SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR AAZ HELD ON 8-9 APRIL 2009, 28-29 OCTOBER 2009 AND 17 NOVEMBER 2009

Disciplinary Committee:
Prof Ng Han Seong (Chairman)
A/Prof Siow Jin Keat (Member)
A/Prof Prabhakaran S/O Krishnan (Member)
Dr Phua Tan Tee (Lay Member)

Legal Assessor: (M/s Drew and Napier LLC)
Mr Jimmy Yim S.C.

Prosecution Counsel (M/s Harry Elias Partnership):
Mr Philip Fong and Ms Kylie Peh (First Tranche)
Mr Francis Goh and Ms Cassandra Ow (Second and Third Tranche)

Defence Counsel (M/s Rodyk & Davidson LLP):
Mr Lek Siang Pheng
Ms Sharon Liu

DECISION OF THE DISCIPLINARY COMMITTEE

A. THE CHARGES

1. The Respondent is Dr AAZ, a registered medical practitioner who practises as an orthopaedic surgeon at Clinic A, at all material times.

2. Dr AAZ faces 2 charges as follows:

Charge 1

That on 6 March 1999, whilst practising as a consultant orthopaedic & trauma surgeon at Clinic A, Dr AAZ recommended and performed the surgery for the excision of a fibromatous lesion of about 2 cm in diameter on the left sole of the Patient, without sufficiently explaining to the Patient the risk of nerve damage to the plantar nerve of the Patient's left sole, and thereby failed to obtain the informed consent of the Patient for the surgery.

Particulars for Charge 1

(a) In or about early March 1999, Dr AAZ examined the Patient who complained of a painful swelling on her left sole. Dr AAZ diagnosed the Patient's condition as Dupuytren's Contracture.

(b) In or about early March 1999, you recommended surgery under LA, to excise the lesion on the plantar aspect of the Patient's left sole.

(c) Prior to the surgery, Dr AAZ failed to highlight the risk of nerve injury to the plantar nerve of the Patient's left sole to the Patient.

(d) On 6 March 1999, Dr AAZ g performed the surgery to excise the lesion on the Patient's left sole under LA.

(e) Dr B, Consultant Pathologist of Services B ("the Lab"), confirmed that the "multiple fibrotic fragments 0.5cm to 1cm received by the Lab after the surgery "measured together in its maximum dimension to be 2.2cm."

and that in relation to the facts alleged Dr AAZ has been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174).

Charge 2

That on 6 March 1999, whilst practising as consultant orthopaedic & trauma at Clinic A, Dr AAZ performed the surgery for the excision of the fibromatous lesion under local anaesthesia ("LA"), when Dr AAZ knew or ought to have known that the surgery should have been performed under general anaesthesia ("GA").

Particulars for Charge 2

(a) In or about early March 1999, Dr AAZ examined the Patient who complained of a pain swelling on her left sole.

(b) In or about early March 1999, Dr AAZ g recommended surgery under LA to excise the lesion on the plantar aspect of the Patient's left sole.

(c) At the time of surgery in 1999, it was standard practice for such surgeries involving lesions of more than 1.5cm in diameter and diagnosed to be Dupuytren's Contracture, to be performed under GA instead of LA.

(d) Dr AAZ knew or ought to have known that the surgery to excise the said lesion should be performed under GA instead of LA.

(e) On 6 March 1999, Dr AAZ performed the surgery to excise the lesion on the Patient's left sole under LA.

(f) Dr B, Consultant Pathologist of Services B ("the Lab"), confirmed that the "multiple fibrotic fragments 0.5cm to 1cm received by the Lab after the surgery "measured together in its maximum dimension to be 2.2cm."

and that in relation to the facts alleged Dr AAZ has been guilty of professional misconduct under section 45(1)(d) of the Medical Registration Act (Cap. 174)."

B. THE COMPLAINT

3. The Complainant is the Patient.

4. On 5 January 2006, the Patient made a statutory declaration and officially lodged her complaint against Dr AAZ with the Singapore Medical Counsel, almost 7 years after the incident.

C. THE MATERIAL FACTS

5. Because the Complaint was made some 7 years after the incident, the recollection of witnesses of fact and its reliability is made more difficult particularly when the records of the Patient's primary case notes had been destroyed by end of 2004, about 5 years after the Patient's last consultation in 1999. Dr AAZ provided only a copy of the Patient's Pathology Report with a short summary made at the time of culling of the medical records, which are essentially secondary records.

6. For instance, the Patient alleged that she had requested for a nerve block for the surgery on 6 March 1999, the day of the surgery. She alleged that this request was rejected by Dr AAZ. But Dr AAZ disputed this.

7. At a post-surgery review, the Patient alleged that she had informed Dr AAZ of the persistent numbness and loss of sensation to her left sole. The Patient was allegedly assured by Dr AAZ that sensory loss was an ordinary reaction to the operation and that sensation would improve over time. But Dr AAZ disputed this

entirely and said that the only review was done on 12 March 1999 and it was uneventful and the wound appeared clean.

8. The Patient alleged that she consulted Dr AAZ again on 4 July 1999 who then gave the Patient a cortisone injection on her left sole. But Dr AAZ denied this altogether.

9. We find little corroboration of these allegations by the Complainant nor do we find support for Dr AAZ's denial. But the burden of proof, we are reminded, is on the Prosecution.

10. On 28 September 2000, the Patient sought treatment from A/Prof C, who was practising as Senior Consultant with the Department of C of the Hospital C at the material time. A/Prof C made a diagnosis of scarring and painful neuroma from injury to the common digital nerve of the toe.

11. On 24 October 2000, A/Prof C performed surgery on the Patient to repair the Patient's injured nerve and to ameliorate the Patient's symptom of painful neuroma. On surgical exploration, a traumatic neuroma was found on the common digital nerve to the big and second toes. There was adhesion of the neuroma to the surrounding scar tissue and the distal plantar fascia. The digital nerve to the big toe was transected and there was a neuroma in continuity to the second toe.

12. On 8 December 2004, the Patient consulted Dr D, then an Associate Consultant Anaesthetist with Hospital D, for pain management. Dr D put the Patient on a diagnostic trial of lignocaine infusion treatment and diagnosed the Patient's condition as 'neuropathic pain'.

D. DR AAZ'S EXPLANATION TO THE COMPLAINTS COMMITTEE

13. On 2 March 2006, the Complaints Committee of the Singapore Medical Council ("Complaints Committee") wrote to Dr AAZ to give him notice of the Complaint filed by the Patient against him and invited him to offer an explanation.

14. On 30 March 2006, Dr AAZ submitted a short Explanation which was regrettably vague and lacking in details in response. He explained to us that he was very upset at that time as he felt that the Complainant and husband were out to extort money from him, made worse by the fact that the husband of the Patient was a fellow doctor. He narrated how the husband, a dermatologist, had come to his clinic seeking monetary contribution for the wife's problems, 7 years after the incident.

E. THE EXPERTS' EVIDENCE

PROSECUTION EXPERT

15. The Prosecution Expert for this inquiry is Dr PE who is a Consultant Orthopaedic Surgeon practising at Clinic E.

16. Dr PE's opinion, *inter alia*, was as follows:

(a) It is not acceptable to perform the excision of a fibromatous lesion, like Dupuytren's Contracture, under LA for the Patient. A nerve block or GA should have been used to avoid distortion of the anatomy caused by LA;

(b) The medial plantar nerve, with branches reaching out to the adjacent sides of the first web space, was just above the Patient's fibromatous lesion. As such, the risk of nerve injury should have been explicitly highlighted to the Patient.

17. Dr PE filed a Further Expert Report dated 24 April 2008. The additional points raised in Dr PE's Further Expert Report, *inter alia*, were as follows:

(a) The Patient's fibromatous lesion was located in the Patient's left plantar fascia and not in the plane superficial to the plantar fascia.

This is consistent with Dr AAZ's notes of:
"excision fibrotic nodule left plantar fascia 6.3.99
Size 2cm diameter
0.3cm thick."

18. In the hearing before us, Dr PE further claimed that regardless of the pre-operation diagnosis, because of the amount of nerves in that area of the foot, the operation had a real risk of nerve damage which should have been explained to the Patient, and that the issue of LA in the surgery was not appropriate as it would distort the anatomy in the area.

DEFENCE EXPERTS

19. The Defence Experts are Dr DE1 and Dr DE2 both of whom had equally impressive professional credentials as the Prosecution's.

20. Dr DE1 practises as a Consultant Orthopaedic Surgeon at Clinic F.

21. Dr DE1's opinion, *inter alia*, was as follows:

(a) Whether to operate the lump under GA or LA is a clinical decision to be made by each surgeon, depending on a few factors, 2 of which relevant to this case are:

(i) the size of the lump: clinical assessment of 3cm diameter or less is often done under LA;

(ii) the palpability of the lump: an easily palpable lump is usually located in the subcutaneous plane superficial to the plantar fascia. This is often removed under LA due to easier surgical access. Once the lump is not easily palpable, it often lies in the deeper plane of the foot and this lump is best removed under GA or regional block;

(b) Dr DE1 opined that since the lump to be operated was assessed clinically to be a small and palpable subcutaneous one (ie. superficial to or on the outer surface of the plantar fascia or aponeurosis) and knowing that in normal anatomy the plantar nerves were deeper than that and well protected by the thick plantar fascia and one layer of muscles, he opined that practising orthopaedic surgeons normally do not need to inform their patients of the risk of damage to the nerves in the course of removing small subcutaneous lump in the sole of the foot. He told us that nerve damage in such operations was rare.

(c) Dr DE1 filed a Further Expert Report dated 23 June 2008. The additional points raised in Dr DE1's Further Expert Report*, inter alia*, are as follows:

(i) The lump was preoperatively assessed by Dr AAZ to be in the subcutaneous region and thus superficial to the plantar fascia;

(ii) At times, a surgeon's preoperative assessment might not turn out during surgery exactly as he had expected. This was what had happened in this case. It was only when the lump was surgically exposed at operation that it was realized that the lump could not be easily removed as a whole but by piecemeal (in pieces) and that the lump was fibrotic;

(iii) Dr AAZ was not aware at the material time that the Patient had previous surgery to the sole of her left foot. The Patient said in evidence it was a minor procedure that it was somewhere else in the foot. Dr AAZ said there were no scars to discern this.

(iv) Dr DE1 opined that the excision of the lump piecemeal (in small portions) was not due to the distortion of the anatomy of the lump caused by the LA infiltration but rather it was due to the nature of the fibromatosis, suspected or diagnosed only when the lump was surgically exposed.

22. Dr DE1 affirmatively concluded that:

(a) "when faced with a small subcutaneous lump in the sole of the foot, Dr AAZ as an orthopaedic surgeon did the right and proper approach by operating on the lump under LA".

(b) "practising orthopaedic surgeons normally do not need to inform their patients of the risk of nerve damage";

F. THE PRE-OPERATION DIAGNOSIS

23. An issue of some significance was Dr AAZ's pre-operation diagnosis. The Prosecution claimed that Dr AAZ had clinically diagnosed the Patient's nodule as a fibromatous lesion being a Dupuytren's Contracture. The particulars in the 2 Charges asserted this.

24. But, in our view, Dr AAZ's evidence is preferred. He had diagnosed this as a subcutaneous nodule, palpable and superficial. This was consistent with the Complainant's evidence too. The note he had sent after the operation to the Clinical Laboratory Request with his handwriting stated "Dupuytren's type nodule

on left foot (?)". He explained that he inserted the question mark as he was unsure of this new diagnosis following the operation. The Prosecution had erroneously relied on this document to show Dr AAZ's pre-operation diagnosis. The Prosecution had apparently misunderstood the situation. The burden of proof of fact being the higher standard required, we have no basis to disbelieve him that his pre-operation diagnosis was "palpable subcutaneous nodule" and not Dupuytren's Contracture.

25. Next, Dr DE2's Expert Report dated 31 January 2008 stated that in the case of the Patient who only had a superficial nodule at the time of consultation with Dr AAZ, LA was an adequate form of anaesthesia.

26. Dr DE2's Opinion was that:

(a) "…the nodule was noted to be superficial. There was no contracture. Dr AAZ's opinion was that this was a superficial fibrotic nodule and not a Dupuytren's Contracture".

(b) "She [the Patient] had only a superficial nodule and no contracture at the time of consultation with Dr AAZ. In my opinion therefore, because the lesion was superficial and there was no obvious contracture, local anaesthesia was an adequate form of anaesthesia"

27. In his testimony, Dr DE2 asserted that there was no need under such circumstances to warn against or obtain consent against nerve damage as the risk of such damage was negligible in such cases.

G. STANDARD OF PROOF

28. The standard of proof in these proceedings is the time-honoured test of proof beyond all reasonable doubt. Given the time lapse and the destruction of medical records (after the 5th year from the last consultation) and after hearing the Complainant, the Respondent, the Experts and witnesses, the Prosecution has not satisfied us that it has been proven beyond all reasonable doubt that the Complainant's and Prosecution's version of facts is correct or that the Respondent's version is wrong.

29. The Prosecution's entire argument in refuting the 2 Defence Experts rested upon the premise that the Defence Experts' opinions were untenable in light of their misunderstanding that Dr AAZ g had clinically diagnosed the Patient as having fibromatous lesion, Dupuytren's Contracture.

30. As stated earlier, we do not have basis to disbelieve Dr AAZ's evidence that his pre-operation diagnosis was simply "palpable subcutaneous nodule".

H. NEW ALLEGATION

31. The Prosecution also raised a new allegation in the course of the hearing, and that was, when the operation revealed that the problem was more complex than a subcutaneous nodule, Dr AAZ should have closed up the wound and discussed the problem with the Complainant first. We found this to be clearly the more prudent thing for a surgeon to do as the operation was not life-threatening and his earlier assessment of a palpable subcutaneous nodule with low risk to nerve damage was wrong by his own explanation. But we feel constrained by the law in relation to the law on charges, this being a quasi–criminal matter. In this regard, we were referred to the decision of the High Court in Lim Teng Ee Joyce v Singapore Medical Council [2005] and Ho Paul v Singapore Medical Council [2008] where the admonition is against finding fault with matters which are not the subject matter of the charge. The 2 Charges related to AAZ's acts and omissions at the pre-operation stage but the new allegation of closing up the wound and attempting discussions with patient and obtaining a new consent is, in our view, outside the present Charges. Regrettably, no application was made to amend the Charges. As such, we cannot entertain this new allegation.

I. CONFLICT OF EXPERTS' OPINIONS

32. The Disciplinary Committee is faced with 2 sets of conflicting opinions from orthopaedic surgeons on both issues in the Charges. We have reviewed their opinions, the reasons and logic given for those opinions.

33. Here the guidance provided by the civil cases on medical negligence is helpful. The Court of Appeal in Dr Khoo James v Gunapathy d/o Muniandy (2002)

reversed the High Court's decision when the latter preferred one medical opinion over another. We need only to refer to the headnotes:

"(1) The legal principle in *Bolam* is the locus classicus. In determining whether a doctor has breached the duty of care owed to his patient, a judge will not find him negligent as long as there is a respectable body of medical opinion, logically held, that supports his actions. Beyond this time-honoured test of liability, neither this court nor any other should have any business vindicating or vilifying the acts of medical practitioners; *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; [1957] 1 WLR 582 followed.

(2) The *Bolam* test, however, did not represent immunity from judicial inquiry over the medical process. An expert view, in order to qualify as representative of a 'responsible' body of medical opinion, had to satisfy the threshold test of logic; *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 4 All ER 771 followed.

(3) The threshold test of logic is an essentially two-stage inquiry. The first inquiry is whether the expert had directed his mind at all to the comparative risks and benefits relating to the matter. The second inquiry relates to whether the medical expert had arrived at a 'defensible conclusion'. This connotes the satisfaction of two concepts. First, the medical opinion must be internally consistent on its face. It must make cogent sense as a whole, such that no part of the opinion contradicts with another. Second, the opinion should not fly in the face of proven extrinsic facts relevant to the matter. It should not ignore or controvert known medical facts or advances in medical knowledge.

(4) Although *Bolam* represents the starting point for the standard of care for all professionals, its specific test refers to the medical profession, and the willingness of the court to adjudicate over differing opinions in other professions should not be transposed to the medical context.

(5) The testimony of the experts called by both parties was on the whole competent and professional. The divergence in their views reflected the innate and genuine intractability of the medical issues involved, and in no way impinged on their honesty or integrity."

34. Although the decision dealt with the approach of judges to medical opinions, it offers the Disciplinary Committee guidance because the members of the Committee, though we are doctors often do not come from the same branch of specialist practice. Thus, we should not judge nor prefer one set of opinion over

another unless that other set of opinion does not cross the threshold of sound reason or logic and general medical practice standards.

35. Similarly, we have been referred to the High Court decision of Denis Matthew Harte v Dr Tan Hun Hoe where these principles were reiterated:

"(1) The duty of the medical practitioner is to exercise reasonable skill and care in treating his patient and the burden lies on the plaintiff to satisfy the court that the defendant was in breach of his duty. Reasonable skill and care are assessed on the basis of the standard of the ordinary skilled man exercising and professing to have that special skill and not on the standard of the highest expert. This is what is known as the 'Bolam test' taken from the direction to the jury of Mc Nair J in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. This test has been restated many times and has been approved by the House of Lords in cases like *White House v Jordan* [1981] 1 All ER 267 and *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 All ER 643.

(2) The standard of care has been held to be a matter of medical judgment in *Sidaway* where Lord Scarman stated:

> 'The *Bolam* principle may be formulated as a rule but a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short the law imposes a duty of care; but the standard of care is a matter of medical judgment.'

In that case, the authoritative proposition of law stated by Lord Browne-Wilkinson in Bolitho v City and Hackney H.A (H.L.(E.)) [1998] A.C 232, which clarifies the ambit of the *Bolam* test was repeated:

"…in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence that the defendant's treatment or diagnosis accorded with medical practice."

"…in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical

practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

I emphasis that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable."

36. Having been directed by these legal principles, in this case, we cannot conclude that both Dr DE1's opinion and Dr DE2's opinion were illogical and unreasonable. We have heard them and observed them during cross-examination. Their views do thereby constitute a body of medical opinion which sanctions Dr AAZ's conduct as being acceptable. To be fair, neither does the Prosecution argue that the 2 Defence Experts' Opinions are illogical or unreasonable, except that their opinions were untenable on the basis that the Prosecution says that Dr AAZ's diagnosis was Dupuytren's Contracture, and not a palpable subcutaneous nodule.

37. If we cannot pass the threshold of liability for civil negligence, then clearly the higher standard of professional misconduct arising from negligence has not been met. On the basis of the 2 Defence Experts' Opinions, we also cannot say that Dr AAZ's conduct herein was an intentional departure from the standards of the profession.

38. For these reasons, we hereby dismiss the case against the Respondent and acquit him of both charges.

39. In conclusion, we express a measure of regret that this Complaint had been brought so late such that the medical records have been destroyed so that collaboration of evidence was made difficult. We also noted the Prosecution's failure to apply to amend the Charges when it had the opportunity to do so.

40. We wish to thank both sets of Counsel for their assistance herein.

Dated this 17th day of November 2009.