MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO. 228/02/93C

IN THE MATTER OF the Medical Practitioners Act 1995

-AND-

IN THE MATTER OF of a charge laid by the Complaints Assessment Committee pursuant to section 93(1)(b) of the Act against **WARREN WING NIN CHAN** Medical Practitioner, formerly of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL:

TRIBUNAL: Miss S M Moran (Chair)

Ms S Cole, Dr B D King, Dr A D Stewart, Dr J L Virtue (Members)

Ms G J Fraser (Secretary MPDT)

Ms H Gibbons (Stenographer)

Hearing held at Wellington on Thursday 7 November 2002

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

No appearance by or on behalf of Dr Chan

SUPPLEMENTARY DECISION

This supplementary decision should be read in conjunction with Decision No. 224/02/93C dated 5 March 2003.

The Substantive Decision

1. In its substantive decision the Tribunal found Dr Chan guilty of the charge of disgraceful conduct laid against him by the Complaints Assessment Committee (the CAC). The charge arose out of medical treatment given by Dr Chan to a patient, Ms A (the complainant) in January 2001.

2. The allegations upon which the charge was brought were that there were serious deficiencies in Dr Chan's practice regarding his communications with and treatment and management of Ms A, who underwent extensive liposuction surgery at Dr Chan's rooms on 27 January 2001. The deficiencies occurred pre-operatively, peri-operatively and post-operatively

3. In accordance with normal practice, details of the facts and circumstances giving rise to the charge together with the Tribunal's findings and reasons are contained in the substantive decision.

4. Dr Chan has taken no step in the proceedings. He did not appear nor have a representative appear on his behalf at the hearing, and has not filed any submissions as to penalty. Submissions have been filed on behalf of the CAC.

The Tribunal's Findings

5. In summary, the Tribunal found that:

5.1. Dr Chan failed to carry out an adequate pre-operative assessment of Ms A, including a clinical examination.

5.2. Dr Chan failed to exercise appropriate professional judgment in offering liposculpture to Ms A in view of her history of eating disorders.

5.3. Dr Chan failed to obtain Ms A's informed consent to his treatment including the anaesthesia and surgical procedure in two respects, that is:

5.3.1. He did not adequately inform Ms A of the anaesthesia process, the surgical procedure and the risks and complications associated with the process and procedure and the post operative care that was required;

and

5.3.2. The consent forms for anaesthesia and for surgery were given to Ms A to sign after she had been given her pre-operative oral sedation, thereby rendering her consent invalid.

5.4. There were serious deficiencies in Dr Chan's anaesthetic practice in four respects, namely,

5.4.1. He failed to provide adequate information to Ms A about the nature and/or effects of the anaesthetic that she was to receive.

5.4.2. There was no anaesthetist present during Ms A's surgery and the drugs administered were in a dosage and combination contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists.

5.4.3. He failed to monitor Ms A's condition adequately during the surgical procedure.

5.4.4. He failed to monitor Ms A's condition adequately post operatively.

5.5. Dr Chan discharged Ms A without any of the usual discharge criteria being met thereby potentially compromising her safety.

5.6. Dr Chan failed, post operatively, to adequately acknowledge or address Ms A's concerns arising from her dissatisfaction with the cosmetic result of the surgery.

Submissions by counsel for Complaints Assessment Committee

6. Counsel for the CAC has submitted that Dr Chan poses a real danger to the safety of the New Zealand public and ought to be removed from the register.

7. Counsel referred to previous disciplinary proceedings and adverse findings against Dr Chan. She stated that this was the fourth charge which Dr Chan has faced before this Tribunal and that he has also faced three charges before its predecessor, the Medical Practitioners Disciplinary Committee.

8. She submitted that in all of those cases the course of conduct displayed by Dr Chan bore remarkable similarity to that which was displayed by him in the present case. The decisions showed that Dr Chan displayed little regard for the need to fully inform a patient of the risks of any operation, to attend to proper administration of the consent procedure, to monitor the patients during the operation and post operatively and to deal promptly with their concerns and fears after the surgery.

9. Counsel for the CAC submitted that despite the numerous charges laid against Dr Chan and the many decisions of the Tribunal which imposed conditions on his practice and suspensions on him, he did not appear to have made any changes to his practice or in any way to have heeded the strictures of the earlier committees, nor made any attempt to understand and remedy the problems which have led him to appear repeatedly before the Tribunal.

10. Counsel submitted that Dr Chan posed a real danger to the safety of the New Zealand public and that his name ought to be removed from the register, that he be censured, fined $15,000 and ordered to pay 60% of the costs of the prosecution.

Previous disciplinary decisions

11. The earlier decisions relating to Dr Chan are referred to below:

(a) On 16 November 1993 the Medical Practitioners Disciplinary Committee found Dr Chan guilty of professional misconduct following a lengthy defended hearing. The charge, dated 11 June 1993, was based on incidents relating to four female patients which occurred between February 1989 and October 1990. The Committee censured Dr Chan, fined him $900 (out of a maximum of $1,000 under the previous Act), ordered him to pay costs of $64,000 which was approximately 55% of the costs of prosecution and hearing, and imposed conditions on his practice for a period not exceeding three years.

Dr Chan appealed to the Medical Council of New Zealand. On 18 December 1996 the Council dismissed the appeal and upheld the Committee's decision.

The Council observed:

(i) 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 that 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.

(ii) That in some cases Dr Chan failed to carry out any pre-operative assessment.

(iii) 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."*

The Medical Council expressed its concern as follows:

> *"In considering the particulars as a whole, the Medical Council was very concerned at the multiple deficiencies demonstrated. The failure to obtain appropriately informed consent, the failure to*

> *undertake appropriate pre-operative examinations and consultations, and the poor standard of post-operative care were all of great concern to the Medical Council as was the clear intention of Dr Chan to mislead patients as to his level of training and expertise. The Medical Council regards the sum of the particulars to amount to a serious level of professional misconduct"*.

Dr Chan appealed to the High Court which dismissed his appeal on 13 February 1996.

Dr Chan appealed to the Court of Appeal which dismissed his appeal on 7 August 1996.

(b) On 1 December 1994 the Medical Practitioners Disciplinary Committee found Dr Chan guilty of professional misconduct in three respects between the period February and March 1992 relating to his management and post operative management of cosmetic surgery performed on a female patient. On 28 April 1995 the Committee censured him, fined him $900 (the maximum under the previous Act was $1,000) and ordered him to pay 75% of the costs of and incidental to the enquiry, and imposed conditions on his practice. In July 1995, on appeal, the Medical Council of New Zealand upheld the Committee's decision.

(c) On 12 November 1996, the Medical Practitioners Disciplinary Committee found Dr Chan guilty of conduct unbecoming a medical practitioner regarding his management of a female patient for breast surgery in 1993 in that he misled her about the results achievable by him and that his management of post operative pain was inadequate. The Committee also described his record keeping as "*deplorable, woefully inadequate in terms of what can be expected of any competent medical practitioner*", although this did not form part of the charge. On 20 January 1997 the Committee censured Dr Chan, fined him $400 (the maximum under the previous Act was $1,000) and ordered him to pay 40% of the costs.

(d) *Substantive Decision 94/99/39C; Penalty Decision 112/99/39C.*

On 29 October 1999 Dr Chan was found guilty of professional misconduct in the context of cosmetic surgery undertaken on a female patient in May 1996 in several respects in that he failed to obtain the patient's informed

consent prior to the liposuction operation, failed to undertake a satisfactory and effective consultation with and assessment of the patient before the operation, and failed to maintain adequate records of operations undertaken including records of case management and pulse oximeter in the context of IV sedation. With regard to this last particular, the Tribunal found the level of culpability to be less than professional misconduct but rather at a level of conduct unbecoming which reflected adversely on the practitioner's fitness to practise medicine. However, on the totality of all the particulars, the Tribunal concluded that the charge was upheld at a level of professional misconduct. On 17 March 2000 the Tribunal censured Dr Chan, fined him $975 (maximum at that time under the previous Act was $1,000), imposed conditions on his practice including supervision, and ordered him to undertake an Ethics Review.

(e) *Substantive Decision 159/00/67C; Penalty Decision 160/00/67C.*

On 22 March 2001 the Tribunal found Dr Chan guilty of professional misconduct regarding a female patient who consulted him in June 1996 and on whom he performed a liposuction procedure in July 1996 in that there were serious deficiencies in his anaesthetic practice (in no less than five respects); that he failed to obtain her informed consent regarding the anaesthetic process and lipsocution/ liposculpture surgery she was to undergo and the risks associated with the procedure; and that he failed to keep adequate records. The Tribunal commented that the omissions identified on the part of Dr Chan demonstrated that the standard of care he provided to his patient *"fell deplorably short"* of the standard of care she was entitled to expect. It also commented that 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 on his part"*. On 27 April 2001 the Tribunal issued its penalty decision. It observed that it had gained the impression from his conduct in relation to the particular charge and from the evidence produced to it at the hearing, that Dr Chan's attitude to his patient, to his profession and to the Tribunal was one of complete indifference. The Tribunal agreed with the submission of counsel for the CAC that the Tribunal's findings confirmed a pattern of Dr Chan's *"reckless disregard"* for his professional duties. The Tribunal

suspended Dr Chan's registration for nine months, ordered that he practise under supervision, censured him, fined him $12,500, awarded 50% of the costs of the prosecution and hearing, ordered publication of his name in the New Zealand Medical Journal, and made recommendations to the Medical Council regarding competence review. In August 2001, following an appeal by Dr Chan, the District Court upheld the Tribunal's decision.

(f) *Substantive Decision 212/01/88C; Penalty Decision 220/01/88C.*

On 1 November 2002 the Tribunal found Dr Chan guilty of professional misconduct in respect of three female patients relating to incidents around 1995, in June 2000, and February/March 2001; and guilty of conduct unbecoming a medical practitioner in respect of four female patients relating to incidents in August 1994, March 1998, June 2000 and October 2000. The complaints covered such matters as failure to carry out an adequate pre-operative patient assessment and clinical examination, failure to inform adequately of the anaesthesia process and surgical procedure and risks and complications associated with them, serious deficiencies in his anaesthetic practice, failure to monitor adequately during the procedure, failure to monitor adequately post operatively, failure with record keeping, and failure to obtain informed consent. On 18 December 2002 the Tribunal censured Dr Chan, fined him $15,000, suspended him from practice for a year on each of the charges of professional misconduct with each period to be served consecutively making a total suspension period of 36 months, imposed conditions on his practice following the expiry of the suspension period, ordered him to pay 45% of the costs, and ordered that a report of the Tribunal's decision be published in the New Zealand Medical Journal. This last decision is under appeal to the District Court by the CAC which sought a finding of disgraceful conduct.

Discussion

12. Section 3 of the Act provides that its principal purpose is *"to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine"*.

13. The liposuction surgery which Ms A underwent was extensive in volume, involving a 4 litre liposuction, and involved several different parts of the body. The complications and risks should have been stated very carefully to Ms A both in general and in specific terms; as should have been the nature and effects of the anaesthetic she was to receive.

14. The expert evidence was that the volume of fat removed was regarded as a major liposculpture procedure for which it would be usual to admit the patient to a hospital overnight for observation because of the risks of significant fluid loss and the need for intravenous hydration and analgesia to ensure the safety and comfort of the patient. Ms A was discharged the same day which should only be contemplated after a prolonged period of observation and evidence of full recovery from the effects of the sedative drugs, evidence that she had adequate pain relief and no evidence of significant ooze from the wound. None of those precautions was put in place. Her discharge (in the circumstances referred to in the substantive decision) was unsafe. As it transpired, Ms A became very unwell during the following days and was only able to make contact with Dr Chan's clinic following repeated calls and messages. Even then, she was not able to speak directly with Dr Chan who, for some reason or other, was always unavailable.

15. A significant part of the brief pre-operative consultation Ms A had with Dr Chan (which the Tribunal found would have been no longer than 15 minutes duration) concentrated on the cost of the procedure; and the documentary evidence produced bore testimony to this which recorded in some detail Dr Chan's handwritten calculations as to the proposed cost of various items showing a total of $7,000.

16. As Ms A stated in evidence, essentially *"he wanted you out the door and paying the deposit"*.

17. While every practitioner is entitled to charge an appropriate fee and conduct his/her practice in an efficient and businesslike manner, the practitioner must observe an appropriate standard of care. The status and privilege of registration brings with it the corresponding duties of care and responsibility.

18. The Tribunal was left with the distinct impression that Dr Chan's attitude towards Ms A was mercenary and predatory, and took advantage of her vulnerability. Ms A engaged Dr Chan's services in the expectation that he would comport himself in accordance with the standards of his profession. He did not do so.

19. As the Tribunal stated in its substantive decision regarding this complaint:

> *"151. Ms A impressed the Tribunal and, we believe, would have impressed a competent practitioner, as a vulnerable young woman who needed and deserved a much closer and more careful assessment. In the circumstances, the timeframe of six days between consultation and surgery was an unreasonably abridged one particularly in view of the inadequate pre-operative assessment. Had she received that assessment and been given the informed advice, to which she was entitled, she may well have elected not to undergo the surgery at all. Even if she had, she would no doubt have made different arrangements for her post-operative care. Her difficulties were compounded by the Clinic's failure to inform her, at the first opportunity, of Dr Chan's subsequent suspension, and then by Dr Chan's cavalier disregard of her plight.*
>
> *152. Dr Chan's conduct in this case – that is, his failure to carry out an adequate pre-operative assessment; his failure to exercise appropriate professional judgment in offering liposuction to Ms A in view of her history of eating disorders; his failure to inform her that liposuction is not a weight loss procedure; his failure to obtain her informed consent to his treatment including the anaesthesia and surgical procedure; his failure to cease operating while further sedative drugs were administered; his failure to keep adequate anaesthetic records in accordance with normal practice; his failure to monitor Ms A's condition adequately during the surgical procedure; his failure to monitor Ms A's condition adequately post-operatively; discharging Ms A without any of the usual discharge criteria being met and thereby potentially compromising her safety; and his failure, post-operatively, to adequately acknowledge or address Ms A's concerns arising from her dissatisfaction with the cosmetic result of the surgery (having taken from her a significant fee of $7,000) –was all pervasive occurring prior to, during and after the surgery, and failed to meet rudimentary requirements or minimum standards of professional care.*

20. The Tribunal was unanimous in its substantive decision that Dr Chan's conduct was seriously negligent, portraying indifference and was an abuse of the privileges which registration confers on a medical practitioner.

21. What is more disturbing is that this is not the first occasion concerning such conduct on the part of Dr Chan.

22. The previous adverse disciplinary findings against Dr Chan display a continuing pattern of conduct and, as submitted by counsel for the CAC, he *"does not appear to have made any changes to his practice or to have in any way heeded the strictures of the earlier committees"*.

23. This Tribunal has concluded that Dr Chan's practice and attitude, as demonstrated in this case, brings with it real dangers for the safety of his patients, particularly potential patients, and thus the public generally.

24. When assessing penalty this Tribunal is entitled, indeed obliged in the public interest, to take into account all of the facts and circumstances which are relevant both to Dr Chan personally and his conduct in respect of the present charge.

25. That includes Dr Chan's previous offending. The Tribunal and its predecessor, the Committee, have both adopted this approach. While the Tribunal has been careful not to punish Dr Chan twice for his past offending in respect of which penalties have already been imposed, it is entitled to consider whether his past offences demonstrate a pattern of serious misconduct which would or might justify the imposition of a penalty beyond a fine or suspension from practice.

26. The Tribunal notes the following features regarding Dr Chan's offending:

    26.1. The fundamental nature of the identified shortcomings in the professional context.

    26.2. The similarity of the nature of the complaints and matters in issue.

    26.3. The fact that the offending has been consistently repeated since 1989.

27. In considering and determining penalty on the present charge, the Tribunal has taken into account the following:

    27.1. All the facts, circumstances and findings relating to the present charge.

    27.2. The background of the previous cases involving Dr Chan and the adverse findings made against him.

    27.3. The penalties imposed in respect of those previous cases.

    27.4. The continuing and repetitive nature of Dr Chan's offending.

27.5. The public interest in maintaining public confidence in the integrity of the professional disciplinary process.

27.6. The need to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine.

28. Dr Chan displayed on this occasion either an inability or an unwillingness or both to practise in accordance with the norms determined by his peers; and from a consumer viewpoint a disregard of the Code of Health and Disability Services Consumers' Rights which came into force on 1 July 1996.

29. Disturbingly, he has displayed similar conduct on numerous previous occasions over a lengthy period as is borne out by the previous disciplinary findings referred to above.

Decision

30. The Tribunal wishes to make it plain it is of the firm view that Dr Chan is an unsafe practitioner. This is not the first occasion on which a professional medical disciplinary body has reached this conclusion. The removal of his name from the register is in the interests of public safety which should outweigh all other considerations including the punitive effect of de-registration. (See *Teviotdale v Preliminary Proceedings Committee* unreported HC21/96 High Court Auckland 18.7.96).

31. Accordingly, the Tribunal has had little difficulty in unanimously concluding that Dr Chan's name should be removed from the register as he poses a danger to the health and safety of members of the public.

32. In addition to removing his name from the register, the Tribunal is satisfied that it is appropriate that Dr Chan be censured and fined.

33. With regard to the fine, taking into account all matters, the Tribunal considers that a fine of $15,000 of a maximum of $20,000 is fair and reasonable in the circumstances.

34. With regard to costs, the Tribunal is satisfied that it is appropriate that Dr Chan should pay a proportion of the costs and expenses of and incidental to the CAC's enquiry and prosecution and the Tribunal's hearing. In determining costs, the Tribunal is aware that costs must not be imposed as a penalty. Costs do not normally exceed 50% of actual costs, unless the particular circumstances of the case call for a greater contribution. (See *Cooray v Preliminary Proceedings Committee* unreported AP23/94 High Court Auckland 14.9.95). Dr Chan has chosen not to appear or be represented at the hearing nor communicate with the Tribunal in any way whatsoever which has caused additional costs relating to service of documents relevant to the proceedings. The actual costs incurred amount to $39,856.65. The Tribunal is of the view that Dr Chan should pay the proportion of 60% of them.

Orders

35. Accordingly, for the reasons set out above, the Tribunal makes the following orders:

(a) Dr Chan's name be removed from the register of medical practitioners pursuant to section 110(a) of the Act.

(b) Dr Chan is censured.

(c) Dr Chan is to pay a fine of $15,000.

(d) Dr Chan is to pay $23,913.99 which represents 60% of the costs of the CAC investigation and prosecution and the Tribunal's hearing.

(e) A report of the Tribunal's substantive decision and this decision is to be published in the New Zealand Medical Journal.

(f) That publication of the name of the complainant is permanently prohibited.

(g) The Tribunal requests that the Medical Council consider notifying the content of this decision to the Registration Board in the particular State in Australia where Dr Chan may be currently employed and/or currently practises.

Addendum

36. Section 111 of the Act provides that where the Tribunal orders the name of the practitioner be removed from the register it may, in that order, fix a time after which the practitioner may apply to have his name restored to the register or any part of the register.

37. While it will ultimately be a decision for the Medical Council of New Zealand whether to restore Dr Chan's name to the register, should he apply, the Tribunal has not fixed a time because in its view it believes that the removal of Dr Chan's name should be permanent.

DATED at Wellington this 8th day of May 2003

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S M Moran
Deputy Chair
Medical Practitioners Disciplinary Tribunal