

**IN THE MEDICAL AND DENTAL
PROFESSIONAL CONDUCT TRIBUNAL**

APPLICATION NO. 1 of 2015

IN THE MATTER of a complaint
by the Fiji Medical Council and
pursuant to Section 74(1) (d) of
the Medical and Dental
Practitioners Decree 2010

BETWEEN : **FIJI MEDICAL COUNCIL**

APPLICANT

AND : **LITIANA BROWNE**

RESPONDENT

BEFORE : The Hon. Mr. Justice David Alfred
Dr Lisa Tikoduadua
Dr Abdul Wahid Khan

**PRESIDENT
MEMBER
MEMBER**

Counsel : Ms N Tikoisuva for the Applicant
Ms L Jackson for the Respondent

Dates of Hearing : 17, 18, 19, 24 and 26 February 2016
Date of Order : 8 July 2016

**ORDER OF THE MEDICAL AND DENTAL
PROFESSIONAL CONDUCT TRIBUNAL**

1. The Applicant, the Fiji Medical Council (FMC) filed a Notice of Complaint against the Respondent, Dr Litiana Browne alleging the following:

*Unprofessional conduct contrary to section 55(1)(c) and section 2(2)
(b) of the Medical and Dental Practitioners Decree 2010 (the
Decree).*

PARTICULARS

The Respondent whilst being a registered medical practitioner, committed unprofessional conduct, that is, in the course of providing medical care and treatment to Shanta Wati Krishna (deceased) the said Respondent was negligent.

THE ALLEGATIONS AGAINST THE RESPONDENT

2. The Applicant contends that the Respondent is subject to disciplinary action, since:
 - (i) The deceased was first seen by the Respondent circa 19 April 2012, with a history of post-menopausal bleeding.
 - (ii) That after medical examination and consultation by the Respondent, the deceased underwent a Total Abdominal Hysterectomy (TAH) on 30 April 2012, at the Suva Private Hospital (SPH) without the benefit of endometrial sampling to confirm whether her conditions were cancer related. She was discharged, post operation, on 3 May 2012.
 - (iii) During her care at the SPH, the Respondent was aware of the persistent abdominal pain, nausea, body pain and vomiting of the deceased, until her discharge.
 - (iv) The deceased was re-admitted to the SPH on 5 May 2012 with the same symptoms noted in (iii) above.
 - (v) The deceased was subsequently transferred to the Colonial War Memorial Hospital (CWM) where she received medical attention until she died on 4 July 2012.
 - (vi) The endometrial tests revealed there was no cancer.
 - (vii) That at all material times, the counseling documentation on management options noted and provided by the Respondent was substandard and contributed to medical decisions being made by the deceased which is not consistent with best practice principles.
 - (viii) The failure of the Respondent to obtain endometrial sampling before providing medical treatment and care options was negligent and may have resulted in an unnecessary Total Hysterectomy.

- (ix) The standard of intra-operative documentation is poor and the Respondent's failure to maintain such records is negligent.
 - (x) As a result of the Respondent's omissions and failures, the Respondent's conduct was below the standard of a reasonable medical practitioner in the circumstances.
3. The Applicant therefore, prayed for, inter-alia, an order that the Tribunal exercise its powers under section 76(3) of the Decree.
4. The Respondent in her Statement of Response to the Allegations alleged, inter-alia, as follows:
- (i) The Respondent denies that she committed any unprofessional conduct.
 - (ii) The deceased informed the Respondent at the initial consultation on 19 April 2012 at Suva Bayview Medical Centre (Bayview), that she had been bleeding for about 3 weeks and wanted her baby bag removed.
 - (iii) At the initial consultation the Respondent informed the deceased that she had to undergo a Dilation and Curetage (D & C) to rule out endometrial cancer. This would cost \$2,000.00. The deceased said she did not have the money for this but only enough for the TAH which would cost \$7,000.00.
 - (iv) At the initial consultation the Respondent conducted a thorough clinical examination of the deceased as well as ordering an ultra sound scan of her pelvis by Samabula Medical Centre. After examining the ultra sound report and reviewing the clinical examination, the Respondent concluded the chance of endometrial cancer in the deceased was low.
 - (v) Therefore, based on the Respondent's clinical examination and the ultra sound report and the deceased's insistence the doctor performed a TAH on 30 April 2012 after the deceased signed a Consent Form for Surgical Operation Procedure which was witnessed by the Respondent.

- (vi) The deceased wanted a TAH to be performed to treat her post-menopausal bleeding and not because of the possibility of cancer.
 - (vii) The most effective cure for post – menopausal bleeding is a TAH, which would not only cure the deceased's post-menopausal bleeding but was also a preventative treatment against cancer developing in the future, and that was why the deceased had insisted on a TAH from the first consultation.
 - (viii) The Respondent contended that she kept thorough notes on the initial consultation at the Bayview Clinic.
 - (ix) The Respondent denied she was negligent and contended the operation cured the deceased from post-menopausal bleeding and was also a preventative treatment against uterine, cervical and ovarian cancers.
 - (x) The Respondent contended the operation was straight forward and absent any complications.
5. The Respondent therefore prayed that the Notice of Complaint and Allegations be dismissed with costs.
6. The hearing commenced with the President giving instruction on the procedure to be followed.
7. The Applicant's first witnesses was Dharmesh Bobby Prasad (PW1) the Chief Executive Officer of the FMC. He received a written complaint from Mr. Bal Krishna, the widower of the deceased. As required, a copy of the letter of complaint was given to the Respondent for her response and her response was forwarded to Mr. Krishna who responded.
8. All documents were then presented to the Medical Professional Conduct Committee (MPCC). After it deliberated it had 3 options *viz*:
- (i) If there were a miscommunication, the MPCC would ask PW1 to talk to the parties.

- (ii) If there were no merits in the complaint, it is disregarded and both parties are notified.
 - (iii) If there is a prima facie case, the matter is referred to an investigator.
9. The MPCC found there was a prima facie case and referred it to Dr James Fong who conducted an investigation. The MPCC obtained a copy of the investigation report. The secretariat of the FMC obtained the patient file from the SPH.
 10. PW1 said the Respondent was a registered medical practitioner with a valid licence for 2012. She practiced general and vocational medicine i.e Obstetrics and Gynaecology (O&G). He tendered a number of documents which were marked as Exhibits P followed by a number in running order. The last of these was the Bundle of the SPH records, which after perusal by Counsel for the Respondent, were confirmed to be in order and marked as Exhibit P8. Some of the Exhibits were submitted by the Respondent.
 11. PW1 was then cross examined by the Respondent's counsel on what transpired in the process towards this hearing.
 12. In re-examination, PW1 stated the FMC informs the practitioner of the outcome of the process.
 13. The next witness was Bal Krishnan, the complainant (PW2). He said his wife was the deceased. He lodged a complaint against the Respondent because it seems to him his wife should not have died in a simple case of a hysterectomy performed by the Respondent. His wife (then 49 years) was examined by the Respondent and she told PW2 that the Respondent advised her the best thing is to get rid of her baby bag (uterus). If not, it could develop into cancer. When PW2 questioned the Respondent, as to how she could tell her to go for an operation, the Respondent told him that his wife was healthy and there should not be any problem. The Respondent asked him to come to the SPH with \$8,000.00, on the following Monday.

14. After the operation the Respondent told him it was successful and everything was all right, and if the ovary had not been taken out it could develop into cancer. Before the surgery there were no tests done. After the surgery, tests were done and all were negative from the report from Australia.
15. The Respondent never told them of the risks involved or the complications that could arise. The Respondent never advised of any tests to be done before the operation, and said the best option was to remove the baby bag. The Respondent never gave a diagnosis before the surgery was done.
16. Under cross examination, PW2 said at the initial consultation at Waimanu Medical Centre, the deceased told the Respondent she had been bleeding for the previous 3 weeks. She did not tell the Respondent to remove her baby bag. She only said to remove the baby bag on the Respondent's advice. The Respondent said that this kind of bleeding could be cancerous. The Respondent never told the deceased that to rule out cancer, a sample of her endometrium was needed. The Respondent never told the deceased that the possibility of cancer was low.
17. The Respondent never said a D&C was necessary for the deceased. The deceased never told the Respondent she had only enough money to cover the costs of the TAH. The deceased's decision to remove the baby bag was not their decision but was based on the Respondent's advice. Everything the deceased did was based on what the Respondent advised.
18. In re-examination, PW2 said if they had been told by the Respondent that the risk of cancer was low they would not have gone for a hysterectomy.
19. In answer to the President, PW2 said they totally relied on the Respondent and in answer to Dr Khan, PW2 said they did not consult any other doctor on the wife's problem.

20. The next witness was Rachel Monika Krishna (PW3), the daughter of the deceased. She said she was with the deceased from the first consultation and was aware of the circumstances leading to the surgery. The Respondent said after menopause, the ovaries and cervix have no purpose, and sent the deceased to get the scan done. The Respondent did not suggest a D&C and never explained any alternative operation and never told them what her diagnosis was. At the first consultation, the deceased was not desperate but after the Respondent said if she did not get it done now then at some later date in her life she will have to have it done, the deceased decided to get it done. The Respondent said there was a possibility it could be cancer.
21. She and her father took the deceased to the SPH on 30 April 2012. She, PW3, only wrote the deceased's name and address on the consent form, Exhibit P8A. After the operation, the deceased was in pain. On day 4 she was discharged. On days 5 and 6 she was vomiting and in pain so her father and her had the deceased readmitted to the SPH.
22. The Respondent and Dr Siti Vuniabola (Siti) came and the Respondent saw her and said she did not know what was happening. After that, the deceased was transferred to and was given a transfusion in the CWM Hospital where she remained for 2 months. Dr Siti said he did not know what was wrong with the deceased and he was going to operate on her to see what was wrong.
23. After the surgery, Dr Siti said there were holes in the deceased's intestine and all the intestinal matter was going into her abdominal cavity. Dr Siti said he cleaned the abdominal walls and did repairs but he had to wait and see if the repairs he did were holding. Dr Siti said he did not know from where the holes came from. The deceased had 2 or 3 more operations in the CWM Hospital. The surgeons kept saying there were leakages and after repairing they would start leaking again.

24. The deceased was unable to walk, unable to talk, unable to eat and remained in the Intensive Care Unit (ICU) in the CWM Hospital on her bed for 2 months until she died. The deceased never had any medical problem before the surgery (TAH) apart from bleeding.
25. In answer to the President. PW3 said the only things on Exhibit P8A, when she handed it to the SPH reception were the deceased's name and address.
26. Under cross-examination by Counsel for the Respondent, PW3 said she was with the deceased at the initial consultation and the deceased did not tell the doctor she wanted the baby bag removed. The Respondent told the deceased that one of the causes of post menopausal bleeding is cancer but the Respondent did not tell the deceased that she required a sample of her baby bag nor that the deceased required a D&C and it would cost approximately \$2,000.00.
27. In re-examination, PW3 said the Respondent did not explain any other causes of the bleeding.
28. The next witness was Dr James Josefa Fong (PW4). He stated he has been the head of the maternity unit, CWM Hospital for 12 years, had been working in the medical area for 25 years and is a specialist in O & G.
29. The FMC by letter submitted a complaint to the conduct committee to investigate. He was part of this committee. They asked for an analysis of the root cause from the CWM Hospital especially the ICU. They said the injury to the intestine was iatrogenic, documented as induced by the treatment. He was tasked to look through all the documents to ascertain if there were any substandard practice.
30. PW4 then made a report and in it he detailed the instances of substandard practices. Taking all the resource material and the guidelines of affiliated

colleges and the United Kingdom and Australia which are up to date, they base their opinion on the best clinical practice within the country. He tendered his report dated 1 July 2013 as Exhibit P10.

31. PW4 referred to Exhibit P8 and said there was evidence of a risk of intestinal injury. Something sinister happened at the time of discharge that required further investigation. This was indicated by the rise in the pulse rate. There was other evidence that the deceased's condition was deteriorating. The surgeons felt the hysterectomy was associated in one way or other with the bowel injury which occurred during the hysterectomy.
32. The risk of surgery depends on whether there is a plan to manage the risk. Here there was no documentation of a plan.
33. Referring to the Consent Form, Exhibit P8A, PW4 said the Respondent's signature is not in Part A. It is conceivable that the patient may not have understood the consent form. It would take 30 minutes to explain the consent form. Five minutes would not be adequate to cover 4 bullet points of Part B of Exhibit P8A. From Exhibit P8, he noted the deceased arrived at 9:30 am in the Operating Theatre and the consent was signed at 9.20am. He did not see in the initial consultation document that a D&C was requested but rejected. From the post operation notes the deceased had more complaints than usual related to the alimentary canal.
34. The tachycardia was persistently high and rising and needed to be assessed. PW4 would not have allowed the deceased to be discharged. The best practice is for such a patient to remain in the hospital for further evaluation. The Respondent discharged her. On the next day after the surgery, the situation became worse. The injury occurred in a very active part of the intestine and it was going to be difficult to repair.

35. Not having a sampling was a significant departure from best practice in the current day. The management choice was not in keeping with current clinical practice. The patient should have been informed of the flow on consequences and it should have been documented. The intra-operative documents should have shown what was done with the adhesions and bowels safely out of the way. If you appreciate there is a risk, it should be documented how you handled the risk. In the absence of documentation of how the adhesions were managed, one cannot be confident in saying that the bowel was not injured while it was being dealt with.
36. A doctor is duty bound to read the notes of the preceding 24 hours. PW4's conclusions are based from the pre-operation to intra-operation and post-operation. He had read the second opinion.
37. In answer to the President, PW4 said his observations and conclusions are based on his O & G experience on the Respondent who is also a practitioner in O & G. In answer to Dr Khan, PW4 said age is a factor in considering whether a doctor is up to date.
38. Under cross-examination by the Respondent's Counsel, PW4 said he was appointed as investigator under the Decree, by the FMC. He did not interview anyone at all. The Respondent's documents state she found adhesions but not what she did about them. PW4 said he did not ask the Respondent for a copy of the initial consultation report. The concern is cancer if there is post-menopausal bleeding. Investigative procedures are carried out. Both a D&C and a biopsy are equally competent in detecting cancer.
39. Both members of the Tribunal take PW4 as competent and possessing up to date data and concur with what he has said.

40. PW4 did not ask the Respondent if she informed the deceased of risks of hysterectomy. One of the risks is gastrointestinal complications. On readmission the Respondent referred the deceased to a general surgeon.
41. After the hysterectomy, the deceased had persistent lower abdominal pain, body pain, nausea and occasional vomiting. These symptoms persisted through day 1, day 2 and day 3. In PW4's opinion, the symptoms appeared to be on the upper limits of the normal and the only evidence of a sinister cause was the increasing heart rate. On the notes, PW4 did not see the symptoms receding. It is normal that they recede with time. Pulse and heart rates were not normal through the 3 days. In general, iatrogenic covers inadvertent injury. On readmission to the SPH, the deceased had generalized abdominal tenderness.
42. PW4 said it does not reflect clinical concern and is not at all good practice to discharge on day 3 with a heart rate of 130 BPM. He did not agree that discharging the deceased on day 3 indicated an adequate level of clinical concern.
43. In re-examination, PW4 said concern for cancer is what dictates investigation of post menopausal bleeding. An endometrial sampling procedure of the lining is the best practice. An ultra sound scan defines a risk but it does not make a pathological diagnosis of cancer.
44. The deceased's death should have been termed a coroner's death, as a death in the I.C.U. General Gynaecologists do not do lymph node dissection. In Fiji there are only 3 who are skilled in doing lymph node dissections and the Respondent is not one of the 3.
45. With this the Applicant closed its case.

46. The Respondent's Counsel made a submission before calling the Respondent to the stand. She said she had been a medical practitioner for more than 40 years and had provided medical treatment generally and specifically in O & G for women. She met the deceased for her first consultation at the Bayview Medical Centre. The deceased was accompanied by her husband and daughter. The Respondent created a folder. The deceased asked for her baby bag to be removed. The Respondent did not perform a D & C, as the deceased said she could not afford the additional cost for that. She wanted a hysterectomy at the SPH. The highest concern to a gynaecologist is the possibility of cancer and the usual procedure is to advise the removal of the baby bag. The uterus and 2 ovaries have ceased operation but are sites for cancer.
47. The Respondent sent her for an ultra sound scan of the pelvis at the Samabula Medical Centre. The ultra sound scan report is Exhibit P8 page 2. If the lining of the uterus is thickened there may be possibility of cancer. Here the lining is normal. The possibility of cancer is much much lower. The Respondent performed an internal examination and advised a D & C so that she could sample the lining before proceeding to do a hysterectomy, because she needed to be sure there was no cancer before the hysterectomy.
48. There was no evidence of cancer. The Respondent saw the ultra sound scan which indicated the risk of cancer was very low. The deceased was informed of the dangers of abdominal surgery *i.e.* heavy bleeding, organ injury and infection. What transpired was recorded in her notes in the Waimanu Medical Centre made the day the deceased and family arrived.
49. At this juncture, the Tribunal examined the suppositious note produced for the first time at the hearing. The Respondent's Counsel informed she had it since 2015 and had not shown to the Applicant's Counsel. This was a sheet of A4 notepaper, blue in colour and in pristine condition. It was not stamped with the

name of the medical practitioner, which is the accepted practice. The President therefore ruled that the note was not accepted as evidence.

50. The Respondent said the deceased refused an endometrial biopsy and as the risk of cancer was low, opted for a hysterectomy. The hysterectomy took place in the SPH. The deceased was admitted on 30 April 2012 and she signed the consent form – Exhibit P8A. Part A is in the Respondent's handwriting and in Part B the signature at the right is the Respondent's, and the deceased signed at the left.
51. The Respondent wrote the date, the name and the address. She did not sign at the signature of medical practitioner. She did not sign Part A because it was not necessary as the deceased spoke English. The Respondent prepared the abdomen and moved the adhesions easily away and packed the bowels out of the surgery site, and proceeded with the hysterectomy which was straight forward. Immediately after the surgery she wrote her report.
52. The deceased's ovaries and uterus were sent overseas and she saw the histological report Exhibit P4 which negated cancer.
53. The deceased was in hospital for 3 days post operation. She was getting better all the time and was discharged on the 3rd day after surgery. The Respondent was happy with her vital signs. On the morning of 5 May 2012 the Respondent received a desperate call from the deceased's husband that she was vomiting and she told him to bring her right back to the SPH.
54. There the Respondent said she looked different. Her abdomen was distended with tenderness. The Respondent checked where the surgery was and it was healing. The Respondent realized after examining her that the symptoms were of a gastrointestinal nature, so she called the surgeon on call and he dictated her care in the SPH.

55. The Respondent said she was served with the complaint on 27 April 2015. The FMC did not inform her they had appointed an investigator and that he had submitted a report. She was not given an opportunity to discuss the matter with Mr Krishna.
56. Under cross-examination, the Respondent said she provided 2 responses to Mr Krishna's letter. She is aware the investigator has powers under the Decree and can exercise any of them. It is true she was first aware of gastrointestinal complications on 5 May 2012.
57. It is correct the deceased was vomiting and nauseous and her pulse rate was high at readmission. These were the same symptoms noted by the nurses immediately after the surgery. The Respondent saw the records. The deceased was in her care. For the first 24 hours after the operation, the Respondent would rely on the nurse's notes.
58. The nurses carry out the Respondent's plan. Continuing to look after the patient is for the nurses who carry out the Respondent's instructions. She is the decision maker for the deceased's care and after care. On 1 May 2012 the symptoms after surgery are gastrointestinal. The symptoms were a lot worse when the deceased came back to the SPH.
59. The Respondent agreed that after the operation, the deceased had the same pain recorded by the nurses. She said she did not review the nurse's notes. She did not agree she failed to note the gastrointestinal problems on 3 May 2012. She said she did not discharge the deceased negligently on 3 May 2012. The D & C is not an option but a prerequisite before a hysterectomy but the deceased refused. She did not agree that she did not explain to them the options available. It was not true they opted for a hysterectomy because she represented to them the removal of the baby bag was the only option.

60. The Respondent said she is 73 years old. She told the deceased the possibility of cancer was low. She denied she told the deceased that cancer was a high risk and the only way to confirm that it is cancer is to remove the baby bag and have it tested. She was made to understand money was an issue to them. It was not true they wanted the best medical advice to address the problem. At this point Dr Khan observed the deceased was asking for something which was not in her best interest.
61. The Respondent said she did not sign Part A. In Part B the deceased was not asked to consent to blood transfusion. She did not explain all of Part B to the deceased before the deceased signed.
62. In re-examination, the Respondent said the symptoms when the deceased was readmitted were different from those when she went home. She said the deceased refused a D & C and told her she had collected enough money for a hysterectomy but could not afford the extra \$2,000.00 for a D & C. She said the deceased told her she wanted the baby bag removed to stop the bleeding.
63. The next witness for the Respondent was Dr Neil Sharma (DW2). He said he was a medical doctor, whose specialty is O & G. He had conducted in excess of 500 hysterectomies and treated hundreds of women with post menopausal bleeding.
64. DW2 supplied a medical report dated 2 February 2016. At this juncture Counsel for the Applicant objected to any materials and evidence that will refer to the notes that the Tribunal has rejected. Counsel for the Respondent said they were acceptable. The President ruled that all references to the initial Bayview notes are inadmissible as evidence, while the rest of the report is, as both members were of this view.
65. DW2 said before a TAH is considered there was a need to look at the patient holistically. The discharge was satisfactory and within the guidelines of good

medical practice. The deceased's symptoms were within range and possibly acceptable in the deceased's case. His opinion was based on the SPH's notes.

66. In answer to the Tribunal, DW2 said the train of events started with the operation (TAH) and ended with the deceased's death.
67. Under cross-examination, DW2 said he does not have a specialist licence from the FMC. His vocational registration ended in 2013 and he is in the process of obtaining accreditation from the FMC. He said he gave this opinion as a general practitioner. With regard to the consent form – Exhibit P8A – he said this is the standard form. Part A is a declaration by the Respondent that they have provided information to the patient regarding the nature and risks. The signature of the Respondent provides certainty they have done their duty to provide information to the patient. Part B is signed by the patient after she is provided with information.
68. PW2 said a hysterectomy is major surgery and there are risks associated with any surgery. In his experience all patients had consented to blood transfusion and were required to sign the consent forms by the Respondent. He considered the nausea, vomiting and gastrointestinal problems combined with increased pulse rate over days 1, 2 and 3 were acceptable.
69. In re examination, DW2 said the deceased was progressively getting better. With that the Respondent closed her case.
70. The President then directed both Counsel to lodge and serve their written submissions and the hearing would continue on 26 February 2016. On that date both Counsel made their closing submissions.
71. Counsel for the Applicant said the case had to be decided on a balance of probabilities whether there was a cause for disciplinary action and whether it

had been established that there was unprofessional conduct. This was the first case of medical negligence in Fiji, and there were 2 elements:

- (1) A duty of care.
- (2) A failing in the standard of care provided.

72. Counsel submitted that the daughter had said the Respondent never told them of any other option than to remove the baby bag. The Respondent should have insisted on a D & C first. The consent was signed at 9:20am and the deceased was in the Operating Theatre at 9:30am – Could the consent have been full and informed? The Respondent had said it was unnecessary to make the declaration.
73. If the Respondent did not review the notes, how could she make her decision. Dr Sharma (DW2) is expressing an opinion after a 7 years lapse in practice and as a general practitioner and not as a specialist. The Respondent knew there was no cancer and therefore there was no need for a hysterectomy and therefore no fees for her. There was no notation of D & C in the notes. There was no record of post operation instructions.
74. Counsel submitted the Applicant had complied with the relevant sections of the Decree, and had proved the complaint of unprofessional conduct. She said the object of the Decree was to protect the public's health and safety and asked if the complaint were proved, that the Tribunal would censure the Respondent impose a substantial fine and restrict the Respondent from practice for a specified time.
75. Counsel for the Respondent then submitted. There were 2 issues: *viz* (1) Has the Applicant complied with the requirement for fairness. (2) Did the Respondent depart from the standard and if so, does it warrant disciplinary action.
76. Counsel said only negligence was particularized, but the Decree does not particularize negligence. Punishment is not the objective. The Australian cases have persuasive value. The test here was whether there was a deliberate departure? The Tribunal must be reasonably satisfied. The Applicant failed to

keep the Respondent informed of the process and Counsel asked if there was procedural fairness here? The Respondent was not given an opportunity to explain to the widower.

77. There was bias by Dr Fong. Because of the lack of fairness and lack of impartiality, the complaint should be rejected.
78. Counsel said the widower could pursue a medical negligence claim in the civil court against the Respondent. She said the Respondent did not sign the declaration because she thought it only had to be signed if there was interpretation. Counsel asked for the complaint to be dismissed. In response to the President's request to Counsel for her response to the Applicant's Counsel's submission on what the Tribunal may order against the Respondent, Counsel said she did not want to say anything in mitigation in response to what the Applicant's Counsel had asked by way of sanction.
79. Counsel for the Applicant in her reply said the cases of judicial review in Australian Courts were not relevant here.
80. The President at the conclusion of the hearing, stated the Tribunal would give its decision in writing after taking time for consideration.
81. The Tribunal before delivering its decision, has perused the written submissions, exhibits and authorities cited.
82. At the outset, it is noted that this is the first Medical Tribunal hearing since the promulgation of the Decree.
83. The hearing has proceeded in a manner that is analogous to the conduct of a case in the civil court, as determined by the Tribunal. The proceedings have complied with what has been laid down in section 75, section 76, section 79, section 80 and section 81 of the Decree.

84. The only departure from the norm in a civil case being heard at first instance, is that here the decision of the Tribunal is either a unanimous or a majority one, except that questions of law or procedure are solely decided by the President.
85. The cases cited by Counsel for the Respondent do not assist her case. In: *Dewan v Medical Board of Australia* (Occupational and Business Regulation) [2012] VCAT 1327, the Tribunal found on a balance of probabilities that Professor Dewan had failed to inform the parents that their child did not have Hirschsprung's disease, and this was professional conduct which was of a lesser standard than that which the public might reasonably expect of a registered medical practitioner.

The case of: *Prendiville & Anor v The Medical Council & Ors* [2007] IEHC 427 was one for judicial review by the High Court of Ireland, of decisions of the Medical Council finding the doctors guilty of professional misconduct, and therefore has no relevance to the instant Tribunal hearing.

86. This brings us to the alleged lack of fairness and impartiality raised by the Respondent's Counsel. It is instructive to note that the Respondent had never at any time before the commencement of the hearing before the Tribunal or at all applied to the High Court for judicial Review to quash the complaint of the FMC and/or the report of the investigator.
87. Without expressing any opinion on these allegations, the Tribunal looks at section 76 of the Decree to ascertain whether these allegations, if true, could vitiate these proceedings. As this is a question of law, the President has carefully considered the submission of the Respondent's Counsel and is of opinion the boundary lines of the province of the Tribunal have been laid down by the lawmaker in section 76(2) of the Decree and therefore the Tribunal must hear the complaint, unless it considers the complaint frivolous or vexatious. The Oxford Advanced Dictionary of Current English defines frivolous as "not serious or important" and vexatious as "annoying". Again, this is a question of law, and the

that is both serious and important and not annoying. The Tribunal is therefore enjoined to hear the complaint.

88. The Tribunal now proceeds to give its unanimous decision on the complaint.

89. Section 55(1) of the Decree states that there is proper cause for disciplinary action against a registered person, which the Respondent is, if “the person commits unprofessional conduct.” Section 2(2) of the Decree states unprofessional conduct” includes:- (b) “incompetence or negligence in relation to the provision of medical or dental treatment.”

Since “negligence” is not defined in the Decree, the Tribunal is constrained to refer to the generally accepted test of professional negligence in Commonwealth countries known as the Bolam test. In *Bolam v Friern Hospital Management Committee* [1957] 2 All E.R 118, McNair J said:

“But where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent It is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.”

90. This was further explained in: *Hunter v Hamley* 1955 S.C 204 by Lord President Clyde when he said: “The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.”

91. This necessitates the Tribunal closely examining the factual matrix of this complaint as revealed by the evidence produced on both sides.

92. We start with the Respondent's medical report on the deceased – Exhibit P2 dated 27 August 2012. This starts with describing her as “a very healthy lady.” She was complaining of “post menopausal bleeding”, bleeding for more than 3 weeks without stopping. An ultra sound scan was done to exclude any other abnormality. Blood tests were done too. Next were discussions on treatment options and with the deceased were her husband and daughter. They were advised that “for most gynaecologists we regard it as “cancer until proven otherwise.” It is that serious regardless whether the bleeding is heavy or not.”
93. The Tribunal pauses to note here that it is clear that the Respondent is telling the deceased and family that cancer is the source of the bleeding, unless the contrary is proved.
94. This is confirmed by the Respondent stating in the report that “It was to Shanta's advantage that we got on with the surgery since she was still bleeding and if our worst fears were confirmed that there was the beginning of abnormal changes then we would be “nipping it in the bud.”
95. These abnormal changes cannot be post-menopausal bleeding which may occur to women of the deceased's age who have final cessation of the menses.
96. Therefore the *raison d'être* for the hysterectomy was the possibility of cancer. Consequently if there was any evidence that it was not cancer then any good doctor would have said that there was no need for the hysterectomy. This evidence became available when the ultra sound result showed the lining of the uterus is normal. Only if the lining of the uterus is thickened then there may be a possibility of cancer. Here the possibility of cancer is much much lower. Then the Respondent saw the ultra sound report which indicated “cancer very low.”
97. With all these evidence at hand for the Respondent, a normal competent doctor would have come to the conclusion that the need for a hysterectomy no longer existed.

98. Further it is hard to believe that if the D & C option had been put to the deceased, she would not have accepted it as it was cheaper than a hysterectomy would have cost. This is shown by the Respondent's statement in her report – Exhibit P2 – where she said the options given were:
1. D&C and if it shows there was malignancy then proceed to hysterectomy OR;
 2. Go ahead with the Abdominal Hysterectomy.
99. It is as plain as a pikestaff that a hysterectomy would only be needed if there were malignancy. This had been ruled out by the ultra sound scan. So on the Respondent's reasoning there was no need now for a hysterectomy. Yet she went ahead with one. Why?
100. The only plausible reason has to be that the Respondent was only interested in having a hysterectomy carried out. And it is this hysterectomy that led to the death of the deceased. This is confirmed by the Respondent's own witness, Dr Neil Sharma, in his evidence when he said the train of events started with the operation (hysterectomy) and ended with the deceased's death.
101. Further, the Respondent failed to sign Part A of the consent Form. The excuse she gave for not signing does not exculpate her. On the contrary it inculpates her. She is asking the Tribunal to conclude she has never performed any such operation in the past or she has an inadequate command of the English language, or because she is advanced in years she is not aware of the serious nature of what Part A connotes or, finally she is indifferent to the fate of the deceased.
102. Whatever the conclusion reached there is no escaping the necessary implication that the Respondent did not inform the deceased of the risks that attend such an operation as a hysterectomy.
103. Thus she has fallen short of the standard of the reasonable medical practitioner in similar circumstances.

104. This is unprofessional conduct which has to be penalized in the interest of the public of Fiji.
105. The Respondent in her letter to the FMC also dated 27 August 2012. Exhibit P3, in Para 5 & 6 makes it crystal clear that it was cancer that was the objective of the surgical intervention when she states "It was only in hind sight now that we now know there was no cancer – we did not know that before." The necessary implication of this must be if it was known that there was no cancer there would have been no hysterectomy. But the truth of the matter is the Respondent did know and knew well before the hysterectomy, that the scan results showed in her own words "there was no cancer."
106. So proceeding with an unnecessary operation for whatever reason, possibly for monetary reasons, an operation which was not in the best interest of the deceased was unprofessional conduct of a serious nature.
107. The discharge of the deceased on day 3 when her medical condition was not of the best is yet another falling on the part of the Respondent from the standard of a reasonable competent medical practitioner.
108. What her witness Dr Sharma (DW2) said in his present position of an ordinary medical practitioner and not that of a specialist, that it was all right to discharge was not evidence of a compliance with the required standard of medical care. In the opinion of the Tribunal this can be considered as evidence of a general and culpable complacency, born of a cavalier failure to exercise common sense.
109. Since there is no plausible evidence that the Respondent had advised the deceased of the risks associated with a hysterectomy, the Tribunal finds the Respondent cannot exonerate herself from the flow on consequences of that operation. These are best described in the evidence of Dr Fong, PW4, when he testified, "In absence of documentation of how adhesions were managed one

cannot be confident in saying that the bowel was not injured while it was being dealt with.” He goes on to say that “the bowel injury occurred during the hysterectomy.” This would be considered as medical negligence anywhere.

110. It is unhappy for Counsel for the Respondent to submit the hysterectomy was successful in stopping the bleeding. Surely the unkindest cut of all was for the family to be told the operation was successful but the patient died thereafter.
111. In: *Sidaway v Royal Bethlehem Hospital Governors* [1984] 1 All E.R 1018, the majority of the judges said the Bolam test applied to all aspects of the doctor’s duty of care: diagnosis, advice and treatment.
112. In *Reynolds v North Tyneside Health Authority* [2002] Lloyd’s Rep. Med. 459, the judge said a finding that it was negligent to ignore a small risk of catastrophic consequences (death or brain damage) was neither unfair nor unrealistic.
113. Here the certificate of death of the deceased states the cause of death as “Multi Organ dysfunction, abdominal catastrophic.”
114. Thus the negligence of the Respondent, her unprofessional conduct and her falling from the requisite standard have all been proved and on the balance of probabilities the Tribunal is satisfied that there is proper cause for disciplinary action against the Respondent.
115. The Tribunal therefore orders:
 - (1) That the Respondent be censured.
 - (2) That the Respondent pay the Fiji Medical Council a fine of \$5,000.00, within 30 days from the date of this order.

- (3) That the Respondent's registration be canceled, her licence be revoked and the Respondent be disqualified from being registered generally for a period of ten (10) years with effect from the date of this order.
- (4) Each party to bear their own costs of these proceedings.

Dated and Delivered at Suva, this 8th day of July 2016.



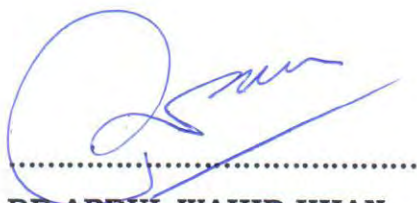
.....
MR JUSTICE DAVID ALFRED -

PRESIDENT



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DR LISA TIKODUADUA -

MEMBER



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DR ABDUL WAHID KHAN -

MEMBER