Dr Eric Gan Keng Seng v Singapore Medical Council
[2010] SGHC 325

Suit No:	Originating Summons No 144 of 2010
Decision Date:	1 November 2010
Court:	High Court
Coram:	Chao Hick Tin JA, Andrew Phang Boon Leong JA and Steven Chong J
Counsel:	Cavinder Bull SC, Harleen Kaur (Drew & Napier LLC) (instructed counsel) & Charles Lin Ming Khin (Donaldson & Burkinshaw) for the plaintiff; Tan Chee Meng SC, Ho Pei Shien Melanie & Chang Man Phing, Emily Su (WongPartnership LLP) for the defendant.

Subject Area / Catchwords

Professions – Medical profession and practice – Professional conduct

Judgment

1 November 2010 Judgment reserved.

Chao Hick Tin JA (delivering the judgment of the court):

1 This is an appeal by Dr Eric Gan Keng Seng ("Dr Gan") against the decision of the Disciplinary Committee ("the DC") of the Singapore Medical Council ("SMC") dated 8 January 2010 finding him guilty of professional misconduct under section 45(1)(*d*) of the Medical Registration Act (Cap 174, 2004 Rev Ed) ("the Act") in relation to his post-operative care of a patient, Mr Toh Hock Ken ("the Patient"). After the DC hearing which took place in two tranches between 12 May 2009 and 15 May 2009 and 6 January 2010 and 8 January 2010, the DC acquitted Dr Gan on the first charge of performing pre-cut sphincterotomy ("the Pre-cut Technique") on the Patient when Dr Gan knew or ought to have known that the procedure was beyond the scope of his competence. However, Dr Gan was convicted on the second charge for wilful neglect of his duties and gross mismanagement of the post-operative treatment of the Patient. The DC imposed the following sanctions:

(a) That Dr Gan be suspended from practice for a period of 6 months;

(b) That Dr Gan be censured;

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

(d) That Dr Gan pay 70% of the costs and expenses of and incidental to the proceedings, including the costs of the solicitor to the SMC and the Legal Assessor.

2 The reasons for the decision of the DC may be found in its written grounds dated 8 January 2010 ("the GD")[note: 1].

Background facts

3 Dr Gan, a medical practitioner of 19 years standing, is a Consultant Surgeon at Mount Elizabeth Hospital and a Visiting Consultant Surgeon at the National University Hospital and Alexandra Hospital ("AH").

4 Dr Gan first saw the Patient on 13 November 2005 when the Patient was admitted to AH after an acute episode of severe, colicky upper abdominal pain[note: 2] . After some treatment, the Patient was discharged from hospital on 15 November 2005. At a follow-up outpatient appointment on 29 November 2005, Dr Gan found that there was a possibility of stone(s) in the Patient's common bile duct and advised the Patient to undergo endoscopic retrograde cholangiopancreatogram ("ERCP"). After being advised by Dr Gan that the ERCP was a very common procedure involving hardly any risk, the Patient agreed. On 6 December 2005, at around 3.00 pm, Dr Gan performed the ERCP on the Patient at AH. The initial attempts at cannulation were unsuccessful and Dr Gan attempted a further procedure, the Pre-cut Technique on the Patient. However, Dr Gan still failed to gain access to the Patient's bile duct and accordingly had to halt the Pre-cut Technique to consider an alternative treatment plan.

5 The sequence of events on that fateful day was noted by the DC as follows (at [8] of the GD):

(A)6 December 2005

(i)1500 – 1550 hours: Dr Gan was unsuccessful in cannulating the bile duct despite performing the [Pre-cut Technique]. The Patient was kept nil-by-mouth post procedure, which was not Dr Gan's usual practice in previous cases. Dr Gan 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 Eugene Lim's assessment was that of "?post [*sic*] ERCP complications". Dr Gan verbally instructed Dr Lim 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 Eugene Lim updated Dr Gan verbally.

(B)7 December 2005

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

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

(ix)Between 1700-1930 hours: A CT scan was ordered.

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

6 From the above tabulation of events, it would be noted that following the failed ERCP procedure (including the Pre-cut Technique) and after instructing the medical team under him to keep the Patient under observation, Dr Gan left AH for the day. At about 6 pm, on the same day, the on-call registrar, Dr Eugene Lim Kee Wee ("Dr Lim"), called Dr Gan to inform him that the Patient looked unwell and had an episode of bilious vomiting and epigastric tenderness but that the Patient's vital signs were normal. Thereupon Dr Gan ordered several tests to be done, including an erect chest X-ray and serum amylase blood test as an initial investigation into the possible post-operative complications. The tests showed that the Patient's amylase was elevated to more than 5 times the normal level at 593U/L[note: 3] and the erect chest X-ray did not reveal any subcutaneous emphysema, pneumomediastinum or gas under the diaphragm. At around 9.50 pm, on that same evening, Dr Lim conveyed the results of the tests to Dr Gan over the telephone. Based on the working diagnosis of acute pancreatitis, Dr Gan instituted treatment for pancreatitis and instructed Dr Lim to keep the Patient fasted, start an IV drip, insert a nasogastric tube into the Patient and administer pethidine. Dr Lim was also instructed to place the Patient under close observation with his abdomen being reviewed periodically.

7 The following morning, on 7 December 2005, at around 8.50 am, Dr Gan visited the Patient at the ward. While the Patient looked well and his vital signs continued to remain normal with no fever, the Patient still complained of abdominal pains and had a slightly distended abdomen with tenderness in the right hypochondrium. Dr Gan also picked up a right pleural effusion and ordered a second chest X-ray to be done on the Patient. The chest X-ray confirmed that the Patient had a right pleural effusion[note: 4].

8 At about 5.00 pm on 7 December 2005, Dr Gan observed that the abdominal signs of the Patient had changed in that the area of tenderness had spread down the Patient's right flank and there was guarding. He immediately ordered a CT scan of the Patient's abdomen and pelvis to ascertain whether there was a perforation of the duodenum. A CT scan of the Patient was performed at around 10.00 pm that same evening. The CT scan revealed the presence of a retroduodenal perforation. Dr Gan performed an emergency exploratory laparotomy on the Patient in the early hours of 8 December 2005. This revealed large amounts of bile stained fluid within the peritoneal cavity, together with some haemoserous fluid. Similar fluid collections were also present in the retroperitoneal spaces[note: 5]. Despite subsequent efforts, the Patient passed away on 22 January 2006 from septicaemia due to intra-abdominal sepsis.

9 On 12 April 2007, Mdm Neo Guat Dee ("Mdm Neo"), the Patient's wife, lodged a complaint against Dr Gan with the SMC. The Complaints Committee, after considering the expert evidence of Dr Cheng Jun ("Dr Cheng"), specialist in Gastroenterology and Internal Medicine at Mount Elizabeth Medical Centre (who later became the sole expert witness for the SMC in its case before the DC), decided that it sufficed to only issue a letter of advice to Dr Gan, advising him to review his practice.

10 Dissatisfied with the decision of the Complaints Committee, the Patient's wife wrote to the Minister of Health, who invoked his powers under the Act to convene a Disciplinary Inquiry. Two charges were proffered against Dr Gan and they were set out in the Notice of Inquiry dated 12 August 2008. The first charge alleged that the Pre-cut Technique which Dr Gan had performed on the Patient was beyond the scope of his competence. However nothing in this charge should concern us here as Dr Gan was acquitted by the DC of the first charge (see [6] of GD). Of greater importance is the second charge ("the Charge") in respect of which the DC had found Dr Gan guilty. The Charge read:

That you [Dr Gan] a registered medical practitioner under the Medical Registration Act (Cap 174), are charged that whilst practising at Alexandra Hospital and the attending physician to [the Patient] for the period 6 December 2005 to 8 December 2005, you were in wilful neglect of your duties and had grossly mismanaged the post-operative treatment of the Patient.

Particulars

(a)The Patient had undergone [ERCP] surgery, involving a procedure called [the Pre-Cut Technique]] at about 3.00 p.m. on 6 December 2005;

(b)Post-surgery, at about 6.00 p.m. on 6 December 2005, the Patient suffered from an episode of bilious vomiting and epigastric tenderness;

(c)Perforation of the duodenum is a known risk of ERCP and [the Pre-cut technique];

(d)Despite the Patient's clinical condition and medical history, you 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;

(e)On the evening of 7 December 2005, a CT scan of the abdomen and pelvis was arranged and revealed the presence of free air and fluid in the right abdomen; and

(f)On 22 January 2006, the Patient passed away from septicaemia due to intra-abdominal sepsis.

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).

11 At the inquiry before the DC, Dr Gan contested both charges. The witnesses for the SMC were:

a) Mdm Neo and

b) Dr Cheng.

12 The witnesses for Dr Gan were:

a) Dr Gan;
b) Dr Michael Hoe Nan Yu ("Dr Hoe"), former Senior Consultant and Chief of Department of Surgery, Changi General Hospital, general surgeon at Gleneagles Medical Centre;
c) Dr Kenneth Mak Seck Wai ("Dr Mak"), Senior Consultant and Head of Department of Surgery, Alexandra Hospital, Deputy Chairman of the Medical Board at Alexandra Hospital, Visiting Consultant at the National University Hospital and Singapore General Hospital, Clinical Director at Jurong Medical Centre;
d) Dr Trevor Leese, former Senior Consultant in the Department of Surgery, Alexandra Hospital, consultant general surgeon at Tasmania Hospital in Burnie, Australia;
e) Dr Lim, former Registrar in Department of Surgery, Alexandra Hospital, Registrar at the Singapore General Hospital; and
f) Dr Gan's expert, Professor Ho Khek Yu ("Prof Ho"), Chief of the Department of Medicine, Senior Consultant at the Department of Gastroenterology & Hepatology and Clinical Director of the Endoscopy Centre of the National University Hospital; Professor of Medicine at Yong Loo Lin School of Medicine at the National University of Singapore.

SMC's case

13 On the mismanagement charge, the SMC's case (the prosecuting party before the DC), was that the perforation of the duodenum was a known risk of ERCP and the Pre-cut Technique (collectively "the Procedures") and it was imperative for Dr Gan to rule out such perforation, especially when Dr Gan was aware of the failed Pre-cut Technique and that any delay in the detection of a perforated duodenum could be fatal. The only conclusive way to determine whether there was perforation of the duodenum was to carry out a CT scan to ascertain the presence of free air in the retroperitoneal area. Given the medical history and clinical symptoms exhibited by the Patient, Dr Gan should have ordered a CT scan when the Patient's symptoms of epigastric pain, bilious vomiting, voluntary guarding and distension continued into 7 December 2005 and it was clear that the Patient's condition had deteriorated. Dr Gan had failed to carry out a CT scan, a very critical investigative step, at any of the material times from the time when the Patient exhibited symptoms on 6 December 2005 to around 5.00 to 7.00 pm on the evening of 7 December 2005, by which time it was too late[note: 6]. The SMC submitted that Dr Gan's failure to order the CT scan in a timely manner amounted to professional misconduct.

Dr Gan's case

14 Dr Gan's case was that the SMC had not proven that no reasonable doctor in Dr Gan's position would have ordered a chest X-ray instead of a CT scan at the material time. Dr Gan argued that he had not grossly mismanaged the post-operative treatment of the Patient as the issue was a matter of clinical judgment and equally competent physicians could arrive at different, yet reasonable management decisions. It was not unreasonable of Dr Gan to have

ordered an erect chest X-ray instead of a CT scan in the first instance. Dr Gan submitted that he was closely and intimately involved in the immediate post-operative care and management of the Patient and hence he was not in wilful neglect of his duties.

The DC's findings

15 The DC found[note: 7] that the Charge had been proven beyond reasonable doubt. Two reasons were specifically highlighted by the DC to justify the conviction of Dr Gan for professional misconduct under section 45(1)(*d*) of the Act[note: 8]:

a)
Dr Gan did not personally assess the Patient's condition on the night of 6 December 2005 after he was notified by Dr Lim that the Patient was unwell following the unsuccessful Pre-cut Technique; and
b)
Dr Gan failed to manage the situation appropriately between the onset of symptoms and signs post-ERCP and the eventual diagnosis of perforation.

16 The DC was of the opinion that Dr Gan should have personally attended to the Patient and evaluated his condition on 6 December 2005 when he was notified that the Patient was unwell following the Procedures carried out by him, and especially after the results of initial tests were available[note: 9]. It added that Dr Gan, by virtue of being the consultant in charge, was 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"[note: 10]. It further stated that relying solely on the assessment of junior doctors, including one still in speciality training, was not in the best interest of the Patient. The DC found that had Dr Gan seen the Patient on the night of 6 December, Dr Gan would have considered ordering a CT scan earlier when the Patient's condition did not improve the following day on 7 December 2005[note: 11].

17 The DC also noted that the chest X-ray conducted on 6 December 2005 did not reveal anything of consequence and the CT scan was the appropriate diagnostic test to be carried out as it would have revealed the perforation of the duodenum[note: 12]. The DC further observed that instead of ordering a CT scan, Dr Gan ordered another chest X-ray on the morning of 7 December 2005 and it was of the view that a more timely CT scan would have been crucial in the management of the Patient[note: 13].

18 Accordingly, the DC was of the opinion that Dr Gan's post-operative care of the Patient fell short of his professional duty to the Patient. It reaffirmed that Dr Gan's failure to personally assess the patient on the night of 6 December 2005 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[note: 14] and found him guilty of professional misconduct under s 45(1)(*d*) of the Act[note: 15].

The present appeal

19 Dr Gan appeals against the decision of the DC on the grounds that:

a)
the DC went beyond the scope of the Charge;
b)
the DC's finding that had Dr Gan personally seen the Patient in the evening of 6 December, he would have considered ordering a CT scan earlier is flawed and not supported by the evidence;
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;
d)
the DC's findings against Dr Gan do not amount to professional misconduct; and
e)
in the event that the conviction is upheld, the sentence imposed by the DC is manifestly excessive.

The role of this court

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

Orders of Disciplinary Committee

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

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

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

Analysis of the DC's decision

Scope of the Charge

22 With these principles in mind, we now turn to address the issues raised in this appeal (see [19] above). The first issue is whether the findings of the DC went beyond the ambit of the Charge (set out above at [10]). The starting point is, and must be, that Dr Gan is only required to respond to the charge and nothing more (see *Lim Teng Ee Joyce v Singapore Medical Council* [2005] 3 SLR(R) 709 at [26] and *Ho Paul v Singapore Medical Council* [2008] 2 SLR(R) 780 at [9] ("*Ho Paul*")).

23 Part IV of the Medical Registration Regulations on Professional Conduct and Discipline (Cap 174, Rg 1, 2000 Rev Ed) ("Medical Registration Regulations"), paragraph 18(1) and (2), prescribes what should be set out in the Notice of Inquiry and how it should be served:

Notice of inquiry

18. —(1) Where a Disciplinary Committee has been appointed under section 42 (1) of the Act, the Council's solicitor shall send a notice in Form B set out in the First Schedule to the practitioner.

(2) The notice referred to in paragraph (1) shall —

(a) specify in the form of a charge or charges determined by the Complaints Committee or (where the matter is referred to the Disciplinary Committee under section 40 (2) of the Act) the Medical Council, the matters which the Disciplinary Committee will inquire into; ...

Form B of the First Schedule of the Medical Registration Regulations provides:

Sir/Madam,

Notice is hereby given to you that in consequence of (a complaint made against you to the Medical Council) (information received by the Medical Council) an inquiry is to be held by the Disciplinary Committee into the following charge (charges) against you:

...

(*If the charge relates to conduct, set out briefly the facts alleged*): and that in relation to the facts alleged you have … (been guilty of professional misconduct).

[italics in original]

24 Dr Gan's case is that the Charge did not particularise the allegation that he was in wilful neglect of his duties by not personally examining the Patient on the night of 6 December 2005. As a result, he argues that he suffered prejudice because:

(i)

neither his written opening statement nor his counsel's oral opening submissions addressed this precise issue[note: 16] ;
(ii)
although the DC did ask some questions concerning his not being present on 6 December 2005, without this fact being stated in the Charge or as a particular relating to the Charge, he would not know what to make of those questions put by the DC[note: 17]; and
(iii)
he was deprived of the opportunity to call the appropriate witnesses to testify on the issue of whether it was necessary for him to personally attend to the Patient and to testify as to the system within which hospitals in Singapore relied on on-call Registrars[note: 18].

Therefore, the DC made a decision to convict Dr Gan without having counsel address the issue in full[note: 19].

25 In *Gobinathan*, the DC found Dr Devathasan guilty of one charge of professional misconduct under s 45(1)(*d*) of the Act, and ordered that he be, *inter alia*, fined $5,000. The charge related to Dr Devathasan's inappropriate administration of Ultrasound Sonolysis or Therapeutic Ultrasound on a patient. One of the reasons why the High Court found that the Disciplinary Committee had erred and allowed the appeal was that the Disciplinary Committee went beyond the scope of the charge in question by drifting beyond a consideration of the use of Therapeutic Ultrasound on the patient specifically to Therapeutic Ultrasound as a modality *per se* without any reference to the Patient. The High Court held that it was not open to the Disciplinary Committee to convict Dr Devathasan on the ground of safety (whether in respect of the patient herself or all patients in general) because there was no reference either in the charge or its particulars to any allegation that Therapeutic Ultrasound was "unsafe" or might cause harm (at [40]). The High Court further noted that:

If the SMC had intended to rely on safety considerations to justify the allegation of misconduct, such a serious allegation ought to have *expressly* formed part of the charge and have been *fully particularised*. …

[emphasis in original]

26 In *Low Cze Hong*, Dr Low appealed against the decision of the Disciplinary Committee finding him guilty of two charges of professional misconduct. One of his grounds of appeal was that certain particulars had not been pleaded and did not fall within the charges. In dismissing the appeal, the High Court, in relation to the allegations of imperfections to the charges, was satisfied (at [50]) that Dr Low was not in any way "misled or prejudiced by the allegedly faulty charges".

27 In *Law Society of Singapore v Ahmad Khalis bin Abdul Ghani* [2006] 4 SLR(R) 308 ("*Law Society of Singapore v Ahmad Khalis*"), in the context of an application taken out by the Law Society of Singapore, under s 98(5) of the Legal Profession Act (Cap 161, 2001 Rev Ed) against the respondent, who was an advocate and solicitor of the Supreme Court of Singapore, to make absolute an order to show cause, the respondent argued that the third charge in that case was vague and unclear. The High Court disagreed (at [61]) and went on to hold (at [62]) that even if

the charge was not as precise as it could have been, the respondent was able to put forward his case with clarity and much force. Drawing support from the Court of Appeal decision in *Chew Seow Leng v PP* [2005] SGCA 11, the High Court in *Law Society of Singapore v Ahmad Khalis* held that there was no question that the respondent was misled or prejudiced by the allegedly faulty charges.

28 In the present case, Dr Gan argues that the finding of the DC, that he was in breach of his duties because he did not personally attend to the Patient on the night of 6 December 2005, is a finding that does not fall within the scope of the Charge.

29 This court is of the opinion 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 wilful neglect of his duties and gross mismanagement in the post-operative treatment of the Patient for the period 6 December 2005 to 8 December 2005.

30 In considering this ground of objection, we must not lose sight of the fact that the thrust of the charge is that Dr Gan, as the consultant who carried out the Procedures which failed, had grossly mismanaged the post operative care of the Patient. The critical consequence thereof was his failure to timely instruct the carrying out of a CT scan on the Patient's abdomen and pelvis, bearing in mind the dire consequences (which Dr Gan claimed he was aware) should there be any delay in the discovery of a duodenal perforation. 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. This would necessarily require an examination of both Dr Gan's acts, as well as his omission. His 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.

31 In this connection, we note that counsel for Dr Gan at the inquiry before the DC sought to call an additional witness, Dr Lim, to ask "some questions ... about how often Dr Gan had come to see the [P]atient…"[note: 20] after the Procedures failed. His counsel, in view of the SMC's objections, explained that he wanted Dr Lim to explain to the DC the standard procedure for consultants in that sort of situation. This was allowed and Dr Lim gave evidence of what he thought of the fact that Dr Gan did not come to the hospital on the evening of 6 December 2005[note: 21]. Moreover, Dr Gan gave evidence that he knew one of the issues was the post-operative care of the Patient on 6 and 7 December 2005[note: 22] and Dr Gan's closing submissions also dealt with Dr Gan's care of the Patient on 6 and 7 December 2005.

32 In coming to its conclusion that Dr Gan should have personally attended on the Patient in the evening of 6 December 2005, instead of relying wholly on the oral report of the on-call Registrar as to the condition of the Patient, what the DC was effectively saying was that had Dr Gan seen the Patient in the evening of 6 December 2005 he would have had a better appreciation or perception of the condition of the Patient and, in turn, would have considered ordering a CT scan of the Patient earlier. Although Dr Lim is a doctor, the fact remains that

unlike Dr Gan, Dr Lim is not a specialist but a trainee specialist. In terms of skills or competence, there would be a difference between a specialist and a trainee specialist. It stands to reason that a clinical examination by a trainee cannot be treated as the same as that done by a specialist. We do not think that Dr Gan was in any way misled as to the case he had to meet *i.e.* a failure to order a CT scan earlier which led the Patient to lose his life.

Whether the DC's findings are flawed and contrary to the evidence

33 We now turn to examine the next two related arguments of Dr Gan (see [19] above) that 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 unjustified ("the first argument") and that the DC's finding that Dr Gan would have considered ordering a CT scan earlier is flawed and not supported by evidence ("the second argument").

34 In relation to the first argument, it is an established fact that Dr Gan did not to attend to the Patient on the night of 6 December 2005. Dr Mak, witness for Dr Gan, gave evidence that they in fact encouraged reviews by procedurists themselves so that any immediate complications or adverse outcomes can be picked up by the procedurist himself[note: 23]. Dr Trevor Leese, another witness for Dr Gan, gave evidence that following an ERCP and the Pre-cut Technique, he would review the patient himself to see if there were any signs of complications. If complications arose after office hours, his evidence was that it would be more difficult and it would depend on who was calling him and what confidence he had in the medical report. He would go back to the hospital to see the patient if he was concerned[note: 24]. Dr Hoe, witness for Dr Gan, also gave evidence that he would assess the patient when he was called and based on the medical report of the Patient at 9.50 pm on 6 December 2005, he was of the view that the Patient was having 'some significant symptoms' and he would like to see the patient himself in order to evaluate him and see how he was faring as compared to what the Patient's condition was, immediately after the Procedures[note: 25].

35 Dr Gan admitted that the Pre-cut Technique is a highly technical and complicated procedure[note: 26]. Dr Gan gave further evidence that a floppy papilla (which the Patient had) makes the Pre-cut Technique "a very high risk"[note: 27]. There is evidence that Dr Gan had an inkling that something was not right after the Procedures as he put the Patient on nil-by-mouth, even though that was not Dr Gan's normal practice (as noted by the DC at [8] of the GD). In other cases involving the Pre-cut Technique, including those where the procedure failed, Dr Gan allowed the patients to have feeds[note: 28].

36 As explained by Dr Cheng, the identification of perforations begins with the doctor's inkling at the outset as to whether he had created a perforation[note: 29]:

At the very beginning certainly when the patient complains just of pain and guarding and discomfort and vomiting, it's hard to tell which is which but it's a high index of suspicion. Pancreatitis being more common, certainly you will keep an eye, but I think if you are talking about perforation, number one, you will -- at the time of procedure, you'll already have an inkling, you know, as to whether you have created a perforation.

The first is when you did the cutting, you then proceed to cannulate on the assumption that you have found the opening to the bile duct. During the cannulation, you go in some space which is not the bile duct and you put contrast in and you'll see, oh, it's not the bile duct so you have already created a kind of perforation. And if the perforation was a little bit more, if you put in more air, you can see air appearing on the X-ray during ERCP. So that already can give you a clue whether there is any perforation.

Then subsequent to that, if you're still looking for -- if you still suspect if a patient has perforation, then clinically at the bedside, if you're not happy with the situation, you should -- you have to do a CT scan to find out what's happening.

37 Dr Gan must have had an inkling that something was not right with the Patient to depart from his normal practice. This can be gleaned from the following evidence of Dr Gan[note: 30]:

THE CHAIRMAN:	I noticed that if [*sic* "in"] those pre-cuts, even the one that you failed, patient was allowed to have feeds.
A:	That is true, if -- if a procedure goes smoothly and I -- I -- I successfully manage to cannulate then I'm -- I'm happy to allow the patient to have feeds. In this particular case, I had performed a pre-cut and I -- I failed to -- to cannulate and that reason I -- I decided to -- to observe the patient for a bit.
THE CHAIRMAN:	So there's possibly some concern --
A:	There may --
THE CHAIRMAN:	-- that you may have had?
A:	There -- there may have been something else that I -- I -- the -- the cut may have been a little rugged or --or something --
THE CHAIRMAN:	Okay. Okay.
A:	-- may have triggered.
THE CHAIRMAN:	Okay.
A:	I --I did not -- as I mentioned earlier see anything to suggest outright perforation.
THE CHAIRMAN:	Sure, sure.
A:	Yes.
THE CHAIRMAN:	But I bet -- I gather, sometimes we've got a sixth sense that --
A:	Yes, sometimes you may have a --

Furthermore, one panel member of the DC noted that Dr Gan must obviously have inflicted an injury that is more significant than a microscopic tear in the duodenum to cause such a large amount of bile to be found in the abdominal cavity[note: 31].

38 Following on from Dr Gan's inkling that something was not right with the Patient, barely three hours after the failed Procedures, the Patient suffered from bilious vomiting, epigastric tenderness and was noted to be unwell. At around 6.00 pm on 6 December 2005, the Patient's condition was serious enough to warrant Dr Lim calling Dr Gan[note: 32].

39 It is true that Guideline 4.1.1.4 of the SMC Ethical Code and Ethical Guidelines ("SMC Ethical Code") provides that:

A doctor may delegate another doctor, nurse, medical student or other health care worker to provide treatment or care on his behalf, but this person must be competent to carry out the care or procedure required. A doctor retains responsibility for the overall management of the patient when he delegates care. If the person delegated to is not duly registered as a practitioner, this must be in the context of a legitimate training programme and the doctor must exercise effective supervision over this person.

Other relevant guidelines include Guideline 4.1.1.5 of the SMC Ethical Code which provides:

A doctor shall provide competent, compassionate and appropriate care to his patient. This includes making necessary and timely visits, arranging appropriate and timely investigations and ensuring that results of tests are communicated to the patient and the most appropriate management is expeditiously provided ...

Further, Guideline 4.1.1.1 of the SMC Ethical Code provides:

A doctor is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.

If treatment is suggested or offered to a patient without such personal evaluation, the doctor must satisfy himself that he has sufficient information available and that the patient's best interest is being served. Such information could be transmitted by voice, electronic or other means by a referring doctor. Only in exceptional or emergency circumstances should diagnosis or treatment be offered without personal contact and without the intermediation of a referring doctor.

We recognise that under Guideline 4.1.1.4, the doctor in charge could delegate to another doctor or nurse, the task of providing treatment or care to a patient. However, here we are not concerned with the administering of treatment or care to a patient but 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 Guideline 4.1.1.5 is particularly germane. The doctor should make necessary and timely visits. He should also make timely investigations. While Guideline 4.1.1.1 permits a doctor to prescribe treatment without personal attendance and evaluation, the doctor must consider the situation carefully to see if it would be in the best interest of the patient to so prescribe. Furthermore, it is only in exceptional or emergency circumstances that diagnosis or treatment be offered without personal contact. In a case such as the present, where one of two known complications from the failed Procedures is duodenal

perforation and it is also known that early detection is of the essence where that complication is concerned, the doctor in charge should act with utmost care.

40 On the present facts, Dr Gan agreed that he did not know whether Dr Lim, who was still under training, had seen a post-retroduodenal perforation[note: 33]. 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. We cannot agree more. We would reiterate what is stated in [32] above that the level of experience, and in turn competence, between the two is obviously different and this would surely have an impact on the clinical assessment of the Patient. Prof Ho, Dr Gan's expert witness, gave evidence that the ability to make an appropriate diagnosis is dependent on the experience of the person examining the patient[note: 34]. Furthermore, Prof Ho was of the opinion that if the case was one of perforation, the doctor should see the patient[note: 35]. Based on Dr Gan's own evidence that the Pre-cut Technique was a highly complicated procedure[note: 36], that Dr Gan had an inkling that something might be wrong with the Patient immediately after the Procedures and that he took abdominal pain post-ERCP seriously[note: 37], we hold that the finding of the DC that Dr Gan should have personally examined the Patient on the night of the 6 December 2005 is not unsafe, unreasonable or contrary to the evidence.

41 The point was made by counsel for Dr Gan that it would have made no difference even if Dr Gan had visited the Patient on the night of 6 December 2005 because he did visit the Patient at 8.50 am the next morning and yet did not think it necessary to order a CT scan. This argument is flawed. If Dr Gan had visited the Patient on the night of 6 December 2005, he would have had a better perception of the Patient's condition and it could have an important impact on his clinical judgment when he saw the Patient the next morning particularly so since Dr Gan emphasized that what he was looking for was progression in the Patient's symptoms[note: 38]. Obviously the DC felt that a doctor must see and examine the Patient in a case such as this before he could make a correct comparison or assessment to determine the next step to take. We fully agree with that.

42 Based on the evidence before it, the DC's opinion, that a reasonably responsible doctor who had performed a procedure which was unsuccessful and which is 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 complication is, in our view, not a finding which is "unsafe, unreasonable or contrary to the evidence". Indeed, this led naturally to the DC's finding (at [16] of the GD) that Dr Gan's failure to manage the situation appropriately between the onset of symptoms and signs post-ERCP and the eventual diagnosis of perforation established the allegation of wilful neglect of Dr Gan's duties constituting professional misconduct. We would reiterate that Dr Lim, the on-call doctor is, unlike Dr Gan, not a specialist but a trainee specialist. In terms of skills or competence, there would be a difference between a specialist and a trainee specialist. It stands to reason that a clinical examination by a trainee cannot be treated as the same as that done by a specialist.

43 On the second argument, the DC stated (at [13] of the GD):

We accept that the timing of certain tests can vary between specialist doctors, but we are of the opinion that had Dr Gan, 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.

44 The DC's point was that if Dr Gan had visited the Patient on the night of 6 December 2005, he would have ordered a more timely CT scan on the Patient. Dr Gan confirmed, based on the symptoms of the Patient reported to him on the night of 6 December 2005, that all was not well with the Patient who could be suffering from either pancreatitis or duodenal perforation, with pancreatitis at the top of his list of differential diagnosis and the second diagnosis was perforation[note: 39].

45 There were also new developments in the Patient's condition between 6 December 2005 and 7 December 2005. We agree that had Dr Gan examined the Patient on 6 December 2005, he would have been in a better position to assess the Patient's change in condition between 6 and 7 December 2005.

46 At around 5.30 am on 7 December 2005, a urinary catheter was inserted into the Patient because he could not pass urine and concentrate urine of 500 ml was thereby collected. At 12.00 pm on 7 December 2005, the Patient passed very concentrated urine. Prof Ho's evidence, when asked whether the white blood count of the Patient being 25,000 post–ERCP combined with poor urine output told him anything, was that it indicated that he was dealing with something severe but did not in some way increase the specificity of a particular diagnosis[note: 40]. Dr Hoe's evidence was that the Patient was having 'some significant symptoms"[note: 41]. Moreover, earlier on, at 10.20 am on 7 December 2005, the Patient was observed to be breathless and tachypnoeic and complained of shortness of breath and pain in the abdomen. A short while later at around 10.30 am, nearly 16 hours after the onset of symptoms, Dr Gan physically examined the Patient and picked up a right pleural effusion. Dr Cheng's opinion in relation to the Patient's shortness of breath was that it was probably the diaphragm being pushed up. This was the usual situation where there was a leak of air in the abdomen[note: 42]. Dr Gan ordered a second chest X-ray which he claimed was to confirm his diagnosis of a pleural effusion[note: 43]. We would observe that the House Officer, Dr Angela Yeo, noted in relation to the second chest X-ray that there was no free gas. Dr Gan's evidence was that he told the House Officer not to write down those words otherwise it would look like he was trying to look for a perforation with the second chest X-ray when that was not the case[note: 44]. However, the House Officer nevertheless went ahead to write down those words. The significance of this bit of evidence cannot be ignored.

47 Based on the biochemistry lab data, the Chairman of the DC noticed that on 7 December 2005 at 10.55 am the Patient was developing an anion gap and was becoming acidotic. The Chairman further noted that the lab data appeared to indicate that Patient was getting sick[note: 45]. At around 4.30 pm on 7 December 2005, Dr Gan physically examined the Patient and noticed a change in the abdomen signs in that the area of tenderness was moving down from the epigastrium and right hypochondrium to the right iliac fossa and he felt that there was guarding. It was only then that he decided to organise an urgent CT scan on the Patient[note: 46].

48 The CT scan showed large amounts of retroperitoneal air, some free intraperitoneal fluid and a large quantity of edema along the right retroperitoneal area[note: 47]. This was consistent with a perforation of the duodenum. An emergency laparotomy was performed early on 8 December 2005 and in the hospital operating notes, the diagnosis put down was mild pancreatitis and retroduodenal perforation[note: 48]. However the diagnosis of retroduodenal perforation came too late and the Patient subsequently passed away on 22 January 2006.

49 Dr Gan and Dr Cheng agreed that an earlier diagnosis of perforation might have improved the Patient's chances of survival. Dr Cheng said that "the complication became much worse as a result of the delay"[note: 49] and Dr Gan agreed that "an earlier diagnosis may have improved [the Patient's] chances...clearly"[note: 50] and a delayed diagnosis of duodenal perforation "of more than 24 hours is associated with higher mortality"[note: 51].

50 While the DC did not fault Dr Gan for not ordering a CT scan of the Patient from the very beginning when symptoms first appeared, the DC thought that a more timely CT scan would have been crucial to the management of the Patient and that Dr Gan would have considered ordering a CT scan earlier if he had seen the Patient earlier. We reiterate our views at [41] above that Dr Gan would have been in a better position to assess the change in the Patient's condition between 6 and 7 December 2005 if he had examined the Patient on the night of 6 December 2005. This would have had an important impact on his clinical judgment and would have caused him to consider ordering a more timely CT scan. One cannot overemphasise the fact that any delay in discovering a duodenal perforation could be life threatening, as in fact was the case here. In view of this grave consequence if a duodenal perforation is not attended to with due despatch, a consequence which Dr Gan said he well knew, we do not think it was wrong for the DC to have found Dr Gan guilty of gross neglect or mismanagement in failing to see the Patient in a more timely fashion, ie the evening of 6 December, which would have led to a more timely CT scan and the discovery of the duodenal perforation in the Patient.

51 Bearing in mind the role of this court as set out in *Gobinathan* and noting that the Disciplinary Committee has the benefit, which we do not have, of hearing oral evidence on both sides and it is a specialist tribunal with its own professional expertise and understands what the medical profession expects of its members, this court is of the opinion that the finding of the DC that Dr Gan had grossly mismanaged the Patient is not unsafe, unreasonable or contrary to the evidence. Despite knowing the risks of duodenal perforations associated with the Procedures and that the Patient had developed new symptoms on 7 December 2005, Dr Gan still failed to order a CT scan earlier than at the time he did.

Conclusion

52 In the result, we are of the opinion that the DC's finding that Dr Gan's wilful neglect of his duties and gross mismanagement of the Patient amounts to professional misconduct under s 45(1)(*d*) of the Act is not unsafe, unreasonable or contrary to the evidence. Given that the DC is a specialist tribunal (see [51] above), we decline to interfere with the decision of the DC and accordingly, the appeal against conviction is dismissed.

Whether the sentence is manifestly excessive

53 We now turn to the question of sentence. Dr Gan relies on Case No 4 of the SMC's sentencing precedents of disciplinary inquiries conducted by the SMC[note: 52] ("Sentencing Precedents") to argue that the sentence ordered by the DC is manifestly excessive. In Case No 4, the doctor faced two charges: first, for failure to adequately assess the medical condition of the patient and to refer the patient to hospital for further management of a serious medical condition being that of septicaemic shock from perforation of the appendix and second, for failure to keep proper medical records of the consultation with the patient. The doctor in that case claimed trial to both charges. The doctor was convicted of both charges under s 45(1)(*d*) of the Act. A fine of $10,000 was imposed, he was censured and ordered to provide a written undertaking to take a full medical history of the patient and to keep adequate clinical records of his findings.

54 On the other hand, the SMC relies on cases such as Case No 1 and 7 of the Sentencing Precedents to argue that the sentence of the DC is not manifestly excessive. In Case No 1 of the Sentencing Precedents, the doctor pleaded guilty to two charges under s 45(1)(*d*) of the Act, namely failure to carry out appropriate clinical examination and/or tests and failure to properly manage an infection which the patient developed during the course of his treatment. The patient died as a result. The doctor was suspended for 3 months, censured and ordered to provide a written undertaking to abstain from similar conduct. In Case No 7 of the Sentencing Precedents, involving an inquiry for infamous conduct in a professional respect, a doctor was charged with four charges involving serious disregard of professional responsibilities and dereliction in the management and care of the patient, viz, (i) in his failure to admit the patient to hospital when her condition warranted it; (ii) in his failure to promptly attend to and examine the patient when he knew her condition was critical; (iii) in prescribing drugs over the telephone without personally examining the patient; and (iv) in delaying performing a C-section on the patient. The doctor was suspended for six months, censured and ordered to provide a written undertaking to abstain from similar conduct. Although the document stated that the doctor was found guilty of charge (ii), it did not indicate what happened to the other charges. However, during oral argument before this court, counsel for the SMC informed us that the other three charges were not proceeded with.

55 In our view, Case No 4 of the Sentencing Precedents relied on by Dr Gan may be distinguished on the ground that there is no evidence that the doctor in that case was a Consultant or that he/she knew of possible complications but failed to carry out the appropriate diagnostic tests. Furthermore, there is no evidence from Case No 4 that the patient died as a result of the doctor's failure to diagnose the patient in a timely fashion. On the other hand Case No 1 seems to have some similarity to the present case although it involved two charges and the doctor was only suspended for three months. As regards Case No 7, which also concerned mismanagement, and which is similar to this case, six months' suspension was imposed. This court had stated in *Ho Paul* (at [15]) that "like cases should be treated alike unless there are good reasons to depart from applicable precedents". Based on Cases No 1 and 7, we do not see how it could be argued that the suspension of six months imposed on Dr Gan was out of line, far less manifestly excessive.

56 In the light of the inadequacies highlighted in the two preceding paragraphs relating to the document setting out the applicable precedents, we would like to make the following comments for future reference. First, in setting out the facts of a precedent, such as Case No 7, where only a

single charge, or for that matter only a number of the original charges were proceeded with, there is no need to list out the charges which were not proceeded with; but if, for any reason, there is a need to do so, details should be given, including a brief explanation as to why it was necessary to list out those abandoned charges. Second, the consequence to the patient as a result of the professional misconduct should be disclosed. This is a highly material fact. Only where this information is furnished would that precedent be of assistance to the Disciplinary Committee, and, in turn, the court, to determine the appropriate sentence, or to determine if the sentence imposed by the DC on an appeal to this court is manifestly excessive.

57 In the result, this appeal is dismissed with costs.

[note: 1]Dr Gan's Core Bundle Vol I, pp 2-7

[note: 2]Dr Gan's Core Bundle Vol I, p 17

[note: 3]Dr Gan's Written Submissions, para 30

[note: 4]Dr Gan's Written Submissions, para 37

[note: 5]Dr Gan's Core Bundle Vol I, p 19

[note: 6]SMC's Closing Submissions before the DC, Record of Proceedings, Vol III E, p 1326 para 91-93

[note: 7]GD at para 17

[note: 8]GD at para 16

[note: 9]GD at para 12

[note: 10]GD at para 12

[note: 11]GD at para 13 and 15

[note: 12]GD at para 13

[note: 13]GD at para 14

[note: 14]GD at para 16

[note: 15]GD at para 18

[note: 16] Dr Gan's Written Submissions, para 134

[note: 17] Dr Gan's Written Submissions, para 140

[note: 18] Dr Gan's Written Submissions, para 146

[note: 19] Dr Gan's Written Submissions, para 141

[note: 20] Record of Proceedings Vol III B, pp 385-386

[note: 21] Record of Proceedings, Vol III C pp 788-789

[note: 22] Record of Proceedings Vol III B pp 498

[note: 23] Record of Proceedings Vol III A, p 208

[note: 24] Record of Proceedings Vol III C pp 690-691

[note: 25] Record of Proceedings Vol III C, pp 756-757

[note: 26] Record of Proceedings Vol III B, pp 453-454

[note: 27] Record of Proceedings Vol III B, p 483

[note: 28] Record of Proceedings Vol III B, p 598

[note: 29] Record of Proceedings Vol III A, pp 156-157

[note: 30] Record of Proceedings Vol III B, p 598

[note: 31] Record of Proceedings Vol III C, p 611

[note: 32] Record of Proceedings Vol III C, p 808

[note: 33] Record of Proceedings Vol III C, p 601

[note: 34] Record of Proceedings Vol III D, pp 1005-1006

[note: 35] Record of Proceedings Vol III D, p 1004

[note: 36] Record of Proceedings Vol III B, p 453-454

[note: 37] Record of Proceedings Vol III B, p 521

[note: 38] Record of Proceedings Vol III B, p 551

[note: 39] Record of Proceedings Vol III B, p 548

[note: 40] Record of Proceedings Vol III C, p 881

[note: 41] Record of Proceedings Vol III C, p 756

[note: 42] Record of Proceedings Vol III B, p 328

[note: 43] Record of Proceedings Vol III B, p 399

[note: 44] Record of Proceedings Vol III B, p 529

[note: 45] Record of Proceedings Vol III C, p 630

[note: 46] Record of Proceedings Vol III B, p 405

[note: 47] Record of Proceedings Vol III B, p 406

[note: 48] Record of Proceedings Vol III B, p 435

[note: 49] Record of Proceedings Vol III A, p 185

[note: 50] Record of Proceedings Vol III B, p 556

[note: 51] Record of Proceedings Vol III B, p 551

[note: 52] Dr Gan's Core Bundle Vol II, p 182