IN THE MATTER OF:	The *Medical Act*, S.N.S. 2011, c. 38
and	
IN THE MATTER OF:	A Settlement Agreement between the College of Physicians and Surgeons of Nova Scotia ("the College") and Dr. Jacob Puthenparumpil ("Dr. Puthenparumpil")

HEARING COMMITTEE DECISION

Date Heard:	April 26, 2019
Location:	Halifax, Nova Scotia
Hearing Committee:	Mr. Raymond F. Larkin, Q.C. Dr. P. Scott Theriault Dr. Cathy MacDougall Dr. Donald Langille Ms. Gwen Haliburton
Counsel:	Marjorie Hickey, QC, Counsel for the College of Physicians and Surgeons of Nova Scotia W. Harry Thurlow, Counsel for Dr. Jacob Puthenparumpil

1. Dr. Jacob Puthenparumpil is a urologist practicing mainly at the Colchester East Hants Health Centre. He is the subject of two unrelated complaints which have been referred to the Hearing Committee.

2. At the hearing on April 26, 2019 the Hearing Committee decided, with reasons to follow, that it would accept a Settlement Agreement between the College and Dr. Puthenparumpil that had been recommended by the Investigation Committee and referred to the Hearing Committee in accordance with Section 103 of the *Medical Practitioners Regulations,* NS Reg. 18/2015. The Settlement Agreement is incorporated into these reasons and attached as Appendix 'A'.

3. A Notice of Hearing, dated March 26, 2019, was provided to Dr. Puthenparumpil by the College. After extensive discussions between Counsel for the College and Dr. Puthenparumpil and consultations with the Investigation Committee it was agreed to issue a revised Notice of Hearing. The revised Notice of Hearing is attached to these reasons as Appendix 'B'.

4. The facts are set out in detail in the Settlement Agreement and need not be repeated. In the complaint involving Patient 'A', Dr. Puthenparumpil performed a surgical procedure without Patient 'A's informed consent. He failed to confirm that Patient 'A' fully understood the procedure when seeking informed consent and proceeded under a mistaken belief that consent had been obtained. Dr. Puthenparumpil had failed to ensure an appropriate system was in place to obtain informed consent.

5. The second complaint related to Dr. Puthenparumpil's post-operative care of Patient 'B'. While Patient 'B' was recovering from surgery to insert a suprapubic catheter Dr. Puthenparumpil failed to recognize the potential for a bowel injury before Patient B's discharge from hospital. He failed to be appropriately responsive to the concerns

expressed by Patient 'B's family respecting the symptoms experienced by Patient 'B'. Tragically, Patient 'B's sigmoid colon had been perforated during the surgical procedure carried out by Dr. Puthenparumpil. His abdominal and peritoneal cavities had filled with stool and he had became septic. Patient 'B' died 13 days later. There is no evidence or any suggestion that Dr. Puthenparumpil's failings in post-operative care caused the death of Patient 'B'.

6. During the investigation of both complaints, Dr. Puthenparumpil provided explanations for his conduct to the Investigation Committee that were not accurate. In the case of Patient 'A', Dr. Puthenparumpil failed to be accurate and complete in his explanations of his communications with Patient 'A'. In connection with Patient 'B', Dr. Puthenparumpil failed to be accurate and consistent in his explanation of his actions to the Investigation Committee.

7. In the Settlement Agreement, Dr. Puthenparumpil admits these facts, and that they constitute professional misconduct.

8. The Hearing Committee agrees that the facts set out in the Settlement Agreement and summarized above were unprofessional and fall within the definition of "professional misconduct" in the *Medical Act*.

9. The Settlement Agreement includes the Agreement between the College and Dr. Puthenparumpil on the disposition of these two complaints. The Settlement Agreement provides:

> 53. The parties acknowledge that the actions of Dr. Puthenparumpil warrant disciplinary sanction. While his lack of a prior disciplinary record provides a mitigating consideration, the parties agree that Dr. Puthenparumpil's actions respecting the obtaining of consent from Patient A and his lack of appropriate response to Patient B and his family

each warrant a reprimand. The parties also agree that Dr. Puthenparumpil's manner of responding to the College in an inaccurate, incomplete and inconsistent manner warrants a disciplinary sanction beyond a reprimand. As a result, the following disposition has been agreed upon:

a. Dr. Puthenparumpil is reprimanded for his professional misconduct arising from the allegations involving Patient A, as set out in paragraph 50, a, b, and c;

b. Dr. Puthenparumpil is reprimanded for his professional misconduct arising from the allegations involving Patient B, as set out in paragraph 51, a, and b;

c. Dr. Puthenparumpil is reprimanded for and shall have his licence to practice medicine suspended for a period of one month, at a time to be agreed upon with the College, as a result of his actions arising from the allegations set out in paragraph 50, d and 51, c;

d. A condition is imposed on Dr. Puthenparumpil's licence to practice medicine requiring him to complete the following remedial education at a time and in such form as determined by the College's Physician Performance Department:

i. Education respecting the meaning and importance of informed consent;
ii. Education respecting the importance of post-operative assessments;
iii. Education respecting the need for ethical communications, with particular emphasis on the need for ethical communication with the College.

54. In the event that Dr. Puthenparumpil does not comply with the conditions outlined above, his licence to practice medicine shall be immediately suspended pending full compliance, as determined by the Physician Performance Department of the College.

10. At the hearing, counsel for the College and for Dr. Puthenparumpil agreed that the one-month suspension referred to in paragraph (c) above should be served between June 22, 2019 and July 21, 2019, inclusive.

Legislative Context and Principles

11. This matter comes before the Hearing Committee in accordance with Section 51 of the *Medical Act*, which provides:

> 51 Where an investigation committee refers a matter to a hearing committee, the College may, before the commencement of a hearing by the hearing committee, enter into a settlement agreement with the respondent, to be dealt with in accordance with the regulations.

12. The Medical Practitioners Regulations make provision for the negotiation of a settlement agreement between the Registrar and the medical practitioner who is subject to a complaint. Sections 101 and 102 of the Regulations provide in part as follows:

> 101 (1) A proposed settlement agreement may be initiated in writing by the Registrar or the respondent at any time before a hearing begins.
>
> (2) A proposed settlement agreement must include all of the following:
>
> (a) sufficient facts and admissions to support the agreed disposition;
> (b) an agreement on costs
> (c) the respondent's consent to a specified disposition conditional on the acceptance of the settlement agreement by an investigation committee and a hearing committee.
>
> (3) A settlement agreement may include any disposition that could be ordered by a hearing committee under the Act or these regulations.

> 102 (1) An investigation committee may recommend acceptance of a settlement agreement if it is satisfied that all of the following conditions are met:
>
> > (a) the public is protected;
> > (b) the conduct or its causes can be, or have been, successfully remedied or treated, and the respondent is likely to successfully pursue any remediation or treatment required;
> > (c) the content of the proposed settlement agreement provides sufficient facts and admissions to support the agreed disposition;
> > (d) settlement is in the best interests of the public and the profession.

13. The procedure to be followed by the Hearing Committee in considering a settlement agreement is set out in Section 103 of the Medical Practitioners Regulations as follows:

> 103 (1) If a hearing committee accepts a settlement agreement, the settlement agreement forms part of the order of a hearing committee disposing of the matter and, except as provided in subsections 104(3) and (4) for breaches of the settlement agreement, there is no hearing.
>
> (2) If a hearing committee does not accept a settlement agreement, it must do one of the following:
>
> > (a) suggest amendments to the settlement agreement and return it to the Registrar and the respondent for review;
> > (b) reject the settlement agreement, in which case the matter is referred to another panel of a hearing committee for a hearing.
>
> (3) If both the Registrar and the respondent do not agree with the amendments to a settlement agreement suggested under clause (2)(a), the settlement agreement is deemed to be rejected and the matter must be referred to another panel of the hearing committee for a hearing.
>
> (4) If both the Registrar and the respondent agree with the amendments to a settlement agreement suggested under clause (2)(a), the settlement agreement must be approved by a hearing committee.

(5) A person who sits on a panel of a hearing committee that considers a settlement agreement must not sit on a panel of a hearing committee that conducts a hearing related to the same complaint.

14. In considering whether to accept a settlement agreement between a medical practitioner and the College, the Hearing Committee is governed by the purpose of the *Medical Act* and the duties of the College generally, as set out in Section 5 of the *Medical Act*, which provides:

5 In order to

(a) serve and protect the public interest in the practice of medicine; and

(b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall

(c) regulate the practice of medicine and govern its members through

(i) the registration, licensing, professional conduct and other processes set out in this Act and the regulations,
(ii) the approval and promotion of a code of ethics,
(iii) the establishment and promotion of standards for the practice of medicine, and
(iv) the establishment and promotion of a continuing professional development program; and

(d) do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College.

15. In accordance with Section 5, the mandate of the Hearing Committee is to serve and protect the public's interest in the practice of medicine. The public interest is first and foremost the protection of the public.

Deference

16. In considering a proposed settlement agreement, the Hearing Committee is generally inclined to defer to the judgement of the Investigation Committee on the terms of the Settlement Agreement. Settlement Agreements are negotiated between the Registrar and the practitioner and include reasonable compromises acceptable to the Investigation Committee. Reasonable, acceptable compromises are beneficial both to the College and the practitioner and consistent with the public interest in expeditious handling of complaints. In matters of disposition where there are licensing sanctions, the Hearing Committee considers whether the sanctions recommended by the Investigation Committee fall within a reasonable range of possible sanctions.

17. In this case, the Investigation Committee has engaged with Dr. Puthenparumpil over a two-year period and played an active role in considering the circumstances that generated the revised Notice of Hearing and the negotiation of the proposed Settlement Agreement. The Investigation Committee has had access to expert advice and information that is not available the Hearing Committee. Considerable deference to the Investigation Committee's recommendations on disposition is appropriate. Accordingly, if the various elements of the recommended disposition fall within a range of reasonable outcomes, the Hearing Committee will accept the recommended dispositions.

Reprimands

18. The Hearing Committee is satisfied that each of the reprimands in the proposed Settlement Agreement fall within the range of reasonable sanctions, particularly in conjunction with the condition on Dr. Puthenparumpil's license to practice, that he complete remedial education respecting the meaning and importance of informed consent and the importance of post-operative assessments.

19. With respect to Patient 'B' the Hearing Committee was concerned about the appropriateness of a reprimand in the circumstances, which included the tragic death of Patient 'B'. However, we were assured by Counsel that nothing in Dr. Puthenparumpil's misconduct caused Patient 'B's death. If it had, obviously, a more serious sanction would have to be considered.

20. A reprimand for professional misconduct is a significant sanction. All medical practitioners take pride in their professionalism in caring for patients. A finding of professional misconduct by a practitioner's peers and its publication for the rest of the profession and, indeed, the public is a serious blow to the reputation of a practitioner. It also sends a message to other practitioners that the College will take seriously the conduct that amounted to professional misconduct in a particular case.

21. In this case, failing to perform a surgical procedure without a patient's informed consent is professional misconduct and a reprimand falls within the reasonable range of sanctions.

22. Likewise, failure to recognize the potential of bowel injury before discharging Patient 'B' without appropriate responses to the concerns expressed by his family is professional misconduct for which a reprimand is appropriate.

One Months' Suspension

23. The proposed disposition also includes a one-month suspension of Dr. Puthenparumpil's license to practice for providing inaccurate, inconsistent and incomplete explanations in his communications with the College during the investigation of the complaints. While a reprimand is a significant sanction, there are circumstances where a reprimand is not a sufficient response to professional misconduct and a stronger sanction is necessary to preserve the integrity of the medical profession and to maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine.

24. The ability of the College to regulate the practice of medicine can be undermined if inaccurate, incomplete and inconsistent explanations are provided by a medical practitioner in response to a complaint under the Medical Act. As uncomfortable as it may be for a medical practitioner to answer to their peers for unprofessional conduct, it is essential that they do so with integrity and that they strive for the most accurate and complete response possible.

25. A one-month suspension is consistent with recent decisions of the Hearing Committee approving settlement agreements.

26. In *College of Physicians and Surgeons of Nova Scotia and Dr. Samuel Chun*, a Hearing Committee approved a one-month suspension largely because the physician had reported to his patient's family physician that he had performed surgery when he had not, and failed to take sufficient steps to ensure that the patient was referred to general surgery. This contributed to a delay in diagnosis of the patient. This Committee concluded that a one-month suspension, although a significant penalty, was proportionate to the physician's misconduct in respect of that patient.

27. The recent decision of this Committee in *College of Physicians and Surgeons of Nova Scotia and Dr. Juan Rivas,* approved a Settlement Agreement that included a three-month suspension. The reasons for the three-month suspension were primarily the failure of the physician involved to follow undertakings given to the College but also included attempting to mislead the College by providing false and incomplete information. We agreed that physician breached his duty to cooperate with the College and the professional conduct process by providing false and incomplete information, and thereby undermined the privilege of physician self-regulation and risked undertaking the public's trust in the medical profession and the College's ability to regulate the practice of medicine.

28. In the course of that *Rivas* decision, we cited *Ontario College of Physicians and Surgeons v Mohammad Rassouli-Rashti,* 2008 ONCPSD 20. In that case, the Discipline Committee of the College of Physicians and Surgeons of Ontario imposed a three-month suspension for intentionally providing false and misleading information to the College on the basis that this penalty would serve as a general deterrent to the membership, showing that attempting to obstruct the College in an investigation into behaviour that is harmful to the public will not be tolerated.

29. The conduct of Dr. Puthenparumpil in the present matter is not identical to the physicians' conduct in these earlier cases. Although Dr. Putherparumpil failed to give accurate and complete explanations to the Investigation Committee, he did not intentionally attempt to obstruct the investigations. In a range of one to three months' possible suspensions his conduct is at the low end of that range. In our opinion a one-month suspension is reasonable and proportionate to the seriousness of Dr. Puthenparumpil's misconduct.

30. In our view, the proposed disposition of these two complaints in the Settlement Agreement falls within the range of reasonable dispositions for the professional misconduct in this case. Accordingly, we accept the recommendation of the Investigation Committee and approve the Settlement Agreement. The Settlement Agreement, including the agreement of the parties that the one month suspension of Dr. Putherparumpil's licence to practice is to be served from June 22, 2019 to July 21, 2019 inclusive, is incorporated into these reasons and constitutes an Order of the Hearing Committee.

Decision issued this 7th day of May, 2019.

Raymond F. Larkin, Q.C., Chair

scott.theriault@nshealth.ca
Digitally signed by scott.theriault@nshealth.ca
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Dr. P. Scott Theriault

Dr. Cathy MacDougall

Dr. Donald Langille

Ms. Gwen Haliburton

TAB A

PROVINCE OF NOVA SCOTIA)

COUNTY OF HALIFAX)

IN THE MATTER OF: The ***Medical Act***, S.N.S. 2011, c. 38

- and-

Dr. Jacob Puthenparumpil

SETTLEMENT AGREEMENT

Dr. Jacob Puthenparumpil, a medical practitioner in the Province of Nova Scotia, and a member of the College of Physicians and Surgeons of Nova Scotia (the "**College**"), hereby agrees with, and consents to, the following in accordance with the provisions of the *Medical Act*:

I. FACTS

BACKGROUND OF DR. PUTHENPARUMPIL

1. Dr. Jacob John Puthenparumpil is a urologist practicing in the Northern Zone, mainly at the Colchester East Hants Health Centre. He also practices part time providing care to military personnel at CFB Stadacona.

2. He received his Royal College accreditation and became fully licensed to practice in Nova Scotia in 2008 after completing a fellowship (2003-2006) and residency (2006-2008) at the QEII Health Sciences in Halifax. Prior to this, Dr. Puthenparumpil practiced in India for 10 years after completing medical School at M.P. Shah Medical College in 1992.

3. Apart from the subject matters of this Settlement Agreement, Dr. Puthenparumpil has had no disciplinary findings against him during the time he has been licensed with the College.

COMPLAINTS TO THE COLLEGE

4. The College received two unrelated complaints against Dr. Puthenparumpi, dated within months of each other and related to care provided to patients in 2016. There have been no other complaints against Dr. Puthenparumpil since the filing of these two complaints.

First Complaint

5. The first complaint was from a 26 year old male patient of Dr. Puthenparumpil, known herein as Patient A.

6. Patient A had an office consultation with Dr. Puthenparumpil respecting pain during sexual function. At the consult meeting, there was discussion about the various options available to address Patient A's symptoms. These options included doing nothing, having a procedure known as a Frenulum Release, or having a circumcision. Dr. Puthenparumpil discussed the risks and success rates of each option. He advised Patient A that if the Frenulum Release did not work Patient A would need to return for the circumcision.

7. Patient A identified clearly to Dr. Puthenparumpil that he wanted to proceed with the Frenulum release. As Patient A left the consultation room Dr. Puthenparumpil handed him a completed a booking slip which read "Circumcision". Patient A then returned to the office to inquire why this notation was on the booking slip and he was advised by Dr. Puthenparumpil that the word "Circumcision" was written so he would have the appropriate surgical tray to perform the Frenulum Release.

8. Dr. Puthenparumpil wrote to Patient A's family physician following this office consult, advising he was proceeding with a Frenulum Release.

9. On the day of the scheduled procedure, prior to entering the Operating Room, Patient A was being prepped by nurses. He was asked the name of the procedure he was undergoing and could not recall the name but described the procedure. One of the nurses asked if it was a Frenulum Release that he was describing and Patient A confirmed that it was.

10. In the Operating Room, prior to the commencement of the procedure, and prior to the administration of any sedation, Dr. Puthenparumpil provided Patient A with a consent form to sign. Patient A read the form which was typed, with the exception of the word "circumcision" which was handwritten. Patient A assumed this was for administrative purposes similar to the booking slip and proceeded under the impression he would only receive a frenulum release. He did not raise questions with Dr. Puthenparumpil or the Physician Assistant who was in attendance as he was confident that Dr. Puthenparumpil knew the procedure he had requested. The staff who were in the OR were different from the nurses who spoke with Patient A about the Frenulum Release during the OR prep.

11. Patient A asked whether Dr Puthenparumpil would be just cutting the little part on the tip and not the whole thing, and Dr. Puthenparumpil replied "No, not the whole thing." This was in keeping with Patient A's understanding of the Frenulum Release procedure.

12. Patient A then underwent a procedure, which he found very painful.

13. When the procedure was complete Patient A learned that he had undergone a circumcision and he was very upset.

14. Dr. Puthenparumpil met with Patient A and his mother in the recovery room. He indicated to Patient A words to the effect of "Well, it's for the best anyway. We probably would have had to come back and do a circumcision, anyway." Patient A responded that he didn't care about that as he had not wanted to have a circumcision performed. Dr. Puthenparumpil advised that he had signed a consent form for a circumcision. Patient A remained very upset.

15. Patient A filed a complaint with the College.

16. In responses provided to the College, Dr Puthenparumpil indicated that during the office consult, he had recommended the circumcision but Patient A was not sure that he wanted to proceed. Dr. Puthenparumpil further states that while he wrote a consult letter to the family physician referring to a Frenulum Release, he knew that it was the minimum procedure he would undertake. He further indicates that he told Patient A on the day of the procedure while in the OR that he did not think Frenulum Release would be adequate, and states he recommended proceeding with a circumcision and recalls using the word "circumcision" in his direct conversation with Patient A.

17. There was nothing in the consult letter to the family physician to suggest the Frenulum Release was the minimum procedure planned by Dr. Puthenparumpil. It was the only procedure that was referericed.

18. In Patient A's communications with the College he indicates there was no uncertainty about the procedure he had selected during the office consult. Further, he states there was no mention of the word "circumcision" by Dr. Puthenparumpil at any time while in the OR.

19. The Physician Assistant who was in attendance in the OR recalls the discussion about cutting the tip, but does not recall at any time that Dr. Puthenparumpil verbalized circumcision as the procedure to be performed.

20. Following this event with Patient A, Dr. Puthenparumpil initiated some changes at the clinic with respect to the manner in which consent was given for surgical procedures, to avoid confusion in the future.

21. Patient A believes the consent procedure was not properly handled and that he had a procedure he had not wanted to undergo.

Second Complaint

22. The second complaint was from the daughter of a 87 year old male patient who had a history of urinary retention issues and bladder outlet obstruction. This patient is referred to herein as Patient B.

23. Following a hospital discharge with an indwelling foley catheter, Patient B was accompanied by his daughter and a caregiver to an office visit with Dr. Puthenparumpil. Options to address Patient B's issues included a trial of voiding versus leaving the indwelling foley catheter on a long term basis. Some months later, Patient B underwent a cystoscopy performed by Dr. Puthenparumpil and no abnormalities were found. He remained with the indwelling catheter which was changed by VON staff.

24. Patient B was later seen by a neurologist who recommended a suprapubic catheter. He was referred to Dr. Puthenparumpil for this purpose. Patient B met with Dr. Puthenparumpil in the presence of his daughter, and it was agreed to proceed with the suprapubic catheter.

25. The risks of the procedure were reviewed with Patient B, including the risk of bowel injury.

26. On the day of surgery, Patient B was seen pre-operatively by the anesthetist, but not by Dr. Puthenparumpil. Hospital protocol did not require a pre-op visit from the surgeon.

27. Patient B was taken to the OR and underwent the procedure to insert the suprapubic catheter. Part of the procedure involved the positioning of the catheter in the bladder, guided by a cystoscope. During the procedure when the catheter was being inserted, it curled into the bladder diverticulum, requiring Dr. Puthenparumpil to pull it back and reposition it.

28. Upon completion of the surgery and time in the recovery room, Patient B was wheeled on a stretcher to the day surgery recovery area, where his daughter and care giver attended with

him. The daughter indicates her father was complaining of pain and he had gross hematuria in his catheter bag. His vital signs were stable.

29. The daughter (who was a registered nurse) asked the nurse on duty if her father could have something for pain, and the nurse advised that patients usually don't need anything for pain following this procedure. The nurse advised she would contact Dr. Puthernparumpil and then returned to say he was on the phone and he would come by when finished.

30. Prior to Dr. Puthenparumpil's arrival, the anesthetist was in the area and the patient's daughter requested that he provide pain medication to her father. Patient B still had his IV line in and the medication was administered intravenously.

31. Within approximately one hour post-surgery, Dr. Puthenparumpil attended in the day surgery recovery area and Patient B's daughter indicates she stepped away from the bed to speak with him, as she did not want her father to overhear her concern about the amount of hematuria in his catheter bag.

32. When Dr. Puthenparumpil arrived in the day surgery recovery area and was met by the daughter, she indicates that before she said anything, Dr. Puthenparumpil indicated that her father did fine. When asked about the hematuria, Dr. Puthenparumpil indicated he would probably have it for a few days and that it was not unusual.

33. Patient B's daughter advised the College that Dr. Puthenparumpil did not speak directly with her father at this time.

34. The nurses later assisted Patient B with putting on his clothes, reinforced the dressing on the suprapubic site, and replaced the catheter bag with a leg bag. They assessed Patient B as meeting the criteria for discharge, and he was discharged within approximately two hours of completion of the surgery, in accordance with hospital protocol. He was given appropriate discharge instructions by the nursing staff.

35. Upon arrival at his home less than an hour later, Patient B complained of severe pain and there was no urine output from the catheter site. His daughter attempted to irrigate the catheter and found his abdomen to be distended and rigid. An ambulance was called and Patient B underwent emergency surgery. When Dr. Puthenparumpil was advised that the daughter called to report she was taking her father to the ER, he telephoned the ER physician to recommend expedited assessment.

36. During this emergency surgery it was learned that the sigmoid colon was perforated during the surgical procedure carried out by Dr. Puthenparumpil. The abdominal and peritoneal cavities had filled with stool and Patient B became septic. He died 13 days later.

37. The patient's daughter filed a complaint with the College. She recognized that bowel injury was a risk of the type of surgery performed on her father. Her concerns focused on the post-operative timeframe, and what she described as a lack of any post-operative assessment by Dr. Puthenparumpil, despite her father's pain and the amount of visible hematuria in the catheter bag.

38. She states that when she had her conversation with Dr. Puthenparumpil after her father had been given pain medication by the anesthetist, he left without doing any physical examination, and that he had neither spoken with her father nor been close enough to the bed to perform any kind of physical examination or to observe the hematuria in the catheter bag.

39. In the responses to the complaint provided by Dr. Puthenparumpil, he acknowledges that he knew that the patient had been in pain and that the anesthetist had given pain medication to Patient B, at the time he met with Patient B's daughter.

40. He states that he performed enough of an assessment of the patient to determine that the suprapubic site was clean and that the stomach was not distended. He states he observed only minor hematuria in the catheter.

41. He indicated that he told the family that he would return to check on Patient B and that he did, in fact, return. He observed the patient to be dressed, spoke directly to him to inquire about his pain, and advised that Patient B told him he was feeling much better and ready to be discharged home.

42. Patient B's daughter disputed the facts contained in Dr. Puthenparumpil's response to the College. She states that Dr. Puthenparumpil only entered the day surgery once and spoke to her, not to her father. She states he did not perform any kind of examination and that he did not observe the amount of hematuria in the catheter bag as the bag was hanging on the opposite side of the bed from where Dr. Puthenparumpil was standing.

43. She states that Dr. Puthenparumpil did not return for a second conversation, and that no physical assessment was done at any time by Dr. Puthenparumpil. There are no chart notes from Dr. Puthenparumpil or the nurses to indicate he performed any kind of examination at any time in the day surgery area.

44. In Dr. Puthenparumpil's further communications with the College, his descriptions of the nature of his assessment evolved. In his interview with the Investigation Committee he indicated that he had palpated the abdominal area. In his most recent communication to the College he indicates that his assessment was more visual. He acknowledged he did not perform a full abdominal palpation but believed he did an appropriate assessment by visualizing the area and gently touching the insertion site to ensure the catheter was intact and the belly was soft. He advised that his hand movement to lift up Patient B's gown and the bed sheet to perform this touching was a very quick and soft movement, and that he did not lift up the gown in a way that would be visible to others in the room.

45. In his interview with the Investigation Committee, Dr. Puthenparumpil told the Committee that when he first arrived in the day surgery area to speak with Patient B's daughter, he had a specific conversation with Patient B about the location of his pain, and that he checked his abdomen, the dressing specifically, and then went around the bed to look at the catheter bag. He reported to the Committee that Patient B's abdomen was soft and not distended, and then indicated he had palpated the abdomen. He also reported to the Committee that when he came back to see Patient B prior to his discharge and spoke with him, he observed the catheter bag to have no worse hematuria than was the case when the patient left the OR.

46. At this time, however, the catheter bag had been changed to a leg bag and was covered by the patient's jogging pants. When this was pointed out to Dr. Puthenparumpil by the Committee he then indicated that he could clearly recall seeing the bottom of the bag.

47. The Investigation Committee was left with differing versions of events that could not be reconciled. They were concerned that Dr. Puthenparumpil's version of events added or varied details each time it was told.

II. MATTERS REFERRED TO HEARING

48. The Investigation Committee conducted a series of interviews with respect to both complaints. Upon completion of the investigation the Committee referred several allegations to a hearing. Following the referral to a hearing and the receipt of further communications from Dr. Puthenparumpil, the allegations were revised and a replacement Notice of Hearing was issued.

49. The Revised Notice of Hearing charges Dr. Puthenparumpil with professional misconduct with respect to the following matters:

50. In connection with Patient A, it is alleged that Dr. Puthenparumpil committed professional misconduct by

a. Failing to confirm that the patient fully understood the procedure when seeking informed consent and thereby proceeded under a mistaken belief that consent had been obtained;

b. Performing the surgical procedure without the patient's informed consent;

c. Failing to ensure an appropriate system was in place to obtain informed consent;

d. In his interactions with the College during the investigation of this matter, failing to be accurate and complete in his explanations of his communications with the patient.

51. In connection with Patient B, it is alleged that Dr. Puthenparumpil committed professional misconduct by:

a. Failing to recognize the potential for bowel injury prior to the patient's discharge;

b. Failing to be appropriately responsive to the concerns expressed by the patient's family respecting the symptoms experienced by the patient;

c. In his interactions with the College during the investigation of this matter, failing to be accurate and consistent in his explanations of his actions.

III. ADMISSIONS

52. Dr. Puthenparumpil admits the allegations outlined above and that these allegations constitute professional misconduct.

IV. DISPOSITION

53. The parties acknowledge that the actions of Dr. Puthenparumpil warrant disciplinary sanction. While his lack of a prior disciplinary record provides a mitigating consideration, the parties agree that Dr. Puthenparumpil's actions respecting the obtaining of consent from Patient A and his lack of appropriate response to Patient B and his family each warrant a reprimand. The parties also agree that Dr. Puthenparumpil's manner of responding to the College in an

inaccurate, incomplete and inconsistent manner warrants a disciplinary sanction beyond a reprimand. As a result, the following disposition has been agreed upon:

a. Dr. Puthenparumpil is reprimanded for his professional misconduct arising from the allegations involving Patient A, as set out in paragraph 50, a, b, and c;

b. Dr. Puthenparumpil is reprimanded for his professional misconduct arising from the allegations involving Patient B, as set out in paragraph 51, a, and b;

c. Dr. Puthenparumpil is reprimanded for and shall have his licence to practice medicine suspended for a period of one month, at a time to be agreed upon with the College, as a result of his actions arising from the allegations set out in paragraph 50, d and 51, c;

d. A condition is imposed on Dr. Puthenparumpil's licence to practice medicine requiring him to complete the following remedial education at a time and in such form as determined by the College's Physician Performance Department:

    i. Education respecting the meaning and importance of informed consent;

    ii. Education respecting the importance of post-operative assessments;

    iii. Education respecting the need for ethical communications, with particular emphasis on the need for ethical communication with the College.

54. In the event that Dr. Puthenparumpil does not comply with the conditions outlined above, his licence to practice medicine shall be immediately suspended pending full compliance, as determined by the Physician Performance Department of the College.

V. RETENTION OF JURISDICTION

55. The Hearing Committee of the College, in its present or successor form, retains jurisdiction over this matter to deal with any issues of interpretation, implementation or variation of this Agreement.

VI. COSTS

56. Dr. Puthenparumpil agrees to pay costs to the College in the amount of $20,000 inclusive of HST, representing a portion of the College's costs of investigating this matter. These costs shall be payable by Dr. Puthenparumpil in quarterly instalments over a three year period, commencing with the first payment of $1666.66 on or before July 31, 2019 and continuing every four months thereafter until paid in full. Costs are a debt due to the College, recoverable by way of civil action in the event Dr. Puthenparumpil does not fulfill the obligations set out in this paragraph. Dr. Puthenparumpil agrees that in the event he defaults on any payment under this agreement, the full amount shall be immediately due, and his licence shall be suspended pending payment in full. In the event the full amount is not paid in full by July 31, 2022, judgment shall be entered against him for the balance of the Costs remaining unpaid together with interest compounded at the rate of six percent (6%) per annum.

VII. PUBLICATION

57. A summary of this Settlement Agreement as prepared by the Registrar, and a summary of any decision rendered by a Hearing Committee, as approved by the Registrar, shall be published on the College's website.

VIII. EFFECTIVE DATE

58. This Settlement Agreement shall only become effective and binding when it has been recommended for acceptance by an Investigation Committee of the College, and accepted by the Hearing Committee appointed to hear this matter.

Dated at Halifax, Nova Scotia on April 26, 2019.

Witness

Dr. Jacob Puthenparumpil

Dated April 26, 2019, 2019

Witness

Marjorie Hickey, Q.C.

Counsel for the College of Physicians and Surgeons of Nova Scotia

Dated Apr 26/19, 2019

Witness

Chair

Investigation Committee, College of

Physicians and Surgeons of Nova Scotia

Witness

Chair

Investigation Committee, College of

Physicians and Surgeons of Nova Scotia

Dated Apr 26, 2019

Dated _____, 2019

Witness

Chair

The Hearing Committee, College of Physicians and Surgeons of Nova Scotia

Dated April 24, 2019

TAB B

PROVINCE OF NOVA SCOTIA)
CITY OF HALIFAX)

IN THE MATTER OF: **The College of Physicians and Surgeons of Nova Scotia**

- and –

IN THE MATTER OF: **Dr. Jacob Puthenparumpil**

REVISED NOTICE OF HEARING

You are hereby notified that the College of Physicians and Surgeons of Nova Scotia will conduct a hearing to consider allegations of professional misconduct and incompetence pursuant to the *Medical Act,* S.N.S. 2011, c. 38.

The hearing will be held at the offices of McInnes Cooper, 1300-1900 Upper Water Street, Purdy's Wharf Tower II, Halifax, Nova Scotia commencing on May 1, 2019 at 0930 and thereafter on such dates as determined by the Hearing Committee.

Your presence at the stated time of the hearing is required. You may attend with legal counsel or other representative of your choice, and may present evidence or witnesses on your behalf.

TAKE NOTICE that if you do not attend this hearing, the Hearing Committee may proceed in your absence and you will not be entitled to any further notice of proceedings.

Any documentary evidence to be used by the Nova Scotia College of Physicians and Surgeons at the hearing will be made available to you in advance of the hearing in accordance with the *Medical Act.* You have all the rights set out in section 53 of the *Medical Act* as well as the disclosure obligations set out in the same section.

The Hearing Committee will consider the following matters:

THAT being registered under the *Medical Act* and being a physician in the Province of Nova Scotia, it is alleged that:

1. With respect to Patient A in relation to a surgical procedure performed on or about May 26, 2016, Dr. Puthenparumpil:

a. Failed to confirm that the patient fully understood the procedure when seeking informed consent and thereby proceeded under a mistaken belief that consent had been obtained;

b. Performed the surgical procedure without the patient's informed consent;

c. Failed to ensure an appropriate system was in place to obtain informed consent.

2. Dr. Puthenparumpil, in his interactions with the College and its Investigation Committee with respect to Patient A, failed to be accurate and complete in his explanations of his communications with the patient.

3. With respect to Patient B in relation to a surgical procedure performed on or about August 29, 2016, Dr. Puthenparumpil:

a. Failed to recognize the potential for bowel injury prior to the patient's discharge;

b. Failed to be appropriately responsive to the concerns expressed by the patient's family respecting the symptoms experienced by the patient.

4. Dr. Puthenparumpil, in his interactions with the College and its Investigation Committee with respect to Patient B, failed to be accurate and consistent in his explanations of his actions.

AND THAT THE ABOVE ALLEGATIONS CONSTITUTE PROFESSIONAL MISCONDUCT.

"professional misconduct" is defined in the *Medical Act* to include:

> such conduct or acts in the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional and that, without limiting the generality of the foregoing, may include breaches of
>
> (i) the Code of Ethics approved by the Council,
>
> (ii) the accepted standards of the practice of medicine, and
>
> (iii) the *Medical Act*, the regulations and policies approved by the Council;

Dated at Halifax, Nova Scotia, this 25th day of April, 2019.

Dr. D.A. Gus Grant
Registrar
College of Physicians and Surgeons of Nova Scotia

cc Mr. Harry Thurlow, Cox & Palmer

Marjorie Hickey, McInnes Cooper