SINGAPORE MEDICAL COUNCIL DISCIPLINARY INQUIRY AGAINST DR ABK ON 23 TO 26 FEBRUARY 2010 AND 10 JULY 2010

Disciplinary Committee:
Prof John Wong - Chairman
A/Prof Siow Jin Keat
Dr Tan Yew Oo
Mr Mark Goh (Lay Member)

Legal Assessor:
Mr Andy Chiok (M/s. Michael Khoo & Partners)

Prosecution Counsel (Wong Partnership LLP):
Mr. Tan Chee Meng SC
Ms. Chang Man Phing
Ms. Maxine Ung

Defence Counsel (M/s Allen & Gledhill):
Mr. Edwin Tong
Mr. Tham Hsu Hsien
Ms. Jacqueline Chua
Ms. Magelene Sim

DECISION OF THE DISCIPLINARY COMMITTEE

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

1. The Respondent is the Head and **[designation redacted]** with Hospital A ("HOSPITAL A") since 2003.

2. These proceedings arose out of a complaint made against the Respondent on 14 December 2006 by the Respondent's patient, Mr. P ("P") to the Singapore Medical Council (the "SMC"). Following the complaint, a written response dated 4 June 2007 was submitted by the Respondent to the Complaints Committee, which then referred the matter to this Committee.

The Charges

3. In the Amended Notice of Inquiry dated 23 February 2010 (at AB1A), the SMC framed three charges ("the Charges") against the Respondent. The 3 Charges (without setting out the full particulars stated therein) are:

> "(1) That you ABK are charged that on or about 13 July 2006, you did perform staple haemorrhoidectomy ("the Surgery") on your patient, one P ("the Patient") without informing him of any alternative treatment options or sufficiently explaining to him the possible risks and complications involved in the Surgery, and

thereby failed to obtain the informed consent of the Patient for the Surgery that was carried out on him.

(2) That you ABK are charged that in the period from on or about 13 July 2006 to on or about 8 August 2006, you were in wilful neglect of your duties to your patient, one P ("the Patient"), in that you grossly mismanaged the post-operative care of the Patient after you had performed staple haemorrhoidectomy ("the Surgery") on him on 13 July 2006.

(3) That you ABK are charged that on or about 26 April 2006, you did make or cause to be made laudatory and/or misleading statements concerning a procedure for the treatment of haemorrhoids and your experience, in a two-page feature published in the Straits Times on 26 April 2006 titled "A pain-free way to treat piles" ("the Article") and "A pain in the rear" ("the 2nd Article"), in breach of paragraph 4.4.2 of the Singapore Medical Council's Ethical Code and Ethical Guidelines."

It is a common thread in all 3 Charges that the Respondent is guilty of professional misconduct under section 45(l)(d) of the Medical Registration Act (Cap. 174) (2004 Rev. Ed.).

4. The Respondent pleaded not guilty to all the Charges.

The Proceedings

5. The hearing was conducted over 4 days. The following witnesses were called on behalf of both parties in the course of the hearing:

<u>For the SMC</u>:

(1) PW1 – Dr. PW1
(2) PW2 – P
(3) PW3 – Dr. PW3
(4) PW4 – Mrs. PW4

(5) PW5 – Dr. PW5

(6) PW6 – Dr. PE (expert)

For the Defence:

(1) DW1 – The Respondent

(2) DW2 – Dr. DE1 (expert)

(3) DW3 – Ms. DW3

(4) DW4 – A/Prof DW4

(5) DW5 – Staff Nurse DW5

(6) DW6 – Staff Nurse DW6

(7) DW7 – Staff Nurse DW7

(8) DW8 – Dr. DE2 (expert)

6. With the consent of both parties, a witness statement of the Respondent was admitted as his evidence-in-chief.

7. Counsel for the SMC objected to the use of witness statements for the Defence's other witnesses and after hearing both counsel on this point, we accept that while the proposed use of these statements would certainly expedite the proceedings, we recognise that due to the factual nature of the Charges, the veracity of the oral evidence of witnesses would be crucial. We therefore upheld the objection by the SMC of the use of witness statements for the other Defence witnesses, and the evidence-in-chief of these witnesses was led orally.

The undisputed facts

8. The following facts are undisputed:

(1) P first consulted the Respondent on 10 July 2006 following a referral by his GP, Dr. PW1 (PW1) on the same day. At the first consultation, the Respondent examined P and found that he had haemorrhoids. At the end of the consultation, arrangements were made for P to undergo stapled haemorrhoidectomy for treatment of his piles.

(2) The stapled haemorrhoidectomy procedure was performed on P on 13 July 2006 at HOSPITAL A as a day surgery. Prior to the procedure on the same day, P signed a Consent of Patient form. At his request, P was warded overnight and was discharged from HOSPITAL A on the following day.

(3) On 17 July 2006, P consulted the Respondent. Before attending the consultation, P sent to HOSPITAL A a fax setting out his condition[1].

(4) Between 18 to 31 July 2006, P consulted another colorectal surgeon, Dr. PW3 at Hospital B, who examined him and administered various medicines.

(5) On 2 August 2006, P consulted the Respondent who examined him. P was advised to be admitted for impacted stools. Between 2 to 8 August 2006, P was an in-patient at HOSPITAL A and he was discharged on 8 August 2006. Thereafter, P no longer consulted the Respondent.

(6) After his second discharge from HOSPITAL A, P consulted Dr. PW5 who from 14 August 2006 managed him as a patient.

The First Charge

9. The gist of the First Charge against the Respondent is that he failed to obtain the informed consent of P for the stapled haemorrhoidectomy procedure. This charge relates to the events that transpired at the consultation on 10 July 2006, and on 13 July 2006 when the stapled haemorrhoidectomy was performed.

10. The SMC's case is that there was no informed consent from P because the Respondent failed to advise P of the risks, complications and treatment options in connection with the treatment of his condition.

11. The position of the Respondent is that the informed consent of P has been obtained prior to the stapled haemorrhoidectomy procedure. The Respondent's case is that from the first consultation with P on 10 July 2006 up to the time when P signed the Consent by Patient form (AB75), the nature, complications and risks in connection with the treatment

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[1] See fax sent by P at AB158

of his piles were explained to him. Informed consent was thus obtained from P prior to him undergoing the stapled haemorrhoidectomy.

The evidence – the SMC's case

12. On the issue of informed consent, P testified that:

a. At the first consultation on 10 July 2006, the Respondent spent only 10 minutes with him and did not provide any detail of the procedure of stapled haemorrhoidectomy. According to P, the consultation was rushed and the Respondent did not explain the risks and complications as well as other treatment options.

b. After his consultation with the Respondent, P left the consultation room and was told by the staff nurse of the cost of $2,500 for the stapled haemorrhoidectomy, the date of the procedure and that he had to take fleet enema the night before the operation.

c. P testified that he wanted more details about the stapled haemorrhoidectomy procedure but was told by the nurse that he would need to get the information from the Respondent.

d. On 13 July 2006, prior to the procedure, P signed a Consent of Patient form which was handed to him by a nurse. He was nervous and did not receive any explanation of the form. P only met the Respondent when the latter turned up at the operating theatre with a few other persons who were masked. He exchanged greetings with the Respondent and then underwent the procedure.

13. The expert witness for the SMC, Dr. PE opined in his expert report that is not appropriate that informed consent be obtained in the operating theatre. Dr. PE's views are that a patient, who had been prepared for surgery and in the operating room awaiting the procedure, and being surrounded by people he did not know, is in a vulnerable position and cannot provide an informed consent.

The Defence's case

14. The Defence's case is that the Respondent had obtained the informed consent of P for the stapled haemorrhoidectomy procedure on two occasions, on 10 July 2006 and on 13 July 2006, the day of the procedure itself. Information on the risks and complications as well as treatment options was communicated to P on these two occasions. In particular, on 13 July 2006 P signed a Consent of Patient form for the procedure that he underwent the same day, and this was explained by the Respondent to P.

15. The Defence also adduced the evidence of A/Prof DW4 who, apart from being the anaesthetist for the procedure performed on P, also testified as a senior member of the management of HOSPITAL A on the procedures for informed consent for the hospital. The tenor of A/Prof DW4's evidence on HOSPITAL A's procedure for obtaining informed consent was that in HOSPITAL A, informed consent need only be obtained prior to the procedure and need not be obtained during consultation.

Undisputed facts in connection with the First Charge

16. In connection with this Charge, the following facts are not disputed:

    a. P attended at the Respondent's clinic on 10 July 2006 following the reference from his GP Dr. PW1.

    b. Following the consultation with the Respondent, on the same day, an appointment was made for P to undergo stapled haemorrhoidectomy on 13 July 2006. P was told of the cost of the procedure, the appointed date for it and was told to take fleet enema the night prior to the procedure.

    c. It is also undisputed that P signed the Consent of Patient form in the morning of 13 July 2006, prior to his procedure.

17. In the course of the hearing, this Committee was referred to the following criteria for "informed consent":

    a. SMC Ethical Guidelines, paragraph 4.2.2

> **"4.2.2 Informed Consent**
> It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and

options for treatment so that he is able to participate in decisions about his treatment If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him. If the patient is a minor, or of diminished ability to give consent, this information shall be explained to his parent, guardian or person responsible for him for the purpose of his consent on behalf of the patient."

b. Hospital A Policies and Procedures "Written Consent"[2]

"Para. 3.3.3 <u>Consent must be informed</u>

a) <u>Information:</u>
The person giving consent must be given adequate information to enable him/her to understand the medical treatment to be done, as well as the risks of complications, and where applicable, alternative modes of treatment available. Where an addendum on the medical treatment is available, this should be used to assist in the explanation during the consent-taking.

b) <u>Understanding:</u>
The signed form by itself does not evidence an informed consent if no proper explanation of the medical treatment to be done was given, or if the person signing the consent form did not understand the medical treatment to be done.

In situation where there is a language barrier, consent should be taken with the presence of an interpreter."

c. PFR6.1 Standard of Joint Commission International[3]

"**Standard**
PFR.6.1 Patients and families receive adequate information about the illness, proposed treatment(s), and care providers so that they are make care decisions.

Intent of PFR.6.1
Staff members clearly explain any proposed treatment(s) or procedures to the patient and. when appropriate, the family. The information provided includes

- the patient's condition;
- the proposed treatment(s);
- potential benefits and drawbacks;
- possible alternatives;
- the likelihood of success;
- possible problems related to recovery; and
- possible results of non-treatment."

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[2] Hospital A Policies and Procedures "Written Consent" – Exhibit "P8"
[3] PFR6.1 Joint Commission International Accreditation Standards for Hospital – Exhibit "P10"

We agree with the criteria set out above.

The consultation on 10 July 2006

18. In his examination, the Respondent was referred to his explanation which was submitted to the Complaints Committee on 4 June 2007 following P's complaint. In respect of the events that happened at the first consultation on 10 July 2006, of the Respondent's evidence, we note that the accounts offered by him in his explanation to the Complaints Committee in 2007 and the statement of his evidence at this hearing differed materially. On the events of 10 July 2006, the relevant portions of the Respondent's explanation offered to the Complaints Committee are:

> "2. Mr. P was referred to me by Dr. PW1 of the Clinic A and was first seen by me on the 10th July 2006. He presented with a history of prolapsed and bleeding piles of 5 years duration and in fact had an episode of massive bleeding 3 months prior to consultation. He also has a known history of irritable bowel syndrome (IBS.). Mr P also gave a significant family history of colorectal cancer. Clinical examination confirmed presence of prolapsed 4th degree piles. The rest of the physical examination was normal. He was advised to have a colonoscopy as he has rectal bleeding, a significant family history of colorectal cancer and his last colonoscopy was performed more than 5 yeas ago. Mr P, however, declined colonoscopy and just wished to have a staple haemorrhoidectomy for his prolapsed piles.
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> 4. The indications, technique, and possible complications of staple haemorrhoidectomy were explained to Mr P in the clinic. Furthermore, brochures and pamphlets regarding staple haemorrhoidectomy are all available in the clinic for patients. Mr P himself also claimed to have read a recent article on staple haemorrhoidectomy in the press. Hence, he appeared knowledgeable about the procedure during our discussion and consented to the surgery, which was performed on the 13th July 2006. …
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> …
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> 27. Mr P's diagnosis of piles was discussed and the various modalities of treatment, including staple haemorrhoidectomy and its possible problems were discussed with him in the clinic. As I mentioned before, there are also standard brochures and pamphlets that are readily available and routinely handed out to patients in our colorectal clinic. During our consultation, Mr P also claimed that he had read the entire article on staple haemorrhoidectomy published in the Straits Times recently and demonstrated some awareness and knowledge of the procedure. Therefore, I am quite surprised to hear that Mr P is claiming that he was not properly advised of the procedure and yet had given his consent in

writing prior' to surgery, stating that he was aware of what surgery he was about to receive."

19. The Respondent's account in his witness statement dated 10 February 2010 of what transpired on 10 July 2006 is of considerably greater detail:

"6. I first saw Mr P on 10 July 2006 at HOSPITAL A. He had been referred to me by his family practitioner Dr PW1 of the Clinic A for recurrent bleeding haemorrhoids of a few years (despite symptomatic treatment) and for potential surgical intervention. A copy of Dr PW1's referral letter (with transcript) is at Exhibit "ABK-3".

7. Mr P provided a history of prolapsed and bleeding heamorrhoids (sic) of 5 years duration. The bleeding recurred on and off but was getting progressively worse recently. In fact, Mr P reported that he had an episode of massive bleeding 3 months before. He informed that his last colonoscopy was done about 5 years ago. He also gave a significant family history of colorectal cancer (his father had colon cancer).

8. On clinical examination, he was found to have prolapsed 4th degree haemorrhoids (i.e. his haemorrhoids were permanently prolapsed and irreducible). The rest of his examination was normal. A copy of the outpatient notes of Mr P on 10 July 2006 is at Exhibit "ABK-4".

9. As Mr P's last colonoscopy was performed more than five years ago, and in light of his rectal bleeding and significant family history of colorectal cancer, I advised Mr P to have a colonoscopy. Mr P declined the colonoscopy.

10. I advised Mr P of the surgical options to treat his 4th degree haemorrhoids. Given the passage of time, I cannot recall precisely the words which I had used in advising Mr P of the surgical options. However, I recall that Mr P was advised of the following:-

    (1) the options of PPH and conventional haemorrhoidectomy (also known as Milligan Morgan Haemorrhoidectomy);

    (2) the nature of the two procedures and the risks and specifically, the potential complications of pain, bleeding and infection which accompany the two procedures;

    (3) PPH involved the use of a stapler to remove tissue from the anus and pull the haemorrhoids back to a position within the anus, and to reduce blood flow to the piles to shrink the piles; and

    (4) PPH is known to be less painful, allows for quicker recovery, than conventional haemorrhoidectomy, but was more expensive.

    This would have been consistent with my usual practice.

11. In addition, I recall that Mr P said that he had read a recent article in the press regarding PPH and was already knowledgeable about the

procedure and engaged in the discussion when I was explaining PPH and the risks and benefits of PPH to him. I believe that Mr P was referring to the article which was published in the Straits Times on 26 April 2006, a copy of which is at Exhibit "ABK-5". HOSPITAL A's pamphlet on "*The Treatment of Piles*" (which provided additional information about PPH, its benefits, risks and complications) would also have been gone through with Mr P as it is part of my standard practice to offer and go through pamphlets on the procedures which a patient is going to undergo with my patients.

12. …

13. Even though I had brought up other options (as part of the discussion), it was clear that Mr P wanted to have PPH. This also accorded with what I believe to be the best option for him. I therefore scheduled Mr P for a PPH day surgery on 13 July 2006. Mr P was asked to read the pamphlet at home and ask any questions he wanted about PPH before the surgery, and to seek a second opinion or discuss with family or friends if he wanted before the surgery. Our staff nurses would advise Mr P of the costs and other administrative matters relating to the PPH before Mr P left the outpatient clinic. A copy of the pamphlet *"The Treatment of* Piles" is at Exhibit "ABK-9"."

20. As a starting point, we looked at the Respondent's case-notes of the consultation on 10 July 2006. These notes provide the most contemporaneous and reliable account of what happened at that first consultation. The Respondent's notes taken at the 10 July 2006 consultation (at AB68 and AB226) do not support his account in respect of the issue of informed consent. In particular,

    a. there is no record of the wish and consent of P to undergo stapled haemorrhoidectomy.

    b. There is also no record of any discussion of treatment options, save for the Respondent's recommendation of (i) colonoscopy (of which P's refusal was duly noted) and (ii) stapled haemorrhoidectomy.

    c. There is also no record of the provision of any advice on the nature of the stapled haemorrhoidectomy procedure and conventional haemorrhoidectomy and the alleged advice by the Respondent on "specifically, the potential complications of pain, bleeding and infection which accompany the two procedures".

21. We have no doubt that the Respondent as a senior specialist should, and would have been aware of the importance and necessity to record details of consultations with

patients. This aspect of medical practice is also embodied in the SMC's Ethical Code and Ethical Guidelines[4]. In particular, we note that part of paragraph 4.1.2 of the Ethical Guidelines states that "*All clinical details, investigation results, discussion of treatment options, informed consents and treatment by drugs or procedures should be documented*". In this regard, it is noteworthy that the above details of the consultation that were material to the Respondent's case on the issue of informed consent were not recorded in his own medical case-notes.

22. We now turn to the accounts provided by the Respondent in his explanation to the Complaints Committee and in his witness statement. This Committee notes that there are material deviations between the two accounts:

    a. The Respondent's explanation in 2007 did not make any reference to the provision of advice to P on the options of stapled haemorrhoidectomy versus conventional haemorrhoidectomy. On the other hand, in his witness statement the Respondent recalled that such advice was provided to P. We are of the view that if indeed the Respondent was able to recall this aspect of the consultation in 2010 when his witness statement was prepared, then in 2007 the Respondent should have been better placed to make the same recollection and include it as part of his explanation and/or in his medical records. However, this point was not included in the 2007 explanation.

    b. In his witness statement, the Respondent's evidence is that he would have gone through with P HOSPITAL A's pamphlet "*The Treatment of Piles*". However, in his 2007 explanation, this fact was absent and the Respondent simply stated that "brochures and pamphlets regarding staple haemorrhoidectomy are all available in the clinic for patients." The important point by the Respondent that he had taken pains to take P through the pamphlet in explaining the risks and complications was not presented in the explanation, and it is a reasonable expectation that such an important fact would have been stated by the Respondent in his explanation.

    c. If it is assumed that the events as recounted by the Respondent took place, the absence of these crucial details in the Respondent's explanation is all the more puzzling and unacceptable when P's complaint (which was forwarded by the

SMC to the Respondent when his explanation was sought in 2007) clearly expressed unhappiness in the duration of, as well as the content of the consultation on 10 July 2006. The Respondent testified under cross-examination that when he saw P's complaint he was "quite shocked". It would therefore have been reasonable to expect that while the 2007 explanation may have been written under a deadline, the Respondent would have been most anxious to address P's concerns in his explanation and to present his side of the story to the Complaints Committee in as much detail as he could muster.

23. Under cross-examination, the Respondent was also asked about his recollection of events in 2007 when he was preparing his explanation. He testified that in 2007, he "*cannot be sure of things*"; and that he could not even recall what P looked like. Since the Respondent had, in 2007 difficulty in recollecting the events that took place in 2006, we do not see how the Respondent can reasonably have a better recollection 3 years later in 2010 when he presented his written statement and the accompanying oral evidence.

24. In presenting the evidence on the first consultation of 10 July 2006, the Respondent also adduced the evidence of Staff Nurse DW5, who testified that she assisted the Respondent and attended to P on 10 July 2006; she witnessed the consultation process. Staff Nurse DW5 also testified that the Respondent explained the risks and complications to P, with reference to HOSPITAL A booklet on haemorrhoids[5] that was found in all consultation rooms. She also testified that the discussion took about 15 to 20 minutes.

25. Under cross-examination,

    a. Staff Nurse DW5 was unable to provide an accurate physical description of P even though she claimed that she remembered him.

    b. The witness was also unable to recollect any discussion between the Respondent and P of the latter's Irritable Bowel Syndrome (IBS), when it is not disputed that it was part of the medical history that the Respondent took on that day. When asked by counsel for the SMC to explain why she would not remember that, no answer was provided by her.

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[4] See para. 4.1.2, SMC Ethical Code and Ethical Guidelines
[5] This is HOSPITAL A pamphlet "The Treatment of Piles" exhibit "R2".

c. Staff Nurse DW5 also testified that the Respondent explained the 3 risks of bleeding, infection and pain to P, and showed him the 3 risks set out in the pamphlet "The Treatment of Piles". However, she was unable to explain how that could be when infection was not listed in the pamphlet as a risk. She then testified that the Respondent had advised the risk of difficulty in passing urine (which is set out in the pamphlet) when that was not the Respondent's evidence.

d. Finally, we looked at the Patient/Family Education Record ("PFER")[6]. This is a document that records the information communicated to a patient undergoing a procedure. Staff Nurse DW5 testified that she filled in the first row of the document at page AB156, where the Respondent was indicated as the "Educator" and the mode of communication was indicated as "D" which stands for "Discussion". We note that there is a provision in the legend at page 155 for the use of a letter "H" to indicate that Handouts were used. Even though both the Respondent and Staff Nurse DW5 testified that HOSPITAL A pamphlet was used to explain, and was given to P, there is no indication of that in the PFER. Staff Nurse DW5's response was that she did not write that down. This Committee does not find that to be a satisfactory explanation, because Staff Nurse DW5 gave evidence that she had completed the PFER, and in the ordinary course of events she would have completed it properly. There was nothing on the facts to explain why she would not record that a handout was given to P, even though it was her testimony that the handout was indeed provided.

26. In view of the above points, having heard the oral testimony of Staff Nurse DW5 and observed her demeanour, we do not find her testimony to be credible or corroborative of the testimony of the Respondent on the events of 10 July 2006. By themselves, the events on 10 July 2006 do not evince any informed consent being obtained from P.

27. We would also address one other point. The Defence raised in closing submissions that the statements of the other witnesses were excluded, the evidence of the Defence's witnesses were given late in the night and that this affected the quality of the evidence[7]. This Committee is surprised that this argument was raised because:

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[6] Patient/Family Education record at AB154

[7] See paragraphs 100 and 104 of the Defence's Closing Submissions.

(1) As stated above, the decision to exclude the statements of the Defence's witnesses (except for the Respondent's) were argued, and this Committee had accepted the SMC's argument that given the emphasis on credibility of witnesses, such statements should not be used as the veracity of evidence has to be tested. The Defence had explained that the use of such statements were to facilitate the expediency of the hearing.

(2) Throughout the hearing, counsel for the Defence did not raise any objection to the calling of the Respondent's witnesses in the manner that was done.

(3) In fact, the Committee was prepared to allocate another date for the taking of the evidence for Nurse DW8, which turned out to be unnecessary as both counsel reached an agreement in respect of the evidence. The Defence could have called their witnesses on another date but did not choose to do so.

(4) If any side was prejudiced by the Defence's order of witnesses, this Committee would have thought that it would be the SMC, whose counsel had to cross-examine them expediently on the last day of the hearing and did not have the same amount of latitude and time as that provided to counsel for the Defence on his cross-examination of the SMC's witnesses.

<u>The consent of P on 13 July 2006</u>

28. We now turn to the events on 13 July 2006. The key question is what were the circumstances under which P signed the Consent of Patient form, and the information that was communicated to him on that day, prior to the procedure. This goes to the ultimate question whether P was sufficiently informed when he signed the Consent of Patient form for the procedure.

29. P's testimony was that on that day, he signed the Consent of Patient form after he had changed into the patient's gown for the procedure (this is undisputed). A nurse gave him the form to sign and no explanation was provided. P did not meet the Respondent until he was in the operating room moments before his procedure. There were, in his words, "a few people" but he only recognised the Respondent. He exchanged pleasantries with the Respondent and then underwent the procedure.

30. The Respondent's case on the events of 13 July 2006 was that:

    a. Informed consent was obtained from P at the operating room by the Respondent, who explained the risks and procedure to him.[8] This was witnessed by the Staff Nurse DW7.

    b. A/Prof DW4 also explained the risks of general anaesthesia to P, and he corroborates the Respondent's practice of explaining and seeking consent in the operating theatre.

    c. P then signed the Consent of Patient form and underwent the procedure.

31. The documents relevant to the events on 13 July 2006 are:

    a. the Consent of Patient form (AB75),

    b. the Anaesthesia Record (AB79),

    c. the Post Anaesthesia Care Monitoring Chart (AB82),

    d. Perioperative Nursing Care Record (AB83),

<u>The question of time spent in the operating theatre</u>

32. One factor relevant to the question of whether informed consent was obtained from P would be the time that the Respondent spent with P. From the Perioperative Nursing Care Record, P arrived at the operating room at 8.50 a.m. and left the theatre at 9.15 a.m., a total time of 25 minutes, which includes the time taken for the procedure. However, in the same document the operation was stated as having started at 9.20 and was completed at 9.30 a.m., which is contrary to the time-out of 9.15 a.m.

33. Other documents provide important indications on the time of the operation:

    a. In the Anaesthesia Record (AB79), P's blood pressure was monitored from 9.00 a.m. until 9.15 a.m.,

b. in the Post Anaesthesia Care Monitoring Chart (AB82), monitoring was carried out at 5-minute intervals commencing from 9.20 a.m., and

c. at section IV of the Perioperative Nursing Care Record (AB86), the time when P arrived at the recovery room (i.e. a room where patients recover from the effects of anaesthesia) was recorded as 9.20 a.m. P was discharged from the recovery room at 9.40 a.m.

34. On the face of the documentary evidence, we are unable to accept that the recording of P's operation from 9.20 a.m. to 9.30 a.m. in the Perioperative Nursing Care Record is accurate. Indeed, in the Respondent's own Operation Report[9], while the same timing of 9.20 a.m. to 9.30 a.m. was stated, we note that the print-out was generated at 9.20 a.m.

35. Questions on the discrepancies in the timings were asked of the Respondent, A/Prof DW4 and Staff Nurse DW7. All of them attributed the inconsistencies to the clocks not being in sync, or being inaccurate. While we can accept that clocks at HOSPITAL A may not be synchronised to some extent; we are unable to agree that the discrepancies in the case-notes can be attributed to this or the alleged inaccuracies, bearing in mind the various sources for the recording of the timings.

36. If indeed the procedure was performed on P from 9.00 a.m. to 9.15 a.m., then the Respondent would have about 10 minutes to obtain the informed consent prior to the signing of the Consent of Patient form and the procedure. This is also consistent with the Ambulatory Surgery Module Periodic Report for 13 July 2006[10], where we note that the time between procedures for the patients before and after P's procedure is about 10 minutes.

37. We note the evidence of the Respondent and of A/Prof DW4 in respect of HOSPITAL A's procedure for obtaining informed consent. HOSPITAL A is a JCI accredited institution with a Standard Operating Procedure and protocol to ensure that informed consent is obtained[11]. In a nutshell, A/Prof DW4's evidence is that informed consent may be obtained at any time prior to a procedure, and not necessarily during consultation in the

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[8] See paragraphs 14 to 17, Respondent's witness statement
[9] See the Operation Report at AB140
[10] Ambulatory Surgery Module Periodic Report for 13 July 2006 – exhibit "R7"

clinic. The important concept of the process, as A/Prof DW4 put it, is that by the time of the procedure, the patient must have been provided with sufficient information to make an informed choice whether to undergo the procedure. A/Prof DW4 gave evidence that in HOSPITAL A, it is not unusual for patients to provide their consent at the operating theatre, although the process of communicating with the patient may have started with consultation at the clinic. We also noted A/Prof DW4's evidence on this aspect (which this Committee finds cavalier and flippant) that informed consent of a patient can even be taken "in the toilet".

38. At this juncture, we note that during submissions, the Defence had introduced a letter by A/Prof O on the practice in HOSPITAL A of taking informed consent from patients in the operating theatre. This letter was penned by A/Prof O after the inquiry had completed the taking of the evidence. In respect of this letter by A/Prof O,

    (1) she was not called as a witness by the Defence, and the SMC had no opportunity to cross-examine her, and that

    (2) in any event, A/Prof O's letter is irrelevant because we accept that given sufficient time and the appropriate circumstances, it is possible for a patient to provide informed consent even in the operating theatre. The issue before this Committee is whether based on the evidence; such informed consent was obtained from P on 13 July 2006?

39. Our view is that on the evidence, after he had completed the first consultation on 10 July 2006, P had effectively agreed to undergo the procedure scheduled for 13 July 2006. In the Ambulatory Surgery Authorisation Form[12] completed by P on 10 July 2006, he had agreed to undergo a blood test[13] and to administer the fleet enema the night before the procedure. P had also agreed to the $2,500 estimate for the cost of the procedure. Here we see the difficulties posed by a process where informed consent may be obtained only at the operating theatre for non-emergency cases; the patient by this time would have taken steps or evinced his intention to undergo the procedure, when the physician or the institution concerned may have yet to complete the process of providing him the information necessary for an informed consent.

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[11] Paragraph 15, Respondent's Skeletal Opening Statement
[12] Ambulatory Surgery Authorisation Form at AB144
[13] The results of the blood test dated 10 July 2006 is at AB125

P's right not to proceed on 13 July 2006

40. This Committee is convinced that in the present case, the process under which P's written "consent" was obtained moments before the stapled haemorrhoidectomy procedure is an unsatisfactory one and in the circumstances P's informed consent was not obtained. We accept that in theory, patients like P have a right not to undergo procedures moments prior to the procedure. However, the reality is that when P turned up at the ASC on 13 July 2006 and was prepared for the procedure, he was not in any frame of mind to receive and evaluate any advice that may be rendered to him on the risks and treatment options. In any event, it is clear from the evidence that by that time, P had already made up his mind to undergo the stapled haemorrhoidectomy procedure. This also seemed to be the Respondent's position in his explanation when he stated[14] that "*The indications, technique and possible complications of stapled haemorrhoidectomy were explained to Mr P* <u>*in the clinic*</u>*. … Hence he appeared knowledgeable about the procedure during our discussion and consented to the surgery, which was performed on the 13th July 2006.*" (underlining added).

41. When cross-examined by the Respondent's counsel on why he did not ask the Respondent on 13 July 2006 for information, P's response was "*I did not ask because I decided to go ahead with the surgery. I already taken the decision to go for the surgery.*" P agreed to undergo the procedure when he attended at the ASC on 13 July 2006, and that consent was based on the information conveyed on 10 July 2006. As set out above, at that juncture i.e. 10 July 2006, P's consent was not an informed one.

42. This Committee agrees with Dr. PE's views that a patient who had been prepared for surgery and in the operating room waiting for the procedure and surrounded by people he did not know is in a vulnerable position. He is not in a position to reasonably ask questions, consider any advice that may be given, evaluate it and reject the planned procedure. There would have been no opportunity for the patient to discuss with family members or to seek another medical opinion. Such concerns were not allayed in the present case.

43. Indeed, by the Respondent's own evidence, he had experienced only 6 cases where patients opted to abandon the procedure at that stage[15]. To put this figure in perspective,

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[14] See paragraph 3 of the Explanation dated 4 June 2007 by the Respondent
[15] See paragraph 16, Respondent's witness statement.

by mid-2006 the Respondent had performed 1,400 stapled haemorrhoidectomy procedures, and would have completed considerably more at the time in 2010 when the witness statement was prepared. The number of patients who opted to abandon the scheduled procedure on the day itself is extremely low, and supports the view of Dr. PE on the difficulties of obtaining a truly informed consent from patients on the operating day.

44. We would add that on this point, the testimony of P corroborated his vulnerability on the day of the operation in the operating theatre. He testified that he did not ask any question because he did not want to do so since he was about to undergo the procedure.

Was informed consent taken from P in the operating theatre?

45. We note that even on the evidence presented on behalf of the Respondent on the communication of information to P on 13 July 2006, the process of seeking an informed consent is unsatisfactory. By the time the Respondent saw P at say 8.50 a.m., he would have just completed his fifth procedure. By then P was dressed for surgery, and being prepared for the procedure and the administration of anaesthesia. Assuming that it was done, the Respondent had about 10 minutes to explain and take P through the contents of the Consent of Patient form, and seek to P's written consent to it. The time of 10 minutes was also provided by Nurse DW7 called by the Respondent.

46. By the Respondent's evidence, he would have also covered the objectives, risks and benefits of stapled haemorrhoidectomy and conventional haemorrhoidectomy[16] and the specific risk of infection[17]. This Committee doubts that within 10 minutes, it was possible for the Respondent to accomplish that, and to afford P the time to make an informed decision. We also question whether P was in any suitable state of mind to consider any other treatment option even if that was presented to him at that stage. P testified that he was "nervous". In any event, as stated above, by the time P attended at the ASC he had already decided to undergo the procedure.

47. Apart from the schedule of 17 procedures between 7.30 a.m. to 1.35 p.m. (including 14 stapled haemorrhoidectomies) on 13 July 2006, the fact that things were moving quickly in the operating room on that day is evident from the testimony of A/Prof DW4 that he explained to P the process and risks of general anaesthesia as he administered the anaesthesia to him, and *after* P had signed the Consent of Patient form. The significance

[16] Paragraph 15, Respondent's witness statement

of this is that the Consent of Patient form also contained P's consent to undergo general anaesthesia, and by A/Prof DW4's testimony this meant that the explanation was given by him *after* the form was signed. We also note that this practice runs contrary to the PFR6.4 standard of Joint Commission International[18] that "Informed consent is obtained *before* surgery, anaesthesia, use of blood and blood and other high-risk treatments and procedures." We add that A/Prof DW4's version of facts in this aspect is also contrary to the version set out by the Respondent in his witness statement that the anaesthetist had explained the risks of general anaesthesia *before* P signed the Consent of Patient form.

48. Apart from the above aspects of the evidence, we would also make an observation. At many points of his testimony, the Respondent's evidence vacillates between facts as he claimed to recollect, and facts as he believed would have taken place in the ordinary course of his practice or routine. As a result, the precision of the Respondent's account of what happened on 10 and 13 July 2006 is affected and that undermined his credibility. On the other hand, P's evidence was consistent and uncomplicated. He did not strike this Committee as an untruthful witness. Further, we appreciate that the events to P as a patient would be significant and vivid to him. Conversely, and as admitted by them, due to the passage of time and the large number of patients that they have seen over the years, the Respondent and A/Prof DW4 were unable to specifically recollect the events relating to this specific patient P and his treatment.

49. We would also add that in respect of the evidence offered by Nurse DW7, this Committee found it to be unhelpful because it was based on what she postulated would have happened as a practice or routine instead of what had actually taken place. This Committee therefore relied substantially on contemporaneous evidence as well as the testimonies of witnesses who gave direct evidence on what actually happened.

<u>Our findings on the First Charge</u>

50. After considering the evidence offered against and for the Respondent, this Committee is of the view that on a totality of the evidence, the version of the facts offered by the SMC on the First Charge is much more credible and is to be preferred to that presented by the Respondent. This Committee cannot find that on the evidence before it, reasonable doubt had been raised by the Respondent that informed consent was obtained from P for

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[17] See paragraph 17, Respondent's witness statement.
[18] Joint Commission International Accreditation Standards for Hospital, 3rd edition, exhibit "P10"

the procedure on 13 July 2006. On a related note, this Committee is aware that mere negligence may not amount to professional misconduct. However, in the present case, given the cumulative evidence on what transpired, we are of the view that the omission by the Respondent is of sufficient severity to constitute serious professional misconduct. There was a breach of the Ethical Guidelines.

51. After due deliberation and consideration of the evidence, this Committee is of the view that the SMC had successfully proven the First Charge against the Respondent, beyond reasonable doubt.

The Second Charge

52. This Charge relates to the Respondent's post-operative care and management of the patient until 8 August 2006 when P was discharged from HOSPITAL A.

53. Broadly, the SMC's case is that the Respondent had grossly mismanaged the post-operative care of P in that

   a. he had prescribed Zelmac to P when it was inappropriate,

   b. failed to carry out a rectal examination of P on 17 July 2006 to exclude the possibility of stricture and dehiscence of the staple line,

   c. during the consultation on 2 August 2006, the Respondent failed to exclude the possibility of stricture and dehiscence of the staple line,

   d. following P's admission to HOSPITAL A on 2 August 2006 until his discharge on 8 August 2006, the Respondent failed to carry out a further rectal examination of P to determine if the fecal impaction had resolved with the laxative treatment and to exclude the possibility of stricture and dehiscence of the staple line.

54. In its submissions, the SMC stated that its case is not one of mismanagement arising from wrong diagnosis or failure to diagnosis the abscess, but one for the Respondent's wilful neglect of his duties to P, consisting of the steps taken or omitted by the Respondent to rule out the relevant complications.

55. The Defence's case is that the Respondent had managed P within the standards of a reasonable colorectal surgeon[19]. The Respondent also stated that it is unreasonable and unsafe to find him guilty of failure to conduct investigations when the SMC cannot show that the pathologies existed during the relevant time.

56. After being presented with the evidence, this Committee is not satisfied that the Respondent had carried out good practice in his post-operative care and management of P. In particular, from the evidence presented, we note the following:

    (1) In respect of the prescription of Zelmac, the SMC's case is that there was no symptom of IBS at the time of prescription. In any event, the SMC's case is that the prescription of Zelmac was inappropriate because the Respondent did not ascertain the type of IBS (whether diarrhoea or constipation predominant) that P had before prescribing him the medication for 8 weeks. Dr. DE1 agreed that this is an acceptable argument. Under cross-examination the Respondent stated that for P, "*Since patient has history of IBS, Zelmac was prescribed to treat IBS and prevent constipation.*"[20] On the evidence, P's IBS is of the diarrhoea-predominant type and the prescription of Zelmac would have a detrimental effect on him, after his surgery. Unfortunately, there is no evidence in the Respondent's case notes of any record of the type of IBS that P had, and we cannot find any credible evidence that the Respondent had applied his mind and differentiated between the different types of IBS before he prescribed the medication.

    (2) On 17 July 2006, P was in urgent need to see the Respondent. The contemporaneous evidence of his facsimile transmission corroborated P's testimony that he was desperate for an appointment to see the Respondent. One of the issues is whether the Respondent conducted a rectal examination of P on that day and if so the reason why it was not done. The Respondent's explanation stated that "*Examination of Mr P then confirmed that the haemorrhoidectomy staple line was completely normal and intact.*" but did not expressly state whether a rectal examination was conducted.

    (3) In his witness statement, the Respondent made a reference to a "clinical assessment" of P but did not expressly state whether a rectal examination was

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[19] See paragraph 125, Defence Closing Submissions
[20] See transcript of Respondent's testimony at page 78, SMC's Closing submissions

carried out. It was only at paragraphs 53 and 56 of his witness statement that the Respondent stated that a rectal examination on 17 July 2006 would have been unwise.

(4) At this juncture, we remind ourselves that the SMC's case is that a rectal examination ought to have been conducted on 17 July 2006; and not that there was a stricture and dehiscence of the staple line on that day. The complaint is against the Respondent's post-operative management and the failure to conduct a rectal examination of P. The Respondent's case is that it was unwise to do so and he did not do so. On the evidence, we are unable to share the Respondent's views entirely. It is undisputed that Dr. PW3 conducted many rectal examinations of P on 18 July 2006 and consecutive days thereafter. No criticism of Dr. PW3's repeated *per* rectal examination was levied by the Respondent. P fully accepted the repeated examination by Dr. PW3, and there is no evidence that he had or would have objected to such an examination by the Respondent.

(5) After his admission on 2 August 2006, P was distressed and agitated, and wanted to be reviewed by the Respondent on 3 August 2006. The frustrations of P and his wife were documented and it was also recorded that they wanted the Respondent to be consulted before any decision was taken[21]. On 3 August 2006 P had been, and was still suffering from diarrhoea and was on painkillers, even though he had been reviewed by the Respondent on 17 July 2006 and Dr. PW3 on several occasions between 18 to 31 July 2006.

(6) Another point by the SMC is that the Respondent did not exclude the possibility of stricture and dehiscence of the staple line. One of the factors is whether the Respondent had taken into account the fact that antibiotics / painkillers, and even fecal impaction might have masked the presence of an abscess and that the Respondent ought to have done more to investigate. We are mindful of the SMC's position that it is not its case that the abscess was present and that the Respondent failed to detect it; the argument is that the Respondent failed to take steps to exclude that. On this point, it is therefore unnecessary for this Committee to make any finding whether an abscess was present when the Respondent's managed P as his patient, and our evaluation of the Respondent's management and conduct was carried out in that light.

(7) We are of the view that on the evidence, including that of the expert witnesses, a senior specialist like the Respondent could have taken more investigations. He could have conducted a rigid sigmoidoscopy, scans, full blood count and urea and electrolyte test but no further investigation was undertaken.

(8) At the consultation with P on 2 August 2006, the Respondent had diagnosed P as having impacted stools and proceeded to treat him on that basis. It is our view that on that occasion and subsequently thereafter, a senior specialist like the Respondent ought to have taken greater care in monitoring the condition and symptoms of P, and ought to be prepared to depart from his initial diagnosis. He ought to have considered differential diagnosis than be contented with his diagnosis of fecal impaction. Further, even if the Respondent had managed the treatment of P with the assistance of his team, this does not absolve him of the responsibilities of a managing physician. Indeed, it is documented that this patient had specifically sought his personal attention and we do not think that sufficient attention was accorded by the Respondent.

(9) P had also suffered significant weight loss; 4 kilograms between his haemorrhoidectomy and his admission to HOSPITAL A on 2 August 2006, and another 2 kilograms during his stay there. It is undisputed on the evidence that such weight loss is serious, and we take the view that this was another factor that should have alerted the Respondent to conduct further investigation.

57. This Committee finds that on a totality basis, the Respondent's conduct of the post-operative management of P was unsatisfactory. As a senior specialist, the Respondent ought to have kept his mind open and be constantly alert to the condition of his patients. He must be prepared to depart from his initial assessment and diagnosis and conduct further investigations if the circumstances warranted that. The Respondent's conduct as a head of department has to be exemplary, which is not the case.

58. However, as stated by counsel for the SMC, all of the particulars of the Second Charge have to be proved. This Committee is unable to find that all of the particulars are proved against the Respondent. Notwithstanding our concerns with the Respondent's conduct and management as set out above, there are reasonable doubts in respect of the

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[21] See AB249 to 250 for P's Patient's records upon admission to HOSPITAL A

evidence led on the particulars relating to the Respondent's treatment and management from 17 July 2006 to 8 August 2006. The SMC failed to pass the hurdle of imputing gross misconduct to the Respondent. Part of the evidence that was led during the inquiry did not specifically prove the particulars levied against the Respondent.

59. For the above reasons, this Committee finds that the Second Charge is not proved against the Respondent.

The Third Charge

60. This charge concerns the articles "A pain-free way to treat piles" and "A pain in the rear" that was published in an edition of "Mind Your Body", a supplement of The Straits Times newspaper on 26 April 2006.

61. The SMC's case is that the Article contained laudatory and misleading statements in that:

(1) Of the laudatory nature, the Article gives the impression that the technique that the Respondent use for the treatment of haemorrhoids is:-

(a) a new method invented by him for the treatment of haemorrhoids:

(b) less painful, causes less bleeding and allows for quicker recovery than the original Longo technique; and

(c) it states that the Respondent had already completed more than 5,000 cases using his technique for the treatment of haemorrhoids.

(2) The Laudatory Statements are misleading, because:-

(a) the technique that the Respondent uses for the treatment of haemorrhoids is not a new method for the treatment of haemorrhoids, but a technique modified from the original Longo technique; and causes more pain when compared to the original Longo technique, and there is no difference in the recovery time and amount of bleeding in his technique when compared to the original Longo technique; and

(b) the 5,000 cases cited by the Respondent were done collectively by the entire **[name of department redacted]** in Hospital A. From 1999 to December 2005, the Respondent had personally performed only about 1,400 cases.

62. After considering the evidence and the submissions by both Counsel, this Committee is of the view that the SMC did not succeed in proving this Charge against the Respondent. The Charge fails for the following main reasons:

(1) We accept the independent evidence of Ms. DW3 from The Straits Times that the Respondent had no inkling of the contents of the Article prior to its publication.

(2) There is no evidence that the Respondent had drafted or provided the relevant offending portions of the Article. There is also no evidence that the Respondent had control of the contents of the Article, especially in the light of Ms. DW3's testimony that she did not send any draft to the Respondent.

(3) The Respondent also had no idea of, or contributed to the layout of the Article, or the usage of headings and sub-captions which were entirely in the purview of The Straits Times. This directly undermined the gravamen of the Charge against the Respondent, i.e. that he had "caused to be published" the offending portions of the Article.

For the above reasons we can find no evidence to support this Charge against the Respondent.

63. Finally, this Committee notes paragraph 4.4.3 of the Ethical Guidelines (Information in the public domain) that states *inter alia* that "*Doctors are responsible for the public statements and for ensuring that journalists do not breach these standards in reporting them. …*" We are of the view that it is incumbent on a medical practitioner to take steps to rectify any departure from the guideline in the event of a breach. Towards this end, we accept the submissions of the SMC, and we are disappointed at the failure of the Respondent to take expedient steps to correct the erroneous figure of 5,000 stapled haemorrhoidectomies carried out by the him as published in the Article once he had notice of the same. We also accept the SMC's point that in response to advertisements taken out by **[name of group redacted]** in The Straits Times in January 2010, the

Respondent together with two other surgeons was quick to correct statements made in those advertisements[22].

64. However, such omission on the part of the Respondent to rectify the error in the articles is not the sole subject matter of the Charge, and hence the said Charge is not proved.

Findings of the Committee

65. On the totality of the evidence, this Committee finds that the First Charge is proved by the SMC against the Respondent. In respect of the Second and the Third Charges, this Committee is not satisfied that the evidence adduced during the course of this inquiry supports the particulars of these Charges as framed by the SMC.

66. The Committee therefore finds that the Respondent is guilty of the professional misconduct in respect of the First Charge and calls for his counsel to address us in mitigation.

Sentencing

67. In the course of mitigation, counsel for the Respondent had relied upon *inter alia* the following:

    (1) The Respondent has a long and unblemished record,

    (2) the Respondent had received widespread recognition and commendation from patients, senior medical practitioners, authorities/mentors and students, and

    (3) there were substantial contributions and voluntary work by the Respondent to society and the community.

    Numerous testimonials were tendered by the Respondent in support of the above.

68. Counsel for the SMC had cited precedents involving a practitioner's failure to obtain informed consent. The punishment in the precedents cited consists of the imposition of a fine and a censure.

69. Apart from the above points, parties also submitted on the issue of costs, bearing in mind the decision of this Committee in respect of the three Charges.

70. We had in the grounds of our decision expressed our views on the serious nature of the misconduct by the Respondent. The Respondent's failure to obtain informed consent of Mr. P, and the process by which the failure took place involved a serious breach of the SMC Ethical Guidelines. The patient was deprived of his right to make an informed decision and the circumstance that Mr. P had to sign a consent form for the first time within a short period of time from disrobing and then having to undergo the operation is an aggravating factor. The manner by which the Respondent failed to obtain informed consent also demonstrated a breach of the spirit of the guidelines and the standards of HOSPITAL A. The Respondent is the head of a department and he leads the way in setting the standard, for his department and the hospital. The facts that evinced the lack of communication however demonstrated the Respondent's endorsement of a practice that clearly depart from the doctors' responsibilities that the patient is adequately informed so that he can participate in decision-making and be aware of the benefits, risks, possible complications and the alternatives available to him.

71. We take the view that in the present case, the circumstances of this case warrant a strong signal to members of the profession that their patients' consent must be obtained properly, both in spirit as well as procedurally. The duty to obtain such consent is a serious one, as it concerns the education and involvement of the patient in the treatment process. The process of taking informed consent is a fundamental pillar of the doctor-patient relationship, where the patient trusts and turns to the physician for his treatment. This case is a timely reminder to the medical profession that obtaining informed consent is not a process to be taken lightly. It ultimately concerns the protection of the lay public at large.

72. While we are aware of the previous sentences imposed, a deterrent sentence is necessary so that standards of the medical profession are upheld. A punishment involving only a fine will not achieve justice in the process.

73. Having regard to the representations made by both counsel and the nature of the misconduct, it is this Committee's decision that the appropriate sentence is as follows:-

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[22] See the advertisements, the response and newspaper article at AB316 to AB321.

a. that the Respondent's registration in the Register of Medical Practitioners shall be suspended for 3 months,

b. the Respondent be censured;

c. that the Respondent shall give a written undertaking to the Medical Council that he will not engage in the conduct complained of or any similar conduct; and

d. that the Respondent pays 70% of all of the costs and expenses of and incidental to these proceedings, including the costs of the solicitor to the SMC and the Legal Assessor.

74. The hearing is hereby concluded.

Dated this 10th day of July 2010.