Medical Practitioners Disciplinary Tribunal

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DECISION NO: 50/98/28C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **SANTOKH SINGH** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Ms S Cole, Professor B D Evans, Dr A F N Sutherland,

Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Wednesday 9 September 1998

APPEARANCES: Ms D Hollings for the Complaints Assessment Committee ("the CAC")

Mr C W James for Dr S Singh.

1. THE CHARGE:

1.1 **A** Complaints Assessment Committee, pursuant to Section 93(1)(b) of the Medical Practitioners' Act 1995, charges that Dr Santokh Singh, Medical Practitioner of Auckland:

1. Failed to supply adequate medical information to NZI Life (now Prudential Insurance Company) when he knew or should have known that his patient, Mr A was suffering from impaired renal function.

2. Failed to supply adequate medical information to Countrywide Life when he knew or should have known that his patient, Mr A was suffering from impaired renal function.

being disgraceful conduct in a professional respect or professional misconduct or conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practise medicine.

2. SUMMARY OF AGREED FACTS:

2.1 **A**, the deceased, was born on xx.

2.2 **MR** A was a patient of Dr Singh.

2.3 **ON** 2 April 1994 Dr Singh received Lab test reports indicating that Mr A had renal failure.

2.4 **ON** or about 5 April 1994 Dr Singh arranged for Mr A to be admitted to xx Hospital. His referral referred to *"known renal failure"*.

2.5 **ON** 1 June 1994 Mr A took out life insurance with NZI Life. Later on NZI Life transferred life policies to Prudential Assurance. Mr A did not advise the insurance company of his illness.

2.6 **DR** Singh received a renal clinic report dated 23 March 1995 which confirmed a diagnosis of *"multiple myeloma with severe renal involvement"*.

2.7 **SUBSEQUENTLY** Dr Singh received copies of reports from:

i) xx Hospital Renal Team Discharge Summary dated 20 April 1994;

ii) Home Dialysis Unit dated 29 April 1994;

iii) xx Hospital Department of Haematology dated 20 May 1994;

iv) Clinical Summary Sheet for admission on 11 July 1994;

v) Renal Clinic dated August 1994;

vi) Department of Haematology, South Auckland Health dated 3 November 1995;

vii) General Medical Clinic at xx Medical Centre dated 13 & 15 March 1996;

viii) South Auckland Renal Medicine, xx Hospital dated 24 June 1996.

2.8 **ON** 30 July 1996 Mr A applied for further death cover, in this instance to Countrywide Life. Once again Mr A did not disclose that he had renal disease. Mr A did tick the *"Yes"* column in reply to a question asking:

"In the past five years have you for any reason consulted a doctor, taken a blood test, been medically examined, treated or hospitalised?"

2.9 **ON** 21 September 1996 Mr A died. The death certificate stated that the cause of death was:

"Cardiomyopathy Vascular Pneumonia - 3 weeks
Myeloma - 2.5 years
Renal Failure - 2.5 years."

2.10 **ON** 25 October 1996 NZI Life wrote to Dr Singh asking for a review of Mr A's medical history, requesting dates and reasons for the consultations for the period June 1989 to June 1994.

2.11 **BY** letter of 19 November 1996 Countrywide Life wrote to Dr Singh requesting a report setting out the details of Mr A's medical history for the past five year period.

2.12 **BY** letter of 2 December 1996 Dr Singh replied to NZI Life. Subsequently NZI Life followed up by telephone and asked for a full history of the illness from which Mr A had died, when the condition was first diagnosed and the subsequent course of the illness and copies of all blood tests and hospital reports. NZI subsequently received by fax from Dr Singh's nurse an inpatient clinical summary which showed that Mr A had been admitted to hospital on the day of one of the consultations noted by Dr Singh.

2.13 **BY** letter of 30 January 1997 Dr Singh replied to the letter from Countrywide Life.

2.14 **BY** letter of 20 February 1997 Countrywide Life wrote again to Dr Singh requesting details about Mr A's admission to xx Hospital on 5 April 1994. No reply was received by Countrywide Life.

2.15 **BY** letter of 2 May 1997 Countrywide Life wrote a complaint to the Medical Council regarding Dr Singh. By letter of 15 April 1997 NZI complained to the Medical Council about Dr Singh.

2.16 **BY** letters dated 19 April 1998 and 19 April 1998 the Complaints Assessment Committee in regard to this matter wrote to Dr Singh asking for his written reply to the complaints.

2.17 **DR** Singh replied by way of letters dated 12 May 1998 and 25 May 1998.

3. DOCUMENTATION:

3.1 **BY** agreement between counsel a number of documents were placed before and considered by the Tribunal. Brief details of some of these documents follow:

3.1.1 1, 1(a), 1(b) and 1(c) - Diagnostic Laboratory Blood Test Results;

3.1.2 2 - Form of GP Referral of Mr A by Dr Singh to the Renal Clinic. Under the section headed *"Problems"* Dr Singh noted *"Complaining of tiredness one month. Seen Saturday. Had fever, lost weight, one month, treatment Fiji. Seen Saturday. Tired, pallor looking. Bloods, acute renal impairment, BP 120/80, Bloods 8/12 Normal, Kidney admit, Renal Unit to Ward 8 under Dr B"*.

3.1.3 3 - South Auckland Health Inpatient Clinical Summary dated 13 April 1994 relating to an admission on 5 April 1994 when diagnoses were made of:

"1. Renal Failure (Interstitial Nephritis)

2. ? Light Chain Myeloma - awaiting confirmation".

3.1.4 4 - Renal Clinic Report of 23 March 1995 addressed to Dr Singh which noted there was no doubt that Mr A had *"near end stage renal failure"*.

3.1.5 5 - xx Hospital Renal Team Discharge Summary dated 20 April 1994 which confirmed, on investigation, that Dr Singh had discovered severe renal failure and referred Mr A to hospital for further assessment.

3.1.6 6 - Home Dialysis Unit Report of 29 April 1994 addressed to Dr Singh which noted the report writer, Dr B, Renal Physician, had told Mr A that day that he had permanent kidney damage which was likely to progress to end stage renal failure.

3.1.7 7 - xx Hospital Department of Haematology report of 20 May 1994 addressed to Dr Singh which diagnosed "*Renal failure secondary to myeloma kidney but insufficient criteria to diagnose myeloma with Bence Jones protein ...."*.

3.1.8 8 - Clinical Summary Sheet for admission to xx Hospital on 11 July 1994 with discharge on 1 August 1994.

Diagnoses of *"Early myeloma/MGUS and renal failure"* inter alia were noted.

3.1.9 9 - Renal Clinic Report of August 1994 addressed to Dr Singh which noted the following problems:

"1. Light chain myeloma with severe renal failure

2. Recent pneumocystis and CMV pneumonia 2° to immunosuppression (admitted 11.7.94 to 1.8.94)

3. Recent hyponatraemia".

3.1.10 10 - xx Hospital Department of Haematology report of 3 November 1995 which confirmed earlier diagnoses.

3.1.11 11 - General Medical Clinic at the xx Medical Centre letter of 13 March 1996 which noted, among other things, that Mr A's *"renal failure is clearly becoming end stage, and he is going to need insertion of a CAPD catheter in the near future"*. The report concluded it was surprising in fact that it had taken Mr A so long to get to end stage renal failure.

3.1.12 12 - Report of South Auckland Renal Medicine, xx Hospital, addressed to Dr Singh and dated 24 June 1996: The report's Assessment was *"End stage renal failure secondary to a light chain paraprotein disorder (not full blown myeloma). No evidence of recurrence of paraproteinaemia"*.

4. NZI LIFE:

4.1 **THERE** being two separate charges, they must be considered separately. However the Tribunal's general impression can be recorded, that Dr Singh was sparing in the extreme with the information which he provided, or did not provide, to both life insurance companies.

4.2 **FORMAL** proof evidence was given by Vicki Lee Chapman, a Senior Underwriter at the Prudential Assurance Company New Zealand Ltd, Prudential having taken over the business of NZI Life.

4.3 **MS** Chapman explained that in 1996 NZI sought reports on two occasions from Dr Singh in relation to policy claims. On both occasions NZI and subsequently Prudential felt that important information relating to the claim event was not given, despite the fact that Dr Singh had the information. It was only through persistence in following other avenues of inquiry that the necessary information was obtained.

4.4 **AT** the conclusion of the formal proof evidence given in respect of both charges, Mr James made an application that there was no case to answer in respect of the NZI charge. The application was opposed by Ms Hollings. The Tribunal then ruled, in dismissing the application, that both charges would need to be fully defended.

4.5 **IT** is necessary to examine carefully the text of the two communications made by Dr Singh to NZI. The first was his handwritten letter of 2 December 1996, which is reproduced below:

"2/12/96

TO NZI
151 QUEEN ST
AUCKLAND

Dear Mrs Debbie McMillan

RE Mr A - DOB xx

As per your request regarding consultations from July 1989 to June 1994. The pattern of consultations are as follow

1) 30/11/90
Cold, Flu like symtoms
BP 120/80 Coldsore settled

2) 16/02/91
Routine Checkup BP 140/80

3) 24/3/93
Flu Itchy back ® eczema : Pimafucort

4) 31/3/94
BP Check
65 kg Nausea (Maxalon)

5) 5/4/94
Abnormal blood test

6) Nausea BP Check 140/80
Oral thrush ® mycostatin oral dp 1 dose QID

7) 120/80 BP

8) *8/8/94* *Wt 56.6*
110/70
Painful foot *Digesic II prn*

9) *24/9/94*
Wt 61 kg *Skin rash 140/80*

10) *8/8/96*
Painful back
? of check 140/80 *Plendil ER 5mg OD.*

I am extremely sorry for the delay.

Hope my report will help assist the distraught family.

Please call me if I can be of any assistance in future.

(Wish you seasons greeting!)

Yours sincerely

Santokh Singh"

4.6 **THE** first point to be made about Dr Singh's letter of 2 December 1996 is that he took almost six weeks to reply to the requests for information concerning Mr A, which was not exactly a prompt reply.

4.7 **SECONDLY** it is noted that Dr Singh's letter of 2 December 1996 did not provide the information which had been actually requested of him. He had been asked to consult his records and "*provide us with a review of the medical history, advising dates and reasons for consultations for the period June 1989 to June 1994"*. Instead Dr Singh chose simply to provide NZI with a list of dates of consultations with brief accompanying details of the reasons for those consultations.

4.8 **MR** James sought to shore up the inadequacies so obvious in the letter of 2 December 1996 by suggesting that the reference of 5/4/94 to an abnormal blood test and referral to xx Hospital were sufficient to put NZI on notice that there was a question mark concerning the health of Mr A - the Tribunal does not accept this proposition.

4.9 **THE** second item of information given to NZI was the copy of the inpatient clinical summary which was faxed through by Dr Singh's nurse. That summary did, as has been explained, advert to the fact that renal failure and the possibility or probability of light chain myeloma had been diagnosed in Mr A's case.

4.10 **THE** charge is that Dr Singh failed to supply adequate information to NZI Life when he knew or should have known that his patient was suffering from impaired renal function.

4.11 **IT** was submitted by Mr James that the request made by NZI was complied with, albeit six or so weeks later, in a rather shabby handwritten note, a note which concludes:

"Please call if I can be of any assistance in future", - a call which was subsequently made, and a call which was subsequently complied with by the furnishing of the Inpatient Clinical Summary. To an absolutely limited degree Mr James argued that Dr Singh complied in respect of the charge arising out of the complaint made by NZI.

4.12 **THE** Tribunal prefers the submissions made by Ms Hollings. The Tribunal agrees with Ms Chapman that Dr Singh's letter of 2 December 1996 to NZI is very sketchy and gives minimal information. The fact of the matter is that the letter in question did not mention any consultations for the illness from which Mr A finally died.

4.13 **THE** information in the Inpatient Clinical Summary was enough to show that material information had been withheld at the time Mr A applied for the policy. Accordingly NZI decided it did not have any liability under the policy. However we record NZI's view, that if the company medical officer had not been personally involved in the assessment of the claim, payment may have been made on the basis of acceptance of Dr Singh's report indicating that the condition from which Mr A died was not known at the time the proposal was completed.

4.14 **TO** suggest that dispatch of a copy of the Inpatient Clinical Summary alone (by fax) was sufficient compliance, is untenable. There were in Dr Singh's possession a veritable raft of documents which attested to the fact of Mr A's serious ill-health. In the Agreed Statement of Facts it was absolutely agreed by Dr Singh that he had received a number of reports from xx Hospital. He received most of them some two years before he wrote the letter of 2 December 1996 to NZI. The series of letters from xx Hospital repeat over and over again Mr A's problems, that he had severe renal failure which progressed to end stage renal failure. At one point Mr A was on the point of death which resulted in his admission to the Intensive Care Unit where he was put on a respirator. Against that background of available medical information, the Tribunal agrees with Ms Hollings it was pathetic for Dr Singh simply to say, by reference to the consultation of 5/4/94, that an abnormal blood test had resulted in referral of Mr A to xx Hospital.

4.15 **THE** Tribunal is satisfied to the required standard, the balance of probabilities and so finds, that Dr Singh failed to supply adequate medical information to NZI Life, (now Prudential Assurance Company) when he knew or should have known that his patient, Mr A, was suffering from impaired renal function.

5. COUNTRYWIDE LIFE:

5.1 **FORMAL** proof evidence was given by Neil Prestwood, a Senior Life Underwriter with Countrywide Life ("Countrywide").

5.2 **MR** Prestwood explained its complaint to the Medical Council was made because Dr Singh appeared to have assisted and attempted to defraud Countrywide insurance services by failing to supply important medical information which it believed he was aware of.

5.3 **AS** was the case with the charge arising out of the NZI complaint, again it is necessary to examine carefully the substance of the information provided by Dr Singh. It will be recalled Countrywide in its letter of 19 November 1996 had requested of Dr Singh *"... a report setting out details of medical history for the past five year period"* plus advice *"when Mr A became aware that he had myeloma and renal failure"*. The response given by Dr Singh in his handwritten letter of 30 January 1997 states:

"To Countrywide Life *30/1/97*

ATTENTION Ms Lesley Smith

RE MR A - DECEASED

As per your request regarding consultations from July 1989 to June 1994. The consultation pattern ~~of~~ is as follow

1) *30/11/91* *Routine check up. Good health*
BP 140/80 Flu like symtoms

2) *16/2/91* *Routine Check up - well.*

3) *24/3/93* *Flue, eczema course ® steroid cream*

4) *31/3/94* *BP Check, 65 kg wt*
130/80
Well

5)	*5/4/94*	*Unwell ref to xx Hospital*		
6)	*Nausea*	*thrush oral*	*Mycostatin oral ?? days*	
7)	*120/80*			
8)	*8/8/94*	*Wt 56.6* *BP 110/70*	*Painful foot*	*Digesic*
9)	*24/9/94*	*Wt 60 kg*	*Skin rash ??*	*Flu 140/80*
10)	*8/8/96*	*Painful back, unwell*		

Kindly contact me if further information is required

Yours faithfully

Santokh Singh"

5.4 **IN** the first instance the letter of 30 January 1997 is significant for the fact that it post-dates the original request for information by some ten weeks, a delay which in the circumstances can only be described as inordinate.

5.5 **SECONDLY** it is to be noted, as was observed by Mr Prestwood, that Dr Singh's reference to a request for details of consultations from July 1989 to June 1994, were certainly not the requests made by Countrywide.

5.6 **FURTHERMORE** as was also noted by Mr Prestwood, the letter of 30 January 1997 failed to mention the very important fact that the deceased was recognised to have chronic renal failure and multiple myeloma in early April 1994.

5.7 **SIGNIFICANT** enough not to be overlooked, which is recorded in the Agreed Statement of Facts, is that Countrywide wrote again to Dr Singh on 20 February 1997 requesting details about

Mr A's admission to xx Hospital on 5 April 1994. No reply was received by Countrywide. Dr Singh said he did not see the follow-up letter from Countrywide. If he had received this letter, he said he would have sent the In-patient Clinical Summary which he had forwarded to NZI as a result of their follow-up inquiry. In this respect we can only reiterate what we said concerning the NZI complaint. With the abundance of information in the possession of Dr Singh from xx Hospital, clearly provision of the Inpatient Clinical Summary was gross under-compliance with the request for information concerning Mr A.

5.8 **THE** fairly strong comments which we directed to Dr Singh's omission to supply information to NZI, especially given the several reports in his possession numbered (i) - (viii) as referred to in the Agreed Statement of Facts, apply equally to the Countrywide situation.

5.9 **ON** a number of occasions during cross-examination and re-examination Dr Singh conceded that a paucity of information was disclosed by him to the two life insurance companies. Whilst Mr Prestwood conceded under cross examination that Dr Singh's letter of the 30th January 1997 was relevant to some of the issues raised in Countrywide's letter of November 1996, much important information was omitted and not addressed by Dr Singh. The letter from Countrywide Life requested that details of Mr A's medical history over the last five year period be "provided". It is the Tribunal's opinion that the dominant factors in Mr A's medical treatment during this period were his renal failure and his multiple myeloma. When summarising Mr A's medical history during this period Dr Singh was at fault not to emphasise these very important medical conditions.

5.10 **THE** Tribunal is satisfied to the required standard, the balance of probabilities and so finds, that Dr Singh failed to supply adequate medical information to Countrywide Life when he knew or should have known that his patient, Mr A, was suffering from impaired renal function.

6. DETERMINATION:

6.1 **HAVING** established to its complete satisfaction that the facts alleged in each charge have been proved to the required standard, it is now necessary for the Tribunal to determine the level of offending which has been established by the proven facts. It will be recalled the charge was framed in a such a way as to leave this aspect to the judgement of the Tribunal.

6.2 **WHILE** the Tribunal is quite apprehensive about the conduct of Dr Singh on the occasions in question, it does not consider that a determination of disgraceful conduct is warranted in this case. Significantly disgraceful conduct, wilfully done, could lead a doctor to being struck off the medical register. Clearly this means something which is of a most serious nature and is often repetitive, occurring over a period of time. Commonly this involves matters of considerable dishonesty, or of a sexual nature, or drug related matters. It could certainly be invoked in cases where severe and repetitive negligence was involved leading to, or potentially leading to, severe sequelae to the patient.

6.3 **IN** *B v The Medical Council* (High Court, Auckland, HC 11/96, Elias J 8 July 1996), the Judge recognised that the predecessor 1968 Medical Practitioners Act, established a hierarchy of conduct for disciplinary purposes. The judgement contains a helpful discussion on what comprised "conduct unbecoming" before the qualification of "adverse reflection on fitness to practise medicine" was added by the 1995 Act. We have decided that the level of misconduct

in this case is in excess of what was commonly understood to be "conduct unbecoming" under the 1968 legislation and also after having due regard to the requirement now of "adverse reflection on fitness to practise medicine".

6.4 **THE** definition of professional misconduct is well established. In *Ongley v Medical Council of New Zealand* [1984] 4NZAR 369, at 374-375, Jeffries J stated in the context of the 1968 Act:

"To return then to the words "professional misconduct" in this Act. .....

In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."

6.5 **WE** believe that the test for professional misconduct established in *Ongley* should be the same under the 1995 Act, despite the altered composition of the Tribunal.

6.6 **NZI** requested *"a review on the medical history"*. The request that Dr Singh advise dates and reasons for consultations must be taken at face value, as in some way being as additional or supplementary to the request for a review on the medical history. Dr Singh chose to interpret the request from NZI as being restricted simply to the pattern of consultations. Despite rigorous cross-examination on the part of Ms Hollings, Dr Singh would not agree that the provision of such limited information by him was intended to mislead the insurance companies. We think otherwise. In our view the limited responses made by Dr Singh to the two insurance companies

were indeed intended to mislead, to the extent that by not mentioning myeloma and renal failure, Dr Singh could be seen to be offering, at the least, passive assistance to payment of the two insurance claims by the late Mr A's estate. In our view no other reasonable explanation can be forthcoming from our examination of the facts. Dr Singh was fully aware of the precarious condition of Mr A's health. For reasons best known or known only to himself, he chose to be excessively sparing and selective in the information he gave to the life insurance companies. On the evidence the only plausible conclusion seems to be, as was intimated by Mr Prestwood, that *"Dr Singh attempted both to mislead .... and to assist Mr A to defraud .... by wilfully failing to disclose important and relevant information that he was aware of"*.

6.7 **MS** Hollings described the key issue as being whether Dr Singh simply failed to provide the information due to administrative overload and oversight, or whether Dr Singh deliberately for other reasons failed to provide the information that he was clearly aware of to the insurance companies.

6.8 **THE** former was the clear impression intended to be taken from Dr Singh's evidence. He explained that by 1996 his practice workload had grown considerably, and he was working very long hours, probably in excess of 60 hours. He was very engrossed in patient care, and as a sole practitioner probably tried to do too much with too little receptionist assistance. He said he only had a receptionist in 1996 who was a Samoan lady who herself was probably overworked. He said shortcomings then existed in administration and the like, and he accepts this solely as his responsibility.

6.9 **AT** that stage Dr Singh explained the practice had grown to a point where people would drop in without an appointment, and as many of these were Indians and Samoans who had difficulty in getting time off work or travelling, he could not turn them away. He said all this put added pressure on him.

6.10 **BY** early 1997 Dr Singh said it was clear to him that his workload was becoming intolerable and that he could not continue with such a small and relatively unqualified staff. Consequently he implemented changes to his practice. He now has a regular Locum, a full-time receptionist, full-time nurse and a part-time practice manager. Systems and procedures have been adopted with the result that the administration and paperwork is much more efficiently handled. He said he now maintains more control over his patient numbers.

6.11 **IN** re-examination by Mr James it was explained by Dr Singh he was overworked and under staffed. He conceded it was unfortunate he had treated these insurance requests as low priority, and that he was deserving of some approbation in respect of providing inadequate information. Dr Singh acknowledged to Mr James that any doctor has an obligation to provide professional information when appropriately asked.

6.12 **THE** Tribunal wishes to remind Dr Singh that the obligation on a doctor to provide such information, also arises out of the contract of insurance entered into between the insurance company and the life assured, in this case the late Mr A. It was unfortunate Dr Singh failed to give due diligence to the declaration given by Mr A to both insurance companies that *"I hereby irrecoverably authorise any hospital, physician, and any other person I have consulted in the past or may consult in the future to furnish to _____ any and all information with*

respect to my medical history, prescriptions or treatment and copies of all hospital or medical records relating to myself".

6.13 **ESSENTIALLY** Dr Singh failed to convey to the two insurance companies the true clinical picture of the late Mr A. There were at least three methods whereby Dr Singh could have communicated the necessary information. First he could have produced his own report, in summary form, of Mr A's health status. Secondly Dr Singh could have written a report of his important consultations with Mr A, together with provision of copies of at least some of the more important hospital reports referred to in paragraph 3 of this Decision. And thirdly, if Dr Singh had just sent on to the two insurance companies the copies alone of the hospital reports, without any covering report, they would immediately have got the gist of Mr A's seriously compromised health. By failing to act in any one of these three ways, Dr Singh damaged the traditional trust which must exist between insurance companies and members of the medical profession.

6.14 **THE** Tribunal is far from persuaded that Dr Singh simply failed to provide the information due to administrative overload and oversight. The Tribunal has made this assessment in reliance on the concluding submissions of Ms Hollings, which were of considerable assistance.

6.15 **FIRST** Dr Singh provided different information to the two insurance companies.

6.16 **SECONDLY** the information provided does not in fact accurately reflect the medical notes of Dr Singh. A prime example is a point raised in questions by Dr Wilson. Dr Singh told both insurance companies the entry of 31 March 1994 was for a blood pressure check and he had told Countrywide that it showed 130/80. There is no mention of a blood pressure check in the

medical notes of that date. In writing a letter 2 ½ years later, Dr Singh appears to have simply made up information, which on the face of it was misleading to the insurance company. Other examples arose in cross examination which need not be canvassed further.

6.17 **THIRDLY** Dr Singh steadfastly maintained he was simply complying strictly in terms of the requests for information by limiting his answers to the representative pattern of consultations. That Dr Singh should not resile from this approach is in the Tribunal's view, completely unrealistic in all the circumstances.

6.18 **FINALLY** a fourth issue is the inadequacy of some of Dr Singh's notes. It is almost unforgivable that the medical notes were so grossly inadequate given the sorry plight of this patient in whose medical condition Dr Singh was so well versed. For all these reasons, and others articulated earlier in this Decision, the Tribunal's determination is that the level of offending on the part of Dr Singh, constitutes professional misconduct rather than conduct unbecoming as statutorily qualified.

6.19 **IN** *Lake v The Medical Council of New Zealand* (Unreported judgement of the High Court, 23 January 1998, Auckland, H.C.123/96, Smellie J), His Honour explained (at p 26) that he had been referred to a number of the older cases in the text books for discussions of conduct unbecoming. He said in his judgement the best treatment of professional misconduct was to be found in the judgement of McGechan J which he handed down in August 1994 in *Cullen v The Preliminary Proceedings Committee* (Wellington Registry, AP225/92). At p 22 of the judgement His Honour explained:

*"At the risk of fatuity "professional" misconduct is not just any variety of misconduct by a person who happens to be a professional. Basically, it is misconduct "as part of the conduct of his profession" (McCarthy J, **Re Mudie** supra). What is meant by "conduct of his profession"? In my view, the exercise, or ostensible exercise, of medical training, skill, or knowledge of a medical practitioner. If the activity involves the real or ostensible medical training, skill or knowledge of a medical practitioner it is professional. If it does not, it is not. (References to exercise and to activity include, of course, occasions of unjustifiable inaction where action properly is called for). The concept of "professional" is not necessarily confined to mere patient care, or to functions which by statute only registered medical practitioner may perform (eg some certifications). It is not necessarily confined to paid activity, or to planned activity. It does not demand the existence of actual training knowledge or skill : the practitioner who pretends to know is fixed with consequences."*

6.20 **THE** Tribunal respectfully agrees with and adopts this statement of opinion. In so doing it holds that the activities of Dr Singh in reporting to the two insurance companies, were clearly professional in nature, and the wilful omission of relevant medical information concerning the late Mr A, on the facts of this case, constitutes professional misconduct.

6.21 **IT** remains for submissions to be made on penalty. At the conclusion of the hearing, Ms Hollings was requested to file her submissions with the Tribunal by 25 September 1998, with Mr James to file his submissions in reply by 9 October 1998.

7. RULING MADE DURING THE COURSE OF THE PROCEEDINGS:

7.1 **AT** the commencement of the hearing Ms Hollings made a formal application for Ms Chapman to give evidence in regard to a second case, about the same time, involving Dr Singh failing to disclose information to NZI about another of his patients. Although no charge was laid in regard to that matter, Ms Hollings explained she wished to be able to call that evidence as similar fact evidence.

7.2 **WRITTEN** submissions were made by Ms Hollings in support of the application. It was submitted by Ms Hollings:

7.2.1 **IT** is accepted that the general rule is that evidence of facts similar to but not part of the main facts to be proved is, in general, not admissible, but this is subject to the similar fact rules.

7.2.2 **IN** summary similar facts which go beyond their proof of propensity and which show striking similarity with the facts to be proven, and have positive probative force, are admissible.

7.2.3 **THE** rule in regards to similar facts is one that arises for the most part in criminal jury trials, but also applies in civil cases.

7.2.4 **A** leading authority in civil cases is *Mood Music Publishing Co v De Woolfe* [1976] 1ALL ER 763. This was an action for infringement of musical copyright. The plaintiff sought to produce evidence that showed that in three other cases the defendant had reproduced musical works which were subject to copyright. In the Court of Appeal Lord Denning stated:

"In civil cases the Courts will admit evidence of similar facts if it is logically probative, that is if it is logically relevant in determining the matter which is at issue; provided that it is not oppressive or unfair to the other side; and also that the other side has fair notice of it and is able to deal with it."

7.2.5 **THAT** case was recently followed by Justice Fisher in *Cook v Evatt and Others* [1992] 1NZLR 673.

This was a civil trial in regard to an alleged breach of fiduciary duty. The property involved had been purchased on the advice of financial advisors who failed to disclose their interest in the property. The plaintiff sought to lead evidence of similar purchases by others. Justice Fisher referred to *Mood Music Publishing Co Limited* and held

that the issue was whether the evidence was logically probative and not oppressive or unfair to the other side. In that case he decided the evidence should be admitted.

7.2.6 **THERE** have also been some recent criminal cases which lay out the principles, in particular another decision of Justice Fisher's *R v P High Court Auckland Trial 45 98* and a Court of Appeal decision in *R v Turner* delivered on 5 May 1997.

7.2.7 **SIMILAR** fact evidence sought to be admitted in regard to this case has logical relevance, and fair notice of the application has been given to the other side.

7.3 **IT** was Mr James' general submission that the CAC dealt with three particular charges, the two A complaint charges, and one further complaint concerning another patient of Dr Singh. Mr James explained that the three potential charges were heard by the CAC, chaired by Dr George Hitchcock, one of the most experienced practitioners from the old era. After hearing evidence from both sides, together with appropriate investigation and inquiry, which included a legal assessor, the decision was reserved. The outcome was the laying of the two charges with respect to the late Mr A, but in respect of the other patient the explanation of Dr Singh was accepted, and no charge was prosecuted on the basis that there was no case to answer in respect of it.

7.4 **MR** James further submitted:

7.4.1 **THE** principle of autrefois acquit applies, whether the proceedings be civil or criminal in nature;

7.4.2 **MS** Hollings is estopped from bringing the application forward because the substance of the matter has been dealt with by another disciplinary body already;

7.4.3 **THE** Agreed Statement Of Facts does not allude to the matter of the second patient;

7.4.4 **NEITHER** he nor his client was adequately prepared to deal with the matter involving the second patient;

7.4.5 **THE** second patient matter is not subject to a charge before the Tribunal;

7.4.6 **ANY** probative value that might exist in respect of the second patient is inordinately outweighed by its prejudicial nature. Because it had been dealt with earlier, it would be both oppressive and unfair to have it included as part of the evidence coming before the Tribunal in respect of the two charges to be faced by Dr Singh.

7.5 **IN** ruling that the application to adduce similar fact evidence be dismissed, the Tribunal explained that the probative force of similar fact evidence depends on three principal factors:

7.5.1 **THE** cogency of the evidence showing bad disposition;

7.5.2 **THE** extent to which such evidence supports the inference sought to be drawn from it;

7.5.3 **THE** degree of relevance of that inference to some fact in issue in the proceedings.

7.6 **ALTHOUGH** acknowledging that the Tribunal's ruling was in essence a response to a legal question, the Chair indicated a very real concern of the members, their discomfort in terms of natural justice, that a matter which had been investigated by a CAC, with a decision made not to take a potential charge any further, should then be used in proceedings which were being prosecuted almost simultaneously in respect of other complaints.

7.7 **IN** indicating that some of the submissions made by Mr James were upheld, the Tribunal explained it was not prepared to accept any suggestion of unpreparedness, because in its view proper notice of the application had been given in adequate time.

DATED at Auckland this 2nd day of October 1998

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal