Commentary on High Court Judgment in Dr Eric Gan Keng Seng v. Singapore Medical Council [2010] SGHC 325

By Ms Kuah Boon Theng

A recent High Court judgment, dismissing an appeal filed by Dr Eric Gan challenging a guilty verdict against him by the Singapore Medical Council Disciplinary Committee (SMC DC), has been generating more than a few ripples within the medical fraternity. Many doctors have remarked that the case appears to send the message that you could be found guilty of professional misconduct simply for not coming back to the hospital after hours to see your patient, and choosing to rely on a more junior member of your team to assess the patient. Doctors have also expressed their fears that this will undermine the "team-based" medical management approach practiced in hospitals, and put a terrible burden on senior doctors.

Lest we be carried away by panic and hysteria over what the larger implications of this decision may mean for doctors, particularly those practicing in hospitals, it is important to study the actual judgment and facts of the case, and try to understand the reasons for the SMC's and the High Court's findings.

Brief Facts:

Dr Gan's patient had been admitted to hospital in November 2005 with severe, colicky upper abdominal pain. Dr Gan suspected gallstones and recommended that the patient undergo an Endoscopic retrograde cholangiopancreatography (ERCP). This was performed in the afternoon of 6 December 2005. During the procedure, Dr Gan noted that the papilla was floppy as a result of which cannulation was difficult. He then decided to proceed to perform a pre-cut sphincterotomy to gain access to the common bile duct, but this failed as well. The procedure then had to be abandoned at 1530hrs.

Contrary to his usual practice, Dr Gan ordered "nil–by–mouth" following the procedure. During the inquiry, it was suggested that he did so because he had an inkling that something might have gone wrong during the procedure, although he maintained that he had not seen anything to suggest an "outright perforation".

At about 1710hrs the patient's abdomen was found to be distended, he was in discomfort, and tenderness was elicited upon palpation. At 1745hrs he had two episodes of bilious vomiting. By 1800hrs he was having epigastric pain radiating to the back and voluntary guarding. At the time, Dr Gan had already left the hospital. The on-call Registrar Dr Lim saw the patient and wrote on the notes "? post ERCP complications". He then telephoned Dr Gan to tell him about the patient's condition. Dr Gan responded by ordering an erect chest x-ray and blood tests, the results of which were later given to Dr Gan by Dr Lim over the telephone at about 2150hrs. The patient had amylase serum levels which were five times the normal level but the x-ray was clear. At the inquiry, Dr Gan admitted that at that time he had considered two possible diagnoses: pancreatitis or a perforated duodenum. The treatment that was actually ordered on the night of 6 December 2005 was based on the presumed diagnosis of pancreatitis.

During the early hours of 7 December 2005, the patient was unable to pass urine, and at 0530hrs a urinary catheter was inserted following which he passed concentrated urine. Dr Gan saw the patient at 0850hrs. At the time of this review, the patient looked well and did not have a fever, but was still complaining of pain and tenderness in the right hypochondrium. When the patient complained of shortness of breath later that morning, Dr Gan again examined him at 1030hrs, and diagnosed a right pleural effusion that was confirmed by x-ray.

Laboratory test results at 1055hrs indicated that the patient was acidotic, and at 1200hrs he was again noted to have very concentrated urine. Dr Gan examined the patient at 1630hrs and noted that the area of tenderness had moved to the lower abdomen. He immediately ordered a CT scan of the abdomen due to the concern that the patient might have a perforated duodenum. The results of CT scan came back at 2330hrs and did confirm presence of a retroduodenal perforation. Dr Gan performed an emergency laparotomy in the early hours of 8 December 2005. Large amounts of bile-stained fluid were found. Despite further treatment, the patient subsequently passed away on 22 January 2006 from complications due to intra-abdominal sepsis.

The SMC Charges and Verdict:

When the SMC's Complaints Committee initially considered the complaint filed by the patient's widow, it decided that it was only necessary to issue Dr Gan with a letter of advice and there was no need for a disciplinary inquiry. But the widow exercised her right of appeal under the Medical Registration Act to the Minister of Health, and the Minister decided to exercise his power to order that the case be referred to disciplinary inquiry after all.

Before the DC, Dr Gan originally faced two charges of professional misconduct. The first was for performing the pre-cut sphincterotomy when he knew or ought to have known that it was beyond the scope of his competence. The DC found him not guilty on the first charge. However, he was found guilty on the second charge of being in willful neglect of his duties and gross mismanagement of the post-operative treatment of his patient. He was ordered to be suspended from practice for six months, given a censure, ordered to give the SMC a written undertaking that he would not repeat such conduct, and also to pay 70% of the costs and expenses of the proceedings.

Grounds of Appeal

Dr Gan appealed on the grounds that the DC's decision on the second charge went beyond the scope of the written charge against him. He also argued that the finding that had he personally seen the patient in the evening of 6 December 2005, he would have considered ordering a CT scan earlier was flawed and not supported by the evidence. He pointed out that he did see the patient the following morning and even then did not order the CT scan. In addition to asking the Court to set aside the DC's guilty finding against him, he also submitted that imposing a six-month suspension on him was manifestly excessive.

Decision of the Court/Reasoning:

The appeal was heard by a Court of three Judges comprising Justices of Appeal Chao Hick Tin and Andrew Phang Boon Leong, and Justice Steven Chong. In a Judgment dated 1 November 2010, Dr Gan's appeal was dismissed. In order for the Court to interfere with the findings of the DC (bearing in mind that unlike the DC, the Judges on appeal did not have the opportunity to hear and judge the evidence first-hand), the Court had to be satisfied that the DC's findings were "unsafe, unreasonable or contrary to the evidence". It decided that there was no evidence that that was the case. In fact, the Court went further and stated that having considered the evidence, it fully agreed with the DC's findings.

What were the reasons that led the Court to eventually reject the arguments made by Dr Gan relating to his post-operative management of the patient on the night of 6 December 2005?

In trying to persuade the Court, Dr Gan's counsel had drawn the Court's direction to the SMC Ethical Code and Ethical Guidelines. Under Guideline 4.1.1.4, it is stated that a doctor can delegate to another doctor the task of providing treatment or care to a patient. Dr Gan argued that what he did was no different than that stated in Guideline 4.1.1.4. But the Court felt there was a distinction. The Court said:

"…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."

Importantly, the Court drew a distinction between "treatment and care" and "clinical assessment of the patient". While it is one thing to ask another doctor to carry out a treatment order for you, it is a quite another to assume that your junior doctor's clinical assessment is necessarily no different from yours. On further reflection, even in the realm of treatment and care, it has to be acknowledged that while there are many instances where it may be perfectly alright to ask another doctor to administer the treatment or care ordered for a patient on your behalf, there must a limit to this, and ultimately the matter of delegation of duties has to be based on a judgment of the abilities and experience of the doctor you are delegating the responsibility to. After all, a senior surgeon cannot simply invoke Guideline 4.1.1.4 to justify asking his junior doctor who lacks skills and experience to perform a complicated surgery in his place.

So Guideline 4.1.1.4 did not provide a total answer to the criticism faced by Dr Gan. Being able to make a judgment to delegate does not obviate the need to ask the question – should you have delegated that responsibility in those specific circumstances? The Court was reminding us that when it came down to a matter of clinical assessment, the clinical acumen of a senior doctor was not the same as that of a more junior doctor. So you cannot simply view them as being interchangeable. You have to apply your mind as to whether it is appropriate in that situation to leave it to the more junior doctor.

The Court also made it a point to note that Guideline 4.1.1.4 was not the only guideline to refer to. Guideline 4.1.1.5 required doctors to make "…necessary and timely visits" to their patients. And Guideline 4.1.1.1 states that doctors are allowed to prescribe treatment without personal attendance and evaluation, but only after the doctor has considered "… the situation carefully to see if it would be in the interest of the patient to so prescribe" and only in "…exceptional and emergency circumstances."

The issue was, considering what had happened during the surgery earlier that afternoon, should Dr Gan have personally examined the patient on the night of 6 December 2005, rather than rely on his Registrar to do so on his behalf? The following passage of the Judgment makes clear the specific facts of this case that eventually weighed against Dr Gan:

"Based on Dr Gan's own evidence that the Pre-cut Technique was a highly complicated procedure, 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, we hold that the finding of the DC that Dr Gan should have personally examined the Patient on the night of 6 December 2005 is not unsafe, unreasonable or contrary to the evidence."

In other words, by Dr Gan's own admission, this was not a run-of-the-mill case, and in fact he already had the feeling that something might be wrong, and he also knew that what might be wrong could be potentially serious. Given all these factors, based on Dr Gan's own evidence, the Court was not about to question why the DC felt that he should have personally attended to his patient. It was clear from the Judgment that the Judges also found it hard to accept the decision Dr Gan made not to return to the hospital that night.

From the feedback I have gathered from some doctors, the issue that they had the greatest difficulty grappling with is with the finding that it was unacceptable for Dr Gan to rely on the clinical assessment of his Registrar. After all, we are not talking about a house officer or a medical officer here. Dr Lim was apparently already six years into practice.

The Court explained:

"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."

Put this way, it is hard to argue against these observations. The qualifications and experience of a doctor does surely make a difference. In this case, it did not help that when asked during the inquiry, Dr Gan had admitted that he did not know if Dr Lim had ever seen a post–retroduodenal perforation. This probably drove home the point that he should not have relied on Dr Lim to recognise a specific complication that Dr Lim might not have seen before.

But some doctors may argue that it was not necessary for Dr Lim to have seen a post-retroduodenal perforation before, and that the issue was whether it was reasonable to expect Dr Lim as a Registrar to recognise an acute abdomen. Many would say the answer should be yes. And for this reason, some doctors have expressed the view that the decision against Dr Gan seemed a bit harsh. Having said that, reading the case as a whole, it seems clear that this case was decided very much based on its specific facts: the surgeon, who had earlier in the day failed to carry out both an ERCP and pre-cut sphincterectomy due to technical problems had admitted he had an inkling that something might have gone wrong. This was a feeling that he alone would have had, not his Registrar, possibly not even his more senior colleague who would not know precisely what happened during the failed cannulation attempts. At the end of the day, the verdict against Dr Gan was no doubt based on the fact that neither the SMC nor the Court could reconcile in their minds why Dr Gan did not go down to assess his patient himself, even when he already had a premonition that something could be wrong. This might have had to do with the manner in which the failed procedure was earlier attempted.

What then, of Dr Gan's argument that even if he had gone to see his patient that night, it

would not have materially changed the medical management? The Court disagreed, and found that 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 this would also have had an important impact on his clinical judgment when he saw the patient the next morning. The Court agreed that this would have caused him to consider ordering a CT scan in a more timely manner. Again, from the feedback that I have received, I gathered that some doctors consider this conclusion rather harsh, one that may have been influenced by the patient's eventual outcome. Again, we have to consider the specific facts. Perhaps if the patient had been in a relatively better condition the night before, as compared to the following morning, it would have been easier for Dr Gan to persuade the SMC and the Court that he would not have ordered anything more than what he eventually did the next morning. But the situation here was reversed. By the time Dr Gan saw the patient the next morning, there was actually some improvement in the patient's condition. Without this improvement, and based on the condition of the patient the night before, it was felt that Dr Gan would probably have ordered the CT scan earlier.

Finally, there was the appeal that the sentence meted out to Dr Gan had been manifestly excessive. Again, Dr Gan's own testimony may have been his undoing. At the hearing before the DC, Dr Gan had agreed with the SMC's expert that an earlier diagnosis of perforation might have improved the patient's chances of survival. The Court emphasised that the consequences that are caused to patients as a result of the doctors' actions are to be regarded as "a highly material fact" when considering sentencing.

The Court stated:

"In view of this grave consequence if a duodenal perforation is not attended to with due dispatch, a consequence which Dr Gan said he well knew, 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… which would have led to a more timely CT scan and the discovery of the duodenal perforation in the Patient."

Implications of the Judgment

It is in fact a very common situation that doctors find themselves having to rely on their colleagues to assess a patient when they are unavailable to attend to the patient themselves. More often than not, it is a more junior colleague who steps in for the senior. So it is understandable why many doctors fear that this judgment will now have widespread repercussions on hospital practice, driving home the message that there are really fewer situations where you can safely delegate clinical assessment to your juniors, than what doctors may have earlier thought.

But at the end of the day, the Gan v. SMC decision was made on the specific facts of the case. In a different situation, for example where the "junior" colleague is more than capable of assessing the situation, the outcome could have been different. The problem is, without being on the ground yourself, how would you know what your "junior" might have missed? That's certainly a risk that many doctors may now be unprepared to take…

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