NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Padamjit Mohan Singh, this is notice that the Discipline Committee ordered that no person shall publish or broadcast any information that could disclose the identity of patients referred to in the Agreed Statement of Facts or any attached documents, or during the course of the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Singh, P. M. (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PADAMJIT MOHAN SINGH

PANEL MEMBERS:

DR. J. WATTS (Chair)
S. BERI
DR. A. SIMPSON
P. GIROUX
DR. P. CHART

Hearing Date:	**June 3, 2013**
Decision Date:	**June 3, 2013**
Release of Written Reasons:	**July 12, 2013**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 3, 2013. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Padamjit Mohan Singh committed an act of professional misconduct:

1) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that she has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Singh is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Singh admitted the allegation of professional misconduct and the allegation of incompetence.

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts and Admission that was filed as an exhibit:

PART I – FACTS

1. Dr. Padamjit Mohan Singh ("Dr. Singh") is an Obstetrician and Gynaecologist practising at Hospital A. Dr. Singh graduated medical school from the University of Pune in 1970 and obtained a Diploma in Obstetrics and Gynecology in 1971 from the

University of Bombay. She did a residency at the Post-graduate Institute of Medical Education and Research at Chandigarh, India and has been practicing obstetrics and gynecology since 1974. She received Royal College of Physicians Surgeons certification on June 30, 1993. She has been a member of the College of Physicians and Surgeons of Ontario (the "College") since July 15, 1993.

2. On October 20, 2009, the College received a report from the Chief of Staff of Hospital A with respect to Dr. Singh's management of two patients. The Chief of Staff raised concerns with Dr. Singh's ability to cope in emergency situations while on call at the Hospital. The report from the Chief of Staff is attached at Tab 1 [to the Agreed Statement of Facts and Admission].

3. On September 21, 2009, Dr. Singh entered into an agreement with Hospital A. The terms of the agreement include:

(a) Dr. Singh withdraws her reapplication for Active Staff privileges and applies for Courtesy Staff privileges only;

(b) Dr. Singh will be granted privileges to work as a surgical assistant at the hospital;

(c) Dr. Singh will be granted privileges to work in the Colposcopy Clinic two days per month;

(d) Dr. Singh will be granted privileges to perform specified minor procedures under general anaesthesia where appropriate. The minor procedures include:

i. Inserting IUDS;
ii. Cone biopsy;
iii. D&C;
iv. Removal of polyps and vaginal cysts;
v. Biopsies;
vi. Incision drainage;
vii. Hysteroscopy;
viii. Hysterosalpingogram
ix. Examination under anesthesia;
x. Balloon ablation
xi. Cauterization; and
xii. Suture and repair

(e) In the event an urgent or emergency situation should arise while performing any of the specified procedures, Dr. Singh agrees to immediately refer and transfer care of the patient to the obstetrician on call.

A copy of the agreement dated September 21, 2009 is attached at Tab 2 [to the Agreed Statement of Facts and Admission].

4. On the basis of this information, the College commenced an investigation under s. 75(1)(a) of the *Health Professions Procedural Code*. The College obtained charts from Dr. Singh's obstetrical and gynaecological practices in the Hospital and in her office.

5. On November 19, 2009, the Department of Anaesthesiology determined that no current member of the department will be made available to provide anaesthesiology coverage to Dr. Singh. As a result, since at least November 2009, Dr. Singh has not been performing: D & C; hysteroscopy; examination under anaesthesia; and balloon ablation. A copy of the letter from Dr. X, Chief of Anaesthesia, to Dr. Y, Department Chief, Obstetrics and Gynaecology, dated November 19, 2009 is attached at Tab 3 [to the Agreed Statement of Facts and Admission].

6. The College retained Dr. Z, Deputy Chief of Obstetrics and Gynaecology, Hospital B, to provide an opinion on the care provided by Dr. Singh. A copy of Dr. Z's report is attached at Tab 4 [to the Agreed Statement of Facts and Admission].

7. Dr. Z reviewed the care and treatment provided to Patient 1. This patient had a caesarean section in the second stage of labour for a non-reassuring fetal heart rate tracing. The baby was delivered after a prolonged amount of time and Apgar scores were poor with the infant requiring resuscitation and transfer. In respect of this case, Dr. Z opined:

(a) Dr. Singh failed to appreciate the significance of the fetal heart rate tracing and allowed the anaesthetist to perform an elective epidural elsewhere instead of dealing with the patient's need for an urgent C-section;

(b) Once in the operating room, Dr. Singh's difficulty in extracting the baby resulted in further delay of newborn resuscitation. Dr. Singh was unable to perform in an emergency situation;

(c) The theme of panic and poor communication with colleague/team members was evident from the interview of those present;

(d) The nurses felt that they had to push Dr. Singh to perform the C-section on a stat basis.

Dr. Z concluded that Dr. Singh failed to demonstrate the appropriate knowledge, skill and judgment expected of a specialist with respect to the care of Patient 1.

8. Dr. Z reviewed the care and treatment provided to Patient 2. This patient presented at 27 weeks with anti-partum haemorrhage and in pre-term labour. In respect of this case, Dr. Z opined:

(a) Dr. Singh failed to communicate the urgency to her colleagues and permitted the anaesthesiologist to provide an elective epidural instead of focusing his attention on the high risk mother;

(b) Dr. Singh had recognized the gravity of the situation by calling for the Sick Kids Transport Team instead of transferring the mother to a tertiary centre. However, Dr. Singh failed to act in a timely fashion to "deliver" the infant when there was a loss of fetal heart rate, as an emergency section would have been taken by a reasonable physician at that point in time under epidural or general anaesthetic.

Dr. Z concluded that this clearly falls below the standards of care by an obstetrician, and that Dr. Singh failed to meet the expected standard with respect to Patient 2's obstetrical care.

9. Dr. Z reviewed the care and treatment provided to Patient 3. This patient wished to have a dermoid removed and surgery was offered. Dr. Singh attempted to perform a laparoscopy, however was incapable of inserting the Veress needle. She then proceeded

to use the Hassan trocar; however, this failed, and the patient underwent a laparotomy and right oophorectomy. In respect of this case, Dr. Z opined:

> Again, another surgical complication arose for a thin patient as Dr. Singh had difficulty with insertion of the Veress needle or Hasson trocar for laparoscopy. Major blood loss for a minor procedure and benign state begs the question as to Dr. Singh's judgment as well as her surgical skills once more.

10. In response, Dr. Singh provided the report of Dr. Q, Staff, Department of Obstetrics and Gynaecology, Hospital C. Dr. Q was asked to provide an opinion in 15 cases in which the College experts were critical of Dr. Singh. He was prepared to provide a supportive opinion of only 11 of those cases. Dr. Q did not provide a supportive opinion in respect of Patient 1, Patient 2 or Patient 3. A copy of Dr. Q's report is attached as Tab 5 [to the Agreed Statement of Facts and Admission].

11. With respect to Dr. Singh's colposcopy practice, Dr. Singh provided a report from Dr. R, Obstetrician Gynaecologist, Hospital D. At the request of Hospital A, Dr. R reviewed Dr. Singh's colposcopy practice and concluded that she appears to practice within the standard of the profession and did not demonstrate any lack of knowledge, skill or judgment or disregard for the safety of her patients. A copy of Dr. R's report dated December 10, 2011 is attached at Tab 6 [to the Agreed Statement of Facts and Admission].

PART II- ADMISSION

12. Dr. Singh admits the facts in paragraphs 1 to 11 and admits that she is incompetent and that she failed to maintain the standard of practice of the profession in her care and treatment of Patient 1, Patient 2 and Patient 3.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Singh's admission and found that she committed an act of professional misconduct, in that she

failed to maintain the standard of practice of the profession, and found her incompetent under subsection 52(1) of the Code in that her care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that she is unfit to continue to practise or that her practice should be restricted.

In making this finding, the Committee notes that the report of Dr. Z clearly describes deficient surgical skills and judgment that include both obstetric and gynaecological care. This deficiency was clear and of a degree that Hospital A curtailed Dr. Singh's privileges and colleagues refused to work with her. The conduct of Dr. Singh as described above fully grounds the findings of a failure to maintain the standard of practice and incompetence.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The proposed penalty components include a reprimand and significant restrictions on Dr. Singh's certificate of registration to ensure safe practice. The penalty also includes costs of hearing time to be paid to the College.

A reprimand is a direct and meaningful way of expressing to the member the Committee's view of her misconduct. A reprimand by one's governing body is a significant event, not to be considered lightly. It can and should be seen as a life changing rebuke to the member. As such, the reprimand addresses the penalty principles of specific and general deterrence.

Dr. Singh's deficiencies in skill and judgment endangered the health of both mothers and newborn babies. Lack of the ability to make appropriate judgments in emergency situations surrounding childbirth is not tolerable in contemporary practice. The Committee had before it convincing evidence that Dr. Singh lacked not only judgment but technical skill as well. Both are essential to provide safe obstetrical and gynaecological surgical care. The expectation is that doctors who practise in the field of obstetrics and gynaecology will have acquired these skills and judgment in training and

will be able to translate them into effective practice. The public and the profession expect and require no less.

Dr. Singh's technical shortcomings extended to gynaecological procedures as well as to her obstetrical practice. Her attempt to perform laparoscopic removal of an ovarian dermoid cyst (Patient#3) further demonstrated her lack of skill and judgment as noted by Dr. Z.

Dr. Singh should have been aware of her lack of skill and difficulty in making critical decisions under stressful situations, yet she continued her obstetrical and gynaecological surgical practice. This resulted in serious errors of commission and omission. Her inability to communicate effectively is of additional concern. That colleagues were aware of concerns regarding the substandard care provided is evident from the refusal to provide anesthesiology coverage. The concern of the hospital is apparent through the marked limitations imposed on hospital based work.

In the face of the facts of this case, the Committee required serious restrictive conditions and these have been proposed jointly by the parties. The terms, conditions and limitations imposed are required to achieve protection of the public and to maintain the public's confidence in the medical profession.

The Committee, upon reviewing the terms, was satisfied that the deficits are addressed. Dr. Singh is permitted only to perform minor procedures not requiring general anesthesia. The public should take comfort as Dr. Singh is prohibited by both the hospital and this College from all labor and delivery. She will have no hospital call work or surgical work in the hospital.

The Committee accepted the report of Dr. R, that Dr. Singh's practice of colposcopy was within the standards of the profession and that she did not demonstrate any lack of knowledge, skill or judgment in this area.

As a mitigating factor, the Committee accepted that Dr. Singh's action in proceeding with an agreed statement of fact and admission resulted in the witnesses avoiding the

inconvenience and stress of a contested hearing. The Committee also considered that Dr. Singh has no prior disciplinary findings.

The courts have made it clear that a joint submission should be accepted by the Committee unless to do so is contrary to the public interest and would bring the administration of justice into disrepute. The Committee concluded after its review of all the circumstances, including the case law provided by the parties, that the penalty proposed in the joint submission was fair, reasonable and appropriate.

ORDER

Therefore, having stated its findings of professional misconduct and incompetence in paragraph 1 of its written order of June 3, 2013, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Singh attend before the Panel to be reprimanded;

3. the Registrar impose the following terms, conditions and limitations on Dr. Singh's Certificate of Registration:

    a) Dr. Singh shall not engage in any labour and delivery practice;

    b) Except as otherwise specified in this Order, Dr. Singh shall not engage in any hospital-based obstetrical/gynaecological practice;

    c) Dr. Singh is permitted to perform colposcopy in the Colposcopy clinic two days per month;

    d) Dr. Singh is permitted to perform the following minor procedures ("Permitted Procedures"), none of which entail intra-abdominal surgery:

        i) Insertion of IUDS;
        ii) Cone biopsy;
        iii) D&C;
        iv) Removal of polyps and vaginal cysts;
        v) Vulvar, vaginal, cervical and endometrial biopsies;

vi) Incision drainage (vulvar, vaginal lesions);
vii) Hysteroscopy;
viii) Hysterosalpingogram;
ix) Examination under anesthesia;
x) Endometrial ablation;
xi) Cauterization; and
xii) Vulvar/vaginal suture and repair (this does not include vaginal hysterectomy, cystocele or rectocele repairs).

e) Dr. Singh shall provide the College with 14 days notice if she intends to commence performing of any one of the Permitted Procedures itemized in paragraph 3(d) above, under general anaesthesia. Dr. Singh shall agree to undergo an assessment(s) of such practice(s) by an assessor appointed by the College of Physicians and Surgeons of Ontario within one year of commencing any Permitted Procedure under general anaesthesia, at the College's expense; and

f) In the event that an urgent or emergency situation arises while Dr. Singh is performing any of the Permitted Procedures, Dr. Singh shall immediately refer and transfer the care of the patient to the obstetrician/gynaecologist on call.

4. Dr. Singh pay costs to the College in the amount of $3,650.00 within (60) days from the date of this Order.

At the conclusion of the hearing, Dr. Singh waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.