MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 159/00/67C

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 K 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

The Charge

1. A Complaints Assessment Committee duly appointed under section 88 of the Medical Practitioners Act 1995 ("the Act") laid the following Charge against Dr Chan:

"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 21st June 1996 and 24th July 1996 acted in a way that amounted to professional misconduct in that:

1. There were serious deficiencies in his anaesthetic practice, namely:

(a) He failed to provide any or proper information to Ms A about the nature of 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 A prior to surgery; and/or
(c) The anaesthetic which he administered to Ms A was outside relevant professional guidelines; and/or
(d) He failed to monitor Ms A's condition adequately during the surgical procedure; and/or
(e) He failed to monitor Ms A's condition adequately post-operatively.

2. Dr Chan failed to meet with Ms A and adequately inform her of the anaesthesia process, the surgical procedure and the risks associated with that procedure 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.

3. Dr Chan failed to keep full and accurate clinical records of his pre-operative, intra-operative and post-operative care of Ms A."

2. In essence, the Charge against Dr Chan alleges that his care and treatment of Ms A, preparatory to and in the course of carrying liposuction surgery, fell short of acceptable standards of care.

Background to the Charge

3. The Charge arises out of events occurring in June and July 1996. In brief, Ms A was dissatisfied with the appearance of her legs, and decided to investigate the possibility of obtaining an improvement in their appearance by having an amount of fat removed from the backs of her legs. She also hoped that the relative sizes of her legs could be equalised as one leg was larger in diameter than the other.

4. Following two visits to Dr Chan's surgery on 21 and 27 June 1996, Ms A decided to go ahead with the surgery, and the liposuction procedure was carried out on 24 July 1996. Despite being advised in the information provided to her by a woman at the clinic whom she assumed was Dr Chan's nurse (she was identified only as "*Geraldine*") that the procedure would be "*painless*", Ms A in fact suffered a great deal of pain and discomfort both during and after the procedure.

5. In the course of the procedure Ms A woke up twice, and on each occasion was feeling a significant amount of pain and she was given further medication. When Ms A awoke after the surgery was completed, she was alone in the dark in a bed in Dr Chan's office. A nurse came in to check if she had someone to take her home, and her mother arrived shortly afterwards to collect her.

6. At around 6.00pm the next day (24hrs post-operatively) Ms A began vomiting and was unwell. She tried to contact Dr Chan by means of the emergency number she had been given, but was unable to do so. She left a message on the pager service but her calls were not returned. Ms A telephoned several times and left messages on each occasion. She became distressed and was in a lot of pain. She received a call from the clinic at approximately 8.00am the next day, by which time the vomiting had ceased.

7. Ms A complained to Dr Chan regarding the care, or more accurately the lack of care, she had received . He responded as follows:

"Thank you for your letter of 5 August 1996.

It has been hectic, I do apologise for the late reply.

You raised two issues. Let me deal with them.

Firstly, your message was not responded to. Neither myself nor my nurse received the message. That is why your call was not answered. I reiterate my apology for that. To avoid a recurrence, patients are now given my cell phone number as well.

Secondly, you complained about intraoperation pain. My practice is to give local anaesthetic and intravenous sedation when the patient experiences discomfort. Please be aware that under sedation, your perception of events could be distorted.

I trust the above has gone some way to alleviating your concerns".

8. By letter dated 25 February 1997, Ms A made a complaint to the Medical Council. In her letter, Ms A complained that Dr Chan had not undertaken any consultation with her; there was no anaesthetist present during the surgery; she had woken twice during the surgery, both times in great pain; all of the information given to her prior to her deciding to go ahead with the surgery had proved to be misleading and incorrect; the results of the surgery were unsatisfactory and not what was promised; she had been unable to contact Dr Chan or to obtain assistance for post-operative vomiting and distress; and she was still experiencing soreness in the area where fat was removed seven months after the surgery.

Evidence for the CAC

9. Evidence for the CAC was given by the complainant, Ms A; and Dr David Chamley, a specialist anaesthetist of Auckland.

Ms A's evidence

10. In giving her evidence Ms A referred to a "*Calendar of Events*" and "*List of Complaints*" which she had prepared in support of her complaint made in 1997. Ms A impressed the Tribunal as a truthful and articulate witness. She appeared to have a good recollection of the events of July 1996, and the documentation which she prepared in support of her complaint was quite detailed, and covered all of the matters which were the subject of her complaint. It was helpful for the Tribunal to have such evidence, prepared relatively close in time to the relevant events, available to it at the hearing.

11. Ms A gave evidence of her two pre-operative consultations with Geraldine, and of the events on 24 and 25 July 1996. The relevant details of these events are referred to in relation to the relevant particulars of the Charge. In summary, Ms A described her initial visit and the information relating to the liposuction procedure given to her by Geraldine.

12. She described also her second visit to the clinic at which she again saw Geraldine, and advised her that she had decided to go ahead with the operation. Ms A filled out an Information Schedule, a 'checklist' medical history; she paid a deposit of $500; signed a consent form for the Operation *"Liposculpture"*; she was given some forms to have blood tests done, some arnica drops, vitamins and instructions of how to use them, and she was given some pre and post-operative instructions. Ms A and Geraldine also made arrangements for the operation to be carried out on 24 July 1996.

13. Ms A described the events of 24 July 1996, including her pre-operative 'consultation' with Dr Chan. This consultation is described more fully later in this decision. She described being taken into an office where she put on a surgical garment. She was given pre-operative medication which made her feel sleepy and nauseous. She complained about her nausea to the nurse assisting her and was told only that it was an effect of the medication she had been given. About half an hour later she was woken and walked into a adjoining room, which she described as resembling a doctor's room, rather than an operating theatre.

14. While she was standing, Dr Chan squatted behind her drawing on her bottom and legs with a pen. She was then told to lay face down on the table, with her hands out in front of her, face down, her head to one side. The sedation medication was administered via a syringe taped to the back of her hand.

15. Ms A also described waking twice during the procedure and being told to lie still. On each occasion she felt a significant amount of pain, and more sedation was administered which made her go back to sleep.

16. Despite being told that the liposuction was a painless procedure, Ms A suffered a great deal of pain post-operatively, and for several weeks after the operation. She was unable to return to work for three weeks, and it was five weeks before she could exercise again.

17. Ms A also described her vomiting, pain and distress post-operatively, and her repeated, unsuccessful attempts to contact Dr Chan, or his staff, at the telephone numbers she had been given.

18. In addition, she was dissatisfied with the results of the surgery. She was told that the fat on the backs of her legs would be removed; it was not. Similarly, she was told that her legs would be the same size after the liposuction, but the asymmetry remains. On seeking a second opinion regarding the outcome of the surgery, Ms A was told that she was not a good candidate for liposuction, and it could not achieve the results she was hoping for because of a stress fracture in her leg.

Dr Chamley's evidence

19. Dr Chamley gave evidence in relation to the guidelines produced for the profession relating to sedation for diagnostic and surgical procedures, frequently carried out by non-anaesthetists; relevant professional standards; the anaesthetic medications administered to Ms A, and her pre-operative, intra-operative and post-operative care.

20. Dr Chamley also produced a number of articles relating to liposuction surgery generally, and in particular, to the risks of liposuction surgery. For example, Dr Chamley produced one article entitled "*Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*", Grazer FM & de Jong RH, published in Plastic and Reconstructive Surgery, January 2000, pp436-446.

21. The authors state that:

"Troubling reports of adverse outcomes after liposuction prompted a census survey of aesthetic plastic surgeons. All 1200 actively practicing North American board-certified ASAPS members were polled by facsimile, then mail, regarding deaths after liposuction. …

Responding plastic surgeons (917 out of 1200) reported 95 uniquely authenticated fatalities in 496,245 lipoplasties. In this census survey, the mortality rate computed to 1 in 5224, or 19.1 per 100,000. A virtually identical 20.3 per 100,000 mortality rate was obtained in a 1997 random survey commissioned by the parent society. Pulmonary thromboembolism remains as the major killer (23.4 +/- 2.6%); lacking consistent medical examiners' toxicology data, the putative role of high-dose lidocaine cardiotoxicity could not be ascertained. Where so stated, ***many deaths occurred during the first night after discharge home; prudence suggests vigilant observation for residual "hangover" from sedative/anaesthetic drugs after lengthy procedures.***

Taken together, these two independent surveys peg the late 1990s mortality rate from liposuction at about 20 per 100,000 or 1 in every 5000 procedures. Set beside the 16.4 per 100,000 fatality rates of US motor vehicle accidents, ***liposuction is not an altogether benign procedure****. … As liposuction is performed largely outside the hospital - distant from peer review, incident reporting and medical examiner scrutiny - the extent of complications from the 293,000 (estimated) lipoplasties performed in 1996 may well be underreported. …"(emphasis added)*

22. Another study (*Suction Lipoplasty: A Report on Complications, Undesired Results, and Patient Satisfaction Based on 3511 Procedures*, Dillerud E, Plastic and Reconstructive Surgery 1991) reported that the most common general complications from suctions lipoplasty were excessive bleeding and complications from anaesthesia. Significantly, the paper reported that *"All patients, apart from those who had minor procedures under local anaesthesia, underwent a strict examination by an anaesthesiologist prior to surgery to possibly detect any subjects at risk*".

23. The satisfaction rate was reported to be 88%. Of the 3511 procedures reported, 334 were later revised, 213 because of asymmetry, underresection or expected skin irregularities. A total of 121 procedures unexpectedly required secondary suction, skin excision or similiquid fat grafting because of "*undesired aesthetic sequelae*." A number of procedures (45/3511) produced sequelae which could not be corrected by secondary procedures, including persistent odema, permanent pigmentation, contour defects, skin depressions, and adhesions.

Legal Assessor

24. The Tribunal had also appointed a legal assessor to attend the hearing, Ms K Davenport, barrister of Auckland. Ms Davenport provided her advice on the relevant law and

applicable legal principles to the Tribunal at the conclusion of the evidence and after Mr Harrison had made his closing submissions.

Evidence for Dr Chan

25. There was no evidence presented on behalf of Dr Chan. In the Checklist completed by Dr Chan prior to the first Directions Conference he advised the Tribunal that he did wish to be heard at the hearing of the Charge, and that the number and identity of the witnesses to be called on his behalf was *"to be advised by counsel"*. He advised the Tribunal that:

"I am awaiting my medical defence to engage a counsel. This may take some time. An adjournment [of the hearing then scheduled for December] may be sought. My defence is in Australia".

26. When the December hearing was adjourned, Dr Chan was advised of a new timetable for the filing of any briefs of evidence, and the bundle of documents. Any witness statements on behalf of Dr Chan were required to be lodged with the Tribunal by 22 January 2001. On 30 January 2001, the Tribunal wrote to Dr Chan noting that it had not received any witness statements from him. The Tribunal advised Dr Chan that he was not obliged to present any evidence in his defence, but asked if he could advise the Tribunal if he did wish to submit any witness statements, or if he was intending to give oral evidence at the hearing. Dr Chan did not reply to that correspondence notwithstanding that it was forwarded to him by mail, and by facsimile.

27. In response to that letter, the Tribunal received a message from his clinic that Dr Chan was en route to Europe, and it wrote again to Dr Chan on 31 January 2001, asking him what his plans were, and again asking him to advise his intentions regarding what evidence, if any, he intended to submit at the hearing.

The Tribunal's decision

28. The Tribunal carefully considered the evidence presented on behalf of the CAC, and Mr Harrison's very helpful submissions. Throughout its deliberations the Tribunal was careful to keep in mind that it had not heard from Dr Chan, and thus the evidence given on behalf of the CAC was not tested by cross-examination or rebuttal evidence. However, the Tribunal was satisfied that Ms A in particular was a strong witness, and, somewhat

unusually in the Tribunal's experience, her evidence was supported by the very detailed record she had prepared relatively close to the time of the events described in her evidence.

29. The Tribunal is satisfied therefore that it had a very good opportunity to assess her credibility as the principal witness for the CAC. Dr Chamley, as the CAC's expert witness, also impressed as a experienced practitioner whose evidence was of a practical and commonsense nature as much as it was technically detailed and informative. On the basis of the evidence provided to it, the Tribunal is satisfied that the Charge is established and Dr Chan is guilty of professional misconduct.

Reasons for decision

Legal issues - The Standard of Proof

30. The standard of proof in disciplinary proceedings is well-established as the civil standard, or the balance of probability. However, it is equally well-established that the standard of proof will vary according to the gravity of the allegations and the level of the charge. In this case, the Charge was laid at the mid-range of the hierarchy of professional disciplinary offences.

31. Accordingly, in its deliberations the Tribunal applied a correspondingly standard of proof, bearing in mind that the standard of proof may also vary within a single case, such as this one, where the Charge contains several particulars and alleges that the particulars, either separately or cumulatively, constitute the Charge.

32. All elements of the Charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

The Burden of Proof

33. The burden of proof is borne by the CAC.

Professional misconduct

34. The definition of professional misconduct is well-established. In *Ongley* (supra), at 374-375, Jefferies J stated (in the context of the 1968 Act) -

"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 judgment 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 layperson at the committee stage."*

35. In relation to this latter point of course, the composition of the Tribunal is now three experienced medical practitioners, a public member and a legally qualified chairperson, effectively two laypersons and three practitioners. But the basic thrust of Jeffries J's approach is unchanged, and that is the approach taken by this Tribunal - to examine the factual and clinical context and to ask itself if it was satisfied that the factual and clinical context was established, and, if so, was Dr Chan's performance of his professional obligations such that this Tribunal is satisfied he is guilty of professional misconduct?

Informed Consent -

36. In relation to the issue of informed consent, Mr Harrison submitted that the legal principles relating to a doctor's obligation to obtain a patient's informed consent before surgery are well settled. He referred to an earlier decision of this Tribunal involving Dr Chan in which similar issues arose (Decision No 94/99/39C, paras 7.21-7.61).

37. Since that decision, the Tribunal has also canvassed the relevant authorities in *CAC v Stubbs*, Decision 116/99/54C ("*Stubbs*") and in *Director of Proceedings v H,* Decision No. 138/00/58D. Both of these decisions in turn relied upon the decisions of the High

Court of New Zealand, *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96) and the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479.

38. The Tribunal has referred consistently to both of *B v The Medical Council* and *Rogers v Whitaker* as these two cases are the leading authorities in relation to the standard and content of the 'duty to inform' and the test against which the practitioner's conduct will be measured. In *Rogers v Whitaker*, the Australian High Court departed from the established law, defined and developed in the UK line of cases starting *with Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. The 'Bolam test' established that the criterion against which a doctor's conduct falls to be judged by is whether it complies with the views of a 'responsible body of medical opinion'.

39. The Australian High Court in *Rogers v Whitaker* departed from this approach and held that while there is a 'single, comprehensive duty of care' which covers diagnosis, treatment and the provision of information so as to secure consent, the content of the duty varies according to which activity the doctor is undertaking. As to whether or not the patient has received sufficient information to allow him or her to make a reasoned choice whether or not to consent to treatment 'is not a question the answer to which depends on medical standards or practice'. That is a matter for the court to determine.

40. The content of this aspect of the doctor's duty was that:

"… a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

41. It is of course also the case that the duty is not limited merely to warnings about risks. It extends to information about any alternatives which may exist for the patient. This approach is consistent with the case law which developed in the USA and Canada, the leading cases being *Canterbury v Spence* (464 F 2d 772(1972)) and *Reibl v Hughes* (1980) 114 DLR (3d) 1. Both of these cases were referred to by Lord Scarman in his minority judgment in *Sidaway v Bethlem Royal Hospital* [1985] 1 All ER 643, all of these cases being referred to in *Rogers v Whitaker*.

42. As stated in *Stubbs*, *Rogers v Whitaker* was referred to by Elias J with approval in *B v Medical Council*, and in extra-curial papers given at medico-legal conferences since that case, the Chief Justice has expressed the view that *Rogers v Whitaker* is good law in NZ. The wording of Right 6(2) of the Code of Health and Disability Consumers' Rights, with its focus on what a 'reasonable consumer, in that consumer's circumstances' needs to make an informed choice, follows closely the approach taken by the court in *Rogers v Whitaker*.

43. In *H*, the Tribunal also referred to an earlier, influential case, *F v R* (1983) 33 SASR 189, in which King CJ very articulately described the underlying philosophy of doctor-patient interaction as follows:

"The governing consideration is the right of every human being to make decisions which affect his own life and welfare and to determine the risks which he is willing to undertake. The presumption is clearly in favour of disclosure of the information which is relevant to the making of a decision."

44. King CJ outlined five factors in determining what a '*careful and responsible'* doctor has a duty to disclose to a patient:

- The duty extends only to those matters which might influence a reasonable person in the patient's position.
- The nature of the treatment is important. The more serious the treatment, the greater the need to keep the patient informed about outcomes and possible risks.
- The nature of any inquiry by the patient.
- The decision as to the nature and extent of disclosure will depend upon the patient's overall medical condition. The 'therapeutic privilege' will be relevant in this regard. If a patient's mental or physical condition may be adversely affected by the disclosure, information may be withheld from the patient.
- The duty to disclose is governed by the overriding requirement that the doctor act in the best interests of the patient.

45. His Honour also recognised that the extent of the duty to advise and disclose will be affected by the surrounding circumstances, such as the existence of emergency conditions, the absence of an opportunity for detached reflection or calm counseling, and the existence of alternative sources of advice. King CJ also acknowledged that some patients will not

want to receive information, and a doctor is not required to inflict information on patients which they do not seek and do not want. What is required is reasonable care on the part of the doctor in exercising a judgment as to the real wishes of his or her patient in relation to receiving information relating to risks. "*If a reasonable exercise of that judgment is against volunteering information, a doctor will not be negligent*."

46. In all respects, this formulation of the duty to inform stands the test of time, and accords with the philosophy and purpose of the modern cases, and more particularly in the New Zealand context, with the requirements of the Code of Health and Disability Services Consumers' Rights, which came into force on 1 July 1996.

47. The fundamental principle is that of self-determination and the right of the individual to decide what happens to their body; a person has a right to know what treatment entails in order to be able to make a reasoned choice and thus, to give valid consent. What the law requires of doctors is that they provide the patient with sufficient information to make a considered decision. It does not require, nor has it been suggested, that the doctor is required to pass on to the patient everything there is to know about a condition or proposed treatment.

48. More recently, the Medical Council has published its Guide to Medical Practice In New Zealand. In that publication, the Council stated that:

"the right to make an informed choice and give informed consent, although superseded by other enactments under common law, is of fundamental importance in the provision of medical care and treatment. … It is clearly not simply a matter of obtaining a signature on a form. Informed consent is a process, involving both doctor and patient, of communicating and discussing the information provided by the doctor so that the patient can take responsibility for making an informed decision about his or her treatment and choose whether or not to give the doctor consent to implement it."

49. In determining the Charge against Dr Chan, the Tribunal has applied the legal principles established and developed in the cases referred to above, bearing in mind that the events in issue arose in July 1996, and therefore must be judged according to the standards which were applicable and acceptable at that time. In that regard, the Medical Council's Statement for the Medical Profession on Information and Consent published in June 1990 is relevant (being current in 1996).

50. In that Statement the Medical Council advised all practitioners that it -

"*takes the view that (except in an emergency or a related circumstance) the proper sharing of information, and the offering of suitable advice to patients, is a mandatory prerequisite to any medical procedure instituted by a medical practitioner. This applies whether the procedure is a diagnostic one, a medical or pharmacological regimen, an anaesthetic, or any surgical, obstetric, or operative procedure."*

51. The Statement went on to set out the *"certain items of information which should always be considered by the doctor"*. These included:

"(a) The nature, status and purpose of the procedure, including its expected benefits, and an indication as to whether it is orthodox, unorthodox or experimental.
(b) The likelihood of available doctors achieving the specific outcome that the patient seeks.
(c) …
(d) The associated physical, emotional, mental, social and sexual outcomes that may accompany the proposed management.
(e) Significant known risks, including general risks associated with procedures such as anaesthesia, the degree of risk and the likelihood of it occurring for that particular patient.
(f) Any likely or common side effects …"

52. The Statement also contained the warning to practitioners that

"The Medical Council affirms that if it can be shown that a doctor has failed to provide adequate information and thereby has failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered as medical misconduct and could be the subject of disciplinary proceedings.

In judging whether the medical practitioner has fallen short of acceptable practice in these matters, disciplinary authorities should have recourse to guidelines that are published from time to time by such bodies as the Medical Council, the Area Health Boards (and their Ethics Committees), the Health Research Council, the Colleges and the New Zealand Medical Association."

Findings in relation to Particulars of the Charge

Particular 1: That there were serious deficiencies in Dr Chan's anaesthetic practice -

53. The alleged deficiencies are that Dr Chan failed to inform Ms A about the effects of the anaesthetic she was to receive; that he did not carry out any adequate or proper anaesthetic assessment prior to surgery; the anaesthetic administered to Ms A was outside

relevant professional guidelines; he failed to monitor her condition adequately during or after the surgery.

54. The Tribunal is satisfied that the evidence, and particularly the documentary evidence provided to it, clearly establishes all of the Particulars as alleged. The Tribunal is satisfied that there was no meaningful information given to Ms A by Dr Chan prior to her liposuction surgery (either in terms of the legal principles referred to herein or the Medical Council's 1990 Statement). Indeed, it seems clear from Ms A's evidence that no information whatsoever was given to her directly by Dr Chan, either in relation to the anaesthetic specifically, or to the liposuction procedure generally.

55. Ms A confirmed that Geraldine had given her a copy of a brochure, in the nature of a marketing brochure, entitled *"Liposculpture The Art of Face and Body Contouring A Guide to Permanent Fat Removal"*, when she first attended at the clinic. Geraldine also gave her pre and post-operation instruction sheets, and she had completed a 'Yes/No' checklist-type "Medical Record" at the time of her second visit to the clinic.

56. In the brochure under the heading "*Does it hurt*?", it states: "*All procedures are performed using mild sedation and local anaesthetic and are safe and quite painless."* That information appears to be the extent of the advice given in relation to the anaesthetics to be administered.

57. As Mr Harrison submitted, Dr Chan took no steps whatsoever to obtain Ms A's informed consent to the liposuction operation at any time on or before the date of the surgery, 24 July 1996. Ms A was told that at her first visit if she was going to go ahead with the surgery, she would have to return to see Dr Chan. However, when she arrived for her second visit, she was told that there had been a mistake, and she had not been booked to see Dr Chan. As a result, he was unavailable and she saw Geraldine again instead. She paid a deposit of $500 as she had been instructed (the cost of the liposuction surgery was $2,500), and she was to pay the balance on the day of the surgery.

58. Accordingly, Ms A did not see Dr Chan until the day of the surgery. She arrived at the clinic at 1.45pm to have anaesthetic cream applied to the back of her hand. One of the

nurses present took her 'before' photos, and the receptionist took the balance of the payment. Ms A then reminded the nurse that she had not seen Dr Chan. The nurse went and got Dr Chan. According to Ms A,

"Dr Chan came out all dressed in green, like in his scrubs or whatever they are called, walks up to me, he said hi, come this way, walks me into a consultation room, he's holding on to the knob of the door, he opens the door, walks in, I followed him in, [he] closes the door, still holding on to the door knob, and says to me "have you got any questions?" and I said "No, they've all been answered", he said, "okay, great", off we go, didn't even let go of the door knob. That was my consultation with him prior to surgery."

59. On the basis of that evidence, Dr Chan made no attempt to counsel Ms A about the particular nature, risks, benefits or wisdom of her liposuction surgery. Nor did he make any attempt to ensure that she understood the information she had been given by any of his staff. He simply proceeded on the premise that Ms A had paid the required charge, and the operation would therefore inevitably proceed.

60. Ms A also gave evidence that she was not told of any anaesthetic risks, either intra-operative risks, or post-operatively. For example, she was not given any information or instructions about precautions she should take after having sedation. She was not warned that she should not drive, or drink alcohol for 24 hours for example. She was told only that she would need someone to collect her after the surgery.

61. In relation to the pre-operative assessment which Dr Chamley considers should have been carried out, he referred to the checklist which Ms A had completed, but considers that such a 'questionnaire' should be an aid to pre-operative assessment, it cannot replace an assessment by the practitioner who is to administer the anaesthetic. Further, although blood tests were apparently requested, there is no record of what these were, their purpose, or the results.

62. In relation to the allegations contained in paragraph (b) of the first Particular, it was Ms A's evidence that Dr Chan did not carry out any pre-operative examination at all. He did not discuss the anaesthesia he was intending to administer at all. He simply injected the back of her hand, which put her to sleep, and when she was roused from the sedation by pain, he simply 'topped up' the sedation. This evidence is consistent with Ms A's records provided to the CAC by Dr Chan.

63. In relation to paragraphs (b) - (e) of Particular 1, Dr Chamley gave evidence that the relevant guidelines and standards applicable to this case is the Australia & New Zealand College of Anaesthetists (ANZCA) Policy Document P9, "*Sedation for Diagnostic and Surgical Procedures*". This guideline applies to sedation carried out by all medical practitioners, including non-anaesthetists, such as Dr Chan, and is widely accepted (albeit not mandatory) across the profession generally as indicated by guidelines produced jointly with the Royal Australasian College of Surgeons (P24), The Royal Australasian College of Dentists (P21), the Royal Australian College of Ophthalmologists (PS36) and the Gastroenterological Society of Australia (P24), all of which incorporate the basic tenets of P9. There are also a number of other policy documents and guidelines which should be read in conjunction with P9, which were referred to by Dr Chamley.

64. The objective of sedation for diagnostic and surgical procedures carried out by non-anaesthetists is to "*… produce a degree of sedation of the patient, **without loss of consciousness,** so that uncomfortable diagnostic and surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render loss of consciousness unlikely*" (Section 1, emphasis added).

65. The underlying principle is that an anaesthetist should be present unless "*rational communication"* with the patient is continuously possible during the procedure (Section 2.5). The practitioner preoccupied with surgical tasks cannot safely undertake the necessary monitoring of a patient in a state of heavy sedation.

66. It was Dr Chamley's evidence that the combination and dosage of the drugs administered by Dr Chan, as recorded on Ms A's *"Information Schedule"* (in effect the operation record) before and during the operation would have been sufficient to put her into a state of heavy sedation leading inevitably to a loss of consciousness. Specifically, the pre-operative medications administered to Ms A were Prednisone, Palfium and Valium. Dr Chamley had no criticism of the doses given, other than to note that would have been difficult to predict the effect that they would have in terms of providing analgesia and sedation.

67. Intra-operatively, the medications administered intravenously are recorded to have been Pethidine (100mgs), Hypnovel (5+1½ +1½ mgs), Maxolon (10mgs) and Claforan. (1 gram). It was Dr Chamley's opinion that:

"Hypnovel and Pethidine tend to have an additive effect in producing sleep and loss of consciousness and one of the techniques for inducing loss of consciousness in patients who do not respond particularly well to Benzodiazepine such as Hypnovel which was used on this occasion is to give small doses of narcotic. It tends to produce an immediate reduction in consciousness. The dose of narcotic in this case is not a small dose, it is a large dose, 100mg of Pethidine would in itself produce quite a depression of reflexes and a degree of sedation. The dose of benzodiazepine used, 5 milligrams at least to start with, although it may have been administered in incremental doses, it is not clear from [the record] I would anticipate it to produce unconsciousness."

68. Asked if he could recall, in his own practice as a specialist anaesthetist, having to administer 8 mgs of Hypnovel to a patient in the course of an operation, Dr Chamley responded that he had never administered a dose in this amount. He commented -

"I think that it's 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."

69. In Dr Chamley's view,

"the biggest risk is the risk of a reduction in the respiratory rate, of stopping breathing and the thing which really concerns me is the fact that there is no evidence that there was any monitoring of the amount of oxygen which Ms A had, there's no evidence of a pulse oximeter being used. There's no record of supplementary oxygen being given and there's no record of particular positioning, other than that it was prone. When you lie someone flat down on their stomach, the airway is normally pretty good as long as the head is in the right position. But if the head is twisted off to the side, then you can have significant obstruction to the airway and I would regard it as dangerous practice."

70. Finally, Dr Chamley made the point that when sedation is administered there is some potential for anterograde amnesia. This would mean that Ms A might not recall accurately events which did happen. However, this did not mean that those events which she did recall did not happen.

71. Notwithstanding that none of this evidence was able to be tested either by cross-examination or rebuttal evidence, the Tribunal is satisfied that the facts and allegations contained in Particular 1 are established. The omissions identified on the part of Dr Chan demonstrate that the standard of the care he provided to Ms A fell deplorably short of the standard of care she was entitled to expect and accordingly he is guilty of professional misconduct.

Particular 2: The allegations that Dr Chan failed to obtain Ms A's informed consent and that he failed to keep adequate records -

72. Ms A told the Tribunal that on both visits to Dr Chan's clinic (on 21/6/96 and 27/6/96), she saw Geraldine only. She told Geraldine what she wanted done, and Geraldine told her how much the procedure would cost; she explained the liposuction procedure, and gave Ms A a form with pre and post-operative instructions.

73. Geraldine told Ms A that she was an ideal candidate for liposculpture and that her results would be very pleasing. Ms A asked her if the results would be permanent, and if all of the fat in the area at the back of her legs would be removed. Geraldine responded positively to both questions. The Tribunal notes that Ms A is of very slender build (her weight was recorded at the time as 54kgs).

74. Ms A also said that Geraldine told her that she should decide quickly if she wanted to go ahead with the liposuction as Dr Chan was very busy and 'got booked up quickly'. Geraldine told her that if she decided to go ahead, she needed to return to the clinic to see Dr Chan. He would describe the procedure in detail, give her forms to have blood tests done, measure her for the post-operative garment, take 'before' photos, and answer any questions she might have.

75. It was on Ms A's second visit to the clinic (after she had decided to go ahead with the surgery) that she signed a consent form for the surgery and was given the pre and post-operative instruction sheets.

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76. Ms A's evidence was that she read the consent form when she signed it. However, with the benefit of hindsight, she had signed the form in the belief that she had understood what she had been told. She told the Tribunal "*…what I know now, there's stuff missing from here and so much I didn't understand at the time. I guess the term has been used before, I felt they did a sales pitch on me from what I know now."* At the time she had signed the form, she had thought that she knew all she needed to know. As she said in response to a question from the Tribunal *"Its only now afterwards when I know what I should have known … I had no reason to be suspicious …".*

77. Ms A went on to state that:

"One thing I would say about the whole thing was when I went along Geraldine made a big thing about he books up really quickly you really need to get in, otherwise you'll have to wait months to have it done. She was trying to force me to book straight away and I said I needed to think about it, and then I felt pressured into it, like I had to make the appointment now or I was going to miss out. So, I signed this because you have to sign before you have the operation, but what I [mean] pressured was no-one was standing over me with a gun, with a pen, but I had been pressured into making the appointment in the first place."

78. When asked by one of the Tribunal members if she had done any research herself into liposuction, Ms A replied:

"No, and that is very unusual for me. … I am usually very thorough in researching things but because they kept saying you need to be quick, you need to get in now, that I felt I didn't have the time to do that, that it was an urgent thing. So, no I didn't."

79. However, it is now well-settled that a doctor's obligation to impart information to his patient does not depend upon the patient's ability to ask the right questions. The process of obtaining informed consent is exactly that; a process. It requires the active participation of the doctor. It is not sufficient merely to obtain a signature on a form. The doctor's obligation is not merely to answer any questions the patient might have, he or she must take an active role and ensure that their patient is fairly and adequately informed of all of the risks, and benefits, of the surgery they are to undergo, and any alternatives.

80. This applies even more so when the surgery is elective, and there is no element of necessity or emergency. Equally, the patient must not be coerced, subtly or otherwise, into agreeing

to undergo surgery. Again, such proscription is even more significant when the surgery is elective, and there is significant financial remuneration to the practitioner. That Ms A may have been coerced, or at least unfairly pressured, into her decision to undergo the liposuction surgery is an aspect of this case which causes the Tribunal concern.

81. The Tribunal is satisfied that Dr Chan did not adequately inform Ms A about the liposuction surgery; he did not adequately disclose the risks of either of the anaesthetic or the surgery; he made no effort to explain the nature, purpose or likely outcome or possible side-effects of the surgery; or to ascertain if the surgery would be beneficial for Ms A, if it was suitable or capable of meeting her expectations, or even what her expectations were.

82. The Tribunal is therefore satisfied that paragraphs (a) and (b) of Particular 2 are established and that Dr Chan fell woefully short of fulfilling his professional obligation to provide Ms A with the information she was entitled to receive to enable her give valid consent to the liposuction procedure.

83. As to the allegation that Dr Chan failed to keep full and adequate clinical records of his pre-operative, intra-operative and post-operative care of Ms A, the Tribunal is also satisfied that this allegation is established. Unfortunately, the inadequacy of the records seems to reflect the content and standard of the care and treatment provided to Ms A by Dr Chan, as much as it reflects any failure to keep an adequate record of the care and treatment which was given to Ms A.

84. For whatever reason, the records are manifestly inadequate. There is no documentation of any pre-operative assessment (by Dr Chan or otherwise); there is no record of Ms A's consultations with Geraldine, or the information provided by her; no record of any information being given or received in relation to the administration of the anaesthetic; no record for example of Ms A's fear of needles or history of pre and post-operative vomiting (information which Ms A said she did give to Geraldine); no record of which local anaesthetic or vaso-constrictor (if any) was administered; no statement as to Ms A's level of consciousness during the procedure; or operation notes.

85. It is especially concerning that there are no notes whatsoever of Ms A's post-operative status. This tends to confirm Ms A's evidence that she was left alone in Dr Chan's office, in the dark, to recover from the surgery. It was Dr Chamley's evidence that it is not appropriate for a patient who has received heavy sedation to be left unattended, and unmonitored in a darkened room. He stated:

"The doses of drugs administered may lead to obtunded protective reflexes, given her earlier complaint of nausea (when the pre-operative medications were given), and apparent lack of fasting, vomiting and aspiration is a risk which does not appear to have been considered, or guarded against."

86. Finally, in terms of the information provided to Ms A, there is no evidence at all that she was ever advised about the risks of liposuction surgery, such as have been reported in the professional literature referred to the Tribunal by Dr Chamley. It is also of concern to the Tribunal that the brochure *"Liposculpture The Art of Face and Body Contouring A Guide to Permanent Fat Removal"* given to Ms A on her first visit to Dr Chan's clinic, makes no mention of any risks.

87. In fact the brochure refers to liposculpture as "*a simple and effective surgical process* .." and states that "*Overall, the procedure is safe when performed by an experienced surgeon. Few complications have occurred in the modern experience of liposculpture."* On the basis of Ms A's evidence that she was given no information about the potential risks or side-effects of liposuction surgery, the information contained in the brochure is grossly inadequate, and in fact quite misleading and deceptive.

88. Accordingly, and taking all of these matters into account, The Tribunal is satisfied that Dr Chan failed to meet his professional obligations to ensure that his patient was adequately and fairly informed regarding the procedure he was to perform.

89. The Tribunal is satisfied therefore that Particular 2 is established at the level charged, professional misconduct. Given the nature and extent of Dr Chan's failure, and the fundamental nature of the requirement to obtain proper informed consent, it is hard to imagine a more complete failure on his part.

90. However, the Tribunal was mindful of the fact that it did not have the opportunity to hear evidence from Dr Chan, and that the events traversed in this hearing occurred nearly four years previously. It would have been interested to ascertain the extent to which Dr Chan's practice and procedures may have changed since that time (or if any of them have been changed as a result of this complaint).

Conclusion

91. Having considered each of the Particulars separately and cumulatively, the Tribunal is satisfied that the Charge is established and that Dr Chan is guilty of professional misconduct.

92. The Tribunal's decision is unanimous.

Orders

93. The Tribunal orders as follows:

93.1 The charge laid against Dr Chan is established and Dr Chan is guilty of professional misconduct;

93.2 The CAC is to lodge submissions as to penalty not later than 10 working days after receipt of this Decision; and

93.3 Submissions as to penalty on behalf of Dr Chan are to be lodged not later than 10 working days thereafter.

94. No extensions of time for the filing of submissions will be given. In the event that no submissions are received within the time periods stipulated, the Tribunal will proceed to determine penalty on the basis of its findings set out in this Decision.

DATED at Auckland this 22nd day of March 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal