MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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THE NAMES AND ANY INFORMATION WHICH WOULD IDENTIFY ANY PATIENT WHO GAVE EVIDENCE, OR WAS REFERRED TO IN EVIDENCE APART FROM MS L CLEMENT ARE SUPPRESSED	**DECISION NO:**	212/01/88C
	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 formerly of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Ms P Kapua (Chair)

Dr F E Bennett, Dr J C Cullen, Dr R S J Gellatly, Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Monday 17, Tuesday 18, Wednesday 19 and Thursday 20 June 2002

APPEARANCES: Ms K G Davenport for a Complaints Assessment Committee ("the CAC")

Mr B A Corkill (Legal Assessor)

No appearance by Dr W W N Chan

WITNESSES: Evidence was heard from the following witnesses:

Mr J A Crisford, Dr P J Beehan, Ms L A Clement,
Ms A, Ms B, Ms C, Dr E P Walker,
Ms G, Ms H, Ms F, Ms E,
Mr D, Ms J A Smylie, Dr T G Short

Charges

As was determined by the Tribunal on 9 May 2002, following an application by the Complaints Assessment Committee, the charges are in the following form:

Disgraceful Conduct

The Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that Warren Chan, Medical Practitioner of Auckland acted in a way that amounted to disgraceful conduct in a professional respect in that:

1. **Lisa Clement**

    1.1 Dr Chan failed to carry out an adequate pre-operative patient assessment and clinical examination.

1.2 Dr Chan failed to adequately inform Lisa Clement of the anaesthesia process, and surgical procedure and the risks and complications associated with that procedure and the operation thereby he failed to:

(a) Obtain Ms Clement's informed consent of the proposed anaesthesia process and surgical procedure; and/or

(b) Obtain Ms Clement's informed consent to the procedure at the time of surgery.

1.3 There were serious deficiencies in Dr Chan's anaesthetic practice, namely:

(a) He failed to provide adequate information to Ms Clement about the nature or effects of the anaesthetic that she was to receive; and/or

(b) He failed to obtain an adequate preoperative medical history from Ms Clement and to ascertain the correct name of the medication she was taking, hence could not have been aware of potential drug interactions; and/or

(c) He failed to notate or document the amount of local anaesthetic used in this procedure thus compromising patients safety.

(d) He failed to adequately monitor Ms Clement's condition during the surgical procedure; and/or

(e) He failed to monitor Ms Clement's condition adequately post-operatively; and/or

(f) He failed to ensure that the normal discharge criteria had been met prior to Ms Clement's discharge after surgery, thereby potentially compromising patient safety.

1.4 Dr Chan failed to convey to Ms Clement that he was not vocationally registered as a plastic surgeon in New Zealand.

2. **A**

2.1 Dr Chan neglected to carry out an adequate pre-operative patient assessment and clinical examination.

2.2 Dr Chan failed to inform Ms A fully of the risks and benefits of the procedure and further failed to advise her whether liposculpture was likely to produce the results Ms A wanted and failed to make her aware that liposculpture is not a treatment for obesity.

2.3 Dr Chan failed to provide Ms A with the opportunity to meet with him prior to the day of surgery and failed to adequately inform her of the anaesthesia process, the surgical procedure and the risks associated with that procedure and possible side effects of surgery and the post-operative care that was required, thereby failing to:

(a) Obtain Ms A's informed consent to his proposed treatment, including the anaesthesia and surgical procedure; and/or

(b) Obtain Ms A's informed consent to the procedure at the time of surgery.

2.4 Dr Chan failed to inform the patient that he was not a vocationally registered plastic surgeon in New Zealand.

2.5 There was serious deficiencies in Dr Chan's anaesthetic practice, namely:

(a) He failed to provide adequate information to Ms A about the nature or affects of the anaesthetic that she was to receive; and/or

(b) He failed to carry out an adequate or proper anaesthetic assessment of Ms A prior to surgery including taking a satisfactory history of her asthma; and/or

(c) He failed to record the amount of local anaesthetic used thus compromising patient safety; and/or

(d) Dr Chan failed to monitor Ms A's condition adequately during the surgical procedure; and/or

2.6 Dr Chan failed to monitor Ms A's adequately post-operatively:

(a) Including monitoring her fluid balance.

(b) Responding appropriately to her concerns about her condition after the operation.

(c) Being aware of the possibility that Ms A's post-operative symptoms may be due to the large amount of fluid removed in the operation and thus very serious.

(d) Refused to see her (to assess her condition) when she asked him to do so, thus compromising her safety.

2.7 Dr Chan discharged Ms A without any of the usual discharge criteria being met, thereby compromising patient safety.

3. **B**

3.1 There were serious deficiencies in Dr Chan's anaesthetic practice, namely:

(a) He failed to provide information to Ms B about the nature or effects of the anaesthetic that she was to receive; and/or

(b) He failed to carry out an adequate or proper anaesthetic assessment of Ms B prior to surgery; and/or

(c) He failed to carry out a proper pre-operative history and assessment particularly with respect to her stated history of smoking and asthma; and/or

(d) He failed to record in the patient records the details of the amount of local anaesthetic used, thus compromising patient safety; and/or

(e) A drug (Maxolon) was administered despite documentation of Maxolon allergy, thereby placing Ms B at serious risk; and/or

(f) He failed to monitor Ms B's condition adequately during the operation and post-operatively;

3.2 Dr Chan failed to adequately inform Ms B of the anaesthesia process, the surgical procedure and the risks and complications associated with that procedure and the post-operative care that was required, thereby failing to obtain Ms B's informed consent to his proposed treatment, including the anaesthesia and surgical procedure.

3.3 Dr Chan failed to inform the patient he was not vocationally registered as a plastic surgeon in New Zealand. The literature provided to the patient was misleading in this regard.

3.4 Dr Chan discharged Ms B without any of the usual discharge criteria being met, thereby potentially compromising her safety.

4. **C**

4.1 Dr Chan failed to inform the patient he was not registered as a plastic surgeon in New Zealand.

4.2 Dr Chan failed to carry out an adequate pre-operative assessment and clinical examination of Ms C prior to surgery.

4.3 Dr Chan failed to adequately inform Ms C of the risks and possible side effects of the surgery, nor was she made aware that the outcome of the procedure may not meet her expectations and therefore Dr Chan failed to obtain Ms C's informed consent to the procedure.

4.4 There were serious deficiencies in Dr Chan's anaesthetic practice, namely:

(a) Dr Chan misled and/or failed to provide adequate information to Ms C about his anaesthetic management.

(b) Dr Chan failed to provide adequate anaesthesia during the procedure, resulting in Ms C suffering severe pain during surgery.

(c) Dr Chan operated without an anaesthetist present during the procedure and drugs were administered by him contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists.

4.5 Dr Chan discharged Ms C without any of the usual discharge criteria being met, thereby compromising her safety.

5. **D**

5.1 Dr Chan performed a rhinoplasty procedure on D while suspended from practising medicine.

5.2 Dr Chan failed to ensure that the patient was aware of the risks and side effects of rhinoplasty, and of the anaesthetic and the operation, and thus failed to get informed consent to the procedure.

5.3 Dr Chan failed to inform the patient that he was not vocationally registered as a plastic surgeon in New Zealand.

5.4 Dr Chan failed to provide the patient with a satisfactory result from the rhinoplasty procedure.

Professional Misconduct

6. **E**

6.1 Dr Chan failed to ensure that the patient was aware of the risks, side effects and possible poor outcome of the rhinoplasty surgery, and thus failed to obtain informed consent.

6.2 Dr Chan failed to inform the patient he was not a vocationally trained plastic surgeon.

6.3 The surgical procedure carried out by Dr Chan was not carried out with the due skill and care expected of a competent medical practitioner working in the area of rhinoplasty procedure.

6.4 Dr Chan failed to obtain informed consent to the procedure by:

(a) Giving the consent form for surgery to the patient to sign after Ms E had been given her pre-operative sedation.

(b) Using foreign implants in the procedure despite his assurance prior to surgery that no foreign implants would be used.

6.5 There were serious deficiencies in Dr Chan's anaesthetic practice namely the immediate post-operative care was unacceptable and unsafe. The guidelines from ANZCA states that even with "*conscious sedation*" the patient must be chaperoned afterwards.

Conduct Unbecoming

7. **F**

7.1 Dr Chan failed to adequately inform Miss F of the anaesthesia process, the surgical procedure and the risks associated with that procedure including the possibility of a less than satisfactory outcome for her, thereby failing to obtain Miss F's informed consent to the proposed anaesthesia process and surgical procedure.

7.2 There was serious deficiencies in Dr Chan's anaesthetic practice, namely:

(a) He failed to provide adequate information to Miss F about the nature or effects of the anaesthetic that she was to receive; and/or

(b) He failed to undertake a pre-operative clinical examination of Miss F; and/or

(c) He failed to obtain an adequate pre-operative medical history from Miss F.

(d) The method of sedation he used was inappropriate for the procedure, resulting in more pain than necessary for Miss F and in any event the method of local anaesthetic used was administered contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists.

7.3 He failed to perform the operation to a reasonable competent standard in that the breast reduction did not lead to any real reduction in her breast size.

7.4 He failed to inform her that he was not a vocationally registered plastic surgeon.

8. **G**

8.1 Dr Chan failed to adequately inform Ms G of the anaesthesia process, the surgical procedure and the risks associated with that procedure including the possibility of a poor outcome for the patient thereby failing to:

(a) Obtain Ms G's informed consent for the proposed anaesthesia process and surgical procedure.

(b) Obtain Ms G's informed consent to the procedure at the time of surgery.

8.2 There were serious deficiencies in Dr Chan's anaesthetic practice, in that he failed to provide adequate information to Ms G about the nature or affects of the anaesthetic that she was to receive.

8.3 He failed to record in the patient records the amount of local anaesthetic used thus compromising patient safety.

8.4 Dr Chan failed to appropriately manage Ms G's condition post-operatively.

8.5 Dr Chan failed to advise Ms G that he was not a vocationally registered plastic surgeon.

9. **Composite Charge – Disgraceful Conduct**

The Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical

Practitioners Act 1995 charges that Warren Chan, Medical Practitioner of Auckland between August 1994 and July 2001 acted in a way that amounted to disgraceful conduct in a professional respect in that:

9.1 He advertised his surgical services to the complainants in a way that did not make it clear that he was not vocationally registered as a plastic surgeon and provided probational material that was misleading in this respect.

9.2 He failed to adequately explain fully the benefits and risks, of the surgical procedure that was to be undertaken, and to advise patients as to whether the procedure sought was appropriate for them, thus failing to obtain informed consent to the procedures.

9.3 He failed to adequately assess the complainants before the operation in order to assess their physical and mental wellbeing, the suitability of the person for the operation and to ensure that they were fully and adequately informed of the procedure that they wished to undertake, and the nature of the anaesthetic to be used, its benefits and risks, including the possibility that there may be some pain and discomfort experienced under local anaesthetic.

9.4 He failed to adequately record in the patients notes (or at all) the amount of local anaesthetic used thus compromising patients safety.

9.5 He carried out the operations with lack of due skill and care.

9.6 Following the completion of the operation, he discharged the complainants without proper assessment of their post-operative wellbeing.

9.7 Following the completion of the operation, he failed to respond to the post-operative concerns of the complainants including failing to see the patients when requested, and failing to act promptly to concerns expressed by them, thus compromising patient safety.

9.8 The particulars of the composite charge relate to the individual complaints by F, B, Lisa Clement, A, E, G and C.

PRELIMINARY MATTERS

1. At the outset, the Tribunal has been faced with the difficulty of dealing with a significant number of complaints against Dr Chan over a time period of some seven years. There have been changes made to the actual charges that were originally lodged and the Tribunal is satisfied that those changes have been made known to Dr Chan well in advance of the hearing by the Tribunal of the charges. It is acknowledged that charges may be amended as a result of evidence that is prepared for a hearing and in this instance that has occurred.

2. Because of the number of charges involving eight complainants and the indication by Ms Davenport that the composite charge was not made in the alternative, the Tribunal was unable to complete its deliberations during the week of hearing and reconvened on 13 August 2002 for further consideration.

3. Dr Chan chose not to attend the hearing or to be represented before the Tribunal. The Tribunal heard from the secretary of the Tribunal who confirmed that she had received email correspondence from Dr Chan on 3 June, in which Dr Chan denied the charges and indicated that he would not be attending the hearing.

4. Attempts have been made to obtain patient records in respect of the complaints before the Tribunal. Dr Chan's response was that he did not have the patient records. As a result of the Tribunal's order as to discovery, John Anthony Crisford was subpoenaed to attend the Tribunal hearing and to bring with him any papers, documents and records relating to Dr Chan's practice, particularly in respect of the complainants in this hearing. Mr Crisford's evidence was that he had purchased Dr Chan's practice on August 28, 2001 which included a number of assets. Mr Crisford stated that he did not obtain any patient records, and that as far as he was aware, Dr Chan had removed them into storage. Mr Crisford had been in contact with Dr Chan who told him that he did not know where the records were. Mr Crisford attempted to determine whether patient information was contained on any of the computer programmes that he had purchased. After a short adjournment, Mr Crisford confirmed to the Tribunal that he had no patient records.

5. As a result of that, the Tribunal has had access to very limited records in respect of the eight complainants. In fact there are only records from Dr Chan's practice, the Australasia Cosmetic Surgery Centre, in respect of three complainants. That situation has contributed to the difficulties facing the Tribunal particularly in respect of charges concerning informed consent and monitoring.

6. It is proposed in the course of this decision to deal first with each of the individual complaints and then to deal with the composite charge.

LEGAL TESTS

7. The test for disgraceful conduct was recently re-stated by the High Court. In *The Director of Proceedings v Parry and MPDT* (Auckland High Court, AP 61-SW01, 15 October 2001) Paterson J stated:

".... There is more than one way of describing the test for "disgraceful conduct in a professional respect." The full Court in ***Brake*** *determined that such conduct could include "serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany resgistration as a medical practitioner." Although a single act of mere negligence could never, in my view, constitute disgraceful conduct, I see no reason for departing from the full Court's view that serious negligence of a non-deliberate nature can in appropriate cases constitute disgraceful conduct. It is not difficult to envisage cases where this could be so, or cases where only one act of serious negligence can amount to disgraceful conduct. ....."* [para 44].

8. The test for professional misconduct has been well established. In *Ongley v Medical Council of New Zealand* [1984] for NZAR369 Jeffries J stated:

"To return then to the words "Professional misconduct" in this Act. In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgement of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the

tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a lay person at the committees stage."

B v *The Medical Council* (High Court, Auckland, 11/96,8/7/96) Elias J stated in respect of conduct unbecoming:

"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practise of comparable practitioners."

9. The relevant principles therefore are:

(a) Disgraceful misconduct is very serious misconduct, either deliberate, or non-deliberate.

(b) A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

(c) The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

(d) The departure from acceptable standards and/or the failure to fulfil professional obligations must be "s*ignificant enough*" to attract sanction for the purposes of protecting the public.

10. The issue of the standard by which Dr Chan is to be assessed was one that the Tribunal sought advice from the Legal Assessor, Mr Corkill. While the Complaints Assessment Committee considers that as Dr Chan was performing surgery, the standard he should be assessed in terms of is that of a surgeon or a vocationally registered plastic surgeon. The Tribunal accepts the advice from Mr Corkill that Dr Chan is a general practitioner practising in a specialised area and that is the standard against which he has been assessed.

11. In this instance, the Tribunal considers that Dr Chan's conduct in the specific areas identified by the Tribunal is culpable and therefore requires disciplinary action against him.

The Tribunal's findings with regard to each complaint, are now set out. There are noticeable themes with regard to some particulars.

Lisa Clement

12. Lisa Clement resides in Christchurch but had breast augmentation carried out by Dr Chan in Auckland in October 2000. She had seen a plastic surgeon in Christchurch but opted for a more cost effective process carried out by Dr Chan on the recommendation of her sister. Ms Clement was assessed by xx who was a trained nurse in Christchurch and she did not meet Dr Chan until the morning of her surgery. Photos had been sent to Dr Chan to assist with choosing the implant. Ms Clement was unhappy with the outcome of the surgery and on her return to Christchurch, she returned to the plastic surgeon that she had first visited who advised her that she needed a breast lift or larger implants to obtain a better result than she had received from Dr Chan.

13. The Tribunal was concerned at the inadequacy of the pre-operative patient assessment and clinical examination of Ms Clement, which the Tribunal notes is a common trend for many of the complainants.

14. The Tribunal agrees that Dr Chan did fail to adequately inform Ms Clement of the anaesthesia process, surgical procedure, risks and complications associated with that procedure and the operation, thereby failing to obtain Ms Clement's informed consent to those processes and procedures. It is noted that there were patient records in respect of Ms Clement and that she did sign an information sheet relating to the anaesthetic. Because there was such a short period of interaction between Ms Clement and Dr Chan, the Tribunal considers that it is unlikely that Ms Clement received the information necessary for her to be able to give informed consent to the process and procedures.

15. The further particulars are essentially repetitive of the charges relating to informed consent.

16. Dr Chan did keep notes for the amount of local anaesthetic although the infiltration rates are not noted. The Tribunal considers that the keeping of infiltration rates is good practice, but on this occasion the failure to do so was not a safety issue.

17. It is accepted that Dr Chan did monitor Ms Clement's condition during the surgical procedure but the Tribunal accepts that there was a failure to monitor her condition adequately post-operatively given that the record shows only one recording taken 20 minutes after the operation.

18. The Tribunal accepts there are grounds for finding that the normal discharge criteria were met. Patient safety was not compromised.

19. Ms Clement was particularly concerned to highlight the fact that she believed that Dr Chan was a professionally qualified plastic surgeon. Dr Chan has in the case of all complaints been charged with failing to convey the fact that he was not vocationally registered as a plastic surgeon in New Zealand to all complainants. While it is clear that Dr Chan did not convey that he was not vocationally registered as a plastic surgeon in New Zealand, this is not a disciplinary matter. It is clear that Dr Chan pointed out particular certificates that he had received in respect of cosmetic surgery, but he does not appear at any stage to have indicated that he had qualifications which he did not hold. It is also to be noted that in a number of instances, the complainants contacted Dr Chan's practice as a result of perusing the Yellow Pages. Dr Chan's practice was listed under cosmetic surgeons and it may well be that a number of the complainants did not distinguish between a cosmetic surgeon and a plastic surgeon. That fact however is not, in the Tribunal's view, a disciplinary matter.

20. In the Tribunal's view, the inadequacy of the pre-operative patient assessment and clinical examination, the failure to adequately inform Ms Clement of the anaesthesia process and surgical procedure and the inadequacy of monitoring her condition post-operatively amounts to conduct unbecoming thereby reflecting adversely on Dr Chan's fitness to practise medicine.

A

21. A was again a xx resident who had liposuction carried out by Dr Chan on 13 June 2000.

22. Ms A was seen by xx in xx and was convinced to have the operation done in Auckland. Ms A was given the address to attend in Auckland and signed the consent for the

operation in front of the receptionist and paid the balance of the money for her procedure. It is Ms A's recollection that she filled in her medical check list at the time including the fact that she was asthmatic and that she had had a previous bad reaction to Hypnovel. Photos were then taken of Ms A and she was given a sedative pill. Ms A then saw Dr Chan for the first time when he drew circles on her body.

23. Ms A recalls waking during the procedure to find Dr Goedecke working on her thigh. She states that she woke because she had sharp stabbing pains that increased as the liposuction probe was advanced. She recalls crying and did not see Dr Chan but tried to gain the attention of Dr Goedecke.

24. After the operation, Ms A was moved to another room where she felt very cold and was shaking. She was told to get dressed into an elastic corset and to put her clothes on over the top. Ms A states that she was told by the nurse that "*4.5 litres were removed at the time of the operation*". Ms A left the Australasia Cosmetic Surgery Clinic without a follow-up appointment despite the fact that there was a clear leakage of blood. Ms A was clearly feeling unwell and returned to a friend's place where she continued to bleed. Her friend rang the Australasia Clinic and was told that that was normal and when asked to see Dr Chan the following day, was told that everything was okay. Ms A's friend rang a plastic surgeon in Auckland, Martin Rees, who spoke to her friend over the telephone and arranged antibiotics for her, but was unable to see her before she left Auckland early on Friday, 15 June. Ms A states that she was very uncomfortable for a further two and a half weeks on her return to xx. Ms A had a check up with xx two weeks later and was told that everything was okay. Ms A was unhappy with the result and visited a plastic surgeon, Dr Peter Walker, three months later and it was his recommendation that Ms A complain to the Medical Council.

25. The Tribunal again was concerned at the inadequacy of the pre-operative patient assessment and clinical examination of Ms A. In this instance, Ms A was an asthmatic and had advised of a previous allergic reaction to Hypnovel. There is no reference or indication that there was any concern regarding this reaction and it may just be fortuitous that there were no adverse consequences as a result of this oversight.

26. While Ms A received a pamphlet concerning liposuction, it is clear that that pamphlet does not inform fully of the risks and benefits of the procedure. The pamphlet essentially is an advertisement for liposculpture headed "*The art of face and body contouring - a guide to permanent fat removal*." The Tribunal has had the benefit of viewing the information pamphlet put out by the Australasian Society of Plastic Surgeons Inc which is a full page pamphlet dealing with the decision to have liposuction, realistic expectations, limitations of liposuction surgery, surgical methods, possible complications of liposuction and surgical instructions. The Australasia Cosmetic Surgery Centre pamphlet put out by Dr Chan sets out what liposculpture is but there is no real information concerning risks. There are some questions and answers which are all put in a positive light for example questions such as "*Does it hurt?*" are responded to with *"All procedures are performed using mild sedation and local anaesthesia and are safe and quite painless*". The Tribunal however does not consider that the particular stating that Dr Chan failed to make her aware that liposculpture is not a treatment for obesity is made out, as that is one of the few matters that the pamphlet does specifically address. The further particulars regarding informed consent are repetitive of the matters relating to the charge of informing of the risks and benefits.

27. Again the fact that Dr Chan failed to inform the patient that he was not a vocationally registered plastic surgeon is not a disciplinary matter; the Tribunal repeats its findings at paragraph 19.

28. The deficiencies in Dr Chan's anaesthetic practice were essentially his failure to carry out an adequate or proper anaesthetic assessment of Ms A prior to surgery including taking a satisfactory history of her asthma. She had however received the information about the anaesthesia process and as the Tribunal had the advantage of patient records in this case, it is clear that the records of the amount of local anaesthetic were kept.

29. The Tribunal is very concerned at the post-operative care Ms A received. In terms of monitoring her fluid balance, this fell short of accepted standards. A bleeding problem was identified, as described at paragraph 24 above. Ms A, through her friend, raised this issue and nothing appears to have been done. To that end there was no appropriate response to Ms A's concerns about her condition after the operation. The lack of adequate

monitoring of her fluid balance post-operatively put Ms A's renal function at significant risk. Dr Chan is also charged with refusing to see Ms A when she asked him to do so, but it is not clear on the face of the evidence that that is what occurred. Ms A was unsure as to whether Dr Chan knew she was there when she returned to the clinic the following day. In her evidence, Ms A was asked if she had asked to see Dr Chan and her reply was:

"Yes, they said he was busy"

She was then asked whether she knew whether he was in the rooms at the time and she stated:

"*I couldn't see him*".

30. The final particular deals with a failure to discharge Ms A with any of the usual discharge criteria. Initially, it was not clear to the Tribunal whether this was a matter properly directed at Dr Chan as he does not appear to have seen her following the operation. However, it is the Tribunal's view that Dr Chan is essentially responsible for all staff he employs at his clinic. In this instance Ms A was bleeding and was discharged with no further instructions as to what to do if the bleeding continued. It is also clear that when the clinic was contacted later, no-one did anything in respect of the bleeding.

31. In the Tribunal's view, the inadequacy of the pre-operative patient assessment and clinical examination, the failure to adequately inform Ms A of the risks and benefits of the surgical procedure and the deficiencies in her post-operative care amount to professional misconduct on the part of Dr Chan.

B

32. Ms B had a mastoplexy carried out by Dr Chan on 5 March 2001. Ms B had contacted the Australasia Cosmetic Surgery Centre after seeing an advertisement in the Yellow Pages and had her first appointment with Dr Chan on 27 February 2001.

33. Ms B understood that she would have dissolvable stitches. During the process of filling in relevant information, Ms B told the nurse that she was allergic to Maxolon

(metoclopramide). She had had a dystonic reaction to Maxolon in the past. Ms B also suffered from asthma and was a smoker. Ms B is one of the few complainants for whom the Tribunal had patient information. It would appear that initially her operation sheet stated that she had no allergies and that has been changed, most likely on the day of the operation. The references on the operation sheet to allergies and current medications appears to be in Ms B's handwriting. As it happened, there was no dystonic reaction as a result of the use of metoclopramide and the dosages involved. As it appears to be a standard practice by Dr Chan to use metoclopramide, it is not clear whether the decision to do so on this occasion was made with any awareness of her previous reaction or any idea of preventing a reoccurrence. There is a failure to document the recognition of the allergy, the reasons for using the drug and the methods for combating the allergy. In the absence of any such reference, it would appear on the face of it that further information was not obtained in respect of the allergy and that it was merely fortuitous that Ms B did not experience an adverse reaction. It is notable that Ms B was not asked at all about the type of reaction she had had to Maxolon.

34. With regard to the failure to provide adequate information about the nature and effects of the anaesthetic, some information was given to Ms B and she had signed the form saying that she understood the issues relating to the anaesthetic. It is clear though that Dr Chan failed to carry out an adequate or proper anaesthetic assessment prior to surgery. This is perhaps most patently seen in respect of Ms B's asthma and history of smoking. Dr Chan did not listen to Ms B's chest or ask any questions at all about her asthma which in the Tribunal's view falls well short of a proper anaesthetic assessment.

35. The fact that the amount of local anaesthetic was not recorded, is not a matter that the Tribunal considers warrants disciplinary action. Ms B suffered severe post-operative infection possibly as a result of the stitches not dissolving. While the Tribunal recognises the severe discomfort caused to Ms B as a result of that, it is clear from her later consultation with Dr de Geus that post-operative infection was not an infrequent complication. It appears that Dr Goedecke had made changes to her antibiotics in an attempt to deal with the infection. The Tribunal does not therefore see that aspect of the management of Ms B as inappropriate. The Tribunal also did not consider the vocational

registration of Dr Chan and whether Ms B was aware of his credentials as relevant for disciplinary action, for the same reasons as set out at paragraph 19 hereof.

36. In the Tribunal's view, the inadequate anaesthetic assessment prior to surgery and the failure to take appropriate action in respect of the allergy to Maxolon were severe short comings by Dr Chan in his treatment of Ms B. The Tribunal considers that the deficiencies are of such severity that they amount to professional misconduct on the part of Dr Chan.

C

37. Ms C had liposuction performed by Dr Chan in March 1998. Ms C had been taking Halcion but had recently stopped and was taking Surmontil to assist with her stopping the Halcion.

38. During the operation Ms C experienced intense pain and asked Dr Chan to stop the process, but her arms were held and she was told to lie back down and to calm down. Unfortunately there are not patient notes for Ms C, but she visited another plastic surgeon four months later and had further surgery done under general anaesthetic as she was dissatisfied with the results from the surgery by Dr Chan.

39. The next particular is that Dr Chan failed to inform Ms C he was not a plastic surgeon when there were apparently indications that he was. The Tribunal is not satisfied that Dr Chan was attempting to hold himself out as a vocationally registered plastic surgeon, and this particular is not made out.

40. The Tribunal is of the view that Dr Chan did fail to carry out an adequate pre-operative assessment and clinical examination prior to surgery. This particular part of Dr Chan's process is similar in respect of most of the complaints made. He has one brief appointment prior to the surgery with the patient who does not seem to have any further contact with Dr Chan until just before the operation. Most of the information given to the patients, as with Ms C is of a positive nature, and there is very little of the risks or alternatives. Ms C confirmed that Dr Chan did not listen to her chest or listen with a stethoscope or take

blood pressure. These findings are also relevant to the allegation that Dr Chan misled and/or failed to provide adequate information to Ms C about his anaesthetic management.

41. Dr Chan failed to inform Ms C about the risks and possible side effects and outcomes, therefore affecting her ability to give informed consent. It is clear that Ms C believed that "*I would feel absolutely nothing*" and that was clearly not the case. The Tribunal also noted that the fact that Ms C had awoken during the surgery indicated the likelihood of the extreme pain that she was in. Therefore, adequate anaesthesia was not provided.

42. The Tribunal was not satisfied that usual discharge criteria were not met.

43. The Tribunal is therefore of the view that the lack of adequate pre-operative assessment and clinical examination prior to surgery and the failure to inform Ms C about the risks and possible side effects and the outcomes amount to conduct unbecoming, thereby reflecting adversely on Dr Chan's fitness to practise medicine

D

44. Mr D had a rhinoplasty procedure carried out on the 3 July 2001 at a time when Dr Chan was suspended from practising. Mr D had contacted the Australasia Cosmetic Surgery Centre after reading the advertisement in the Yellow Pages and was accompanied at his first consultation by his partner. Mr D was unhappy with the outcome of the surgery. At the first consultation Dr Chan had explained the procedure and on the day of the surgery, Mr D was seen by a nurse and was taken into a room and given pre-operative medication. When he woke for a third time during the operation, Dr Chan was cleaning the blood on the side of his nose. Mr D saw Dr Chan one week later and the plaster was taken off his nose.

45. Mr D was clearly unhappy with the results of the surgery and wished to make a further appointment with Dr Chan, but was met with some resistance and was told that Dr Chan had been suspended and could no longer see him. He and his partner had a meeting with xx the nurse, who attempted to explain that what had happened to Dr Chan in terms of his practice had occurred as a result of professional jealousy. Mr D considered going to work

in America and was advised that to have his nose redone in America would cost about US$8,000. He sought to have Dr Chan pay that money but Dr Chan's response was that he would pay for Mr D to go to Australia where Dr Chan would do the operation again for free. Mr D did not want Dr Chan to operate and Dr Chan offered Mr D the opportunity to have someone else in Australia do the operation. Agreement was not reached and Mr D was told that Dr Chan did not have the money and eventually Mr D was offered his money back, but he did not accept this and threatened to go public. A complaint of extortion was made by Dr Chan's office to the xx Police and Mr D was spoken to about that.

46. While the Tribunal has had considerable concern about the lack of information about risks and side effects of the procedures being explained to patients, in this instance Mr D had the benefit of being accompanied by a partner with a nursing background. She acknowledged in her evidence that she had asked Dr Chan about the complications and there had been discussion of them. The issue of not informing patients that he was not a vocationally registered plastic surgeon has already been dealt with at paragraph 39 above. In respect of the particular alleging a failure to provide a satisfactory result, Mr D was not happy with the result but that appears to have been a subjective cosmetic issue for Mr D, and does not warrant a disciplinary finding. This topic is discussed further, below.

47. The only matter that remains outstanding is the fact of Dr Chan performing the operation and consulting with patients while he was suspended. The Tribunal is satisfied that as at 12 June 2001, Dr Chan was suspended from practice as a result of an order of the Tribunal dated 27 April 2001. It is clear that that order was the subject of an appeal by Dr Chan to the District Court which did not have the effect of staying the order and it is noted that the District Court dismissed the appeal on 8 August 2001. This would seem to coincide with the reaction of staff at the Australasia Cosmetic Surgery Clinic following Mr D's operation. Section 109 of the Medical Practitioners Act 1995 sets out the grounds on which a medical practitioner may be disciplined. Those grounds are set out in the alternative, the relevant matters being:

"(a) Has been guilty of disgraceful conduct in a professional respect; or…

(g) Has breached any order of the Tribunal made under section 110 of this Act".

48. The Complaints Assessment Committee has charged that Dr Chan is guilty of disgraceful conduct in a professional respect by virtue of practising medicine while suspended. Section 109(1)(g) sets out an alternative charge that will be relevant in circumstances where there has been a breach of any order of the Tribunal made under Section 110 of the Act. The Tribunal considers that the charge of "*disgraceful conduct in a professional respect*" relates to actions or omissions that a practitioner does while carrying out his or her medical practice. The Complaints Assessment Committee is asking the Tribunal to determine that the fact that Dr Chan should not have been practising medicine at this stage is in itself disgraceful conduct in a professional respect. Had there been no specific provision relating to the breaching of an order of the Tribunal, such an argument may have gained some support. This was a matter that could have been the subject of a charge under section 109(1)(g) of the Act. Further, section 9 of the Act states that no person shall practise medicine under the title of a medical practitioner unless he or she holds both probationary registration, general registration or vocational registration and a current practising certificate. At this particular time, Dr Chan's registration was suspended and section 142 provides that every person who commits an offence against section 9 of the Act is liable on summary conviction to a fine not exceeding $10,000. A charge under section 109(1)(g) or prosecution with regard to section 9 of the Act have not been brought in respect of Dr Chan practising while suspended. The Tribunal is unable to deal further with this matter. It is this Tribunal's view that practising while suspended does not amount to disgraceful conduct in terms of section 109(1)(a) as a matter of law. In light of that conclusion, the Tribunal makes no finding as to the factual allegation.

49. The Tribunal therefore considers that the charge against Dr Chan in respect of the treatment of D has not been made out and accordingly it is dismissed.

E

50. Ms E had rhinoplasty procedure done during 1995. Ms E had had rhinoplasty in 1988, 1993 and 1995. The operation in 1988 had been unsuccessful which Ms E attributed to miscommunication on her part and in 1993 the bridge was grafted by Dr de Gues. Dr

Chan was to operate by using cartilage from behind Ms E's ear. Ms E had stated clearly that she did not want a silicon implant because of the adverse publicity about silicon at the time and she was told that the operation would be done with cartilage from behind her ear. Five years after the operation, Ms E was faced with a boil on her nose and it was found that it had been caused by a silicon implant protruding through the skin which had to be removed and was done so by Dr Rees.

51. There are no patient notes from Dr Chan in respect of Ms E's surgery and clearly the passage of time makes this particular complaint difficult to assess. It would appear that this surgery took place prior to the 1995 Act and is therefore dealt with in terms of section 154 of the Act which relates to disciplinary offences committed before the commencement of the Act. The Tribunal also recognises that there have been significant advances in respect of informed consent procedures over the last seven years.

52. The significant issue in respect of Ms E's case is that she received a silicon implant, which was completely contrary to her wishes and was not ever told of that development. It was only the medical difficulty she had five years later that resulted in her knowing about the silicon implant. This falls well short of the information necessary for any patient to give informed consent. It is a matter of grave concern that Dr Chan felt he was able to undertake a procedure so clearly against the wishes of the patient.

53. In all other respects, the particulars in respect of Ms E are either not relevant or not made out in terms of the circumstances of the procedure. There is some doubt as to whether Ms E's consent to this operation was obtained before or after she had received sedation. If she were given sedation and then asked to sign, this would be a procedure not consistent with the process adopted for other complainants. In the absence of specific knowledge the Tribunal finds itself unable to determine whether such a failure occurred.

54. As regards the allegation that Dr Chan was not a vocationally trained plastic surgeon, the Tribunal repeats its findings at paragraph 39 hereof.

55. The particular concerning post-operative care related to the degree of assistance given after the procedure. Given the lapse of time, Ms E naturally had difficulty recalling all these details. This particular is not made out.

56. Given the failure to inform the patient of the use of the silicon implant, the Tribunal considers that this failure amounts to professional misconduct.

F

57. Ms F had a breast reduction performed by Dr Chan on 15 June 2000. Ms F is xx and had made enquires before coming to New Zealand about breast reduction surgery and was attracted by the cost of the procedure by Dr Chan. Ms F was unable to attend the hearing as she has returned to xx but she was available by telephone link to answer questions before the Tribunal. Ms F had the surgery undertaken under local anaesthetic and was told that she would feel no pain but awoke several times during the surgery because of the pain she felt. She is not satisfied with the results which were supposed to see her move to a C cup. Instead she is still wearing E cup sized bras.

58. The Tribunal had the benefit of evidence from Dr Beehan who is a plastic surgeon from Hamilton. It was his evidence that a breast reduction should essentially be undertaken under a general anaesthetic because of the length of time of the operation and that the fact that it involves significant blood loss. Ms F had asked questions about breast feeding in respect of the breast reduction and her evidence was that Dr Chan had been relatively dismissive of that concern. It seems that Ms F had had at least two consultation visits with Dr Chan discussing what was proposed, although it is clear that some of the risks and complications were not spelled out by Dr Chan which is consistent with his approach to any of the surgery he undertakes.

59. Ms F suffered from asthma and it is clear that there was a failure to undertake a pre-operative medical clinical examination and to obtain an adequate pre-operative medical history. There is no reference of discussion relating to the asthma and no examination of Ms F's chest in terms of the asthma.

60. It is difficult to know the amount of information that was given to Ms F, although as noted, there were two consultations. As regards the failure to inform Ms F that Dr Chan was not a plastic surgeon, the Tribunal repeats its findings at paragraph 39 hereof.

61. The Tribunal is concerned that the method of sedation was inappropriate for the surgery that was undertaken and it is clear from the expert evidence submitted to the Tribunal that those undertaking that surgery consider that it is a matter best done under general anaesthetic. Because of this, there has been a failure to perform this surgery to a reasonably competent standard.

62. As a result, it is the Tribunal's view that these failures on the part of Dr Chan amount to conduct unbecoming that reflects adversely on his fitness to practise medicine.

G

63. Ms G had liposculpture performed by Dr Chan in August 1994. She travelled from xx for the operation. Ms G had a very brief consultation with Dr Chan and was reassured that she would feel no pain. Following the surgery, Ms G suffered further pain and on contacting the Australasia Cosmetic Surgery Clinic was told to take Panadol. She then approached her general practitioner and was given a prescription for a stronger pain killer. Ms G was bedridden for about three weeks and was off work for about six weeks. Her stitches were removed after two weeks but she did not see Dr Chan. The pain that she suffered both during and following the surgery was intense and was not in any way part of her expectation in respect of the surgery. This is again a matter prior to the Medical Practitioners Act 1995 and prior to the Health and Disability Commissioners Act 1994. To that end, issues about informed consent are within a different context. There were however serious deficiencies in the anaesthetic practice given the pain experienced by Ms G and this is confirmed by the experiences of other complainants.

64. As regards the particular concerning information in the patient records, the patient records were unfortunately not available to the Tribunal and it has been unable to take this matter further.

65. The Tribunal was also concerned at the poor post-operative care given to Ms G who was an out of town patient. No information appears to have been given to her and she was brushed off by Australasia Cosmetic Surgery Clinic staff when seeking help for the pain and discomfort she was suffering.

66. As regards the particular concerning Dr Chan's status, the Tribunal repeats its conclusion as set out at paragraph 39.

67. As a result, the Tribunal considers that in the information and anaesthetic practice of Dr Chan and the post-operative management of Ms G, Dr Chan is guilty of conduct unbecoming which reflects adversely on Dr Chan's fitness to practise medicine.

COMPOSITE CHARGE

68. Ms Davenport advised the Tribunal towards to the end of the hearing that the composite charge was to be an additional charge and not to be dealt with as an alternative charge. Ms Davenport sought leave to amend the composite charge to exclude any reference to particulars relating to the treatment and management of Mr D. Ms Davenport took this action to avoid any doubt that the composite charge should only be founded on particulars at a time when Dr Chan was registered to practise medicine as opposed to being suspended. As the amendments were to delete particulars (not add to them), the Tribunal allowed, albeit at a late stage, the amendment to the composite charge.

69. It was Ms Davenport's submission that the Tribunal could look at the particulars of each of the individual charges and determine whether there were grounds for disciplinary action in respect of those charges. She also then invited the Tribunal to apply those same particulars collectively to a ninth charge alleging disgraceful conduct and relying on a pattern of behaviour that may collectively satisfy a particular threshold relating to professional misconduct. Ms Davenport relied on *Duncan v The Medical Practitioners Disciplinary Committee* [1996] 1NZLR513 where the Court of Appeal agreed that the particulars within a charge could be taken both individually and cumulatively to see whether or not they established professional misconduct. As the legal assessor advised the Tribunal, *Duncan* was concerned with a number of particulars that cumulatively

established a pattern of behaviour that amounted to professional misconduct. There was in the *Duncan* case just one cumulative charge and not an individual charge in addition to a cumulative charge.

70. The Tribunal is concerned that what is proposed by the Complaints Assessment Committee is essentially charging Dr Chan twice in respect of the same incident. It is unfortunate that Dr Chan was not present before the Tribunal to argue for himself the issue of whether he considers himself to be prejudiced by such an approach, but the Tribunal has considered at length this approach and has concluded that it is an approach that may well have been warranted as an alternative but not as an additional charge. The Tribunal considers that *Duncan* does not provide that charges can be assessed on an individual basis and then again on a cumulative basis. The Tribunal considers that *Duncan* provides for a cumulative charge of professional misconduct but does not contemplate a situation where a practitioner could be facing two charges in respect of the same incident. Accordingly, the Tribunal does not consider that the cumulative or composite charge as an additional charge against Dr Chan has been made out and it is accordingly dismissed.

CONCLUDING MATTERS

71. The Tribunal has been faced with a number of individual complaints and a composite charge incorporating all but one of those individual complaints. Because of the number of complaints, the Tribunal feels compelled to comment on the fact that during the course of the hearing and the extensive consideration by the Tribunal following the hearing, there are matters in respect of the particulars that perhaps do not reflect all concerns the Complaints Assessment Committee may have had in respect of Dr Chan. It is unfortunate that emphasis is being placed on Dr Chan's failure to advise patients that he was not a vocationally registered plastic surgeon which is not a matter that the Tribunal should have needed to have been concerned with. It is clear in every instance that Dr Chan did not ever hold himself out to be a plastic surgeon and that the majority of the complainants approached Dr Chan following a perusal of the Yellow Pages under a listing of Cosmetic Surgeons. It may well be that those who are vocationally registered as plastic surgeons have some concerns about others carrying out work in this field and that seems to have been an influence in people making complaints.

72. There are always difficulties in cosmetic surgery in respect of the expected outcomes for people undertaking that surgery. Dissatisfaction with cosmetic surgery outcomes is not in and of itself a disciplinary matter. The issues of appropriate pre-operative assessment, appropriate and proper information and monitoring during the surgical procedure and post-operative care are valid issues. Charges that incorporate particulars about patient satisfaction with the outcome of cosmetic surgery is not always helpful in dealing with the actual practice concerns and perhaps detract somewhat from those issues where complainants appear to be motivated by such dissatisfaction coupled with encouragement from those who are practising in a similar area.

DECISION

73. The Tribunal therefore finds that Warren Wing Nin Chan, Medical Practitioner of Auckland is guilty of professional misconduct in respect of his treatment of:

(a) Ms A

(b) Ms B

(c) Ms E

74. The Tribunal finds that Warren Wing Nin Chan is guilty of conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practice medicine in respect of his treatment of:

(a) Lisa Clement

(b) Ms C

(c) Ms F

(d) Ms G

75. The Tribunal finds that Warren Wing Nin Chan is not guilty of professional misconduct in respect of his treatment of D.

76. The Tribunal invites counsel for the Complaints Assessment Committee to file written submissions as to appropriate penalty. These submissions are to be filed two weeks from

the date of this decision. The submissions will be served on Dr Chan, if reasonably possible; if so served, he will be given a further two weeks to make any submissions he wishes to make in reply.

77. The Tribunal confirms that it has made orders suppressing the names and any information which would identify any patient who gave evidence, or was referred to in evidence, apart from Ms L Clement.

DATED at Auckland this 1st day of November 2002

.....

P Kapua

Deputy Chair

Medical Practitioners Disciplinary Tribunal