Koh's sentence also pertained to another charge relating to his provision of a treatment to the patient that was outside the norms of acceptable medical practice.

22. We also wish to make it clear that our decision not to impose a suspension on Dr Gan should not be taken to mean that we regard the failure to obtain informed consent as a non-serious duty. As stated in paragraph 15, the duty to obtain informed consent and provide adequate information is an extremely serious duty expected of doctors. These duties are amongst the core pillars of the doctor-patient relationship which is based on trust. The seriousness with which these duties are regarded can be seen in cases such as *Eu Kong Weng v SMC* [2011] SGHC 68 ("***Eu***") where the Court went as far as upholding the suspension of a doctor who had not informed a patient of alternative treatment options nor explained the possible risks involved in the procedure. We hasten to add that we distinguish *Eu's* case from the instant case. In *Eu's* case, the surgery was highly invasive and there was no discussion of alternative treatment options, let alone the associated risks. The Court's determination of sentence was made on the basis that the patient was not informed of all his options —which is made clear at paragraph 5:

> "*On the issue of sentencing … a doctor must explain to the patient* ***all the options*** *(of which he has knowledge) and risks involved before treating the patient.*" (emphasis added).

23. Similar to *Eu's* case, in *Dr Looi Kook Poh's* Disciplinary Committee Inquiry, the doctor was suspended (as well as fined $10,000.00, censured and required to provide a written undertaking to the SMC as to future conduct). Dr Looi not only failed to obtain informed consent but failed to exercise due care in the management of the patient. Specifically, Dr Looi's patient had only consented to undergo Tenolysis of his right wrist, yet Dr Looi performed this treatment on the patient's wrist *as well as* performed ulnar neurolysis and repair. Dr Looi also instructed a nurse to falsify the medical records in an attempt to cover his actions up, a factor the Disciplinary Committee considered to be "*even more objectionable and repugnant*" than the lack of obtaining informed consent (at paragraphs 15 to 16 of the Grounds of Decision). In our view, the weight of the sentence, particularly the suspension, was to address Dr Looi's failure to exercise due care in the management of the patient concerned as well as the falsification of the medical records. In that case, the Disciplinary Committee regarded all the charges to be "*intertwined*" and they were "*considered together in deciding the total sentence*" (at paragraph 19).

24. We also regard *Dr Wong Yoke Meng's* case (which the Counsel for SMC referred to) where the doctor was suspended from practice, as far more egregious than Dr Gan's case. In that case, Dr Wong was guilty of 13 charges (of which 6 charges were related to lack of informed consent). However, it should be noted that the doctor performed, *inter alia*, stem cell injections (and other treatments such as coffee

enemas) on his patients, which were not medically proven as a treatment at the time. These treatments were also performed outside of the doctor's registered specialty. In our judgment, this case cannot be used as authority for the proposition that the failure to obtain informed consent is in and of itself, reason enough to impose a suspension upon a doctor. Seen in the context of the various other serious charges, suspension was appropriate in Dr Wong's case. Therefore, in summary, insofar as sentencing precedents go in respect of the failure to procure informed consent, the correct and consistent position would be a fine and not suspension, in the absence of significant aggravating factors.

**Mitigation**

25. In mitigation, we also take into account that Dr Gan had pleaded guilty to the two Charges which saved time and cost for the SMC and the Disciplinary Committee. We also accept that the EVLT procedure was not an inappropriate treatment under the circumstances and that Dr Gan had recommended a conservative approach, over a two month period of consultation, prior to the treatment. As mentioned above, we believed Dr Gan's failure to adequately apprise the Patient was not intentional and Dr Gan appeared to act in good faith with the best interests of the Patient at heart. Dr Gan's advice to the Patient to pursue a more conservative treatment is indicative that Dr Gan was not trying to mislead the Patient into undergoing the Surgery. We are also of the view that Dr Gan has displayed genuine remorse for his actions and has amended relevant aspects of his practice (such as referring patients to a separate consultation with the relevant colleague, and giving the patient a 'risk assessment form') to ensure that similar mistakes are not repeated in future. We should also add that Dr Gan provided his full co-operation in assisting the disciplinary process at all times.

26. We also note that there are no significant aggravating factors (such as deliberate misrepresentation) that we are aware of to displace the various mitigation factors.

27. We have also taken into consideration that the disciplinary process itself has served to impose a measure of extra-curial punishment on Dr Gan. The events giving rise to this Disciplinary Committee date back to May 2009. The SMC officially made Dr Gan aware of the complaint by the Patient by way of correspondence on 8 December 2010. Although the initial Complaints Committee dismissed the complaint on 10 February 2012, an appeal was made by the Patient to the Minister, who allowed the appeal. Dr Gan was subsequently informed of the pending disciplinary proceedings against him in about September 2012. However, for a period of nearly two years no further information or formal charges were communicated to Dr Gan. Ultimately, Dr Gan was served with the Notice of Inquiry on 9 June 2014. The SMC's explanation for the lengthy delay was that it was unable to obtain expert reports. We do not find this convincing and note that one of Dr PE2's expert report was dated 15 May 2013. We echo [89] of *Low*'s case where the court observed—after commenting on the three year delay between the complaint and the service of the Notice of Inquiry:

"*Whilst that did not affect our decision in this case, we must remind counsel that any unjustified delay will not only unnecessarily prolong the anxiety of the doctor being investigated, but may also be detrimental to the witnesses' recollection of relevant events. The SMC ought to approach the prosecution of disciplinary cases with greater swiftness and vigour.* ***Justice must not only be done but must be seen to be done promptly. Otherwise, the process will itself become the punishment***." (emphasis added)

28. For the sake of completeness, we state that we are aware of Dr Gan's previous disciplinary antecedent (the decision of the Disciplinary Committee dated 8 January 2010—see *Gan Keng Seng Eric v Singapore Medical Council* [2010] SGHC 325). However, we have not given this antecedent much weight as it concerned a charge of post-operative management of a patient and not informed consent. The Disciplinary Committee's Grounds of Decision was handed down to Dr Gan on 8 January 2010 which was some six or so months after the material events that gave rise to this Disciplinary Inquiry.

29. In arriving at the sentence, we have also taken into consideration various favourable testimonials provided by Dr Gan's peers in the profession. These testimonials have been provided by respected members of the profession, amongst others, Professor D1 (Senior Consultant, Department of XXX, XXX Hospital), Associate Professor D2 (Medical Board, XXX Hospital) and Professor D3 (Former President of the XXX) amongst others.

30. We also add that we do not agree with Dr Gan's counsel that censure is inappropriate in this case. Dr Gan has pleaded guilty to two charges concerning professional misconduct. In our view, it would be incongruent to *not* censure a doctor when he is guilty of professional misconduct. Censure goes to the very essence of a charge of professional misconduct. Dr Gan's counsel has not pointed us to any precedents concerning findings of professional misconduct where censure was not included.

31. Finally, as for costs, the Third Charge was withdrawn by the SMC. While it may have been withdrawn as part of the plea bargaining process, it may have well been withdrawn because the SMC had insufficient confidence in prosecuting it successfully. It is not transparent to us, nor should it be as it is likely to be part of privileged communications one way or the other. We will not speculate. We do not believe it fair to visit the costs associated with the Third Charge on Dr Gan.

**Publication of decision**

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

33. The hearing is hereby concluded.

Dated this 11th day of February 2015.