Professional Misconduct (Med10/151P)

Charge

The Professional Conduct Committee (PCC) brought three charges against Dr Sajan Singh Bhatia (the Doctor). The charges are detailed below:

1. The Doctor practised medicine between 22 December 2008 and 15 July 2009 while not holding a current Annual Practising Certificate (APC).

2. Between 13 February 2007 and 15 July 2009 the Doctor failed to comply with conditions imposed on his scope of practice by the Health Practitioners Disciplinary Tribunal (HPDT) in that he:
   a. Failed to attend a peer review group meeting at least once every 6 weeks;
   b. Failed to confirm his attendance at peer review group meetings to the Medical Council;
   c. Failed to undergo a clinical audit every 3 months;
   d. Failed to provide the results of clinical audits to the Medical Council;
   e. Failed to work under supervision as required.

3. Between 7 December 2008 and 18 June 2009 the Doctor failed to provide a patient with the appropriate standard of medical care or treatment including:
   a. Failing to arrange and administer BCG treatment;
   b. Failing to undertake upper urinary tract imaging;
   c. Failing to consider the possibility of cancer recurrence
   d. Failed to appropriately or adequately communicate with a patient.
   e. Failed to arrange or put into place alternate care arrangements for a patient.

The PCC charged that each charge separately amounted to professional misconduct.

Findings

The Tribunal found the Doctor guilty of professional misconduct for each charge.

Background

At the time these charges were brought, the Doctor was a practising urologist in Invercargill. The Doctor did not attend the hearing and was not represented. The Tribunal understood that the Doctor resided in South Australia at the time of the hearing.
**Charge 1**—In September 2007 the Southern Cross Hospital in Invercargill changed its credentialing policy and the Doctor was asked for his credentialing papers. The Doctor offered a variety of excuses each time he was asked for them, until eventually in February 2009 he supplied the completed papers but not his APC. Subsequently, the hospital followed up with the Medical Council as the Doctor’s name no longer appeared on the Medical Register.

On 24 June 2009 the Doctor was advised by letter from the Southern Cross Hospital that he could no longer operate there. The hospital confirmed that since 10 December 2008 the Doctor had carried out 13 operations on surgical lists at the Southern Cross Hospital.

**Charge 2**—The Registrar of the New Zealand Medical Council confirmed that conditions as ordered at a previous HPDT hearing were placed on the Doctor’s practice from 2007.

In November 2008 the Medical Council advised the Doctor it would not renew his APC because he had not attended peer review meetings and that he had two audits by educational supervisors but not a clinical audit as required by the HPDT.

**Charge 3**—The Patient had suffered from bladder cancer since 2000. In January 2009 she discussed with the Doctor instituting another form of treatment called BCG which he said he would organise for her. She said he never organised that treatment.

Prior to a regular check up in May 2009, the Patient went to the Doctor’s office complaining of frequent and painful urination and that her urine was claret coloured. The Doctor prescribed her antibiotics, medication to stop her urinating so frequently and medication to help her sleep. The Patient took the medication but was not better and later admitted to the A & E and diagnosed with kidney stones. Another urologist, at the hospital diagnosed that she had a tumour on her left kidney.

### Reasons for Findings

**Charge 1**—This charge related to the Doctor practising medicine while not holding a current practising certificate under section 100 (1)(d). The Tribunal considered that section 100 (1)(d) is a strict liability offence in that the Tribunal simply needed to find that at the relevant time the Doctor did not have a practising certificate and that he was still practising. The Tribunal found the section did not require the Tribunal to undertake an analysis of whether the APC was withdrawn for reasons that it accepted as valid.

The criteria for discipline as set out in section 100 (1)(d) states that the practitioner has practised while not holding a current practising certificate. The Tribunal found the use of the words “not holding” suggested that it is the fact of the being without an APC which constituted the offence, rather than the “knowing” of the absence of the APC.

However, the Tribunal then went onto consider that even if its interpretation was incorrect, and it was necessary for the Tribunal to consider if the Doctor knew he was practising without an APC; it did not accept the Doctor’s version of events and his claim that he had no knowledge until June 2009. The Tribunal found on the balance of probabilities that the Doctor was aware he had no practising certificate. The Tribunal considered the facts suggested that the Doctor was aware he had no practising certificate. The Tribunal considered the onus must be on him to ensure that the APC was actually issued.
The Tribunal was satisfied that the charge was proved under section 100 (1)(d) and warranted the imposition of a disciplinary sanction.

**Charge 2**—The conditions imposed by the Medical Council were those conditions imposed upon the Doctor at a previous HPDT hearing and by the Medical Council after the competence assessment. Five conditions were imposed as set out above under Charge 2.

The Tribunal considered it must determine whether, objectively, the Doctor did comply with the conditions upon his practice. It found that the Doctor adopted a very laconic attitude to the compliance with the conditions and the education programme and did not trouble himself to clarify whether or not the supervision was clinical supervision, clinical audit or educational support (or all three).

The Doctor’s wife was ill at the time and subsequently died. This undeniably would have distracted the Doctor from his practice and the conditions on his practice. However, the Tribunal was left with a sense of frustration in trying to determine whether or not the Doctor simply did not comply with the conditions or was muddled by the apparent overlap between the two and his belief that Dr Davidson and Dr English were providing all the clinical oversight/supervision/education that he needed. He obviously understood that he had separate peer review obligations as he has tried to involve Dr Ngaei in his peer review team.

The Tribunal found that the Doctor did not take responsibility to resolve the issues and did not comply with the conditions imposed on his practice. The Tribunal found the charge established and it warranted disciplinary sanction.

**Charge 3**—The Tribunal, when considering particular (a), found that the Doctor failed to arrange and administer the BCG treatment for his Patient. The Tribunal noted there was no evidence that it would have prevented her cancer. Although the Patient subsequently had the treatment and benefited from it, the Tribunal did not find that the Doctor’s oversight in failing to undertake the procedure was sufficiently serious on its own to warrant disciplinary sanction.

The Tribunal found the Doctor failed to undertake upper urinary tract imaging for the Patient after initial measures to address her symptoms failed and that particular (b) did warrant disciplinary sanction.

The Tribunal found that on the facts, the Doctor did consider cancer recurrence and therefore particular(c) was not established. The Tribunal found that although the Doctor’s responses to the Patient were probably clinically inadequate, particular (d) related only to the communication, and the Tribunal did not believe his communication skills at that time were such that he should be found guilty of professional misconduct.

The Tribunal also did not find particular (e) proved. Dr Bhatia’s relationship with the Patient had ended by the time he finally acknowledged he did not have a practising certificate. He continued to treat her after 18 December 2009 and while he should not have done so, the Tribunal considered that charge 1 addressed this point.

In respect of charge 3 overall the Tribunal found particular (b) established and warranted disciplinary sanction. Particular (a) was proved but not sufficient on its own to warrant disciplinary sanction. Particulars (c), (d) and (e) were not proved

The Tribunal found that when taken together, established particulars (a) and (b) were sufficiently serious as to warrant disciplinary sanction.
Penalty

The Doctor was censured and his registration was cancelled. He was ordered to pay 25% of the costs. The Tribunal expressed its strong disapproval for the Doctor’s conduct.

The Tribunal directed that a copy of the decision be published on the Tribunal’s website. The Tribunal further directed that a notice stating the effect of the decision be published in the New Zealand Medical Journal.

The full decisions relating to the case can be found on the Tribunal web site at www.hpdtnz.org.nz
Reference No: Med10/151P.