MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO:	160/00/67C
IN THE MATTER	of the Medical Practitioners Act 1995
	-AND-
IN THE MATTER	of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **WARREN WING NIN CHAN** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mrs J Courtney, Dr G S Douglas, Dr B D King, Dr L F Wilson (Members)

Ms Kim Davies (Hearing Officer)

Ms K G Davenport (Legal Assessor)

Ms H Gibbons (Stenographer)

Ms J Wareham (Scopist)

Hearing held at Auckland on Wednesday 7 February 2001

APPEARANCES: Mr R Harrison QC for a Complaints Assessment Committee ("the CAC")

Dr W W N Chan - Not represented.

SUPPLEMENTARY DECISION:

THIS supplementary decision should be read in conjunction with Decision No. 159/00/67C dated 22 March 2001.

The Decision

1. In its Decision referred to above, the Tribunal found Dr Chan guilty of the Charge of professional misconduct laid against him by the Complaints Assessment Committee ("the CAC"). The Charge arose out of medical care given by Dr Chan to a patient, Ms A, in June and July 1996.

2. The allegations upon which the Charge was based were that there were serious deficiencies in Dr Chan's anaesthetic practice; that Dr Chan failed to adequately inform Ms A of the anaesthetic process, the surgical procedure (liposuction/liposculpture)) she was to undergo and the risks associated with that procedure; that he failed to provide adequate post-operative care; and that he failed to keep full and accurate records of his pre-operative, intra-operative and post-operative care of Ms A.

The Tribunal's Findings

3. The Tribunal's findings and the reasons for its Decision are set out in its Decision. In summary, those findings included:

3.1 The Tribunal was satisfied that there was no meaningful information given to Ms A prior to her liposuction surgery, either in terms of the relevant legal principles or the Medical Council's 1990 Statement to medical practitioners (para 54);

3.2 The Tribunal was satisfied that Dr Chan gave Ms A no information regarding the procedure, the anaesthetic to be administered, or any risks of the surgery, prior to the surgery being carried out on 24 July 1996 (para 54);

3.3 The Tribunal accepted the CAC's submission that Dr Chan took no steps whatsoever to obtain Ms A's informed consent to the liposuction operation. On the basis of Ms A's evidence, the Tribunal was satisfied that this omission extended to a failure to provide any information to Ms A regarding the particular nature, risks, benefits or wisdom of the surgery (para 57);

3.4 Dr Chan made no meaningful attempt to ascertain if Ms A understood information given to her by his employees (para 59);

3.5 He did not carry out any pre-operative assessment or physical examination of Ms A to ascertain if it was safe to administer an anaesthetic, which anaesthetic included the administration of 8 mgs of the sedative/hypnotic Hypnovel (paras 60-61 inc);

3.6 The CAC's witness, Dr Chamley confirmed that he had never administered a dose in this amount. His evidence was that this was *"an excessively large dose to use on a patient who is lying in the prone position, who has an unprotected airway, and in the presence of both Pethidine administered intravenously plus the additional effect from Valium and Palfium administered pre-operatively would raise serious concerns as to the possibility of respiratory obstruction or cessation of breathing"* (para 68);

3.7 Dr Chamley told the Tribunal that he regarded the combination of the drugs used to anaesthetise Ms A and the prone position she was placed in for the liposuction surgery as "*dangerous practice*". The Tribunal accepted that evidence notwithstanding that Dr Chan did not attend at the hearing and no evidence in his defence was offered, thereby precluding any opportunity to test this evidence either by cross-examination or rebuttal evidence (para 69);

3.8 The relevant guidelines and standards applicable to this case (ANZCA *Policy Document P9, Sedation for Diagnostic and Surgical Procedures*) which applies to sedation carried out by all medical practitioners, including non-anaesthetists like Dr Chan, clearly states that the object of sedation for diagnostic and surgical procedures carried out by non-anaesthetists is to *"… produce a degree of sedation for the patient, without loss of consciousness, so that uncomfortable diagnostic and surgical procedures may be facilitated. …"* (paras 63-64);

3.9 The underlying principle of the guidelines, which every practitioner should be aware of and which are widely accepted (albeit not mandatory) across the profession, is that an anaesthetist should be present unless "*rational communication*" with the patient is continuously possible during the procedure. The combination of drugs administered to Ms A would have been sufficient to put her into a state of heavy sedation leading inevitably to a loss of consciousness (para 65). It was Ms A's evidence that when she awoke in the course of the operation, with significant pain, more sedation was administered to make her go back to sleep (para 15);

3.10 The omissions identified on the part of Dr Chan demonstrate that the standard of care he provided to Ms A fell deplorably short of the standard of care she was entitled to expect (para 71);

3.11 The doctor's obligation to ensure that the patient is fairly and adequately informed of all of the risks, and benefits, of the surgery they are to undergo, and any

alternatives, applies even more so when the surgery is elective and there is no element of necessity or emergency (such as applied in Ms A's case, para 79-80);

3.12 A doctor's obligation to impart information to his patient does not depend upon the patient's ability to ask the right questions; it is a process; it requires the active participation of the doctor (para 79);

3.13 The patient must not be coerced, subtly or otherwise, into agreeing to undergo surgery, especially in circumstances where the surgery is elective, and there is significant financial remuneration to the practitioner (para 80);

3.14 In relation to the allegation that he failed to keep adequate records of his care of Ms A, the Tribunal's view was that the inadequacy of Dr Chan's record-keeping reflected the content and standard of his care of Ms A generally. The records were manifestly inadequate, and lacked any record of consultations, no record of which local anaesthetic was administered pre-operatively, no record of any tests or investigations undertaken pre-operatively, no record of post-operative monitoring, no record of information given or received (for example, there was no record Ms A telling Dr Chan's staff of her history of pre and post-operative vomiting) (para 84);

3.15 Notwithstanding this latter information provided by Ms A, and the heavy sedation administered, she was apparently left alone in the dark (post 6.00 pm on a July evening), in Dr Chan's office, post-operatively (para 85);

3.16 In relation to Particular 2, given the nature and extent of Dr Chan's failure, and the fundamental nature of the requirement to obtain proper informed consent, it was hard to imagine a more complete failure in his professional obligations on his part (para 89).

4. As already stated, Dr Chan did not appear at the hearing of the charge. An application for an adjournment of the hearing was received by the Tribunal on the morning of the hearing. That application was refused, for the reasons set out in Decision No. 158/00/67C.

5. However, the Tribunal's impression, gained from Dr Chan's conduct in relation to this Charge generally, and from the evidence provided to it at the hearing, is that Dr Chan's attitude to his patient, to his profession, and to this Tribunal is one of complete indifference and disinterest. This indifference, and his failings and omissions in this case, go to fundamental professional duties and obligations.

6. Mr Harrison QC, counsel for the CAC has submitted that the Tribunal's findings confirm a pattern of Dr Chan's *"reckless disregard"* for his professional duties. The Tribunal accepts that submission and has come to the view that Dr Chan's attitude demonstrated in this case carries with it real dangers for the safety of his patients, particularly potential patients, and thus the public generally.

7. It is also clear from the evidence provided at the hearing that liposuction surgery is not *"completely safe"*, as Dr Chan would have it in the information brochure provided to prospective patients. Recent surveys and research into liposuction are referred to in the Tribunal's substantive decision. In that research, the late 1990s mortality rate for liposuction is reported to be about 20 per 100,000 or 1 per 5000 procedures carried out in the United States. To put that in some context, the fatality rate of US motor vehicle accidents is 16.4 per 100,000 accidents.

8. Of even more concern in the present context, the most common general complications are excessive bleeding and complications from anaesthesia and, particularly relevant in the context of evidence of a complete absence of pre-operative anaesthetic assessment and post-operative care, *"many deaths occurred during the first night after discharge home; prudence suggests vigilant observation for residual "hangover" from sedative/anaesthetic drugs after lengthy procedures"*.

9. It is the Tribunal's clear view that Dr Chan is an unsafe practitioner.

10. In view of these concerns, the Tribunal spent some time on the day of the hearing considering whether or not it should exercise its powers under s104 of the Act, and suspend Dr Chan's registration until this Charge was resolved. Alternatively, having heard the evidence given by Ms A and Dr Chamley, it also considered amending the Charge to one of disgraceful conduct. Pursuant to clause 14 of the First Schedule the Tribunal may amend a charge in any way during the hearing of the charge.

11. Mr Harrison has also referred to Dr Chan's history of adverse professional disciplinary findings, and the persistent theme of the findings made by this Tribunal in Decision No 94/99/39C, and by its predecessor, the Medical Practitioners Disciplinary Committee (MPDC) on two occasions (appeals in respect of which were dismissed by the Medical Council in 1995 and 1996 respectively). As Mr Harrison has pointed out, Dr Chan has been on notice that his practices and procedures in relation to providing information, obtaining consent, and his clinical/operative procedures, are deficient since at least July 1995.

12. Dr Chan's history of professional disciplinary offending and the persistent themes in the nature of that offending were also taken into account by the Tribunal in the context of its considering whether or not to exercise its powers under s104 or clause 14.

13. In the event, the Tribunal decided that because:
    (a) it had not heard from Dr Chan, and he had not therefore had an opportunity to defend the Charge (although the Tribunal was satisfied that that was entirely a circumstance brought about by Dr Chan's own conduct);
    (b) the CAC did not make any application to the Tribunal in this regard;
    (c) the events under review occurred in 1996; and
    (d) the Tribunal had no knowledge of Dr Chan's current practices, (although Dr Chan's non-appearance at the hearing meant that the Tribunal was unable to ascertain what his current practices are directly from him);

    it would not exercise any of its powers provided under s 104 or clause 14, but it would wait to hear from Dr Chan in the event he lodged any submissions in relation to penalty.

14. In view of Dr Chan's non-appearance at the hearing and the nature of his conduct to date in relation to the charge generally, the Tribunal advised Dr Chan that no extension of the time allowed for him to make such submissions would be granted.

15. However, the facts and circumstances which lead to the Tribunal considering whether or not it should exercise its powers under s104 or clause 14, remain relevant in the context of the Tribunal's considerations as to the appropriate sanction it should impose in relation to this Charge. Perhaps most relevantly in the context of the Medical Practitioners Act with its statement of *"principal purpose"* being to protect the health and safety of members of the public, the Tribunal must take into account its finding that Dr Chan is an unsafe practitioner, and the fact that as long ago as 1996 the Medical Council recorded in a decision on appeal that it agreed with the MPDC that Dr Chan's anaesthetic procedure in acting as both surgeon and anaesthetist (and given the nature of the anaesthetic used) was *"dangerous practice"*.

16. The Medical Council is also on record as agreeing with MPDC findings that:
    - the methods used by Dr Chan and his staff to discuss the potential outcomes of liposuction were effectively no more than a sales pitch to encourage patients to undertake the procedure and this failure to give unbiased and objective advice meant in effect that the patients were proceeding to undergo liposuction procedures without having provided fully informed consent;
    - that in some cases Dr Chan failed to carry out any pre-operative assessment;
    - that Dr Chan's practice of offering liposuction to patients no matter what the nature of their complaint was regarded by the Council *"as showing the mischievous disregard for the welfare of the patients in his care and [the Council] felt that this in itself illustrated the folly of a practitioner concentrating in a very narrow field with inappropriate and insufficient training to provide more appropriate therapy where that was indicated."*

17. Mr Harrison has submitted that, in the context of the purposes of professional disciplinary procedures summarised by Eichelbaum CJ in *Dentice v Valuers Board* [1992] 1 NZLR 720, 724-725 (followed by the Full Court of the High Court *in Brake v Preliminary*

Proceedings Committee for the Medical Council of New Zealand [1997] 1 NZLR 71, 82) that the most material of these purposes in this present case are the protection of the public, ensuring that Dr Chan should not practice cosmetic surgery if his conduct makes him unfit for that role, and ensuring that Dr Chan's conduct conforms to the standards generally expected of him by the profession.

18. Obviously, what flows from the statutory purpose of the legislation under which it is established, and in the context of the purposes and objectives of the professional disciplinary process generally, is that the Tribunal is obliged, as a matter of law, precedent and plain commonsense, to ensure that any penalty it imposes appropriately takes into account all of the facts and circumstances that are relevant both to the individual practitioner and its findings on the particular charge to which the penalty relates.

19. Furthermore, in accepting Mr Harrison's submission that it is entitled to take into account *"the sustained findings of professional misconduct findings against Dr Chan, and the 'common thread of reckless indifference to the wellbeing of his patients, manifested by his habitual failures to advise properly or at all about the risks associated with the type of elective surgery that he performs and to conform to necessary anaesthetic procedures"*, the Tribunal considers that in the interests of public safety, it <u>must</u> take all of these matters into account when determining penalty.

20. As it has stated on previous occasions in this context, the Tribunal is satisfied that previous offending and adverse findings should not be ignored, and the underlying purpose of the Tribunal's jurisdiction mandates that is not required to do so. The Tribunal, and its predecessors, have consistently adopted this approach and taken previous offending into account when determining the appropriate penalty in any particular case. This is especially the case in this present context taking into account relevant features of Dr Chan's offending:

(a) the fundamental nature of the identified shortcomings in the professional context;

(b) the similarity of the nature of the complaints and matters at issue; and

(c) the fact that the offending has been repeated over a relatively short period of time. This present charge is the fourth such charge laid against Dr Chan since 1995.

21. Therefore, in determining penalty on this occasion, the Tribunal has taken into account all of the facts, circumstances and findings present in relation to this current charge, the background of the previous cases involving Dr Chan and the adverse findings made against him, the penalties imposed in relation thereto, the public interest in maintaining public confidence in the integrity of the professional disciplinary process and its role in the context of the purposes and objectives of the Act, i.e. to ensure that doctors are competent to practise medicine, and the public interest in safe, ethical medical practice generally.

Jurisdiction

22. The current Act came into force on 1 July 1996. The Tribunal therefore has jurisdiction to impose any of the penalties provided in section 110(1) in relation to professional misconduct occurring post-1 July 1996.

23. Notwithstanding that Ms A's transaction with Dr Chan may have commenced at the date of her first visit to his clinic on 21 June 1996, the Tribunal is satisfied that the relevant dates for the purposes of the Charge and the findings made against Dr Chan are 24 and 25 July 1996.

24. Up to and including 24 and 25 July 1996, Dr Chan had the opportunity to consult with Ms A; to provide Ms A with adequate and appropriate information sufficient to enable her to give her informed consent to the liposuction procedure; to ensure that the necessary pre and intra-operative assessments, examinations and monitoring were carried out and that the liposuction surgery proceeded safely and in accordance with all relevant guidelines and standards; to provide appropriate post-operative care, and generally to carry out all of his professional duties and obligations owed to Ms A thereby providing her with care and treatment that was clinically and professionally appropriate, and to which she was entitled.

25. Thus, the critical date is the date of the operation, 24 July 1996, and, as Mr Harrison has submitted, all of the deficiencies which are the subject of the Charge are referable to this event. The conduct of Dr Chan's nurse in her consultations with Ms A prior to 24 July 1996 is interesting but irrelevant. It is Dr Chan's conduct which is the subject of the

Charge. The deficiencies, omissions, and reckless indifference are his, and these crystallised on 24 July 1996.

26. It was on that date that Ms A was most in need of Dr Chan's diligent observance of all of his professional duties and obligations; she depended on him, she trusted him, and he failed her.

Orders & Reasons

Suspension

27. Dr Chan's registration as a medical practitioner is suspended for nine months.

Reasons

28. Mr Harrison has submitted that suspension of Dr Chan's name from the medical register is the only means of protecting the public from continued exposure to his professional misconduct and ensuring that Dr Chan conforms to the standards expected of him. He will ignore any other sanction.

29. Pursuant to s.110(1)(b), the Tribunal has the power to suspend Dr Chan for a period not exceeding 12 months, and Mr Harrison has sought suspension for the maximum term. However, from 1 July this year doctors on the general register will be required to practise under general oversight (s20). Dr Chan has no specialist or vocational registration and is therefore registered on the general register of practitioners.

30. General oversight is mandatory in the Act, and is a 'key tool' provided in the Act to ensure doctors' ongoing competence, which in turn will help to protect the public. Oversight involves *"an ongoing, supportive, educative and collegial relationship between two doctors …"*. The overseer must be a registered medical practitioner, registered on the vocational register working in the same branch as the doctor being overseen.

31. However, the Tribunal has also taken into account that oversight is not supervision, although a supervisory role may sometimes be necessary. The Tribunal is satisfied that in all the circumstances and taking into account all of the factors referred to in paragraphs 15

and 30 herein, and the findings detailed in its substantive Decision, a period of suspension is clearly mandated .

32. Accordingly, the Tribunal has determined that a period of nine months suspension of Dr Chan's registration is fair and appropriate. The period of suspension is to take effect from the date of this Decision.

33. In the event that Dr Chan lodges an appeal against this Decision the Tribunal wishes to emphasise its belief that, while it considers that a period of suspension is an appropriate penalty in this case, suspension is warranted given the Tribunal's collective belief that Dr Chan is an unsafe practitioner, and this is not the first time that a professional disciplinary body has made that determination. His suspension is required in the interests of public safety, and this consideration should outweigh all other considerations including the punitive effect of suspending Dr Chan's registration. The Tribunal will oppose any application for a stay of its order suspending Dr Chan's registration pending the determination of any appeal.

Supervision

34. The Tribunal considers that Dr Chan should be required to practice under supervision. However, it notes that it has previously ordered supervision but that Dr Chan has been unable to find any suitable practitioner who is willing to take on this responsibility. An appeal against this aspect of the Tribunal's decision dated 17/3/00 has resulted in a stay of that order on the basis that supervision *'has proved impracticable'* and the decision has been remitted back to the Tribunal for re-consideration.

35. In light of this development, the Tribunal accepts that it would be futile to make any order for supervision in this case. In any event, by the date of the expiry of the period of suspension Dr Chan will be required to practise under oversight. It is the Tribunal's fervent hope that the practical effect of this will be to achieve some supervision of Dr Chan's practice by a suitable, vocationally registered, practitioner, and that Dr Chan will put the period of his suspension to good use by undertaking further studies or re-training, and/or otherwise remedying his professional shortcomings.

36. However, the absence of any practical ability to order supervision in the meantime makes it even more important that the period of suspension commence without any delay. This will at least cover the period to 1 July and provide some time for Dr Chan to locate an overseer.

Censure

37. Dr Chan should be censured.

Fine

38. Dr Chan is to pay a fine in the amount of $12,500.

Reasons

39. S110(1)e) permits the Tribunal to order that the practitioner pay a fine not exceeding $20,000. This ability to impose a monetary penalty is especially significant in the present overall context. In his opening submissions made at the hearing Mr Harrison submitted that *"if the evidence of Ms A and Dr Chamley is accepted, it portrays a disturbing level of indifference and abuse of the privileges accompanying registration as a medical practitioner. It paints a picture of a doctor driven by mercenary considerations and devoid of any genuine care or concern for the best interests of his patient."*

40. The Tribunal did accept the evidence given by Ms A and Dr Chamley. On that basis, it also accepts that Mr Harrison's submission is not unfair. It is an apt description of Dr Chan's attitude to his patients and to his profession. It is hard to resist the inference that Dr Chan's practice is all about 'the bottom line'; it certainly appears to be more about commerce than care.

41. The Tribunal does not intend any slight to business per se, however, as a medical practitioner Dr Chan enjoys the status and privileges of a professional person. It is that status and those privileges which enable him to charge fees for his services, and his patients engage his services because they assume that Dr Chan will observe an appropriate

standard of care. They rely upon the profession, and the professional bodies, and the law, to protect their interests and to ensure that only practitioners who are responsible, professionally competent and safe are allowed to practise.

42. However, the indicia of a relationship of care between Dr Chan and his patients is virtually absent. On the basis of the evidence given in this hearing, and in the cases referred to by Mr Harrison, Dr Chan exhibits a disturbing lack of insight, compassion or concern for the wellbeing of his patients, or indeed any apparent interest at all in his patients as people; no sense of their vulnerabilities, except the opportunities these may present.

43. If Ms A's experience is typical (and on the basis of the previous cases it would appear so) patients simply turn up at Dr Chan's clinic (presumably in response to his advertising). They are 'processed' by Dr Chan's staff and receive the standard 'sales pitch'. In Ms A's case, she told the Tribunal that she felt *"pressured"* into undergoing the liposuction surgery. The liposuction surgery is carried out 'on demand', and then, for all practical and clinical purposes, the patients are simply 'parked', (in Ms A's case in Dr Chan's office in the dark, alone and unmonitored), left to wake up and they are then sent home, with no adequate procedures in place for post-operative care.

44. If Dr Chan is more interested in his business than his profession, then Mr Harrison is correct. It is only by imposing penalties which affect his business interests that the Tribunal can hope to influence his professional conduct. In all the circumstances, the imposition of a substantial fine is appropriate.

45. Taking into account that a finding of professional misconduct falls in the middle of the range of grounds upon which a practitioner may be disciplined (s109), and balancing that factor against the serious nature of the misconduct on the part of Dr Chan in this case, and the other factors already referred to, the Tribunal considers that a fine in the amount of $12,500 is fair and reasonable.

Costs

46. Similarly, the Tribunal considers that Dr Chan should pay a proportion of the total costs incurred to date by the CAC and the Tribunal which is consistent in terms of similar cases, yet also reflects the particular facts and circumstances present in this case.

47. In making its determination on costs the Tribunal has borne in mind that costs must not be imposed as a penalty, and the guideline has been that costs do not normally exceed 50% of actual costs, unless the particular circumstances of the case warrant a greater proportion. In this case, given that the Tribunal has ordered a substantial fine, and suspended Dr Chan's registration, the Tribunal has determined that costs within the usual parameters are appropriate.

48. Accordingly Dr Chan is ordered to pay $19,201.90 which represents 50% of the costs of and incidental to the inquiry by the CAC, prosecution of the charge by the CAC and the hearing by the Tribunal.

Publication

49. The Tribunal orders publication of the above orders in the New Zealand Medical Journal pursuant to Section 138 of the Act.

Recommendation to the Medical Council

50. Pursuant to s60 of the Act, the Medical Council may, at any time, review the competence of any medical practitioner who holds a current practising certificate, whether or not there is reason to believe that the practitioner's competence may be deficient. The Tribunal is not aware if any such review of Dr Chan's practice has ever been carried out, or is currently underway, however it considers that such a review is required in the public interest.

51. Obviously such a review is not possible during the period of suspension of Dr Chan's practising certificate ordered by this Tribunal. However it will recommend to the Council that a comprehensive review of Dr Chan's competence should be commenced as soon as

practicable upon the reinstatement of his registration. This review should cover all aspects of Dr Chan's practice including his anaesthetic practices.

52. The Tribunal considers that a competence review should be carried out in addition to the requirements for general oversight which Dr Chan will be required to comply with in any event. This is because the Tribunal considers that the nature and extent of the concerns which have arisen regarding Dr Chan's practice require that his professional practice should be subject to a level of scrutiny and review over and above that required of other doctors on the general register. Also, it may be necessary for the Council to put in place a competence programme, which cannot be done until the Council has completed the competence review process.

DATED at Auckland this 27th day of April 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal