

**IN THE NEW
SOUTH WALES
MEDICAL TRIBUNAL**

No 774 of 2005

THE MEDICAL PRACTICE ACT 1992

IN RE

Suman SOOD

DEPUTY CHAIRPERSON

His Honour Judge Walmsley SC

MEMBERS

Dr Victoria Sutton

Ms Jennifer Houen

Dr John Quilter

HEARING DATES

11-15 September 2006

19 September 2006

DATE OF DETERMINATION

6 October 2006

Pursuant to Clause 6 of Schedule 2 to the *Medical Practice Act 1992* the Tribunal has made a Non-Publication order in respect of the names and addresses of patients.

ORDERS

1. The respondent is deregistered.
2. The respondent is not to apply for re-registration as a medical practitioner for ten years.

1. The name of the former medical practitioner (the respondent), at her request, was removed from the register of names kept under the **Medical Practice Act** (The Act) on 31st August 2006. The questions for the Tribunal are what findings should be made and whether the Tribunal should order she be deregistered. The effect of ordering the deregistration of someone whose name is no longer on the Register, is that he or she cannot apply for registration. Instead, he or she must, in order to be re-registered, seek a review of the deregistration order, under Division 3 of Part 6 of the Act. This Tribunal may, if persuaded that it is appropriate, order that no such application be made before a certain period of time has elapsed. The power to make such orders is in section 64 of the Act, whose terms are as follows:

“64 Tribunal can suspend or deregister in certain cases

(1) The Tribunal may by order suspend a person from practising medicine for a specified period or direct that a person be deregistered if the Tribunal is satisfied (when it finds on a complaint about the person):

(a) that the person is not competent to practise medicine, or

(b) that the person is guilty of professional misconduct, or

(c) that the person has been convicted of or made the subject of a criminal finding for an offence, either in or outside New South Wales, and the circumstances of the offence render the person unfit in the public interest to practise medicine, or

(d) that the person is not of good character.

(2) An order that a person be deregistered is an order that the person’s name be removed from the Register or (if the person has already ceased to be registered) that the person not be re-registered.

(3) An order may also provide that an application for review of the order under Division 3 of Part 6 may not be made until after a specified time.”

2. The foundation for this application, by the Health Care Complaints Commission (HCCC), is the Amended Complaint filed by leave on 11th September 2006, the first day of the hearing. It was an amended version of a complaint first filed on 18th January 2005. Omitting formal parts, the HCCC complains as follows:

“that **Dr Suman Sood, Medical Practitioner**, of PO Box 150A of South Strathfield NSW 2136 in the State of New South Wales (“the practitioner”) being a medical practitioner registered under the Act:

Complaint 1

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that on 7 November 1998 the practitioner demonstrated a lack of adequate knowledge, skill, judgement and/or care in the management and/or treatment of LK (“the patient”).

Particulars of Complaint 1

The practitioner was working as a general practitioner at premises known as the Australian Women’s Health Clinic situated at 41 Court Road Fairfield. There she undertook a termination of a twin pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care and/or contravened provisions of the **Medical Practice Regulation** 1998 in the following respects:

- (a) She performed the termination of the patient’s pregnancy in the said clinic when doing so exposed her to an unnecessary risk of injury;
- (b) She undertook the termination when she had insufficient skill and/or experience to do so;
- (c) The clinic lacked the appropriate facilities and/or equipment to safely conduct the procedure;
- (d) She failed to warn the patient adequately or at all that there was a risk that her uterus would be perforated and of the potential consequences of having a perforated uterus;
- (d) She failed to take adequate precautions to minimise the risk of uterine perforation;
- (e) She directed the use of an inappropriate dilating agent, viz. Misoprostol, thereby unnecessarily increasing the risk of trauma to the patient’s cervix and uterus, including perforating the uterus;
- (f) She used the drug Misoprostol in an inappropriate manner in that she did not allow sufficient time for it to take effect before commencing the procedure;
- (g) She failed to document the administration of the drug Misoprostol pre-operatively;
- (h) She continued the surgical procedure inappropriately when she was aware or should have been aware that the uterus had been perforated;
- (i) She failed to appreciate in a timely manner that she had perforated the patient’s uterus;
- (j) She failed to provide appropriate post-operative care in that she:
 - iv) failed to call an ambulance as soon as she was aware that she had damaged blood vessels;
 - v) did not accompany the patient to hospital or arrange for another doctor to do so despite the fact that she had recently been given anaesthetic agents, had a perforated uterus and was in a semi-conscious state;
- (k) She failed to ensure that there was proper infection control throughout the period in which the patient was present at the clinic;
- (l) She failed to pay due respect to the patient’s right to privacy;
- (m) She referred the patient to Westmead Hospital and directed the ambulance officer to take her there although it was not the nearest hospital with

- suitable operating facilities, thereby unnecessarily endangering the patient's welfare;
- (n) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details required by Clause 13 and Schedule 2 of the **Medical Practice Regulation 1998**.

Complaint 2

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that on 6 April 2001 the practitioner demonstrated a lack of adequate knowledge, skill, judgement and/or care in the management and/or treatment of LH ("the patient").

Particulars of Complaint 2

The practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic at Fairfield. There she performed the termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care and/or improper or unethical conduct in the following respects:

- (a) The patient was left unattended in recovery after the procedure;
- (b) The patient was attended by staff who were not adequately qualified for the job;
- (c) She did not provide for or arrange for adequate follow-up care;
- (d) She provided the patient with a discharge letter which stated that the procedure was "complete and uneventful". This was misleading, inaccurate and/or inadequate;
- (e) She breached conditions imposed on her registration by the NSW Medical Board in that she did not have a registered nurse in the same room as the patient post-operatively for a period of at least one hour, although intravenous sedation had been used.

Complaint 3

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that on 14 December 2001 and 18 December 2001 the practitioner demonstrated a lack of adequate knowledge, skill, judgement and/or care in the management and/or treatment of ND ("the patient") and/or contravened provisions of the **Medical Practice Regulation 1998**.

Particulars of Complaint 3

The practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic at Fairfield. She saw the patient on 14 December 2001 and 18 December 2001. On 18 December 2001, she performed a termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care in the following respects:

14 December 2001

- (a) She sought and obtained consent from the patient to terminate the pregnancy before confirming the gestational age by ultrasound (or otherwise);

18 December 2001

- (b) She failed to document the administration of a drug to prepare the cervix for the procedure;
- (c) She did not have in-house ultrasound available although she was performing a termination of pregnancy beyond the first trimester;
- (d) She failed to ensure that the patient had adequate intravenous access in situ to enable fluids to be given before the patient was transferred to ultrasound facilities and/or to hospital;
- (e) She transported the patient to hospital by car;
- (f) She unreasonably delayed transferring the patient to hospital;

14 December 2001 and 18 December 2001

- (g) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details required by Clause 13 and Schedule 2 of the **Medical Practice Regulation 1998**

Complaint 4

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in May 2002 in that the practitioner demonstrated a lack of adequate knowledge, skill, judgement and/or care and/or contravened provisions of the **Medical Practice Regulation 1998** in her management and treatment of LT (“the patient”).

Particulars of Complaint 4

The practitioner was working as a general practitioner at premises known as the Australian Women’s Health Clinic at Fairfield. There she performed a termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care in the following respects:

1. On or about 18 May 2002 she consulted with the patient and:
 - (a) She agreed to perform a termination of pregnancy for the patient when the foetus was more than 20 weeks gestation and
 - i) She was insufficiently experienced in the performance of late second trimester terminations;
 - ii) The Clinic lacked the appropriate facilities, staffing and equipment to safely conduct late second trimester terminations;
 - iii) She failed to adequately assess the risks involved in proceeding with the termination;
 - iv) The proposed method of termination was unsafe;
 - v) She did not obtain informed consent.
 - (b) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details

required by Clause 13 and Schedule 2 of the **Medical Practice Regulation** 1998

- (c) She failed to provide adequate or appropriate counselling to the patient in relation to the termination of the pregnancy.
- 2. On or about 20 May 2002 she administered a drug, *viz.* Misoprostol, to the patient to prepare the cervix for termination or to induce labour and
 - i) She permitted her to leave the clinic after the drug had been administered;
 - ii) She did not monitor or make any arrangements to monitor the patient after the drug had been administered;
 - iii) She failed to provide the patient with adequate advice and information about the nature of the medication including its effects and side effects and, in particular, she failed to warn her of the possibility that she might go into labour.
 - iv) She failed to adequately assess, advise and manage the patient when informed that she was experiencing abdominal pains after taking the drug.

Complaint 5

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that on 20 May 2002 she engaged in improper and unethical conduct in that she charged a patient, LT, a fee for the medication she dispensed to her that was greatly in excess of the likely cost to the patient had she purchased the medication from a retail pharmacy and/or in excess of its cost to the practitioner, contrary to the provisions of s 28 of the **Pharmacy Act** 1964.

Complaint 6

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that she engaged in improper and unethical conduct in connection with an inquiry into the practitioner's conduct undertaken by delegates of the NSW Medical Board on 12 June 2002 ("the s 66 inquiry").

Particulars of Complaint 6

- (a) The practitioner provided the s 66 inquiry with an account of her care and treatment of LT ("the patient") that was deliberately false and/or misleading.
- (b) The practitioner constructed a note of her consultation with the patient that was deliberately false and/or misleading and sought to rely upon that note at the s 66 inquiry.

Complaint 7

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that the practitioner has demonstrated a lack of adequate knowledge, skill, judgement and/or care in the practice of medicine and/or engaged in improper and unethical conduct in her management and treatment of TJ ("the patient").

Particulars of Complaint 7

In June 2002 the practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic ("the Clinic") at Fairfield where the patient consulted her.

- (a) She provided medical services to the patient when the Medical Board had made a decision suspending her from practice, when she knew or should have known that it was improper or unethical for her to do so.
- (b) She informed the patient she had cancer when the patient did not and when the histopathology report provided no support for such a diagnosis.
- (c) She provided the patient with a discharge letter that stated that she had undergone a termination of pregnancy when she had not.
- (d) She submitted or authorised or permitted staff employed in the Clinic to submit a claim for payment of Medicare benefits to the Health Insurance Commission for performance of a termination of pregnancy on TJ on 15 June 2002 when no such service had been provided.
- (e) She permitted the patient to leave the clinic unaccompanied in a taxi after undergoing a dilatation and curettage under sedation on 15 June 2002.

Complaint 8

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that between 12 June and 3 July 2002 the practitioner engaged in improper or unethical conduct by practising or, alternatively, holding herself out as a medical practitioner when she was not entitled to do so in contravention of s 105 of the **Medical Practice Act** 1992 or, alternatively, when she knew that the Medical Board had made a decision to suspend her from practice and when that decision had neither been stayed nor set aside

Particulars of Complaint 8

- (a) The Medical Board made a decision suspending the practitioner from practice following the s 66 inquiry on 12 June 2002.
- (b) That decision was stayed on 3 July 2002.
- (c) Between 12 June 2002 and 3 July 2002 she practiced, or alternatively held herself out, as a medical practitioner when she was not entitled to do so, or alternatively when she knew or should have known that it was improper or unethical for her to do so.

Complaint 9

Is not of good character.

Particulars of Complaint 9

- (a) The practitioner constructed a note of her consultation with patient LT on 20 May 2002 that, to her knowledge, was false and/or misleading;
- (b) She deliberately misled the Medical Board by providing to the s 66 inquiry on 12 June 2002 an account of her care and treatment of the patient LT that, to her knowledge, was false and/or misleading;
- (c) Between 12 June and 3 July 2002 she practised as a medical practitioner despite an order of the Medical Board suspending her from practice and in contravention of s 105 of the Act;

- (d) Between 12 June and 3 July 2002 she held herself out as a medical practitioner contrary to s 105 of the Act;
- (e) She made notes for patient LH that contained false and/or misleading information.
- (f) She provided patient LH with a discharge letter that contained false and/or misleading information about the procedure she had conducted;
- (g) She misled the District Court about her character, reputation and professional standing in the matter of *R v Suman Sood* (04/11/1102);
- (h) She breached undertakings she gave to the Federal Magistrate's Court in bankruptcy proceedings;
- (i) The practitioner is a dishonest person.

Complaint 10

On 23 August 2006 the practitioner was convicted of the charge that on 20 May 2002 at Fairfield in the State of New South Wales she did unlawfully administer to a woman a drug with intent to procure her miscarriage.

Complaint 11

On 23 August 2006 the practitioner was convicted of the charge that on 20 May 2002 at Fairfield in the State of New South Wales she did unlawfully cause to be taken by a woman a drug with intent to procure her miscarriage.”

3. In support of the complaint the HCCC tendered 6 volumes of material, including a large part of the transcripts of criminal proceedings recently concluded, in which the respondent was convicted of two counts, contrary to the provisions of section 83 **Crimes Act 1900**. In short, those offences were ‘unlawfully’ administering a drug to a woman with intent to procure her miscarriage, and ‘unlawfully’ causing a drug to be taken by a woman with intent to procure her miscarriage. The HCCC tendered some additional material during the course of the hearing.
4. On the first day of the hearing, the respondent was represented by solicitors, and by both senior and junior counsel. However, once senior counsel for the HCCC had opened the case, and argument had concluded about some summonses the HCCC had served, her legal representatives withdrew from further participation in the hearing. Mr Boulton SC, who appeared with Mr M Fordham for the respondent, told the Tribunal his client only now wanted to be heard on questions of costs. So for the remainder of the hearing, only the HCCC was represented before the Tribunal. The Tribunal is satisfied however that the respondent’s representatives were provided with copies of documents as they were tendered, if they had not previously been served.

5. On 8th September 2006 the respondent's solicitors had written to the registrar of the Tribunal saying among other things:

“As you know, on 30 August 2006 my client requested that her name be removed from the Register of Medical Practitioners effective from 31 August. The NSW Medical Board has confirmed that my client's name has now been removed. My client has also informed the Medical Board that she will not apply for registration in New South Wales in the future.

After careful consideration, my client will consent to Orders that she is guilty of unsatisfactory professional conduct and professional misconduct within the meaning of section 36 and section 37 of the **Medical Practice Act** 1992. My client has signed at the foot of this letter.

The decision not to contest the hearing and to consent to these Orders reflects my client's concern for her former patients. In addition, my client has accepted counsel's advice that it is inappropriate for her to comment on the particulars in the Complaint whilst the criminal proceedings are continuing. This is particularly so given that Section 128 of the **Evidence Act** does not apply to the Medical Tribunal proceedings and the limited protection afforded to my client by Section 122 of the Medical Practice Act.

In these circumstances it is important that the Tribunal proceedings be conducted in a pragmatic and focused manner. Thus, I advise that my client:

- Consents to Orders being made that she is guilty of unsatisfactory professional conduct and professional misconduct within the meaning of section 36 and section 37 of the **Medical Practice Act** 1992;
- Does not require any witnesses to attend for cross examination;
- Will not object to any of the material which you seek to tender; and
- Respectfully suggests that in the interests of the patients that the determination be made on the papers.”

6. Ms A. Katzmann SC, who with Ms K. Sant appeared for the HCCC, referred the Tribunal to *New South Wales Bar Association v Cummins* (2002) 52 NSWLR 279 at [24] and [25] where Spigelman CJ said:

“24 In a case such as the present, where there is no substantive contest as to the ultimate operative order which the Court should make, it is of particular significance that the Court should record its findings. As Kirby P said in *Prothonotary of the Supreme Court of New South Wales v Ritchard* (Court of Appeal, 31 July 1987, unreported) at 4:

"For the ordinary case, the Court has adopted the principle that, normally, it will state its findings on the totality of the matters put forward as constituting professional misconduct, so that these will be

available to be dealt with, should they ever become relevant to any future application by the former solicitor for readmission to practise."

His Honour referred to *Law Society of New South Wales v Seymour* (Court of Appeal, 14 April 1982, unreported) and *Bridges v Law Society of New South Wales* [1983] 2 NSWLR 361 at 362.

25 Kirby P went on to say in *Prothonotary v Ritchard* (at 4–5):

"... Although the opinion must be reached that the offences warrant at the time of order permanent removal, the removal of a solicitor from the Roll is not necessarily intended to be permanent in fact. See Ex parte Evatt; Re New South Wales Bar Association (1969) 71 SR (NSW) 153 at 157; 90 WN (Pt 2) (NSW) 50 at 32. People can redeem themselves and demonstrate it by later conduct as a number of cases in this State, both of solicitors and barristers, show. Because that opinion may give encouragement, in due course of time, to an application to be readmitted, it is all the more important that the unfortunate saga of the opponent's misdeeds should be collected and found by the Court." "

7. Thus, although the respondent does not contest the matters in the amended complaint, the Tribunal must in making its findings consider, and set out in some detail, the factual background. Ultimately the Tribunal took Mr Boulton SC to agree this was the approach the Tribunal should take.

Respondent's Background

8. Ms Sood was born in India on 23rd September 1949, and is aged 57. In 1971 she graduated with the degrees of MB and BS from Punjab University in New Delhi. In 1973 she obtained a Diploma of Gynaecology and Obstetrics from that university. She came to Australia in 1991, first settling in Adelaide. On arrival in Adelaide she obtained work as Senior RMO, Queen Victoria Hospital, Adelaide. She was then Senior RMO in the Department of Paediatrics at Modbury Hospital, Adelaide, from December 1991 to January 1992. From February 1992 to August 1992 she had a position as Registrar in Obstetrics and Gynaecology, Maryborough Base Hospital, Maryborough in Queensland, although worked there only for two weeks. She began general practice in Australia at Argyle St Camden NSW in November 1992. Between that time and 2004 she also practised in Rosemeadow, Eagle Vale, Fairfield and Liverpool.

9. A doctor who qualifies in medicine in India before practising in Australia usually must pass an examination set and marked by the Australian Medical Council. The respondent sat for and passed that examination on her first attempt, in 1992. She was, shortly after, registered to practice in NSW. From shortly after the time she commenced her practice at Camden, until 2004, she practised extensively in the area of women's health with a particular emphasis on terminations of pregnancy.

Standard of Proof

10. It is important to recognize that, unlike a criminal case, where an offence must be proved beyond reasonable doubt, in a disciplinary tribunal such as this one, there is a lesser standard of proof, namely the balance of probabilities. Though it is said that the Tribunal applies the *Briginshaw* test, this does not mean a higher standard than balance of probabilities. Rather, the test requires the Tribunal to have due regard to the issues so that "[T]he seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal": *Briginshaw v Briginshaw* (1938) 60 CLR @ 362 (Dixon J). For a recent case where the balance of probabilities was considered, see *Gianoutsos v Glykis* [2006] NSWCCA 137 @ [47]-[51]: "[W]hat is required is that when loading the scales appropriate weight is given to the matters to which Dixon J referred": McClellan CJ at CL (Sully, Hislop JJ agreeing).

Unanswered Allegations

11. The HCCC between 11th November 2003 and 4th November 2004 sent letters to the respondent setting out the substance of the complaints 1-8 inclusive, which the Tribunal has had to consider: see exhibits AE – AJ. She did not reply to them. Thus those allegations against her have gone unanswered both in that correspondence, and during the course of the hearing. The Tribunal's attention was drawn to *Bowen-James v Walton and Ors* (unreported C/A, 5/8/91) where at p. 14 the Court of Appeal (Samuels, Meagher and Handley JJA) said:

“[I]f a medical practitioner fails to answer by giving his or her account of the matters charged, there can be no complaint if the Tribunal draws the unfavourable evidentiary inference which absence from the witness box commonly attracts.”

Unsatisfactory Professional Conduct

12. The HCCC has submitted that, quite apart from the respondent’s own concession that we should find her conduct amounts to unsatisfactory professional conduct and professional misconduct, when we consider the facts proved, not only would we make those findings, but we would consider her conduct of such gravity, we would order her deregistration.
13. ‘Unsatisfactory professional conduct’ is defined in s 36 of the Act. Its meaning altered with the amendments introduced by the **Health Registration Legislation Amendment Act 2004**. However, the new definition does not apply here because the complaint was referred to the Tribunal before the amendment commenced on 1 March 2005.¹
14. ‘Unsatisfactory professional conduct’ includes:
- (a) Any conduct that demonstrates a lack of adequate knowledge, skill, judgment or care, by the practitioner in the practice of medicine.
 - (b) Any contravention by the practitioner (whether by act or omission) of a provision of the Act or the regulations.
 - (c) Any contravention by the practitioner (whether by act or omission) of a condition to which his or her registration is subject.
 - (m) Any improper or unethical conduct.

¹ See Schedule 4 Part 4 Clause 11 of the **Health Care Complaints Act 1993** which provides that an amendment made to a health registration Act (including the **Medical Practice Act**) by the **Health Registration Legislation Amendment Act 2004** does not apply to a complaint that was referred to a Committee or Tribunal under the health registration Act before the commencement of the amendment or to a complaint where an inquiry into it had commenced before the commencement of the amendment

15. Neither “improper” nor “unethical” is defined in the Act. Black’s *Law Dictionary* defines “improper” as “1. incorrect, unsuitable or irregular; 2. fraudulent or otherwise wrongful” and “unethical” as “not in conformity with moral norms or standards of professional conduct”. This accords with the ordinary English meanings of the words. The *Macquarie Dictionary* defines “improper” relevantly as not in accordance with propriety of behaviour, manners etc. or abnormal or irregular, and “unethical” as “contrary to moral precept; immoral; 2. in contravention of some code of professional conduct.”
16. While the Tribunal must take into account medical opinion about whether a practitioner’s conduct has or has not met the required standard, it is for the Tribunal to make a decision about whether the conduct satisfies the statutory test for unsatisfactory professional conduct.

Professional Misconduct

17. “Professional misconduct” is defined in s 37 of the Act to mean “unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner’s name from the Register”. Thus, whether unsatisfactory professional conduct, if proved, amounts to professional misconduct, is a question of degree and will depend on the level of criticism mounted by experts of the doctor’s conduct. In *Pillai v Messiter* (No. 2) (1989) 16 NSWLR 197 at 200-201 Kirby P said:

“Departures from elementary and generally accepted standards, of which a medical practitioner could scarcely be heard to say that he or she was ignorant, could amount to such professional misconduct: ... But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes **a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner..**

...

In giving meaning to the phrase ‘misconduct in a professional respect’ in the context within which it appears, it must be kept in mind that the consequence of an affirmative finding is drastic for the practitioner. And the purpose of providing such a drastic consequence is not punishment of the practitioner as such but protection of the public. **The public needs to be protected from delinquents and wrong-doers within professions. It**

also needs to be protected from seriously incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements. Such people should be removed from the register or from the relevant roll of practitioners, at least until they can demonstrate that their disqualifying imperfections have been removed.”

18. Although, strictly speaking, the statutory definition of professional misconduct makes it unnecessary to turn to common law definitions, the common law approach may give content to the statutory meaning (*cf. Prothonotary of the Supreme Court of New South Wales v McCaffery* [2004] NSWCA 470 at [46].) At common law, before a doctor’s name was removed from the Register, proof was needed of “conduct which would reasonably be regarded as disgraceful or dishonourable” by one’s peers: *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750 and other authorities collected by Spigelman CJ (with whom Mason P and Handley JA agreed) in *New South Wales Bar Association v Cummins* (2001) 52 NSWLR 279 at [36]ff. It is inconceivable that a tribunal would consider removal from the register or suspension to be justified in any case where there was no evidence of disapproval by any peer. Indeed, as the Tribunal remarked in *Furey* (23 December 2002), it has regarded as a prerequisite for a finding of professional misconduct, a finding that the practitioner has conducted himself or herself in a way that attracts the severe or strong disapproval of “peers of reputable standing” or, at least, that his or her conduct is “so obviously wrong that a peer who did not strongly disapprove would not be thinking reasonably”: *Davis* (2 December 1994).

19. It would be wrong to superimpose on the legislation a requirement that the conduct be disgraceful or dishonourable before a finding of professional misconduct could be made. But in any case, reckless indifference or gross negligence in a professional respect would be regarded as disgraceful and dishonourable conduct by professional brethren of good repute and competency: *Basser v Medical Board of Victoria* [1981] VR 953.

The Complaints

20. In large part, the complaints about the respondent concern her treatment of five patients. They relate to her competence, her ethics and her honesty. As we have noted, throughout most of her time in general practice in NSW the respondent worked in or conducted clinics for women patients, with an emphasis on termination of pregnancy. Terminations of pregnancy are not unlawful in NSW if performed by a medical practitioner who honestly believes on reasonable grounds the termination is necessary to preserve the patient from serious danger to her life or physical or mental health which continuation of the pregnancy would entail: *R v Wald* [1971] 3 NSWDCR 25; *CES v Superclinics (Aust) Pty Ltd* (1995) 38 NSWLR 47. Although most terminations of pregnancy occur in the early stage, or first trimester (up to 12 weeks gestation), a termination may be lawful if performed well beyond that stage, including beyond 20 weeks gestation. However the procedure is simpler and less potentially harmful for the mother in the early stages, so the test for ‘lawfulness’ becomes harder to satisfy as gestation age increases.

21. All but one of the five patients who are the subject of the complaint saw the respondent for a termination of pregnancy. All four experienced significant and unexpected sequelae. The fifth patient saw her for a dilatation and curettage and was given an incorrect diagnosis and incorrectly made to believe for a time she had a life threatening condition. All five cases are alleged to involve serious breaches of the respondent’s professional obligations. The Tribunal made an order on the first day of the hearing that the names and addresses of patients not be disclosed. The patients will be referred to by initials. The Tribunal considers that in the case of people who accompanied the patients to see the respondent, their names should not be published either. So the names of such witnesses are not used. They are also given initials.

22. We shall now deal with the complaints one by one, and part by part.

Particulars of Complaint 1

The practitioner was working as a general practitioner at premises known as the Australian Women’s Health Clinic situated at 41 Court Road Fairfield. There she undertook a termination of a twin pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate

knowledge, skill, judgement and/or care and/or contravened provisions of the *Medical Practice Regulation 1998* in the following respects:

(a) She performed the termination of the patient's pregnancy in the said clinic when doing so exposed her to an unnecessary risk of injury;

23. LK already had two children when she became pregnant with twins. She suffered from a number of health problems and she and her partner decided she should have a termination of pregnancy. On 7th November 1998 she went with her partner's sister to the respondent's rooms at 41 Court Rd Fairfield. She had an ultrasound, showing a twin pregnancy of 15 weeks gestation. She saw the respondent. She spent some time with a counsellor. She was given some medication, was instructed to wait while it had effect, was taken to a room adjoining the waiting room, was anaesthetised, and underwent a procedure to terminate the pregnancy. The respondent performed the procedure. It consisted of a dilatation and curettage. It involved inserting instruments through the cervix, into the uterus, and removing uterine contents.
24. Unfortunately, while performing the termination, the respondent perforated the wall of her uterus. This complication is well recognized by specialists in the field of practice. If an instrument goes through the wall, it can cause considerable damage to nearby organs and blood vessels. So that, when a doctor realizes he or she has caused an instrument to perforate the uterus, it is important to stop the procedure. Depending on the size of the hole in the uterine wall, it may be necessary for the patient to have surgical repair. Treatment for the potential complications of a perforated uterus is not usually available in a clinic of a type where the respondent performed the procedure on LK.
25. Pregnancy terminations performed between 13 to 28 weeks of gestation are known as mid trimester procedures. By the time a foetus reaches this stage of development the wall of the uterus is more vascular, and, typically, softer, and easier to perforate with larger instruments.

26. A number of complaints made by the HCCC about the respondent's treatment of LK concern what it alleges are unsatisfactory aspects of the termination procedure, and what she did after the perforation occurred.
27. According to LK, whose evidence before the Tribunal was not contested, her first memory after she was given an anaesthetic was waking up at Westmead Hospital, where she learned that the procedure had gone wrong, that she had been taken to Westmead by ambulance, and had lost 11 units of blood. LK remained in intensive care at Westmead Hospital for some days, finally being discharged on 13th November 1998, followed by an admission for further recuperation to Campbelltown hospital on 17th November 1998. While at Westmead she had surgery to repair the perforation. She has been advised that by reason of the perforation, further births will need to be by caesarean section. So the consequences to her of the perforation were significant.
28. To see something of the background to the complaints, it is revealing to look at the background to her transfer to Westmead Hospital. Her friend Ms L, who accompanied her to the respondent's rooms, spoke to the respondent shortly after the perforation had occurred. She was given a brief description of it. An ultrasound may be used to locate a perforation, although it is a matter of controversy as to whether Ms Sood should have had an ultrasound performed before an ambulance was called for. There was an ultrasonographer working in the premises that day. Ms L says (though Ms Sood denies this) that Ms Sood told her that after the perforation, she had had to wait for the ultrasonographer to finish having a donut at a local coffee shop before an ultrasound could be taken. LK's friend was then permitted to see the patient. She later described the surgery as 'extremely dirty and unhygienic'. She saw LK 'with her legs apart and blood everywhere'.
29. She could see people walking through a 'back alley' beside the recovery room. She saw cockroaches coming in through the back door. She was shocked by what she saw, and started to vomit. Ms Sood told her her friend would get her money back.

30. Some time later the patient complained to the HCCC. She also sued for and recovered damages against Ms Sood in the District Court at Campbelltown. Some of the evidence in that case was tendered to the Tribunal.
31. When LK had her procedure at the respondent's rooms the respondent employed Dr Nicole Gastaldin to administer sedation and anaesthetics. Dr Gastaldin gave several statements to the HCCC. At that time she had had three years of experience working in termination of pregnancy clinics, and had performed several thousand terminations and administered a similar number of sedations, and general anaesthetics, for the procedure. She only worked with the respondent for a total of fourteen days between 9th October 1998 and 11th December 1998.
32. During the course of this procedure she saw the respondent on two occasions remove sponge forceps grasping what appeared to be a small piece of omentum, the respondent telling her a perforation had never happened to her before. Omentum refers to the fatty layer covering abdominal organs. So the appearance of omentum suggested the instrument had moved into the abdominal cavity. That is diagnostic of a perforation.
33. Dr Gastaldin told the respondent she thought the tissue had the appearance of omentum. The procedure was then stopped, an ultrasound confirming a perforation had occurred.
34. Dr Gastaldin ceased working with the respondent as she said she was 'not comfortable with the standard of practice there. I felt that it was not up to safety standards'. She regarded a pulse oximeter in a clinic such as this as 'requisite'. A pulse oximeter, apart from measuring the pulse, warns if the oxygen saturation level is too low. There was one present in Ms Sood's surgery when Dr Gastaldin worked there but it was not routinely used and its alarm did not work. It had been her experience, especially with a 14 or more week pregnancy, to do the procedure under ultrasound guidance. This helped ensure there were not retained products. However, she noted that terminations in this clinic were not done under ultrasound guidance. LK's was not done under ultrasound guidance. The ultrasound was only used after the emergency arose. Dr Gastaldin was extremely critical of the

respondent's methods and attitude. When she worked there, no registered nurses were employed. Theatre staff were untrained in emergency resuscitation techniques and sterilization. She observed theatre staff not comply with sterile techniques. She was not made aware of any emergency arrangements with local hospitals to admit patients in cases of emergency. She regarded as appropriate standards for terminations, those of the Abortion Providers Federation of Australia. The respondent's clinic in her view fell below those standards.

35. She did not regard the clinic as taking sufficient care to prevent patient to patient disease transmission. For example, the respondent told her she would use the same syringe on more than one patient if there was an unused quantity of medication left over from an earlier patient. She observed the recovery room bedding was not clean; vinyl sheets would be blood stained from one patient when another would be permitted to lie on them; pillow cases showed substantial saliva and lipstick stains, and were cleaned less often than weekly.

36. In clinics involved in this procedure, it is good practice to have available large bore cannulae so fluids can be restored quickly. There were no large bore cannulae kept on the respondent's premises and Dr Gastaldin would bring her own. She expressed concern about the system of transferring patients post-operatively, with a trolley being used that was 1-2 feet higher than the bed. She was critical of the lack of nursing assistance in monitoring patients, or in preparing and administering fluids and antibiotics.

37. Dr Gastaldin gave a description of the procedure as she observed it, which the respondent performed on LK.

“During the procedure, from my position at the anaesthetic patient's head of the table, I observed Dr Sood remove the sponge forceps which were grasping what appeared to be a small piece of omentum. She asked me my opinion, and I responded to the effect that it had the appearance of omentum. She re-introduced the sponge forceps, as I passed to the other side of the patient to introduce an 18G cannula to [LK's] antecubital fossa, and requested fluids and a giving set from the nurse. The cannula used for [LK] was one of several that I had brought in to the clinic that morning from my own stock. I had observed previously that no cannulae were present at the clinic, although smaller gauge butterfly sets were present.

Dr Sood again removed the sponge forceps grasping what appeared to be a small piece of omentum. Dr Sood made comment that a perforation had never happened to her before. The procedure was halted and the ultrasonographer was called to perform an ultrasound. I do not recall any delay in the arrival of the ultrasonographer.”

38. Dr Healy, a Melbourne practitioner with 22 years of experience, gave evidence in the damages claim, and that evidence, with additional opinion, was in evidence before us. She had undertaken 35,000 terminations although only did first trimester procedures. There were opinions in evidence from another highly experienced practitioner in the field of termination, Dr Philip Goldstone, (whose oral evidence the Tribunal had the benefit of) Dr Brian Peat, Director of Obstetrics, Women’s and Children’s Hospital, Adelaide, and Dr Brodie, the founding director of Australian Birth Control Services, a general practitioner, with 28 years experience of performing terminations. We shall return to aspects of the evidence of all of these.

39. The Tribunal had the benefit of statements from an ambulance officer who took LK to Westmead Hospital on 7th November 1998. Sharon Barlow, ambulance officer paramedic, said when she went to get LK she and her fellow officers were told to enter through a laneway. She observed refuse from nearby shops stacked in the lane. A double door opened from the lane straight into the recovery room. She described that room as ‘shabby and dark with poor lighting’. Across the door, leading to the rear lane, there was a half curtain on a rod, half way across the doorway, giving little privacy. She was told the perforation had occurred 20-30 minutes before her arrival. Although she was told the patient was to be taken to Westmead, she questioned that, as Fairfield and Liverpool Hospitals were much closer.

Was the patient exposed to an unnecessary risk of injury?

40. It is important that a clinic have proper equipment, and take adequate measures to avoid infection. Dr Healy ‘would severely disapprove if no cannulae were present’ at the clinic when the procedure was performed. She described equipment present as ‘inadequate’. Dr Goldstone said a more substantial intravenous cannula should have been used, given this was a second trimester termination and LK had a

history of hyperemesis. He said the clinic was 'ill equipped to cope with an operative emergency' if Ms Barlow's description was accurate. Accepting the accuracy of the descriptions of Dr Gastaldin and Ms Barlow, Dr Peat was also critical of the standard of equipment.

41. The Standards of Practice of the Abortion Providers Federation of Australia (which describes a second trimester as a pregnancy of duration 13-28 weeks from last menstrual period) incorporates the N.H.M.R.C guideline called 'Infection Control in the Health Care Setting'. At p.28 that guideline says "Injectable products in multi-dose vials should not be used except in particular cases". (None of those cases apply here).

42. The Tribunal accepts the evidence of LK and Ms L, Dr Gastaldin, Ms Barlow, Dr Healy, Dr Peat and Dr Goldstone, especially insofar as any of their evidence conflicts with that of the respondent. She has not contradicted, or attempted to, the evidence of the observations or description of her premises or equipment, made by Dr Gastaldin, Ms Barlow and Ms L.

43. The Tribunal finds Ms Sood performed the termination of the patient's pregnancy in the clinic when doing so exposed her to an unnecessary risk of injury.

(b) She undertook the termination when she had insufficient skill and/or experience to do so;

44. Second trimester terminations are associated with a higher rate of complications: Dr Goldstone.² Further, the evidence shows LK had, in 1990, undergone a radical diathermy. That is also a known risk factor for perforation.³ (LK said Ms Sood did not ask her for that part of her history. It is certainly not recorded, although her previous caesarean is).

45. Dr Peat said that to be competent to perform second trimester terminations of twins at 16 weeks requires specific training and a system of audit and review. He said women (such as LK) are at a significant risk of cervical and uterine trauma if

² Ex. E Tab 20 p. 1

³ Dr Healey Ex G Tab 3 T 13

excessive dilatation occurs, and this is more likely using the Misoprostal regime Ms Sood used to dilate the cervix.

46. There was evidence before the Tribunal in the form of the transcript of findings of an enquiry held on 8th June 1995 by the New South Wales Medical Board under s.66 (1) of the Act. At that enquiry Ms Sood is recorded as having said she only undertook first trimester terminations and would refer later term patients to another clinic. There was another enquiry under s.66 (1) on 12th June 2002. At that enquiry Ms Sood said she had commenced undertaking second trimester terminations in approximately 1994-5.
47. The HCCC submits that the only way the two statements can stand together is if she did not commence second trimester terminations until after June 1995. If that is so, given the way she conducted the procedure on this occasion, it is unlikely she had sufficient experience or skill to carry out second trimester terminations, it submitted.
48. The Tribunal sees Ms Sood's statements as consistent: suggesting she only began performing second trimester terminations after June 1995, a little over three years before she operated on LK. There is no evidence she had the training Dr Peat said one should have for conducting second trimester terminations. Nor is there any evidence her cases were ever audited and reviewed. Indeed, although her C.V. shows she attended a number of continuing education courses, none of them suggest they were associated with this field of endeavour. Dr Peat said that "to undertake a second trimester TOP without adequate training, ongoing experience including audit and case review, with an improper technique and in substandard premises would invite my severe disapproval".⁴
49. The Tribunal infers the respondent did have insufficient skill and experience for second trimester terminations.
50. The Tribunal finds this part of the complaint is proved.

⁴ Ex E Tab 21 p 3

(c)The clinic lacked the appropriate facilities and/or equipment to safely conduct the procedure;

51. The Tribunal has set out above in some detail, the state of the facilities and equipment, the views of those who commented on them and the fact that the Tribunal accepts those (other than Ms Sood) who have given evidence about those matters.

52. The Tribunal finds this part of the complaint proved.

(d) (where it first appears) She failed to warn the patient adequately or at all that there was a risk that her uterus would be perforated and of the potential consequences of having a perforated uterus;

53. This part of the complaint is not happily drafted. Senior Counsel for the HCCC invited the Tribunal to interpret ‘would’ as ‘could’, and that is the way we read it. Whether it be read as ‘would’ or ‘could’, we take the complaint to be that she was not warned of the possibility that her uterus might be perforated.

54. In the evidence she gave to the District Court, LK said she was not warned by Ms Sood her uterus might be perforated and was simply asked to sign a consent document. It is clear from her cross-examination that there was some discussion about the procedure. However, she denied being told the procedure might damage her organs, and said in any event she could not read properly when given the document. However she did agree she had not told Ms Sood she could not read. The document, which is in evidence, does not mention that perforation is a risk, though it does say ‘instrumental trauma’ is a possible complication.

55. Perforation of the uterus clearly is a significant risk. Dr Healy said she had a rate of one in 5000 cases. Dr Peat said it can be up to 1.4% if done (as here) without ultrasound guidance. The evidence establishes the consequences of perforation can be very significant. In LK’s case she required a laparotomy, ligation of blood vessels, repair of the uterine wall, bilateral iliac artery ligation and ligation of bleeders in left ovarian fossa.⁵

⁵ Ex E Tab 17 p. 21

56. At common law a medical practitioner has an obligation to a patient to inform him or her of the nature of an intended procedure. The choice by a patient to undergo surgery has no meaning unless made on the basis of relevant information and advice: *Rogers v Whitaker* (1992) 175 CLR 279 @ 489 (Mason CJ Brennan, Dawson, Toohey, McHugh JJ).

57. The Tribunal is satisfied LK was not given all relevant information and advice. In particular she was never warned her uterus might be perforated.

58. This part of the complaint is made out.

(d) (where it secondly appears) She failed to take adequate precautions to minimise the risk of uterine perforation;

59. There are steps which can be taken to reduce the risk of uterine perforation. One is the use of ultrasound guidance: Dr Peat Ex E Tab 2, p.2. Although Dr Peat concedes there are some very experienced operators who do not use it routinely so 'it is hard to too strongly disapprove' of Ms Sood for not doing so here. He quotes studies which show the perforation rate drops from 1.4% without, to 0.2% with, ultrasound guidance in second trimester terminations, however.

60. Dr Peat, from Dr Gastaldin's account of the procedure, concluded from the type of perforation here, that there was a 'lack of cervical preparation and an attempt to over-dilate the cervix by mechanical means'.

61. Dr Goldstone is critical of Ms Sood's use of the medication called Misoprostol for cervical preparation, given she had had a caesarean section. He said the preferable means of preparing the cervix was the insertion of a series of laminaria rods, with a request to the patient to return for the procedure on the next day. That involved a two stage procedure, as opposed to the one stage approach which Ms Sood used. He said if the one stage approach using Misoprostol were to be used LK should have had a far more extensive explanation than she in fact had, and that

given she had a history of a caesarean, the decision to use Misoprostol was erroneous – most practitioners would have used laminaria rods.

62. This part of the complaint is made out.

(e) She directed the use of an inappropriate dilating agent, viz. Misoprostol, thereby unnecessarily increasing the risk of trauma to the patient's cervix and uterus, including perforating the uterus;

63. The evidence on which the HCCC relies to establish this is under (d)(where it secondly appears) above. This part of the complaint is made out.

(f) She used the drug Misoprostol in an inappropriate manner in that she did not allow sufficient time for it to take effect before commencing the procedure;

64. Dr Goldstone said if Misoprostol were to be used there should have been sufficient time allowed between its administration and the procedure – a minimum of 1 ½ to 2 hours. LK's friend, Ms L, said LK had the medication at 10.30 – 10.45. Ms Sood's referral letter says the time was 10am and the procedure approximately 11.30am. The Tribunal prefers Ms L's evidence where it varies from that of Ms Sood. Ms Sood did not dispute her version before the Tribunal, and did not confirm her own. On other aspects of Ms L's evidence, such as the state of the procedure room, there is substantial harmony with the evidence of Ms Barlow. The Tribunal finds the Misoprostol was administered only about an hour before the procedure and that insufficient time was allowed to elapse before the procedure was performed. This part of the complaint is made out.

(g) She failed to document the administration of the drug Misoprostol pre-operatively;

65. Any medication given to a patient must be documented.⁶ But the only record produced by Ms Sood about the use of Misoprostol on LK was in her referral letter to Westmead Hospital. Her own records do not mention it. This part of the complaint is made out.

⁶ Dr Goldstone Ex E Tab 20 p.2.

(h) She continued the surgical procedure inappropriately when she was aware or should have been aware that the uterus had been perforated;

66. On this issue, as in all others, the Tribunal accepts Dr Gastaldin's evidence where it differs from that of Ms Sood. Our reasons include the very thorough descriptions given by Dr Gastaldin, the fact that her view about the clinic's shortcomings accord with those of experts retained by the HCCC, and Ms Sood's not contradicting her version before the Tribunal. Further, Dr Goldstone says the operative findings at Westmead Hospital are more consistent with the evidence of Dr Gastaldin than of Ms Sood.
67. It will be recalled that Dr Gastaldin saw Ms Sood twice remove sponge forceps, gripping what to her had the appearance of omentum. The fact that on the first occasion she withdrew what appeared to be omentum is diagnostic of a perforation. Indeed, Dr Healy called it 'incontrovertible proof'. Given the appearance of the tissue, Dr Healy would 'strongly disapprove' of her continuing with the procedure, and says she should have stopped it then. Dr Goldstone said most practitioners would halt the procedure immediately, although some may complete it under ultrasonic control. In his view, if the tissue was omental, it indicated a significant risk of injury to bowel or pelvic structures, and the termination should only have been completed under laparoscopic control in a hospital setting. Fortunately, such severe damage was not found by the surgeon at Westmead Hospital, but as the notes state, a pelvic haematoma needed to be evacuated, a significant number of blood vessels required ligation, and bilateral internal iliac artery (the major artery to the pelvis) ligation was required to achieve haemostasis.
68. Even if it were thought appropriate to pass an instrument into the uterus again, it should have been one which was much narrower than forceps such as a uterine sound, since the forceps could have caused more damage.⁷
69. The Tribunal is firmly of the view that after the first time she withdrew the tissue Dr Gastaldin thought was omentum, she should have ceased the procedure.

⁷ Dr Healy Ex G Tab 3 T 145.12

70. This part of the complaint is made out.

(i) She failed to appreciate in a timely manner that she had perforated the patient's uterus;

71. The evidence for this is in (h) above. For the same reasons as (h) is made out, so is (i).

(j) She failed to provide appropriate post-operative care in that she:
iv) failed to call an ambulance as soon as she was aware that she had damaged blood vessels;
v) did not accompany the patient to hospital or arrange for another doctor to do so despite the fact that she had recently been given anaesthetic agents, had a perforated uterus and was in a semi-conscious state;

72. The uterus was perforated at about 11.30am, according to the respondent's note at Ex E Tab 7. The ambulance was not called until 11.51am.⁸ The perforation was lateral, in the place where the major blood vessels were. The most important thing in those circumstances was to arrange transport to hospital so that resuscitation could be undertaken in a better equipped facility.⁹ Although Ms Sood had an ultrasound done first, this was unnecessary because the presence of the tissue which appeared to be omentum was diagnostic of perforation.¹⁰ The decision to delay calling an ambulance was described by Dr Healy as "appalling medical management".¹¹ She registered a severe degree of disapproval for this, and expected her colleagues would also disapprove.

73. It is not in dispute that Ms Sood did not accompany her in the ambulance. The ambulance officer however said she would not have felt confident having Ms Sood accompany her in the ambulance as she appeared to lack confidence herself and seemed not to know what to do. No expert witness has condemned her decision not to accompany the patient in the ambulance.

⁸ Ex E Tab 7

⁹ Dr Healy in Ex G Tab 3 T145/14-55

¹⁰ Dr Gastaldin Ex G Tab 2 [13]; Dr Healy Ex E Tab 18 p 5-6 and in Ex G Tab 3 at T145/45.

¹¹ Dr Healy exhibit AA [10]

74. The Tribunal finds established (j) (iv) but as to (j)(v) is not satisfied to the requisite degree of proof that Ms Sood should have accompanied the patient in the ambulance or have arranged for another doctor to do so.

(k) She failed to ensure that there was proper infection control throughout the period in which the patient was present at the clinic;

75. We have referred to the observations of lay witnesses about the close proximity of the clinic to garbage, and the presence of cockroaches, and of Dr Gastaldin as to multiple use of syringes, poor or no training of staff in infection control, the failure to clean vinyl sheets between patients, and the failure to change pillow slips.

76. This part of the complaint is made out.

(l) She failed to pay due respect to the patient's right to privacy;

77. We have referred to the evidence of a curtain across only half of a doorway sheltering patients from passersby in the adjacent lane. When the ambulance officers arrived they found LK not covered by a sheet but by paper towels.¹² Dr Healy considered it inappropriate for Ms L to be allowed in to see her "in a state of extremity".¹³

78. This part of the complaint is made out.

(m) She referred the patient to Westmead Hospital and directed the ambulance officer to take her there although it was not the nearest hospital with suitable operating facilities, thereby unnecessarily endangering the patient's welfare;

79. When the ambulance arrived LK's eyes were not opening, she was orientated but had no motor response, registering a score of 7 on the Glasgow coma scale,¹⁴ probably reflecting the fact that she was still sedated.¹⁵ She was pale, cool to touch and, with increasing consciousness, complaining of pain.¹⁶

¹² Ex E Tab 14 p.2

¹³ Ex E Tab 18 p.4

¹⁴ See ambulance report Ex E Tab 14

¹⁵ Ibid.

¹⁶ Ibid.

80. Ms Barlow, the ambulance officer, said Ms Sood instructed her that the patient be taken to Westmead Hospital Accident and Emergency Department. She asked that she be permitted to transfer her to Fairfield Hospital, due to her condition, and its closer proximity, but Ms Sood did not agree that was where she should go, saying her presentation was due to the sedation she had received.
81. When LK arrived at the hospital she was pale and haemodynamically unstable.¹⁷ Dr Healy concluded she had become haemodynamically unstable en route.¹⁸ At the very least she was potentially unstable at the outset.¹⁹ Pre-operatively her blood pressure was 114/76, her pulse 76 and regular.²⁰ Ambulance records show that on their arrival at Ms Sood's clinic her pulse rate was 100 and systolic blood pressure 100. On her arrival at Westmead Hospital her pulse rate was 110 and her systolic blood pressure was 70. Thus her blood pressure was falling and her pulse rising. She subsequently required a large amount of blood and intravenous fluids. We conclude that before transfer she had the potential to become haemodynamically unstable.
82. Ms Sood made no notes at all of post operative observations. So there is no evidence (other than Ms Sood's post event assertions) she was aware of her actual haemodynamic state.²¹
83. Dr Healy said this transfer decision placed the patient in serious danger²² and demonstrated a lack of judgment on her part.²³ Even if her observations were stable, the patient was still at significant risk of haemodynamic collapse in the short term. There was no good reason to delay the transfer to hospital,²⁴ she said. She registered severe disapproval of the post operative management.

¹⁷ Ex E Tab 17

¹⁸ Dr Healy Ex E Tab 18 p 5

¹⁹ Dr Healy in Ex G Tab 3at T149/20-25

²⁰ See record at Ex E Tab 7

²¹ Ex E Tab 18

²² Dr Healy 23 October 1999 (Ex E Tab 18).

²³ Dr Healy Ex E Tab 18 [5]

²⁴ Dr Healy in Ex G Tab 3at T147/25-40

84. Dr Goldstone described the decision as ‘inappropriate’ but would not condemn it on the available information.²⁵

85. The Tribunal has some concern about whether this part of the complaint is established, given that Westmead Hospital is a major teaching hospital and more likely than Fairfield (which is not a teaching hospital) to have facilities to deal with this emergency. But the evidence put forward by the HCCC is uncontradicted.

86. The Tribunal thus accepts that evidence and finds this part of the complaint made out.

(n) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details required by Clause 13 and Schedule 2 of the Medical Practice Regulation 1998.

87. Clauses 13 and 14 in Schedule 2 of the **Medical Practice Regulations 1998** provide:

“13. Records relating to patients

(1) A registered medical practitioner or medical corporation engaged in the provision of medical services must, in accordance with clauses 14-17 and Schedule 2, make and keep a record, or ensure that a record is made and kept, for each patient of the medical practitioner or corporation.

(2) This clause does not affect section 127 (4) of the Act.

(3) For avoidance of doubt, contravention of this clause is not an offence.

14. When records are to be made

(1) A record must be made contemporaneously with the provision of the medical treatment or other medical service or as soon as practicable afterwards.

(2) This clause may be complied with by the making of further entries in a single record that relates to the patient concerned.”

88. As the Tribunal has noted, the only record made by the respondent of the administration of Misoprostol was in the letter of referral. Her failure to note the drug’s administration in her own notes is in breach of clause 14. Further the Tribunal accepts the HCCC’s submission the notes do not record observations made during and after the procedure and should have. A breach of a provision of the

²⁵ Dr Goldstone Ex E Tab 20 p 3

Medical Practice Regulations is deemed by s.36(1) of the Act to be unsatisfactory professional conduct.

89. This part of the complaint is made out.

Particulars of Complaint 2

The practitioner was working as a general practitioner at premises known as the Australian Women’s Health Clinic at Fairfield. There she performed the termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care and/or improper or unethical conduct in the following respects:

(a) The patient was left unattended in recovery after the procedure;

90. LH, then aged 30, went to Ms Sood’s rooms at Suite 4/9 Kenyon Street, Fairfield, at 9.15am on 6th April 2001. She had had 3 children and was pregnant again and had problems in continuing with this pregnancy. She was 11 weeks pregnant. At that time Ms Sood employed a Dr Richard Allen to carry out anaesthesia and sedation. When she arrived at the clinic the patient saw Dr Allen and was told the procedure would be quick and there would be little bleeding. According to her he said: “[T]he whole procedure takes one minute and you will sleep for about an hour, have a cup of tea and go home”.²⁶

91. She saw a counsellor, then the respondent. The procedure was discussed. She was anaesthetised. Her next memory was of being in a different room, and of being covered in blood. Her underpants were soaked in blood. An employee, Emma, gave her a change of underpants. Dr Allen gave her an injection, and she slept. Her statement continued:

“I woke up in another room. I was cold and felt wet. I lifted the quilt that was over me. I saw that I was covered in blood from underneath my breasts to the top of my legs. My underpants were soaked in blood. I called out for someone.

A girl came in and said her name was Emma. I told her I was in pain. I showed her the blood and she asked me if I had any more underpants. I said, “Yes, my husband’s got them.” She went away. She came back with

²⁶ Ex E Tab 23

another pair of my underpants and changed me. The male doctor came in and he said, "You want pain relief?" I said, "Yes". He gave me a needle. He didn't tell me what was in the needle.

After that, I remember waking up again and I was feeling wet and I was still in pain. I called out "Emma". She came in and I told her I was wet again. She asked if I had any more underpants and I said "No". She said "Maybe I can find some, because sometimes women leave them here." She came back with a pair of underpants and told me to put them over the top of the pants I had on. I said, "I can't because they're wet. Don't worry, I'll just put on my long pants." I stood up. I think Emma helped me to get up while I was putting the pants on. Then I realized that I had blood pouring out and blood clots. I think I fainted.

I next became aware that I was back in the surgery room. I remember rolling onto the surgery bed. I could hear Dr Sood speaking. The male doctor and the blonde nurse were there. I heard Dr Sood say, "Get me another bucket because this one is full".

The male doctor said something like "Dr Sood has to feel inside you to see what's going on", and he told me to relax. My legs were in stirrups.

Dr Sood put her hand inside me. I was screaming because it was hurting. She took her hand out and put one hand on top of the other and pushed down on my stomach above the pubic area. I started screaming out and telling her to stop. She didn't stop. She was pushing harder. It was hurting me a lot. I couldn't breathe properly and I was crying. I grabbed hold of her hands to try to push them away. I felt that she didn't have gloves on. After that, I think I must have blacked out. I remember something was put into my vagina. I also felt something being pulled out from inside me. I was then taken to another room. Dr Sood didn't say anything. The male doctor was speaking. I remember him saying that she had to put a tampon inside me. I heard someone call for rags. I asked the male doctor if I was going to be put to sleep again. He said, "No you'll be fine".

In the other room, I called out to find out what time it was. Somebody told me that it was 2.45. I had stopped bleeding and felt relieved. I asked to ring my husband. I walked to the reception area and the receptionist rang my husband. I went back to the room and asked someone whether I could lie down again. I was told it was ok. I can't remember who I spoke to.

I lied on the bed. Dr Sood came in a couple of times, but didn't speak to me. I asked if I could get up. I don't remember who I asked. I sat on a chair in the same room.

I saw Dr Sood. I said "Excuse me Doctor, can I go and wait there?" and I pointed to the foyer. She came up to me and grabbed me under the top of my left arm and she said something like "No you have to pay your fees." I said, "Okay, my husband will pay when he comes back. I just want to wait out there." She started to squeeze my arm hard and was staring into my eyes. She told me she was going to ring the Police. I reached out to grab her glasses and they fell on the floor.

At some stage I became aware that the blonde nurse was there too. She was on my other side and was holding my other arm.

Dr Sood was saying lots of things like “Let’s get the police,” “Let’s lock her away” and that they would put me in a restraint. I was crying. Dr Sood and the blonde nurse had me on both sides. Somehow I ended up on the bed. I was face down on the bed leaning forward. I couldn’t move. I remember my hair being pulled. I remember that I was slapped a number of times on the face. I think it must have been Dr Sood who did it. She was angry.

Dr Sood rolled me on my side and said she’d give me a needle and I’d never see my husband again. The nurse held me. Dr Sood was on my left side and the nurse was on my right side. I was petrified and I was crying. I said, “I’ll be good, I’ll be good”. Dr Sood left the room.

The blonde nurse stayed with me. She was rubbing my forehead. I think she said that I’d lost a lot of blood but that I’d be okay. She left.

I was on the bed and the rails were up. I crawled out of the bed. I heard my husband’s voice. He was saying that was going to park the car. I heard my children’s voices. I walked to the door and walked out of the Clinic with my daughters. I was wearing the long pants that I had arrived in, which were covered in blood. I saw a friend named Paul and told him not to leave me. My husband went into the clinic and he came back a few minutes later.

The next day I went and reported this to the police, and was examined at Liverpool Hospital.”

92. When he came, her husband was provided with what appears to be a standard form of letter to give her G.P. It said inter alia:

“Thank you for referring [LH] for termination of pregnancy. The procedure was complete and uneventful...”

93. It noted blood loss at less than 100ml.

94. In a letter to the HCCC Ms Sood later conceded there had been a large amount of abnormal bleeding and said she had investigated it, performing a vaginal examination and uterus massage. A second suction and curette had been performed. She could find no reason for the abnormal bleeding. She says after the second procedure a blue sheet under the patient was soaked and she had called for another and ‘may have also called for a dish for the bleeding and the packs’. After she was returned to recovery ‘she was monitored...by both Dr Allen and Minna Zoretic’. [Ms Zoretic is an enrolled nurse]. Ms Zoretic later told her the patient had climbed

out of the end of the bed, when the rails were up, and when she had not been assessed as ready to get up. This was about 1 ½ hours after the second procedure. She and Ms Zoretic then put her back to bed and they were both ‘firm with our advice’ she should be in bed.

95. On 19th April 2001 the patient was admitted to Fairfield Hospital with vaginal bleeding, clots and pelvic pain. She was diagnosed as having retained products of conception and anaemia, secondary to blood loss. A curette was performed. She was discharged. She was re-admitted to hospital on 27th April, 5 days later, as profuse vaginal bleeding had resumed.

96. A number of complaints were made originally, including an unlawful restraint, and an assault. However the complaints pursued before us involved her care after the initial procedure, when she says she was left unattended for a lengthy time; the use by Ms Sood of inadequately qualified staff, lack of documentation of the treatment and her post-procedure follow up.

Was the patient left unattended in recovery after the procedure?

97. When she first went into recovery the patient was apparently attended by Emma Quantik.²⁷ In a statement to the HCCC she confirms some of the patient’s history of events shortly after the first procedure. Minna Zoretic says she left her to make some tea, returned and found her bleeding. She called Dr Allen, who asked her to call Ms Sood. The patient was agitated and frightened. She said that after the second procedure, the patient was returned to recovery. That was about 12.30pm. She reviewed her at 12.45. She observed her at 1, 1.15 and 1.30. At 2pm she found her out of bed, demanding to be allowed to go home.

98. The Tribunal is satisfied that while Ms Zoretic was absent from recovery after the second operation, the patient was unattended. It is highly unlikely she would have been permitted to climb the rails and leave the bed had she been supervised. Further, it is clear from the statement of Ms Zoretic that Ms Quantik, the only

²⁷ Ex E Tab 23 [10]

registered nurse on duty that day, was not present throughout this period. Indeed, she left work at 1.30 pm.²⁸ Ms Zoretic says the incident when she noticed the patient was out of bed occurred at about 2 p.m.²⁹ Ms Mafiti, the other employee, said she worked in theatre, not recovery. No-one else suggested otherwise.³⁰ Moreover, she left at 1.00 pm that day.³¹ Finally, there is no evidence to suggest that anyone else was present. Dr Allen’s statement might be said to give rise to an inference that he was present the whole time,³² but the notes indicate only that he saw her at 1 pm and 2.15 pm.³³

99. The HCCC sought a peer reviewer’s opinion from Dr Murray, a very experienced general practitioner. Dr Murray says acute recovery wards require constant supervision for the safety of semi-conscious patients. Noting that after the second procedure, while Minna Zoretic was in the kitchen area,³⁴ the patient got out of her railed bed and made her way to another area where she sat on a chair,³⁵ Dr Murray is ‘mildly critical’ of the respondent.³⁶ It seems to the Tribunal likely she was also left alone after the first operation while Ms Zoretic went to make tea,³⁷ before returning to find Emma Quantik with the patient, who she said was bleeding.³⁸
100. Dr Goldstone stated that he and his peers would “strongly disapprove of this unacceptable deviation from acceptable standard of care”, unless the recovery nurse was only briefly helping a patient in the bathroom.³⁹
101. This part of the complaint is made out.

(b) The patient was attended by staff who were not adequately qualified for the job;

²⁸ Quantik Ex E Tab 30 [1]

²⁹ Zoretic Ex E Tab 28

³⁰ Mafiti Ex E Tab 29

³¹ Ibid.

³² Allen Ex E Tab 27 [10]

³³ Ex E Tab 26. Handwritten notes.

³⁴ Zoretic Ex E Tab 28[14]

³⁵ Ibid.

³⁶ Ex E Tab 32

³⁷ Ex E Tab 28 [7]

³⁸ ibid

³⁹ Dr Goldstone Ex G Tab 5 p 1

102. As we have noted, when the patient was attended in recovery the first time she was cared for by a registered nurse, Emma Quantik. However, after 1.30 pm, when Ms Quantik left for the day, there was no registered nurse in recovery supervising the patient. Ms Zoretic was an enrolled nurse and Ms Mafiti held a nurse's aid certificate.

103. It is significant at this stage of the narrative to relate some history concerning Ms Sood's dealings with the Medical Board. There were complaints made about her concerning circumcisions and terminations of pregnancy she had performed in the early 1990's. On 22nd August 1998 the Professional Standards Committee found her guilty of unsatisfactory professional conduct. She was reprimanded 'in the strongest possible terms'. The following conditions were then placed on her registration:

2.

- i) That Dr Sood be prohibited from performing circumcisions and/or recircumcisions in her surgery in any circumstances;
- ii) That a qualified registered medical practitioner be present in theatre at all times to take responsibility for anaesthesia while Dr Sood undertakes any procedures using intravenous sedation;
- iii) That a registered nurse be present in theatre at all times while Dr Sood undertakes any procedure using local anaesthetic only;
- iv) That Dr Sood be responsible for ensuring a registered nurse is in the same room as any patient post-operatively who has undertaken a procedure using intravenous sedation for a period of at least one hour;

3.

- i) That Dr Sood do all acts and things and sign all documents necessary to apply for and enrol in the 1998 institute of Counselling course in communication/counselling, held at the Australian Catholic University in Strathfield one evening a week for two terms of 14 weeks.
- ii) That Dr Sood satisfactorily complete the course in 1998 and attain the graduate certificate;
- iii) That Dr Sood pay the full costs of, and incidental to, enrolment and attendance at the course.

104. She was still subject to those conditions when she treated this patient.

105. Given condition 2. iv), the events of that day, that surgery was complete at about 12.30 and Ms Quantik, the only registered nurse on duty that day left at 1.30 and is

not recorded as having supervised the patient between 12.30 and 1.30, it is clear the patient was not left in the hands of a registered nurse for at least an hour after intravenous sedation. This was a breach of the conditions. This part of the complaint is made out.

(c) She did not provide for or arrange for adequate follow-up care;

106. The patient left the clinic a fairly short time after suffering the bleeding which necessitated the second procedure, and without the cause of the bleeding having been ascertained. The respondent was unable to explain why the patient had bled. The patient was simply given a letter for her GP. For the reasons given below, the letter was misleading.

107. Though the HCCC submitted to us that the patient was not given an ‘after care’ sheet (usually given to patients after a procedure) we are not persuaded she was not given one. The records suggest she was.

108. However, this was a most significant event, and there were, in essence, no arrangements made at all for follow up. The reason for the bleeding was unknown. This part of the complaint is made out.

(d) She provided the patient with a discharge letter which stated that the procedure was “complete and uneventful”. This was misleading, inaccurate and/or inadequate;

109. Given there were two procedures, and an attempt to stop significant bleeding and that Ms Sood did not know the cause of the bleeding, to permit the patient to depart with a letter saying the procedure was ‘complete and uneventful’ is, to say the least, misleading.

110. Dr Murray notes that the discharge letter describing the procedure as ‘complete and uneventful’ was untrue and says this would attract ‘moderate criticism’ from her.⁴⁰ Dr Goldstone describes the letter as ‘inaccurate’. Ms Sood herself when

⁴⁰ Ex E Tab 31p 2

responding to the HCCC after a complaint was made described the second procedure as an ‘emergency procedure’.⁴¹

111. The Tribunal is persuaded this part of the complaint is made out.

112. The HCCC also made a submission that there was a breach of the Medical Practice Regulation on documentation. However, although in the Tribunal’s view this is made out, it was not part of the amended complaint, and we have ignored it save for what appears in this paragraph.

(e) She breached conditions imposed on her registration by the NSW Medical Board in that she did not have a registered nurse in the same room as the patient post-operatively for a period of at least one hour, although intravenous sedation had been used.

113. This refers to the conditions imposed on her right to practice in 1998.

114. The respondent when responding to the HCCC’s complaint claimed Ms Quantik was the registered nurse working in the practice that day. No other employee she nominated was a registered nurse.⁴² The respondent said the task of caring for the patient was entrusted to Ms Zoretic.⁴³ Ms Zoretic was not a registered, but an enrolled nurse.⁴⁴ Ms Quantik, herself, does not claim to have looked after the patient in recovery after her second procedure. None of the records suggest she did.

115. The Tribunal is persuaded this part of the complaint is made out.

General

116. As Dr Murray notes, if post-termination bleeding occurs, it is important to exclude uterine perforations and retained products as causes. Thus, conducting the

⁴¹ Ex E Tab 26 p.6

⁴² Sood Ex E Tab 25[9]

⁴³ Sood Ex E Tab 25 [14]

⁴⁴ Ex E Tab 28

second procedure, and the bimanual uterine compression, were appropriate procedures.

117. However the want of qualified assistants and apparent lack of supervision tend to explain and illustrate a poor standard of post procedural care, and are consistent with a breach of the conditions on which she was permitted to practice.

Particulars of Complaint 3

The practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic at Fairfield. She saw the patient on 14 December 2001 and 18 December 2001. On 18 December 2001, she performed a termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care in the following respects:

14 December 2001 (a Friday)

118. ND was almost 25 years of age when she presented at the respondent's clinic at 3/9 Kenyon St, Fairfield for termination of a 15 weeks and 5 days pregnancy. She spoke to Ms Sood and discussed the procedure. She was sent for an ultrasound at a nearby clinic run by Rayscan. The results were telephoned to Ms Sood. The patient spoke to the anaesthetist. Though the procedure could have been performed that afternoon, it did not suit ND and she arranged to return for it on the following Tuesday, the 18th.
119. She returned the following Tuesday. She was given pills to take, being told they were to make her uterus softer. She waited in the waiting room for about an hour. Then she was asked to change, and taken to the procedure room. She was anaesthetized. On becoming conscious she found herself in a different room, and in pain. Two people she had not seen before then assisted her outside and into a car, and took her back to the ultrasound clinic.
120. She had another ultrasound. One of those who had accompanied her said she would have to go to hospital. She was driven back to Ms Sood's clinic. She lay down, in pain.

121. Ms Sood then spoke to her and said she had perforated her uterus. Ms Sood later drove her to Fairfield Hospital, telling her she did not call an ambulance as it might have taken her to Liverpool and she had already spoken to a doctor at Fairfield. ND was admitted to Fairfield Hospital for 5 days.
122. In the new year she received a Get Well card and a cheque for the return of her fees from Ms Sood.
123. While she was at Fairfield Hospital she had a laparotomy for repair of her perforated uterus.
124. ND says it was never explained to her that perforation of the uterus was a possible complication. When a complaint was made to the HCCC Ms Sood said another doctor, Dr Silva 'would normally go through the Operation Risk Information sheet. The first risk under the heading 'Procedure Risks' is the risk of perforation and refers to the possibility of the need for surgery'. She said she would go through with the patient the matters on the consent form where the patient acknowledged that the risks, including instrumental trauma, have been explained.
125. This procedure was not done under ultrasound guidance. There was no ultrasound at the clinic.
126. The Tribunal will now consider each part of the complaint.
- (a) She sought and obtained consent from the patient to terminate the pregnancy before confirming the gestational age by ultrasound (or otherwise);**
127. Statements from the patient and Ms Sood confirm that when ND went to the clinic on 14th December she signed a consent form for the surgery before there was confirmation of gestational age.
128. However, when the patient returned the following week, she signed a second consent form.

129. Dr Goldstone said that given gestational age was not known when the first consent form was signed she could not have given an informed consent since the more advanced the gestation, the greater the risks in the procedure of perforation and heavy bleeding.

130. Dr Goldstone says not obtaining gestational age before consent is a matter he believes the general body of his peers would especially disapprove of.

131. The Tribunal accepts this reasoning and finds this part of the complaint made out.

(b) She failed to document the administration of a drug to prepare the cervix for the procedure;

132. The respondent's notes for the patient do not record the fact that Misoprostol was administered, although other drugs are recorded. Ms Sood says she gave medication 'to prepare the cervix' and the patient was asked to wait 1 ½ to 2 hours. Dr Goldstone infers Misoprostol was the drug she was given and describes her failure to document the drug as a 'deficiency'. The failure is also a contravention of Medical Practice Regulation 14.⁴⁵

133. This part of the complaint is made out.

(c) She did not have in-house ultrasound available although she was performing a termination of pregnancy beyond the first trimester;

134. This was a second trimester termination. Dr Goldstone knows of no other clinic providing terminations of pregnancy which did not have 'basic ultrasound facilities on site'. But he would not condemn her, given the close proximity of the nearby Rayscan clinic, though he said absence of an ultrasound in the clinic was 'unusual and not ideal'. We have referred earlier to Dr Peat's evidence that ultrasound guidance can reduce the risk of perforation, studies showing a drop from 1.4% without, to 0.2% with, ultrasound guidance, in second trimester terminations.

⁴⁵ Ex G Tab 7 p.2

135. Dr Goldstone said ultrasound guidance may reduce the risk of perforation and would certainly reduce the risk of further damage once a perforation has occurred.

136. The Tribunal is persuaded this part of the complaint is made out.

(d) She failed to ensure that the patient had adequate intravenous access in situ to enable fluids to be given before the patient was transferred to ultrasound facilities and/or to hospital;

137. The patient was given no intravenous access for fluids either when taken to the ultrasonographer or to Fairfield Hospital.

138. Dr Goldstone does not comment specifically on the visit to Rayscan but as to the transfer to Fairfield Hospital he said this:

“Dr Sood states that her decision to drive [ND] to hospital herself was based on the fact that [her] condition was stable. There are no records to confirm this assessment by Dr Sood or her anaesthetist. Her vital signs on arrival at Fairfield Hospital suggest she was haemodynamically stable, however the presence of severe abdominal pain (which had required an injection, I assume narcotic pain relief, at Sood’s clinic) would suggest intraperitoneal blood or visceral injury, and such a patient is at risk of decompensating very quickly. I personally would not transfer such a patient to hospital myself, and am not aware of other practitioners who have transferred such patients in a similar way.

My most severe criticism of Dr Sood’s management of [ND] during this period is that she arrived at Fairfield Hospital without intravenous access. I would expect that once perforation was suspected at the time of the procedure that the intravenous access used for sedation should have remained in. Certainly intravenous access should have been re-instated prior to transfer.

To transfer [ND] in a private vehicle if she was indeed haemodynamically stable may be acceptable, but to do so without intravenous access I would describe as negligent, and certainly below what would be accepted clinical practice in such a situation. I am not sure what equipment Dr Sood carries in her vehicle, but I would question her ability to resuscitate the patient if she decompensated haemodynamically en route. If an ambulance had been called to this situation, I am without doubt they would not have transferred her without intravenous access.”

139. We do not accept Ms Sood’s assertion she took the patient in her car because she was in a stable condition. According to the patient, whose evidence we prefer,

Ms Sood told her she did not call an ambulance as it ‘might have taken me to Liverpool instead of Fairfield and she had already spoken to the doctor from Fairfield’. We accept Ms Sood told her that. However the explanation the ambulance might take her to Liverpool Hospital by mistake is one we think implausible. Whatever the real reason Ms Sood took her by car, we consider it was inappropriate for her to do so.

140. As to that part of the complaint which refers to the transfer to Fairfield Hospital, we find it made out. Although Dr Goldstone did not specifically say intravenous access should have been available when she was taken to Rayscan he did say that once perforation was suspected, intravenous access should have remained in. The reason she was sent to Rayscan was a suspected perforation. It follows he considers the intravenous access ought to have remained in place when she was taken there. Dr Brodie said it would only have been permissible to take her to Rayscan with at least one wide bore IV cannula in situ with IV fluid being administered.⁴⁶ This part of the complaint is made out.

(e) She transported the patient to hospital by car;

141. The evidence and our finding in (d) covers both the evidence and findings in (e).

(f) She unreasonably delayed transferring the patient to hospital;

142. Although Dr Goldstone does not expressly comment on the question of delay, he does state that it would generally be reasonable to transfer a patient under these circumstances, without radiological confirmation. There is no independent evidence to confirm the respondent’s assertion that Fairfield Hospital insisted on it. It is difficult to understand why that would be so. Dr Goldstone was sceptical of it. If nothing else, it probably indicated that the respondent did not give the necessary information to the hospital.⁴⁷ For the reasons transfer by car and transfer without IV access were said to be dangerous, the HCCC submitted the delay was unacceptable.

⁴⁶ Ex E Tab 39

⁴⁷ Dr Goldstone's evidence in this matter at T95/11-17

143. The Tribunal does not accept Ms Sood's assertion that a Fairfield Hospital registrar 'insisted' on an ultrasound to assist "in the faster processing of the patient on arrival".⁴⁸

144. The registrar was not called or even identified. Although Ms Sood said the Rayscan clinic was only 100 m from her surgery, and that may be correct in the sense that was the distance between the two, a map of the area suggests the distance she had to travel was much further, as she could not take a direct route. There was a considerable delay in her getting attention when the patient finally did arrive at Fairfield Hospital. The lack of any intravenous access in the meantime was criticized by Dr Goldstone. This part of the complaint is made out.

(g) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details required by Clause 13 and Schedule 2 of the *Medical Practice Regulation 1998*

145. There were no notes about the treatment. Dr Goldstone, especially considering there was an adverse outcome, describes the respondent's failure to complete the operative record, as a 'gross deficiency'.⁴⁹ This part of the complaint is made out.

Complaints 4 and 5

146. Both of these complaints relate to the same patient, LT. LT, born 28/9/01, and aged 21 at the relevant time, became pregnant early in 2002. An ultrasound on 18/5/02 suggested a 22-23 weeks pregnancy. As the Tribunal has noted, a termination of pregnancy is not unlawful, so long as the conditions set out above [para 20] are satisfied. So it is not of itself unlawful for a termination to be performed with a 22-23 weeks gestation.

147. However because those terminations have more complications, most clinics do not conduct them. The patient went to Ms Sood's clinic at Fairfield with her cousin, CK, on 18th May 2002. According to the patient, arrangements were made for her to return on Monday 20th May to take some tablets to 'start off the procedure'. She

⁴⁸ Ex G Tab 37 Letter from Ms Sood to HCCC 12 March 2003

⁴⁹ Ex G Tab 7

went that day and saw Ms Sood, who examined her and placed a tablet or some tablets in her vagina and gave her one or two to take orally. She told her 'the tablets will make it easier to get the baby out'. She was asked to wait for 'an hour or so' in case of 'a reaction or something' and to return the following day for the procedure. She was given Ms Sood's card with her telephone number on it. Unfortunately she was not told that with the use of that medication some women went into premature labour.

148. The patient went home after waiting an hour in the waiting room.
149. That night the patient developed pains in her stomach. Her cousin telephoned Ms Sood on the number the patient had been given. She was advised to take Panadol or Nurofen. However, pain persisted.
150. At about 3 – 3.30 am she went to the toilet and felt what she later learned were a foetus and the placenta being expelled from her vagina. An ambulance then came. She told the ambulance officer there was a baby in the toilet and had intended having an abortion and had taken tablets in preparation for that. She and the baby were taken to hospital. Though ambulance men told her the baby was dead, nurses at the hospital said the baby was breathing. The baby did not live.
151. The police became involved. On the Tuesday morning, whilst the patient was in hospital, she answered her mobile phone to find Ms Sood enquiring if she was still coming in for her termination. She told Ms Sood she had had the baby and was in hospital. Ms Sood asked what she was proposing to do about paying the outstanding \$100 for the tablets. She replied that she did not know, and terminated the call.
152. By reason of her having prescribed the tablets for LT, Ms Sood was charged with manslaughter in respect of the death of the baby. Since, according to the patient, she had both inserted a tablet in her vagina and given her tablets to take orally, which had brought about the abortion, she was charged with the two counts under section 83 of the **Crimes Act** 1900. She pleaded not guilty. She was later

found by a jury to be not guilty of manslaughter but guilty to the two counts under section 83.

153. The respondent did not give evidence at her trial but there was material before the jury from which her position is clear. It was always her case that she did not give the patient any medication to help with a termination. Rather, she said she gave her analgesic tablets. And though she did examine her vaginally on Monday 21st May, she placed a speculum in her vagina to check for infection: not tablets. Further, she never intended to perform a termination. All she ever proposed to do was to help refer her to a clinic in Queensland which performed late second trimester terminations, after having enquiries made in Queensland about the price of an abortion there.

154. A few weeks after the termination, the respondent was dealt with by the Medical Board which had received a complaint. She gave the Board an account of events. Her account was tendered to the jury and to us. In short, she denied her patient's version of events.

155. However, there was before the Board and the jury, a wealth of evidence consistent with and supportive of accounts given by the patient and her cousin. For example the Fairfield Hospital note says:

“P/S: Complete abortion after given inducing medication. N/V since last Monday. Urged by mother to have preg. test. ...

Pt attended the “Australian Women’s Health Clinic” and given oral (x 2) and PV (pessaries) inducing medication with planned abortion today on payment of \$1400. (Pt “knew about the clinic” when asked who was source of referral.)...⁵⁰

156. There were ambulance records and other histories in hospital notes to like effect. Telephone records from Ms Sood’s clinic showed a call to the patient’s mobile on Tuesday 22nd May.⁵¹ The patient’s description of the drugs matched the

⁵⁰ Ex F Tab 15

⁵¹ Ex L T 728-23

description of Misoprostal, which has the effect of softening the uterus.⁵² The description of her labour was consistent with her having had Misoprostal.⁵³

157. Descriptions of how and when the drug was given to other patients of Ms Sood were consistent with the patient's.⁵⁴

158. Expert evidence showed Misoprostol was the most likely drug to have been given.⁵⁵

159. Consistently with her denial she was only to help find the patient a clinic to go to in Queensland, the respondent told the Medical Board she asked Dr Allen (who was still working with her) to phone Queensland clinics on 21st May to find out the cost of an abortion. The telephone records do not confirm he made any such calls. In any event, as she later told the Board, she already knew how much they charged. There were later found to be records of calls to Queensland abortion clinics on Dr Allen's phone records, but not till 9th and 10th June. Of course those phone records were not in evidence at the Board hearing. Notification of the Board's hearing was received by the respondent on 6th June 2002. During the course of that hearing a statement from Dr Allen supporting Ms Sood's version was tendered. It read as follows:

“Statement of Dr Richard Allen

1. I am a medical practitioner, and have worked with Dr Suman Sood for the last several years, giving intravenous sedation to patients for whom Dr Sood performs the procedure of termination of pregnancy (“TOP”).
2. On Tuesday 21 May 2002 I was asked by Dr Sood to call a clinic in Brisbane to enquire as to whether they could perform a TOP at 23-25 weeks gestation, and as to the cost of termination at that time.
3. The person I spoke to at the Brisbane clinic told me that they did do TOP's at that stage, that the patient would need an ultrasound and that it would cost \$2,500. I gave that information to Dr Sood.
4. In my experience with working with Dr Sood a TOP has never been performed in relation to a pregnancy of over 20 weeks gestation at Dr Sood's practice, to my knowledge.”

⁵² Ex P

⁵³ Dr Brodie Ex F Tab 16 p. 7

⁵⁴ E.g. ND was given Misoprostal and told it would make the uterus softer.

⁵⁵ Dr Peat said this was the most likely drug: Ex L T 1064.21

160. In the course of the jury trial in 2006 Dr Allen said this account was false, and had been written at the behest of Ms Sood. Although he later sought to retreat from this position.⁵⁶
161. The police executed a search warrant at the respondent's rooms on 22nd May. She produced no notes about the patient, and her answers to police were somewhat equivocal as to whether in fact she had any. But on 12 June 2002 a detailed set of notes was produced to the Board. They appear to the Tribunal to be somewhat more detailed than her notes concerning other patients, which are in evidence. We were asked by the HCCC to infer she misled the police and created those notes well after the event.
162. The notes are largely supportive of her version, and, in the main, at odds with that of the patient.
163. Having considered the evidence before the Tribunal we unhesitatingly accept the evidence of the patient and reject (where it is in conflict with her evidence) that of the respondent. In preferring LT's evidence the Tribunal takes into account among other matters:
- (a) its consistency with that of her cousin;
 - (b) insofar as she asserts, and the respondent denies, she had an appointment to see the respondent on the Monday, but merely happened to be there when the patient was, that the patient's evidence is corroborated by her cousin, as well as the respondent's receptionist, Joan Chodat;
 - (c) the patient told her mother she had an appointment that day, (the respondent denied that she did) although initially the respondent told police she came in that day to see the patient;
 - (d) it is unlikely the patient would be mistaken about whether it was a finger (as the patient said) or a speculum (as the respondent said) which was placed in her vagina that day;

⁵⁶ The Tribunal has made a number of references to Dr Allen in these reasons. He did not give evidence before the Tribunal so our sources of information about his role in matters is documentary only.

- (e) the patient told her cousin after the meeting with the respondent that day she was given an oral tablet and one vaginally: a similar history was given to her mother soon after;
- (f) the radio call to the ambulance service, called by her mother, said “woman with abdominal pain post taking an abortion pill”. Her mother gave the ambulance officers a similar history, as did the patient;
- (g) there are the histories in hospital records to which we have referred;
- (h) the telephone records to which we have referred for 22/5/02;
- (i) the apparently accurate description by the patient of the tablets she says she was given, suggesting strongly they were Misoprostol;
- (j) the unlikelihood the respondent would have given her card to the patient with her telephone number if, as the respondent asserted, she was simply to be referred elsewhere for the procedure;
- (k) the premature labour and delivering of the foetus were consistent with the use of Misoprostol: her clinic had it in stock: Ms Zoretic said patients over 16 weeks gestation were given 2 tablets to dilate the uterus and soften the cervix, and the respondent generally did this in her office.⁵⁷ LK and ND were also second trimester patients who were given Misoprostol. Drs Peat and Goldstone thought that was what the drug was from its description by the patient;
- (l) Ms Sood, according to the evidence, told her receptionist when police arrived to execute the search warrant that she had done something “silly”. That, we accept, is suggestive of a consciousness of guilt;
- (m) She said she directed a nurse to explain the risks of the procedure. That seems an odd thing for someone who was not proposing to conduct the procedure.

164. The Tribunal is satisfied therefore that the respondent lied to the Medical Board at its meeting on 12th June 2002, and persuaded Dr Allen to provide a false story about contacting Queensland clinics.

165. We shall now turn to consider the individual parts of complaints 4 and 5.

Particulars of Complaint 4

⁵⁷ TLT 593.5-10

The practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic at Fairfield. There she performed a termination of pregnancy on the patient. Her management and/or treatment of the patient demonstrated a lack of adequate knowledge, skill, judgement and/or care in the following respects:

- 1. On or about 18 May 2002 she consulted with the patient and:
(a) She agreed to perform a termination of pregnancy for the patient when the foetus was more than 20 weeks gestation and
i) She was insufficiently experienced in the performance of late second trimester terminations;**

166. As gestation increases, so do the risks of the procedure. After 20 weeks there is an increased risk of perforation, damage to the cervix, clotting disorders, haemorrhage and infection.⁵⁸ The risks associated with termination after 20 weeks are greater than the risks associated with labour at full term.⁵⁹ One of the risks is that the patient can go into labour and deliver the foetus.⁶⁰ That was the risk that materialised here. The risk is accentuated where the procedure is performed by a doctor inexperienced in the method.⁶¹

167. Dr Brodie considers Ms Sood made a serious error of judgement in agreeing to terminate LT's pregnancy, given the method she adopted, viz administering Misoprostol, then letting her leave, with arrangements to return the next day. Her decision to proceed was one which attracted his strong disapproval and in his view would not be acceptable within the medical profession. Dr Kuah, a specialist obstetrician and gynaecologist, provided an opinion on her treatment of LT. Based on her curriculum vitae, he said "it would be difficult to believe she would have good and adequate training" to terminate a post 20 week pregnancy.

168. Ms Sood told the Medical Board on 12th June 2002 "I do not do post 20 weeks. I am not covered by my insurance policy after 20 weeks". Although the Tribunal considers anything said by the respondent should be treated with caution, it does accept that evidence to the extent it shows she did them, at most, rarely. This part of the complaint is made out.

⁵⁸ Ex L T964: Dr Brodie.

⁵⁹ Ex LT965/11

⁶⁰ Dr Brodie Ex F Tab 16 p7

⁶¹ Dr Brodie Ex F Tab 16 pp 5-6

ii) The Clinic lacked the appropriate facilities, staffing and equipment to safely conduct late second trimester terminations;

169. Dr Kuah's view is that a post 20 week termination should not be performed outside a hospital setting through a day surgery. Both Drs Brodie and Peat said an ultrasound should be available when such a termination is performed. Dr Gastaldin said an ultrasound was 'mandatory'.

170. Dr Peat emphasised the need for resuscitation equipment, adequately trained personnel and a clear network with nearby services.⁶²

171. There is no evidence the respondent had an ultrasound. The evidence concerning ND shows she did not have one in December 2001. That is significant given Dr Peat's evidence that the dangers of retained products probably do not increase if ultrasound is used during the procedure but there would be a greater risk in pregnancies over 20 weeks compared to earlier ones if ultrasound were not used.⁶³

172. The evidence about what happened at Westmead Hospital on this occasion and in LK's case and at Fairfield in ND's case demonstrates that the necessary network with local hospitals for after hours and emergency care was not in place.

173. The evidence shows the risks were explained by an enrolled nurse who did not know what her gestation period was or what procedure was proposed.

174. This part of the complaint is made out.

iii) She failed to adequately assess the risks involved in proceeding with the termination;

⁶² Ex G Tab 12 5.2

⁶³ Ex L T1060/55-1061/5

175. The HCCC asks that the Tribunal infer this, bearing in mind the risks of the termination to which we have made reference, and the method the respondent adopted, involving administration of Misoprostol with its risk of causing onset of labour. We do draw the inference from those matters. This part of the complaint is made out.

iv) The proposed method of termination was unsafe;

176. We are satisfied Misoprostol was provided to the patient. We infer the respondent intended to perform a straight dilatation and evacuation procedure.⁶⁴ That is because that is Dr Brodie's view and we agree with and adopt his reasoning. Putting aside her action in allowing the patient to leave the clinic, her proposed method was unsafe in such an advanced pregnancy. Neither Dr Brodie⁶⁵ nor Dr Kuah would perform such a procedure.⁶⁶ As to whether giving the Misoprostol at around 1:30 p.m. the day before was unusual, Dr Peat was not sure as he said it may have been a technique that worked well for the respondent.⁶⁷ However, as we have noted, the respondent told the Medical Board she only performed terminations under 20 weeks. If that was true, she had had no previous experience with such a technique. As we note above, we have inferred she did them rarely. Dr Peat said he was not aware of anyone for whom this was usual practice. He did not think he had ever heard of its being done in that way.⁶⁸ Misoprostol he said was a "pretty unpredictable" drug.⁶⁹ Particularly, given we are not persuaded she was experienced in the procedure with post 20 week terminations, we are satisfied this part of the complaint is made out.

v) She did not obtain informed consent.

177. Once the procedure had begun it had to proceed to completion. Therefore, informed consent would have included counselling and giving of information about

⁶⁴ Dr Brodie Ex F Tab 16 p 6 and Ex L T964/15-22

⁶⁵ Dr Brodie Ex L T991

⁶⁶ See Dr Kuah's evidence to the s 66 enquiry. Ex H Tab 5 p 9

⁶⁷ Ex L T1065/49

⁶⁸ Ex L T1067/28-32

⁶⁹ Ex L T1066/1 and Ex F [25]

the risks of the procedure before the cervical dilating agent was administered, in the Tribunal's view.

178. The respondent had an obligation to provide the patient with the necessary information. There is evidence that her employee, Ms Zoretic, gave her some information. But, as we have observed, Ms Zoretic did not know her gestational age or what procedure would be adopted. With the use of Misoprostol, the Tribunal considers she should have been warned she might come to early labour.

179. Although we are satisfied Ms Zoretic gave some information, she does not say she discussed this issue. Nor does the respondent. Dr Peat says she should have been given written instructions. Failure to warn of early labour attracted Dr Brodie's strong disapproval.⁷⁰ We are satisfied the patient was not warned of the possibility of early labour.

180. This part of the complaint is made out.

(b) She failed to make a proper and/or contemporaneous record of the particulars of treatment she provided in the form and containing the details required by Clause 13 and Schedule 2 of the *Medical Practice Regulation 1998*.

181. The respondent has produced no note of the consultation on 18th May 2002. There were notes for the consultation of 20th May 2002. Having seen the interview with the respondent on the video of the execution of the search warrant, and bearing in mind the notes were first produced on 12th June 2002, and unusually detailed, we infer they were not produced 'as soon as practicable' after the provision of the relevant medical treatment: see **Medical Practice Regulation 14**.

182. So this part of the complaint is made out. This conduct is deemed by s. 36(1) to be unsatisfactory professional conduct.

(c) She failed to provide adequate or appropriate counselling to the patient in relation to the termination of the pregnancy.

183. The relevant evidence and findings in (a)(v) above cover this.

⁷⁰ Ex F Tab 16 p. 11

2. On or about 20 May 2002 she administered a drug, viz. Misoprostol, to the patient to prepare the cervix for termination or to induce labour and

i) She permitted her to leave the clinic after the drug had been administered;

184. Misoprostol (trade name Cytotec) is a synthetic prostaglandin.⁷¹ It can be given orally, sub-lingually or vaginally.⁷² It is commonly used in termination procedures over 12 weeks' gestation, to assist in softening the cervix⁷³ to allow a dilatation and evacuation to take place later.⁷⁴ It is generally contraindicated in pregnancy because it induces uterine contractions and is associated with abortion, premature birth and foetal death.⁷⁵ Preparing the cervix with Misoprostol, however, is good practice in preparation for a termination.⁷⁶ Its main risks are the onset of contractions and preterm labour. Some patients develop a temperature. Diarrhoea is not uncommon.⁷⁷

185. We are satisfied she did leave the clinic, having had Misoprostol administered. We are satisfied this part of the complaint is made out.

ii) She did not monitor or make any arrangements to monitor the patient after the drug had been administered;

186. Dr Brodie said practitioners if giving Misoprostol should keep the patient in their clinic until the termination has completed – as she may come to labour and deliver the foetus.

187. We accept the patient's evidence that she left the respondent's rooms on 20th May 2002 and was not monitored in any way until she went into labour. This part of the complaint is made out.

iii) She failed to provide the patient with adequate advice and information about the nature of the medication including its effects and side effects

⁷¹ Dr Gastaldin Ex F Tab 11[6]

⁷² Dr Peat Ex F Tab 17 p 1-2

⁷³ Dr Gastaldin Ex F Tab 11[6]

⁷⁴ Dr Peat Ex F Tab 17 p 2. C.f. Dr Gastaldin Ex F Tab 11[6]

⁷⁵ MIMS 1-1

⁷⁶ Dr Brodie Ex F Tab 16 p 6

⁷⁷ Dr Peat Ex F Tab 17 p 2

and, in particular, she failed to warn her of the possibility that she might go into labour.

188. Dr Peat said that in cases where Misoprostol was used in Adelaide in the case of advanced gestation, if the patient was sent away she was given an after hours number, written instructions about pain or bleeding, the name of a hospital to go to, and a warning of the risk of going into labour.

189. However the practice of giving Misoprostol overnight, even with that information and access has, he said, been abandoned in Adelaide because a number of women who took Misoprostol went into labour and ended up in hospital.

190. We are satisfied the respondent did not give the patient any advice about the Misoprostol she was given.

191. Both Drs Brodie and Peat are critical of her for that. This part of the complaint is made out.

iv) She failed to adequately assess, advise and manage the patient when informed that she was experiencing abdominal pains after taking the drug.

192. According to CK's accounts of the evening of 20th May 2002, when the patient developed abdominal cramps, she phoned the respondent and said the patient had 'really bad period pain. Is she allowed to do anything?' and was told 'she can take either Panadol or Neurofen'. Dr Brodie says she should have been told to go to an accident and emergency department. Dr Peat was also critical of the lack of proper advice given. This part of the complaint is made out.

Complaint 5

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that on 20 May 2002 she engaged in improper and unethical conduct in that she charged a patient, LT, a fee for the medication she dispensed to her that was greatly in excess of the likely cost to the patient had she purchased the medication from a retail pharmacy and/or in excess of its cost to the practitioner, contrary to the provisions of s 28 of the *Pharmacy Act 1964*.

193. Section 28 of the **Pharmacy Act** 1964 provides as follows:

“(1) A person, other than a pharmacist or a person acting under the personal supervision of a pharmacist, must not dispense or compound any medicine on the order or prescription of a medical practitioner, nurse practitioner or registered optometrist.

(2) This section does not prevent an authorised person from dispensing medicine in the ordinary course of his or her profession:

(a) if the practitioner does not charge for the medicine more than its cost to the practitioner, or

(b) if, because of the circumstances of the case (such as where the medicine is dispensed in a location in which there is no pharmacist), it would be unreasonable to require the medicine to be obtained from a pharmacist, or

(c) in such circumstances as may be prescribed by the regulations.

(3) In this section:

"authorised person" means:

(a) a medical practitioner, or

(b) a nurse practitioner who is authorised to dispense the medicine concerned under section 17A of the Poisons and Therapeutic Goods Act 1966 , or

(c) a registered optometrist who is authorised to dispense the medicine concerned under section 17B of the Poisons and Therapeutic Goods Act 1966 .”

194. According to the patient, on 20th May, when she was given the tablets we are satisfied was Misoprostol, the respondent said:

“You have to give me \$500 to pay for the tablets. That is how much they cost.”

195. She paid her \$400 in cash (all she had) and Ms Sood said she could bring the rest the next day.

196. A possibility arises that this money was to be part of what she says the respondent quoted for the procedure she was to have the next day. That, the patient

says, was the assumption she made.⁷⁸ However the respondent has not contradicted the assertions in the complaint, and the patient's evidence as to her conversations with the respondent on 18th May suggests the quote was for the procedure only. Her cousin said she spoke to Ms Sood on the phone on 17th May and was told: "It will cost \$1800 for the termination procedure".

197. By reason of s.28 **Pharmacy Act** the respondent was not permitted to charge for this medication beyond the cost to her. There was evidence before us that the cost to the respondent was probably only a few cents, no more than 50c.⁷⁹ Indeed, the patient could have acquired them herself by private script for about 50c.⁸⁰

198. We are satisfied this part of the complaint is made out.

Particulars of Complaint 6

(a) The practitioner provided the s 66 inquiry with an account of her care and treatment of LT ("the patient") which was deliberately false and/or misleading.

199. When on 12th June 2002 she appeared before the Medical Board concerning her part in the treatment of LT, inter alia:

- (a) She denied administering any medication to the patient;
- (b) She maintained the patient's return the following day was only for the purpose of getting a referral to a Brisbane clinic;
- (c) She said she had enlisted Dr Allen's help on 21st May in telephoning Brisbane clinics for a quote;
- (d) She said that at no time had she agreed to perform a termination for her;
- (e) She said that at no time had she asked for or received any money from her;
- (f) She said she wrote her notes concerning her consultation with the patient on 20th May 2002, about half an hour after seeing her, but when she was at her rooms at Eagle Vale.

⁷⁸ Ex F Tab 1 para [17]

⁷⁹ Dr Goldstone T79/25,56

⁸⁰ Dr Healy Ex AA [14]

200. The Tribunal is persuaded to the necessary degree of proof that all of these statements to the Board were false, and deliberately so. We have already given our reasons for that.

201. To mislead the Medical Board is, on its own, so serious that we are satisfied it amounts to professional misconduct.

(b) The practitioner constructed a note of her consultation with the patient that was deliberately false and/or misleading and sought to rely upon that note at the s 66 inquiry.

202. Our findings under (a) cover this.

Complaint 7

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that the practitioner has demonstrated a lack of adequate knowledge, skill, judgement and/or care in the practice of medicine and/or engaged in improper and unethical conduct in her management and treatment of TJ (“the patient”).

Particulars of Complaint 7

In June 2002 the practitioner was working as a general practitioner at premises known as the Australian Women’s Health Clinic (“the Clinic”) at Fairfield where the patient consulted her.

- (a) She provided medical services to the patient when the Medical Board had made a decision suspending her from practice, when she knew or should have known that it was improper or unethical for her to do so.**
- (b) She informed the patient she had cancer when the patient did not and when the histopathology report provided no support for such a diagnosis.**
- (c) She provided the patient with a discharge letter that stated that she had undergone a termination of pregnancy when she had not.**
- (d) She submitted or authorised or permitted staff employed in the Clinic to submit a claim for payment of Medicare benefits to the Health Insurance Commission for performance of a termination of pregnancy on TJ on 15 June 2002 when no such service had been provided.**
- (e) She permitted the patient to leave the clinic unaccompanied in a taxi after undergoing a dilatation and curettage under sedation on 15 June 2002.**

203. This and complaint 8 both refer to matters concerning a patient, TJ. It is to be recalled that there was, in relation to matters arising from Ms Sood's treatment of LT, a meeting of the Medical Board on 12th June 2002. On that day, acting under the powers the Board had under s.66(1) of the Act, the Board suspended the respondent's right to practice for 8 weeks. Evidence concerning the patient TJ however shows that the respondent ignored the order of suspension and continued to practice as though the Board had never made the order.
204. TJ (born 3/10/66) had been having a lot of heavy menstrual bleeding and pain. Her general practitioner considered she should have a gynaecological review. The patient thought, incorrectly, that Ms Sood was a gynaecologist.
205. She made an appointment to see her. On 24th May 2002 she first saw her. She was told she might have a pelvic infection. She was advised to have a pap smear. She was told that Ms Sood did not have time to take the sample that day. She returned on a later day and this was done. She returned on 27th May, and was told the results were clear. She was advised she should have a diagnostic dilation and curettage. She had had one before and so was familiar with the process.
206. She made a booking for the respondent to do this on 13th June. As it turned out, that was the day after the respondent had been suspended from practice. She went to the respondent's practice that day. She observed the respondent was wearing a plaster cast on one of her arms. The plaster appeared fresh. She assumed her arm was broken. The respondent said she was getting a doctor friend to perform the procedure but she would have to come back on a later day. She came back on 15th June. The waiting room was full. She saw Dr Allen, who said he would do the anaesthetic. She went to the procedure room and was given an anaesthetic injection. Before the procedure she observed the respondent in the surgery, wearing a mask and a gown. After she regained consciousness Ms Sood handed her a letter and said she could leave. Not a lot of attention can have been given to this letter. It is clearly a standard form of letter given to patients who have had a pregnancy terminated. In part, it read:

“Dear Dr,

Thank you for referring [TJ] for termination of pregnancy. The procedure was complete and uneventful”.

It continued to describe various matters appropriate to a termination of pregnancy. It had on the bottom “Dr S Sood.”

207. On 18th June 2002 she was having heavy bleeding and rang and left a message for Ms Sood to phone her. Ms Sood phoned her some time after and said the dilatation and curette result had come back and it was important that she see her to explain the result. She could not tell her the result over the phone but she ought not panic in the meantime. The respondent could not see her immediately but made an appointment two days later. On 20th June she went to the surgery. Ms Sood asked the receptionist to contact Dr Allen immediately, saying she needed to get in touch with a specialist with a view to having TJ admitted to hospital. She was then taken into the consulting room and told she had cancer. She began to cry. Ms Sood took her hand and said she was a “very lucky girl” that Ms Sood had done the curette because the cancer had been detected – another three or four months and it might have been too late. Ms Sood showed her a letter from the pathology laboratory. But TJ could not understand it and said so. Ms Sood said it meant the cancer was at early stages and ‘they’ would be able to remove her womb to clear it, though she was not sure how much had to be removed. TJ had not had children and was extremely upset. Then Dr Allen was called in to give a letter to a specialist at Liverpool Hospital. Ms Sood said she would contact the hospital so she could be admitted straight away. She suggested TJ leave and come back later. She returned as requested an hour or so later but Ms Sood had gone. She was worried about what to do about going to hospital. The receptionist left a message for the specialist to call back.

208. TJ finally returned home and made calls throughout the day to Ms Sood’s practice. She spoke to her own close family members and told them she needed to have urgent surgery and why. Finally, a receptionist from Ms Sood’s rooms phoned and said she had an appointment to see the specialist on 24 June at 11am. TJ was somewhat perplexed. Was she to have surgery that day? She was concerned about

fasting and the like. The receptionist could not answer any of her questions. The next few days were full of anxiety for her.

209. On 24th June 2002 she saw an oncologist at Liverpool Hospital called Dr Chan. He appeared not to know why she was there. He phoned Dr Allen (the author of the referral letter) who told him that Ms Sood had done the procedure, not Dr Allen. Dr Chan had her pathology slides. TJ of course had seen Ms Sood on the day of her procedure with an apparently broken arm. She felt ill at the thought that someone with a broken arm had done the procedure. Later in the week she spoke to Dr Chan again. He had had the pathology slides re-examined. Contrary to what Ms Sood had told her on 20th June 2002 she did not have cancer. The pathology results showed no abnormality.

210. Procedures later conducted by Dr Chan confirmed she was clear of cancer but had other conditions which helped to explain the symptoms for which she had consulted Ms Sood in the first place. TJ suffered a great deal of anxiety and depression in the months following these events.

211. At no time when she was seeing Ms Sood did she or her staff or Dr Allen tell her Ms Sood was suspended from practice. In fact, when she complained about Ms Sood to the HCCC she did not know she had been suspended.

212. TJ gave evidence before the Tribunal. She gave a moving account of some of her contacts with the former doctor. Following those events, she told us, she had become suicidal. Giving evidence in these proceedings was, for her, a means of bringing these events to an end. She explained how her experiences with the respondent had made it difficult for her to trust doctors. She does not know whether someone who says he or she is a doctor really is one or really will do his or her best for her. She found Ms Sood very uncaring and offhand when telling her she had cancer – not even suggesting she should bring someone with her, though she must have known what she would be told.

213. We shall now deal with the individual parts of the complaint.

Particulars of Complaint 7

In June 2002 the practitioner was working as a general practitioner at premises known as the Australian Women's Health Clinic ("the Clinic") at Fairfield where the patient consulted her.

(a) She provided medical services to the patient when the Medical Board had made a decision suspending her from practice, when she knew or should have known that it was improper or unethical for her to do so.

214. The respondent's suspension from practice began on 12th June 2002 and ceased on 3rd July, when the suspension was stayed by an order of the Supreme Court. The HCCC tendered records from Medicare relating to TJ. Whilst they show TJ was provided services by Ms Sood on 24, 27 and 29 May, and 7 June, they show none during the period of suspension. They do show however that on 15th June 2002, Dr Allen received a fee for a surgery consultation as well as a fee for 'Evacuation of contents of gravid uterus'. The term 'Evacuation of contents of gravid uterus' is an item appropriate to termination of a pregnancy. 'Gravid' means pregnant.⁸¹
215. As TJ recorded in her complaint to the HCCC, she was not pregnant when she saw Ms Sood. Indeed, she was not sexually active.
216. There is ample evidence the respondent provided medical services when she was suspended from practice. First, she continued to use the title 'Doctor'. She used that title on the letter she gave TJ. In passing herself off as a doctor, she was acting contrary to the provisions of s.105 of the Act, which forbids unqualified people from using the title 'doctor'.
217. Next, the evidence satisfies the Tribunal that Ms Sood carried out the dilatation and curettage. It is true Dr Allen signed the referral letter to Liverpool Hospital in which the procedure was described. However, in a statement to the HCCC he said the letter is in the hand writing of Ms Sood, his signature being the only part in his hand. The patient saw her in the procedure room wearing a gown and mask on the day of her procedure.

⁸¹ Butterworths Medical Dictionary (2nd Edition)

218. Pathology reports are addressed to Ms Sood and pathology requests were signed by her. Dr Chan's report following his consultation with TJ is addressed to her. Dr Chan's notes show he was told Ms Sood performed the dilatation and curettage. The respondent herself when telling the patient she had cancer said she was very lucky 'I carried out the curette'.

219. The Tribunal considered, but did not form any final view about, the significance of Ms Sood's wearing plaster on her arm the day after she was suspended from practice, and whether it might have been a pretence so she would not have to tell patients she had been suspended. However, Ms Katzmann SC did not urge us to make a finding on the matter, and we have not done so.

220. A highly experienced general practitioner, Dr Chung, expressed his severe disapproval for her conduct in holding herself out as a doctor when her right to practice had been suspended. This part of the complaint is made out.

(b) She informed the patient she had cancer when the patient did not, and when the histopathology report provided no support for such a diagnosis.

221. It is revealing to set out the terms of the pathology report Ms Sood was relying on when she told the patient she had cancer. The report said inter alia:

“Macroscopic: Specimen consists of irregular pieces of dark tissue together about 2 grams. All tissue processed in one cassette.

Macroscopic: 1/ Endometrium shows small inactive glands and some glands in early proliferative phase. There is no evidence of malignancy.
2/ One piece shows endocervix with adenomatous hyperplasia of glands with satisfaction. In places the pattern is papillary.
Very early low grade papillary adenocarcinoma of cervix has to be ruled out.

Conclusion: 1/ ENDOMETRIUM PROLIFERATIVE PHASE
2/ ENDOCERVIX SHOWS ATYPICAL PAPILLARY HYPERPLASIA.

Note: Follow up of endocervix with pap smear and repeat biopsy are advised if clinically indicated. Slide is enclosed so that the patient can be referred to a specialist gynaecologist.”

222. It is important to note the caveat:

“Very early low grade papillary adenocarcinoma of cervix has to be ruled out”

223. So one can understand why the possibility of cancer of the cervix suggested itself to the respondent. The real challenge was in how she dealt with that information when explaining it, and the need for any follow up of the patient.

224. The HCCC obtained an opinion from Dr Chung about the way Ms Sood went about talking to TJ about this result. He said that if it were true Ms Sood told the patient she had cancer and would require surgery, that was something which he would regard as ‘unconscionable’. He continued:

“The alarm [in] such false information given to any person could only have serious, perhaps catastrophic emotional effects...This conduct attracts my severe disapproval and, in my opinion, this conduct would attract the severe disapproval of my peers.”⁸²

225. Of course, in an atmosphere where a patient is asked to return after a diagnostic dilatation and curette and the test results say ‘low grade papillary adenocarcinoma of cervix has to be ruled out’, it can happen that an anxious patient can misunderstand what she is being told and ‘hear’ only ‘carcinoma’.

226. So the Tribunal has considered whether such a misunderstanding may have occurred here. However, quite apart from the fact that the patient’s version of the conversation with Ms Sood is uncontradicted, other aspects of what the patient told the HCCC suggest that on Ms Sood’s part there was a deal of activity consistent with her seeing some urgency in the patient’s seeing an oncologist urgently – indeed – on the day she had the conversation with the patient her staff tried to get her in to see him.

227. The Tribunal accepts that Ms Sood did tell the patient that day she had cancer and would need surgery. However it does not accept there was no support for the

⁸² Ex F Tab 29 p.4

diagnosis. Given our finding that Ms Sood used the words attributed to her by the patient, we find only the first part of the complaint made out.

- (c) **She provided the patient with a discharge letter that stated that she had undergone a termination of pregnancy when she had not.**

228. Dr Chung expresses his severe disapproval for this conduct. We are satisfied this part of the complaint is made out.

- (d) **She submitted or authorised or permitted staff employed in the Clinic to submit a claim for payment of Medicare benefits to the Health Insurance Commission for performance of a termination of pregnancy on TJ on 15 June 2002 when no such service had been provided.**

229. Given we are satisfied she conducted the procedure, and worked with Dr Allen, we are satisfied she caused the claim to be submitted to Medicare claiming Dr Allen undertook the procedure.

230. Dr Chung expresses his severe disapproval for this. We are satisfied this part of the complaint is made out.

- (e) **She permitted the patient to leave the clinic unaccompanied in a taxi after undergoing a dilatation and curettage under sedation on 15 June 2002.**

231. TJ told the HCCC that when she arranged to have the dilatation and curettage she was not told she should be accompanied home after the procedure. So she went home in a taxi by herself, and unaccompanied, as she had not brought anyone with her. We accept TJ's evidence on that issue, as we do on all issues.

232. Dr Ian Chung said Ms Sood's conduct in letting her leave unaccompanied was inappropriate and attracted his severe disapproval. We are satisfied this part of the complaint is made out.

Complaint 8

Is guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of s 36 and s 37 of the Act in that between 12 June and 3 July 2002 the practitioner engaged in improper or unethical conduct by practising or, alternatively, holding

herself out as a medical practitioner when she was not entitled to do so in contravention of s 105 of the *Medical Practice Act 1992* or, alternatively, when she knew that the Medical Board had made a decision to suspend her from practice and when that decision had neither been stayed nor set aside

Particulars of Complaint 8

(a) The Medical Board made a decision suspending the practitioner from practice following the s 66 inquiry on 12 June 2002.

(b) That decision was stayed on 3 July 2002.

(c) Between 12 June 2002 and 3 July 2002 she practiced, or alternatively held herself out, as a medical practitioner when she was not entitled to do so, or alternatively when she knew or should have known that it was improper or unethical for her to do so.

233. The factual background to this complaint is set out above under complaint 7.

The Tribunal is satisfied that at the time of her suspension the respondent:

(a) knew she was suspended;

(b) knew she was not permitted to practise medicine;

(c) continued in the face of that knowledge, to practise.

234. By reason of the matters in [230] the Tribunal is satisfied the respondent has little, if any, regard for the law, especially for the laws which govern the licensing and practice of the medical profession. Nor do we consider she has any regard for the patients for whose protection the laws exist. Nor, in the Tribunal's view, does the respondent have any regard for the medical profession in which she worked, and the need for the public to trust that profession.

235. In the Tribunal's view her conduct in continuing to practice when suspended amounts to professional misconduct. It is a 'deliberate departure from accepted standards'.⁸³

Complaint 9

Is not of good character.

Particulars of Complaint 9

⁸³ *Pillai* [[18]]

- (a) The practitioner constructed a note of her consultation with patient LT on 20 May 2002 that, to her knowledge, was false and/or misleading;
- (b) She deliberately misled the Medical Board by providing to the s 66 inquiry on 12 June 2002 an account of her care and treatment of the patient LT that, to her knowledge, was false and/or misleading;
- (c) Between 12 June and 8 July 2002 she practised as a medical practitioner despite an order of the Medical Board suspending her from practice and in contravention of s 105 of the Act;
- (d) Between 12 June and 8 July 2002 she held herself out as a medical practitioner contrary to s 105 of the Act;
- (e) She made notes for patient LH that contained false and/or misleading information.
- (f) She provided patient LH with a discharge letter that contained false and/or misleading information about the procedure she had conducted;
- (g) She misled the District Court about her character, reputation and professional standing in the matter of *R v Suman Sood* (04/11/1102);
- (h) She breached undertakings she gave to the Federal Magistrate's Court in bankruptcy proceedings;
- (i) The practitioner is a dishonest person.

236. Bearing in mind issues which have arisen in the investigation of the respondent's treatment of the five patients referred to above, the HCCC says she is not of good character, and provided a number of particulars to make good that allegation. We shall deal with them one by one.

Particulars of Complaint 9

- (a) The practitioner constructed a note of her consultation with patient LT on 20 May 2002 that, to her knowledge, was false and/or misleading;

237. The Tribunal has set out above its views about the notes made by the respondent concerning her meeting with the patient LT on 20th May 2002. The note and her apparent explanations as given to the Medical Board on 12th June 2002 is as follows:

“L...T [didn't have the file with me at Eagle Vale and had forgotten her surname' 20/5 C/o abd pain for 1-2 hrs. Loose motions x 1
o [no] vomiting
23 + wk preg[nancy]
120/70
[abdomen diagram] ut[erus]=dates firm tender does not relax
?Vraxton Hicks
?labour

P/v N/a [nothing abnormal] Cx [cervix] closed no discharge
Adv[ised] PCM [paracetamol] Triprofen samples, no better – hosp[ital].
For ref[erral] tomorrow – rates?”

238. As is clear, the note is confirmatory of the case the respondent put to the Medical Board.
239. It contains no reference to Misoprostol, which we are satisfied she did give the patient that day, but does refer to analgesia the patient says was not given, and which we are satisfied was not given.
240. The words ‘For ref tomorrow – rates’ we are satisfied do not reflect any discussion that day or any other day with the patient.
241. We are satisfied the note is a deliberate concoction containing some correct matters (such as 23+ week pregnancy) but containing, largely, matters purporting to record matters which did not in fact occur.
242. We are satisfied this note was a false one which Ms Sood constructed.
- (b) She deliberately misled the Medical Board by providing to the s 66 inquiry on 12 June 2002 an account of her care and treatment of the patient LT that, to her knowledge, was false and/or misleading;**
243. This refers to what she told the Board – in essence that she gave her patient analgesics on 20th May and was only seeing her the next day to help her find a Queensland clinic to perform a termination. The Tribunal is satisfied this account was false and knowingly so, and that she deliberately misled the Medical Board as alleged.
- (c) Between 12 June and 3 July 2002 she practised as a medical practitioner despite an order of the Medical Board suspending her from practice and in contravention of s 105 of the Act;**
244. To hold oneself out as having the right to practice, knowing one is not, as we are satisfied she did, amounts to a falsehood directed at patients, medical colleagues and

funding bodies and is directly contrary to the provisions of s.105 of the **Medical Practice Act** which provides:

“105 Use of misleading titles etc

(1) A person who is not a registered medical practitioner must not take or use any name, initials, word, title, addition, description or symbol which having regard to the circumstances in which it is taken or used indicates or is capable of being understood to indicate or is calculated to lead persons to infer that:

(a) the person possesses a degree, diploma, or other qualification of a nature which would entitle the person to be registered as a medical practitioner, or

(b) the person is registered as a medical practitioner under this Act.

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(2) A person who is not a registered medical practitioner must not advertise himself or herself, or hold himself or herself out, to be a registered medical practitioner, doctor of medicine, physician, surgeon, legally or duly qualified medical practitioner, qualified medical practitioner or medical practitioner.

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(3) A person who is not a registered medical practitioner must not advertise or hold himself or herself out to be entitled, qualified, able or willing to practise medicine or surgery in any of its branches or to give or perform any medical or surgical advice, service, attendance or operation.

Maximum penalty: 50 penalty units or imprisonment for 12 months, or both.

(4) This section does not apply to an advertisement or holding out by any member of a life-saving, ambulance or first-aid association that is a charitable institution, or by a member of a mine rescue organisation, in relation to the lawful exercise of his or her functions or duties as a member of the association or organisation.

(5) Proceedings for an offence against this section may be commenced at any time within 2 years after the alleged commission of the offence.”

245. This part of the complaint is made out.

(d) Between 12 June and 3 July 2002 she held herself out as a medical practitioner contrary to s 105 of the Act;

246. This matter is covered by (c) above.

(e) She made notes for patient LH that contained false and/or misleading information.

247. This part of the complaint refers to the provision of a letter to the husband of a patient who had just undergone a termination of pregnancy followed by very considerable and unexpected and unexplained bleeding, followed by a repeat procedure and an unusually long period of rest at her rooms. The letter, it will be recalled, said ‘The procedure was complete and uneventful’.

248. It is hard to see that she did not apply her mind to this letter. The events of that day would have been fresh. They had been eventful. It is hard to resist the notion the respondent did send the letter, knowing it to be false. We are persuaded this part of the complaint is made out.

(f) She provided patient LH with a discharge letter that contained false and/or misleading information about the procedure she had conducted;

249. This part of the complaint refers to notes made on the patient’s records saying blood loss was “minimal”. We make the same remarks and draw the same conclusions as in (e). We find this part of the complaint made out.

(g) She misled the District Court about her character, reputation and professional standing in the matter of *R v Suman Sood* (04/11/1102);

250. In 2005 the respondent stood trial before a jury in the District Court of New South Wales, having been charged with fraud. She was found guilty and convicted and sentenced. She appealed and the convictions were set aside in April 2006. In the sentencing proceedings before His Honour Judge Blackmore SC the respondent, through her counsel, tendered evidence about her character and her skills as a medical practitioner. In the submission of the HCCC, that evidence was so persuasive that when he sentenced her on 29th April 2005⁸⁴ his Honour was moved to conclude:

⁸⁴ Ex G Tab 9

“She is clearly a skilled practitioner whose services the community can ill afford to be without.”

He remarked:

“It is indeed a shame that this offence has in effect blackened her previous good reputation and character”.

His Honour also observed:

“She is apparently a respected practitioner in [the practice of termination of pregnancies]”

251. The HCCC submits she deliberately kept back her true history from the sentencing judge, misled him and presented or allowed to be presented a distorted picture. Thus there is further evidence of a lack of candour, it was submitted.
252. The HCCC tendered to the Tribunal a number of references which had been tendered to his Honour, as well as the probation and parole report, a transcript of submissions on sentencing, and his Honour’s remarks on sentence. The references were addressed either to the presiding judge, or to her then solicitor. It is apparent from the letters the referees were told she had been found guilty of an offence or some offences involving fraud, but from the content of the letters we infer they were not told anything of her history with the Medical Board. The respondent gave no evidence before the sentencing judge.
253. By reason of what appears below, there is no doubt his Honour had a picture of the respondent quite at odds with the one this Tribunal has.
254. The HCCC tendered to us material to show that over the years when in practice in NSW the respondent was the subject of a large number of complaints about her skills, and character as a medical practitioner. By no means all of the complaints were upheld by the appropriate authorities. But some were. And on one occasion, in 1997, her professional colleagues on the Professional Standards Committee reprimanded her ‘in the strongest possible terms’ and imposed upon her future right to practice the conditions we have set out above at [103]. The findings made, including details of the relevant complaints and patient histories, were as follows:

(a) **Complaint 1 - DB**

Between 5 March 1993 and 21 April 1993, whilst employed as a general practitioner, in Dr Rajan Parhawk's surgery in Camden, her treatment and management of a patient (who consulted her to obtain a prescription for the contraceptive pill) demonstrated a lack of adequate knowledge, skill, judgment or care in the practice of medicine in that:

- She failed to perform an adequate physical examination
- She failed to take an adequate history
- She incorrectly (twice) prescribed a flu vaccine, Vacigrip, instead of the contraceptive injection, Depo Provera, which the Committee regarded as a very serious error.⁸⁵
- She failed to maintain any clinical records. The respondent in fact admitted that she failed to make a single clinical note of the consultation on 21 April 1993. The Committee regarded that failure as “a serious departure from acceptable standards of practice”. The respondent's explanation was that she was seeing 50-60 patients in a 12 hour day and was distracted by difficult personal circumstances. The Committee criticised her failure to make alternative arrangements for her patients, given her level of stress and consequent lack of focus on the patient's needs, and accepted with concern DB's evidence she had lost confidence in the medical profession.

(b) **Complaint 2 – VR**

On 6 May 1994, whilst working as a general practitioner at 33 Fitzgibbon Lane, Rosemeadow, the practitioner's treatment of the patient demonstrated a lack of adequate knowledge, skill, judgment or care in the practice of medicine in that:

- she performed a vaginal examination without providing adequate explanation.
- She performed a termination of pregnancy using intravenous sedation without an appropriately qualified and trained person to assist in the procedure. The

⁸⁵ She wrote two scripts, not one, and then failed to read the label on the injection when she administered it. The Committee found this suggested a lack of concentration which could have resulted in “disastrous consequences” for the patient.

respondent had her receptionist assist, something she admitted to the PCC was inappropriate.

- She failed to provide appropriate post-operative care for the patient (particular 5).

(c) Complaint 3 – BH

On 12 July 1994, whilst working as a general practitioner at 33 Fitzgibbon Lane, Rosemeadow, the practitioner's treatment of the patient (an 8 months old baby boy) demonstrated a lack of adequate knowledge, skill, judgment or care in the practice of medicine in that:

- She inappropriately and/or incorrectly performed a re-circumcision on the baby. She never informed his parents that there was any alternative available. She never raised the possibility of a referral to a specialist for an opinion or the baby being operated on in hospital under general anaesthetic. She told the Committee that she did not consider referring the baby. The baby bled profusely and was still bleeding heavily by the time he got to hospital. The procedure she undertook considerably shortened the baby's penis. The expert evidence was that a recircumcision should not be done in a doctor's surgery and was not clinically indicated in any event. According to the Committee's decision the peer reviewers were appalled by the respondent's conduct and "highly critical" of her. The Committee accepted evidence from the baby's father (albeit that it was denied by the doctor) that a cautery had been applied on multiple occasions causing the baby to emit "gut wrenching" screams every time it was applied. It found that she lacked the skills or knowledge necessary to undertake the procedure and that her management of the patient was "inappropriate and incompetent from start to finish".
- She failed to make appropriate transfer arrangements to Campbelltown Hospital. The baby was transferred by his father and in his father's car accompanied by a receptionist and the baby's mother. The Committee found that the respondent had a duty to arrange for a medically trained person to accompany the baby to the hospital.

The Professional Standards Committee regarded Ms Sood's management of this patient as "a very serious departure from appropriate standards of practice."(p. 18).

(d) Complaint 4 – JP

On 12 July 1994, whilst working as a general practitioner at 33 Fitzgibbon Lane, Rosemeadow, the practitioner's treatment of the patient demonstrated a lack of adequate knowledge, skill, judgment or care in the practice of medicine in that:

- She failed to explain to the patient that incomplete pregnancy is one of the risks and complications associated with a termination of pregnancy (despite the expert evidence to the effect that failure to remove the foetal sac is the primary risk of performing terminations under 6 weeks' gestation). Both peer reviewers were seriously critical of this omission.
- She made an untruthful statement when the patient asked her about the results of the ultrasound.
- She failed to adequately assess the presence of pregnancy tissue when examining products of conception. The pregnancy was missed although the respondent said that at the time she was convinced she saw the sac when she examined the products of conception. The experts felt that this showed a lack of skill and experience in identifying an early foetus. This was potentially very serious as no reassurance could be given that this was not an ectopic pregnancy. The patient should have been followed up closely and frequently to exclude the possibility of ectopic gestation.
- She failed to adequately investigate the patient's persistent complaints of sickness and cramping.

(e) Complaint 5

Between 1993 and 1995, whilst working as a general practitioner, the practitioner's performance of terminations of pregnancies demonstrated a lack of adequate knowledge, skill, judgment or care in the practice of medicine in that:

- She failed to provide independent counselling to women undergoing terminations of pregnancies.
- She failed to perform TOPS with the assistance of sufficiently experienced and/or trained staff.

The evidence was that the receptionists assisted although the doctor did not expect them to know about resuscitation, to administer injections, to observe signs of shock or coma.

- She performed TOPS using IV sedation without an appropriately qualified and trained person to assist in the procedures.

This was a breach of the 1991 guidelines prepared by the RACS Faculty of Anaesthetists.

- She failed to provide post-operative care by sufficiently experienced and/or trained staff.

Until June 1995 she left to receptionists the task of checking the patients' breathing although they were not trained to cope with cardio--respiratory collapse. The evidence that was accepted included evidence that a pulse oximeter was not used before early 1995 although it should have been used post operatively for at least 10 minutes, and observations were not taken at sufficiently frequent intervals.

(f) The Committee concluded that the respondent had "shown a serious inadequacy of attitude of caring for a number of patients who have been subjected to pain and suffering which could have been avoided." Complaints relating to four patients it regarded as "very serious matters".⁸⁶ All patients and the father of the baby boy the subject of the third complaint all "gave distressing accounts of the effect of the respondent's conduct on their confidence in the medical profession" and the Committee found that "it is likely they will all experience long term emotional effects". It also found that the baby boy was likely to suffer both physically and emotionally.⁸⁷

(g) The Committee observed that "it is a serious matter when patients perceive a practitioner's conduct as uncaring and unprofessional. It shows a lack of skill in communicating and a careless disregard for the needs of the patient."⁸⁸

(h) The Committee also raised its concerns that the respondent did not protect her young assistants by warning them of the risks of contamination from washings mixed with body fluid. It was not compulsory for them to wear protective masks or

⁸⁶ Report of Professional Standards Committee 28 July 1997 p 29

⁸⁷ Report of Professional Standards Committee 28 July 1997 p 29-30

⁸⁸ Report of Professional Standards Committee 28 July 1997 p 30

glasses or gowns nor were they given hepatitis B injections without incurring a cost. It stated that “this potentially serious risk to staff” was “incompatible with responsible professional behaviour.”⁸⁹ Although a complaint about failure to use sterilised equipment during TOPS was not upheld, the Committee expressed its concern that “The respondent’s attention to infection control procedures was seriously inadequate through the relevant period.”⁹⁰ It noted that, not only did she not protect her staff from potential infection nor insist on the use of sterile gowns and gloves until late in the relevant period but also Dr Brodie, who visited the surgery in November 1995 was not satisfied at that time that her autoclave reached the required standards nor that an ideal system for the cleaning of instruments was in place.⁹¹

(i) There was criticism in evidence before the Committee about the respondent’s record keeping and her surgery’s facilities.⁹²

(j) The Committee considered the respondent was slow to make concessions and tended to place blame on the patients.⁹³ The Committee warned her that a change in her attitude was mandatory.⁹⁴

255. One readily sees why the HCCC complains that the respondent deliberately misled the District Court by presenting a positive case that she was, and was regarded, as caring and competent.

256. The Tribunal is satisfied that the respondent was well aware of the Professional Standards Committee’s findings in 1997 when instructing her counsel on her sentencing proceedings. Of course we do not, and cannot know, what instructions were given to her counsel, but by reason of the Bar rules which bound her counsel we infer she failed to instruct her counsel of the matters in [254]. By Rule 21 of the **New South Wales Barrister Rules** it is provided:

⁸⁹ Report of Professional Standards Committee 28 July 1997 p 26

⁹⁰ Report of Professional Standards Committee 28 July 1997 p 28

⁹¹ Report of the Professional Standards Committee 28 July 1997 p 28

⁹² Report of Professional Standards Committee 28 July 1997 p 30.8

⁹³ Report of Professional Standards Committee 28 July 1997 p 30

⁹⁴ Report of Professional Standards Committee 28 July 1997 p 31.3

“A barrister must not knowingly made a misleading statement to a court on any matter”.

And Rule 29 says:

“A barrister will not have made a misleading statement to a court simply by failing to disclose facts known to the barrister concerning the client’s character or past, when the barrister makes other statements concerning those matters to the court, and those statements are not themselves misleading.”

257. As we see it, and as we infer, her counsel could not have been told of her history in [254] or he would not have made the submissions he did.

258. Ms Sood has not sought to answer the complaint that she misled the court in the way alleged.

259. The Tribunal is persuaded the respondent did deliberately mislead the District Court by putting forward a positive case about her character, reputation, and professional standing, when she knew it to be a significantly incomplete and inaccurate picture.

260. This part of the complaint is made out.

(h) She breached undertakings she gave to the Federal Magistrate’s Court in bankruptcy proceedings;

261. Late in 2005 and early in 2006 the respondent was involved in litigation in the Federal Magistrates Court concerning money she owed to a company called Crown Diagnostic Imaging Pty Ltd. From several judgements of the Federal Magistrate’s Court it is apparent that she owed that company \$59,013.05.

262. The company obtained judgement against her for that sum in the Local Court on 10th September 2004. By application dated 23 June 2005 the company applied for a sequestration order against her estate. The matter was before the Federal Magistrate’s Court on 16th December 2005 for hearing. On that day the respondent gave the court a written undertaking containing inter alia, the following:

“The respondent, Dr Sood, undertakes to the Court, to:
2. Do everything that is within her power, influence and control to cause the applicant to be paid the judgment debt as soon as possible, and specifically:
a. To promptly instruct the trustee of the superannuation trust to make the payment;
b. To diligently and promptly communicate with CommSec and any other party who may be able to affect the trustee’s ability to make the payment and remove any hurdles to sale of the shares held by the trustee;
c. Cause payment to be made as soon as the shares are sold;
d. To keep the solicitor for the applicant informed of any difficulties with CommSec.”

263. The application for the sequestration order was then adjourned until 21st February 2006. The debt was not paid. On 21st February 2006 her solicitor sought a further adjournment. He conceded on his client’s behalf she had not complied with her undertakings to the extent that the creditor was not paid. The Magistrate did not decide whether or not the failure to comply with the undertakings amounted to a contempt. But he proceeded to make a sequestration order on the basis that she owed a large sum and her “affairs would probably best be placed into the hands of a controlling trustee”.

264. The respondent’s failure to pay the debt does not of itself amount to a failure to comply with the undertaking or dishonesty or evidence of a lack of good character, even in the absence of answering material from the respondent. There may be good reasons why she did not pay. The Federal Magistrate’s Court did not explore the matter.

265. We are not persuaded to the appropriate degree of proof that this part of the complaint is made out.

(i) The practitioner is a dishonest person.

266. The matters established in (a) to (g) above amply demonstrate to the Tribunal that Ms Sood is a dishonest person. However, the HCCC drew the Tribunal’s attention to some additional matters, if more were necessary, to establish that proposition. We shall now consider them.

267. On 2nd July 2004 Ms Sood gave an undertaking to the Medical Board that she would not perform terminations of pregnancy under any circumstances. The HCCC tendered an advertisement apparently from the Parramatta Sun, an outer Sydney suburb newspaper, dated 8th March 2006. It is as follows:

“Dr. Ms. Suman Sood

8 Dunmore Street, Wentworthville

Ph: 9636 4454 Fax: 9687 8767

BULK BILLING

We provide:

- Women’s Health + Men’s Health
- Pregnancy Choices Incl. Terminations
- Menopause Choices
- IUD, Mirena, Implanon (Contraception)
- Sexual Health & Pap Smear
- Counselling, Anxiety & Addiction Mx
- Weight Control

*** Helping women make their choice*** ”

268. The HCCC submitted that although there is no evidence she has been performing terminations, that advertisement shows she is not prepared to honour “the spirit” of her own undertaking, and is further evidence of dishonest character. The advertisement does not say she will conduct the terminations, however, and, while we agree that it suggests she was not at the time abiding by the spirit of her undertaking, we are not satisfied to the requisite degree of proof it establishes she was in fact acting in breach of her undertaking. There is no evidence she was conducting terminations and, whilst one may speculate, more is needed before we would conclude on the balance of probabilities the advertisement proves a breach of the undertaking.

269. Next, Ms Katzmann SC tendered two press releases, apparently issued about these proceedings.⁹⁵

270. In the first, dated 30th August 2006, having announced she had withdrawn her name from the medical register, she said:

“Press Release for Dr Suman Sood

⁹⁵ Ex N

Today Dr Suman Sood announced that she has withdrawn her name from the Register of Medical Practitioners of NSW, with effect from 31 August 2006 and apologized for any inconvenience caused to her patients as a result of the withdrawal.

'I have taken this extreme action in the best interests of my patients. My court proceedings and the recent media frenzy have been distressing. Many of my patients have been disturbed by the media coverage which contained inaccuracies and distorted accounts of my treatment of some patients. I can only speculate as to the source or sources for these stories. By withdrawing my name from the Register I will be able to fully concentrate on my forthcoming court hearings without exposing my patients to any further uncertainty about their future medical care.

Being an Australian, I am committed to upholding the Australian spirit of fairness and moral integrity.

As a Medical Practitioner, I have always endeavoured to care, assist and provide selfless professional service to the community in whatever capacity I could and as a citizen, I shall continue to do the same in future.

I take this opportunity to thank all my patients, colleagues and well wishers for their continued support, faith and confidence shown during this tumultuous period.

I am confident that truth will ultimately prevail and justice will be achieved.'

Date: 30 August 2006

271. The next one was dated 11th September 2006, the first day of these proceedings.

It is as follows:

“Dr Suman Sood’s Press Release

Dr Suman Sood – Medical Tribunal

I, Suman Sood have decided not to contest the HCCC at the Medical Tribunal proceedings. I have accepted my counsel Mr. Boulten and Mr Fordham’s advise that it is inappropriate for me to comment on the particulars in the HCCC case whilst the criminal proceedings are continuing. This is particularly so given that Section 128 of the Evidence Act does not apply to the Medical Tribunal proceedings and the limited protection provided to me by Section 122 of the Medical Practice Act.

Ms. Barbara Crossin has informed the HCCC regarding this. She also has stated in her letter to HCCC that this decision also reflects Dr. Suman Sood’s concern for her former patients.”

272. Ms Katzmann SC submitted the press releases show on Ms Sood's part a lack of insight as to her wrongdoing and a lack of any form of acknowledgement she did wrong. Further, she submitted that given the criminal proceedings referred to in the second press release only concerned the patient LT, the reference to s. 128 **Evidence Act** and the limits to which it gives a protection in this Tribunal, is not relevant to complaints which do not touch that patient's treatment.

273. Ms Katzmann SC submitted that Ms Sood could have, but did not, acknowledge her wrongdoing, but instead, by issuing statements including 'truth will ultimately prevail and justice will be achieved' merely persisted with what she had said in the past, a position 'which locks herself into a series of lies'.⁹⁶

274. Having considered them, we do not see the press releases of themselves as establishing dishonesty. However the one dated 30th August 2006, we consider, at the very least shows a lack of insight on her part.

275. There were, however, other instances of dishonesty established to the Tribunal's satisfaction:

- (a) It is apparent from her solicitor's affidavit used in the Supreme Court proceedings on 3rd July 2002 and thereafter, to stay the Medical Board's suspension order, that she falsely instructed her solicitor she had closed her practice following her suspension on 12th June 2002, when, as we have found, she continued to practice as though the order was never made;
- (b) Ms Sood applied for registration in Queensland on 1st October 2004. When doing so, she acknowledged she was subject to disciplinary proceedings, and purported to give a 'list of complaints'.⁹⁷ We are satisfied the list was both incomplete and misleading, and deliberately so.
- (c) She applied for registration in the ACT on 21st January 2003. The ACT Board asked her about disciplinary proceedings, including preliminary investigations or actions which might lead to disciplinary proceedings. But she gave only details of the conditions attached to her registration. When the ACT Board

⁹⁶ T 207

⁹⁷ Ex 'AK'

learned (as we are satisfied was the fact) there were thirteen open, current, investigations into her conduct, it refused her registration as her statement supplied was ‘materially false or misleading’. The Tribunal is satisfied that she gave the ACT Board information which was false, and knew it to be;

- (d) The Tribunal is satisfied she persuaded Dr Allen to give a false account of his part in the LT case when she appeared before the Medical Board on 12th June 2002;
- (e) The Tribunal is satisfied she persuaded Dr Allen to help her hide the fact she conducted the dilatation and curettage on TJ.

276. We are persuaded that the respondent is a dishonest person.

277. As Priestley JA said in *Richter v Walton* (NSWCA, 15 September 1993, unreported),

“Even in regard to the most commonplace medical matters the trust a patient places in a doctor is considerable. In some cases, ... the patient's trust cannot help but be almost absolute. The doctor's power in regard to the patient in such cases is also very great. I do not mean power in an abstract way but as a matter of fact; the extent of the power will vary according to the temperament of the patient, but the doctor with some patients and for limited periods, because of the relationship in which they are temporarily placed, is in a position to do whatever the doctor wants with the body of the patient. This is one of the reasons why doctors are subject to correspondingly great obligations and are expected to maintain very high standards: all this being very much in the public interest.”⁹⁸

278. Similarly, in *Medical Practitioners Board of Victoria v McGoldrick* [1999] VSCA 215 Buchanan JA said at [24]

“Medical practitioners occupy a position of considerable trust, and it is in the public interest that they should merit that trust. Accordingly, it is to be expected that medical practitioners will be scrupulously honest in their dealings with patients, with other doctors and those in related professions such as nurses, radiologists and technicians and support staff and with the government departments with which they deal in the course of their practice.”

⁹⁸ Adopted by the Court in *Health Care Complaints Commission v Litchfield* (1997) 41 NSWLR 630 at 638

279. In *McBride v Walton* (NSWCA 15 July 1994, BC 9402907) in dismissing the appellant's submission that the doctor's practice of medicine has not been affected by any manifestation of dishonesty, Handley JA observed:

“Parliament has made a legislative judgment that persons who were not of good character should not be registered. Medicine was to be an honourable as well as skilled and learned profession” (BC9402907 at 6).

280. Having in mind our findings as to her dishonesty, we are persuaded the respondent is not of good character.

Complaint 10

On 23 August 2006 the practitioner was convicted of the charge that on 20 May 2002 at Fairfield in the State of New South Wales she did unlawfully administer to a woman a drug with intent to procure her miscarriage.

281. The HCCC tendered a certificate of conviction to make good this complaint. We are satisfied it is made out.

Complaint 11

On 23 August 2006 the practitioner was convicted of the charge that on 20 May 2002 at Fairfield in the State of New South Wales she did unlawfully cause to be taken by a woman a drug with intent to procure her miscarriage.

282. The HCCC tendered a certificate of conviction to make good this complaint. We are satisfied it is made out.

Conclusion and Summary

283. By reason of the Tribunal's findings above, we are satisfied the respondent is guilty of unsatisfactory professional conduct and professional misconduct as alleged, in complaints 1, 2, 3, 4, 5, 6, 7, and 8. We also find proved 9, 10 and 11, and by reason of those findings we are also satisfied the respondent is guilty of 'unsatisfactory professional conduct' and 'professional misconduct', as well as being not of good character.

284. The complaints established show that the respondent:
- (a) lacks competence as a medical practitioner;
 - (b) is dishonest with her patients, fellow professionals, and the Health Insurance Commission;
 - (c) has knowingly misled the Medical Board and the District Court and others;
 - (d) has failed to keep proper medical records, and has created false ones when she has seen it as necessary in her own interests;
 - (e) shows indifference to orders of the Medical Board and to legislation which regulates the Medical Profession.
 - (f) Has difficulties learning from complaints and peer reviews.
285. Proceedings before the Tribunal are not to punish a doctor, although its orders may have that effect. The Tribunal is concerned rather with the protection of the public and maintaining the standards of the profession: *Law Society of NSW v Foreman* (1994) 34 NSWLR 408; *HCCC v Litchfield* (1997) 41 NSWLR 630 @ 637D – 638E; *Buttsworth v Walton* BC 9101315 @ 15.
286. We bear in mind too that although a doctor has been dealt with by the criminal law where the conduct dealt with by the Tribunal has criminal consequences, it is no defence in the proceedings before the Tribunal that double jeopardy is involved: *Litchfield @ 635D*); *Zaidi v HCCC* (1998) 44 NSWLR 82 @ 93F.
287. This case shows very clearly a need to protect the public from an incompetent and dishonest medical practitioner, and assist to maintain public trust in the medical profession.
288. By reason of the respondent's serious flaws in ability and character, the Tribunal has serious doubts that she will ever be regarded as a fit and proper person to practise medicine. We see the only way to provide properly for the protection of the public, and maintenance of standards in and respect for the medical profession, is to order her deregistration and restrict her from re-applying for ten years.

Findings and Orders

1. The respondent is guilty of
 - (a) unsatisfactory professional conduct;
 - (b) professional misconduct
2. The respondent is not of good character.

Orders

1. The respondent is deregistered.
2. The practitioner is not to apply for re-registration as a medical practitioner for ten years.

Judge WALMSLEY SC

Dr V SUTTON

Dr J QUILTER

Ms J HOUEN