MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO. 224/02/93C

IN THE MATTER OF the Medical Practitioners Act 1995

A N D

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

No appearance by or on behalf of Dr Chan

Particulars of the Charge

The Complaints Assessment Committee ("CAC") pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that Warren Chan, Medical Practitioner of Auckland during the period January to June 2001 acted in a way that amounted to disgraceful conduct in a professional respect in that:

1. Dr Chan continued to consult with and make arrangements for further surgery with Ms A, regarding his previously performed liposuction while suspended from practising medicine; and/or

2. Dr Chan failed to inform Ms A that he was suspended from practising medicine while continuing to consult with her and to make arrangements for further remedial surgery; and/or

3. Dr Chan failed to inform Ms A that he was not a vocationally registered plastic surgeon in New Zealand; and/or

4. Dr Chan failed to carry out an adequate pre-operative patient assessment, including a clinical examination; and/or

5. Dr Chan failed to exercise appropriate professional judgment in offering liposculpture to Ms A in view of her history of Anorexia Nervosa, chronic benzodiazepine use and her recommended weight for her height based on Body Mass Index.

6. Dr Chan failed to obtain Ms A's informed consent to his proposed treatment including the anaesthesia and surgical procedure in that

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

   (b) The consent forms for anaesthesia and for surgery were given to Ms A to sign after she had been given the preoperative oral sedation.

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

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

   (b) There was no anaesthetist present during Ms A's surgery and drugs were administered in a dosage and combination contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists which state that unless an anaesthetist is present, only conscious sedation may be used. The dosage of drugs

and combination of drugs administered to Ms A could reasonably be expected to result in loss of consciousness.

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

(d) He failed to monitor Ms A's condition adequately post-operatively.

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

9. 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.

The Plea

1. Dr Chan took no step in the proceedings. The Tribunal was satisfied that all appropriate steps had been taken on its behalf to notify Dr Chan in accordance with the requirements of section 103 of the Medical Practitioners Act 1995.

Onus of Proof

2. The onus of proof is borne by the Complaints Assessment Committee.

Standard of Proof

3. With regard to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. However, the standard of proof

varies according to the gravity of the allegations and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged.

Ongley v Medical Council of New Zealand [1984] 4 NZAR 369 at 375 to 376.

Brake v Preliminary Proceedings Committee (Full Court, High Court, Auckland, 169/95, 8 August 1996 at page 8).

Witnesses for the Complaints Assessment Committee

4. The Complaints Assessment Committee called four witnesses:

4.1 Ms A, the complainant, who participated in the hearing by telephone conference from Australia.

4.2 Mr Patrick Jerome Beehan a plastic and reconstructive surgeon of Hamilton. He was called as an expert.

4.3 Dr Timothy Gordon Short, a vocationally registered anaesthetist of Auckland. He was called as an expert.

4.4 Ms Gabriel Jan Fraser, the Secretary of the Tribunal, who gave evidence as to proof of service and registration.

Dr Chan – No Appearance

5. Dr Chan did not take any step in the proceedings. He did not appear at the hearing and did not call any evidence on his own behalf.

Background Events and Evidence

6. Ms A is 29 years of age. She is 155 cm in height. At the relevant time she weighed approximately 52 kilograms. On 21 January 2001 Ms A consulted Dr Chan at his

clinic in Remuera, Auckland. Ms A had found Dr Chan's name and address in the Yellow Pages of the telephone directory and had arranged a free consultation. Ms A wished to discuss a large liposuction on her hips, arms, bottom, thighs and stomach.

7. Ms A told the Tribunal she had lived in England for a year and a half during which time she had developed anorexia and bulimia. Her lowest weight was 44 kilograms and when she returned to New Zealand it increased to approximately 52 or 53 kilograms with a maximum of about 55 kilograms. At the time she first consulted Dr Chan on 21 January, she had been back in New Zealand about six months but said she was still suffering from various eating disorders.

8. She had also been addicted to sleeping pills on and off for about five years and was currently taking Diazepam for this. She had also been taking Halcion intermittently with Diazepam but did not take them together and was not taking Halcion at that time.

21 January 2001 First Consultation

9. Ms A said when she attended her first consultation the nurses at the clinic invited her to look through folders of *"before and after"* photographs of *"recipients of Dr Chan's surgical procedures"* which looked *"absolutely fantastic"* and letters of testimonial.

10. She had not undergone liposuction or any similar procedure before.

11. She said Dr Chan told her he was the most experienced cosmetic surgeon in Australasia and that he had performed more operations than any other doctor in either country. He presented as self-assured and confident. While he did not tell Ms A what his actual qualifications were, he indicated that he had all the necessary qualifications and was reliable, talented and very good at what he did. There was also information about him in the Yellow Pages as well as certificates displayed at his clinic.

12. Ms A, in a light-hearted manner, asked Dr Chan whether he had many complaints or people returning unhappy with their results. He replied that all his patients were very happy but there were *"often people who needed bits fixed up"* and that sometimes

"touch ups" were needed to be done but that was *"no problem at all"*. In such a situation all the person needed to do was make a further booking with no additional charge involved.

13. She asked what could *"go wrong"* or what was *"the worst case scenario"* or *"the dangers of it"*. She said he did not respond but *"brushed off"* her questions.

14. Prior to the consultation she had undertaken of her own volition some research on the internet regarding the type of anaesthetic and understood she might be vaguely aware of the procedure but there would be no pain.

15. Dr Chan told her the procedure would be painless and that she would be in a twilight state where she would not be fully anaesthetised but nor would she feel anything.

16. Other than this, she said Dr Chan did not tell her anything about the risks associated with the anaesthetic she would have if she were to undergo the liposuction.

17. She told Dr Chan about her use of Diazepam and whether it would affect the anaesthetic. He assured her it would not.

18. She was concerned whether she would put on any weight after surgery and what she might expect.

19. She said he told her that as the fat cells would have been removed from the body she would not put weight back on but that some women who did, put it on their breasts which was a positive thing.

20. She said she was concerned at the start of the consultation that Dr Chan might laugh at her and say she did not need liposuction because she was within the 52 kilogram weight range but he said he could definitely help her.

21. He did not ask her about her eating disorders. She said he told her it would be like a new start for her and that once she had the liposuction sorted out then she needed to keep a healthy diet and get her life back in balance.

22. Dr Chan asked to look at her body unclothed. She identified the areas she would like changed. He stated he could do what she wanted. He did not take photographs at this consultation.

23. He appeared unconcerned and did not discuss her expectations or the potential outcome.

24. He made some jottings as to the cost of the procedure, taking into account the areas she had identified (arms, stomach, buttocks and thighs) and arrived at a figure of $7,000. Ms A asked if she could discuss with him at the time of surgery the exact areas she would like treated depending on how much money she had at that time. Dr Chan agreed to this.

25. Essentially, Ms A said Dr Chan offered very little information and asked her if she had any questions.

26. She said this was *"a general question relating to anything else. But having asked me the question he was just so rushed that you couldn't even have time to think really. He was just sort of – basically it was almost a token question and he wanted you out the door and paying the deposit"*.

27. She felt Dr Chan was in a hurry and that there was *"no time to really go into depth about anything"*.

28. She was clear in her recollection that the consultation with Dr Chan took no more than 15 minutes.

29. Ms A said the nurse told her how busy Dr Chan was and that they were fully booked for the ensuing three months but there happened to be one space available (it was six days hence). Ms A was so anxious to have the procedure that she made the booking there and then for 27 January 2001 and paid the booking fee of $500.

30. Ms A thought that at the time she paid the booking fee she also filled in *"a very basic form"* about her health.

31. The only form dated 21 January 2001 produced to the Tribunal (which was contained in Ms A's file at Dr Chan's clinic and forwarded to her at a later date is headed *"Australasia Cosmetic Centre – Information Schedule"*. (It is incorrectly dated 2000 but it was accepted in evidence it should have been 2001).

32. This form provides for information relating to Ms A's address, occupation, date of birth, height and weight. General health is ticked as excellent, smoking and alcohol intake as moderate. It provides for *"Current Medication"* which is recorded as *"occasionally diazepam"*; and for *"Allergies"* with boxes for *"sticking plaster"*, *"Penicillin"*, and *"medications"*. No allergies are recorded. Other than these, there is no provision or request for any other health information.

33. It contains a question whether the referral was from one's doctor (Ms A ticked *"no"*). Immediately under it the form seeks the *"source"* of the referral which has 10 categories – *"Yellow Pages"* (which Ms A ticked), *"Sunday News, Magazine, TV Guide, Radio, Friend/Family, Herald, Chinese Paper, TV, Other."*

34. It asks whether the patient has ever received a brochure from the Clinic (Ms A ticked *"no"*) and the cosmetic procedure of interest (Ms A recorded *"liposuction"*).

35. With regard to the provision of written material, Ms A thought Dr Chan had given her a promotional brochure about cosmetic surgery and what it could do for those who undergo it.

36. There is a document *"Neurolept Anaesthetic Information Sheet"* which Ms A signed and dated 27 January 2001 in her handwriting. The Tribunal accepts she was given this document to sign on the day of the surgery. However, she believed she had been given a document by the nurse *"which had like instructions"* when she paid the deposit of $500. For the purposes of this hearing, the Tribunal finds that she received an unsigned copy of this document on 21 January or a document to like effect.

37. There is a further document *"Operation Sheet"* with the date of 27 January 2001 typewritten on it. There is a section at the bottom *"Medical History"* which Ms A signed. There is no date provided for this section. It has thirteen boxes providing for

a yes/no answer including such conditions as *hypertension, heart disease and diabetes* as well as *alcohol* and *smoker*, and a provision for *allergies* and *current medications*. Ms A has written *"Diazepam"* and someone else has written *"5 mg every 2-3 days*". It is not clear from the evidence whether Ms A was presented with this document at the consultation of 21 January or on the day of surgery. However, she did say she thought that at the time she paid the $500 deposit she *"may have filled out a quick form"* … asking *"about diabetes or high blood pressure or things like that, a basic medical form"*. While it is possible Ms A may have also signed the *"Operation Sheet"* document on 21 January the Tribunal considers it unlikely. The Tribunal notes that she has ticked *"no"* for "*smoker"* on the *"Information Schedule"* dated 21 January but has answered *"do you smoke"* as *"moderate"* on the *"Operation Sheet"* document. It is unlikely she would have given two different answers on the same day to the same question. The more likely scenario is that this latter document was not presented to her until the day of surgery.

38. She did not seek to discuss liposculpture with anyone else as she thought she was sufficiently informed from what Dr Chan had said to her which in essence was *"he was so experienced that nothing could go wrong and he did thousands of these every year and everyone was happy"*.

39. When asked what Dr Chan told her about the post operative period she said he did not tell her anything but the nurse told her she would have massage sessions and be a little sore for the first month and quite swollen, and that some people return to work a few days later while others, depending on the degree of surgery, might need to take a few extra days off work. As a result, Ms A did not plan to take extra time off work.

40. Following this consultation and prior to the surgery, Ms A thought either a nurse telephoned her (or she telephoned the nurse) when she was told not to eat before the surgery.

27 January 2001 – Liposuction surgery

41. Ms A attended Dr Chan's clinic in Sunset Road, Mairangi Bay, Auckland on 27 January. It was a Saturday and a long weekend with Auckland Anniversary day on

the following Monday. She was uncertain as to the time she arrived. Initially she thought it was 9am but the documents produced recorded a start time for the surgery at 12.45pm and a finish time of 15.40pm. She had arranged to attend the clinic on a later occasion at 9am and agreed it was possible she could have got the times confused.

42. However, she was certain of the sequence of events after her arrival at the clinic until the start of the surgery.

43. She said she waited a few minutes while the nurses made preparations. She was then given two pills by the nurse which she was told were sedatives. While the "Operation Sheet" produced to the Tribunal records 7.5mg of Hypnovel being given at 12.05pm and 12.30pm, it was Ms A's recollection they were given to her at the same time and within 5 minutes of her arrival at the Clinic.

44. About 15 minutes later she was taken to a room to see Dr Chan. They sat down and agreed to the areas to be treated which were her stomach, back, hips, inner and outer thighs and upper arms. She agreed to a total cost of $7,000.

45. Dr Chan was already dressed for surgery. He did not give her any explanation about the procedure. She said it was just a matter of checking the areas she wanted treated and *"that was it. I don't think we spoke more than two or three sentences at that time"*.

46. She went to reception and paid the balance of $6,500 with her Visa card.

47. She said it was at the same time she was given the consent form *"Consent to operation for cosmetic surgery"* by the nurse to sign. She was given no explanation concerning it. She read it and signed it.

48. It provided consent for liposuction of *"Arms, Hips, Butt, outer thigh, U and L abdomen, inner thighs"*. The words "*inner thighs"* were added in handwriting which Ms A said was not her handwriting. It was witnessed by a person described as a *"nurse consultant"*.

49. Ms A was then taken into the operating theatre. As well as Dr Chan there were two other persons present, the nurse known to Ms A as Kathy and another person, later identified as Dr Goedeke. However, Ms A was not told at the time who Dr Goedeke was, what his qualifications were, nor his role. Ms A said *"He just suddenly appeared in the operating theatre"*.

50. Ms A said her memories were quite clear of some things which occurred during the operation and described her recollection in some detail. In summary, she believed either the nurse or Dr Goedeke monitored the administration of the sedative through an IV line in her arm; she remembered talking *incessantly* to Dr Goedeke while under the twilight anaesthetic; she recalled a monitor attached to her finger which she thought was a pulse monitor; she recalled waking about three times during the procedure each time being in a different position; she felt significant pain on each occasion; she recalled seeing Dr Chan and Dr Goedeke holding one leg each; she recalled the cannula *"poking"* into her legs and causing pain; she recalled the nurse alerting the surgeons to her discomfort; she believed she was given more drugs to prevent her feeling the pain; and she felt herself drifting in and out of consciousness for the rest of the procedure. She said Dr Chan did not speak to her directly at all during the operation.

51. With regard to the recovery procedure, the next thing which Ms A recalled was being in a standing position with the nurse helping to put on an outer body garment made of a stretchy material. She was assisted to lie down on a bed by the nurse and told to rest for a while. She said she did not see Dr Chan again.

52. Ms A thought she remained in the clinic recovering for about an hour before she left. She told the nurses that she was being collected by a friend who would meet her at the front of the surgery. However, she walked to her car and drove to her friend's house in Mairangi Bay. She told the Tribunal that the nurses were aware that she had driven herself when she left the clinic because, at a subsequent attendance at the clinic when she was having a massage, the nurse told her she was *a bit naughty* as they had seen her go out of the clinic and get into her car and drive off.

53. Ms A said that while at her friend's house blood started to ooze from the incisions, soaking the body garment and onto the carpet. Her friend wrapped her in towels for about an hour. Her friend gave her a drink but she was unable to take more than a little sip as she felt nauseated. She said she was quite shaky and still very affected by the drugs she had been given during the operation. She believed she stayed with her friend for about an hour and a half and that by the time she left there it would have been about three hours after the operation had finished.

54. It then took her a further hour for the drive to xx where she was staying. During the drive to xx she tried to concentrate on driving and not get blood *all over the car*. She described the experience as *quite awful*. Once she arrived at xx, she became more shaky and nauseated and felt very weak. She was staying at xx by herself in order to recuperate in privacy for the following two to three days. She had to walk down some stairs to the bedroom where she got into bed and where she stayed for the following two days as she could barely move due to the pain. She passed out on the first occasion when she got out of bed and tried to stand up and would have fainted in all on two or three occasions *"trying to sit up and stand up"* without success. She described her state as *"nausea and just incredible agony even though I was taking the pain killers I had been given"*. She said she was scared because she was by herself and in so much pain that she could not move and was afraid something had gone wrong. Ms A had understood that the recovery was going to be straightforward and had not expected this outcome. It was only after two days that she was able to get up and move about a little and later, at the end of the second day, she was able to eat a small amount and take some fluids and go to the toilet with a little more ease without passing out.

55. Ms A told the Tribunal that she started leaving many messages, the day after the procedure, for Dr Chan to call her. She said she telephoned both clinics several times only to get the message paging service. She left her number but was not called back immediately despite her urgent messages. She was eventually telephoned by a nurse and was told that her symptoms were normal and to rest. She made further phone calls to the nurses and on occasions could not get through as there was no-one available. She wanted to speak directly to Dr Chan but the nurses would always say that *he was too busy or not available or in surgery or doing something*. On the

occasions she did make contact she said she understood from what they said that he was aware of her messages.

56. Ms A described the following five weeks as being very difficult. She returned to work but the bleeding was continual and seeped through her body garment. She had difficulty sitting in the office due to pain. At night she was unable to sleep. She said she had no idea her body would be so swollen and covered in bruises.

57. She subsequently attended Dr Chan's clinic (confirmed by a document headed *"Post-Lipo treatment"*) on 3, 10, 15 and 22 February for massage sessions with Dr Chan's nurse at further cost. She did not see Dr Chan on any of these occasions.

58. At one of those sessions which she believed was on 15 February, Ms A expressed concern that one hip was indented while the other had a disproportionate amount of fat sticking out. Nurse Kathy noted this in her file. The nurse said she would inform Dr Chan and agreed there was a difference but explained it would come right after the swelling disappeared.

59. During a massage session on 22 February, Ms A was referred to Dr Goedeke as Dr Chan was unavailable. She said Dr Goedeke agreed there was a difference in her hips and suggested a little of the excess fat could still be trimmed from her stomach and upper arms for a more satisfactory result. He told her that after liposuction, common corrective procedures were required to fix uneven areas.

60. On 17 May 2001 the clinic forwarded to Ms A copies of photographs taken by them following her surgical procedure. Ms A thought they were taken about 3 months post-operatively. This would make the date about 27 April 2001. Ms A said she thought Dr Chan was available for a few seconds when the *"after"* photographs were taken and she showed him the areas to which she says he responded *"we'll book a corrective procedure – that's fine"*. However, Ms A could not be sure of the precise date. A document produced *"Post-Lipo Treatment"* records attendances on 3, 10, 15 and 22 February 2001 when Ms A had massage sessions. A further form has a date of 3 March 2001 with *"Comments: (Surgeon/Nurse Consultant)"* and records that corrective surgery needs to be done to the left and right hips and the left and right

upper arms. There were no documents produced which recorded any attendances after 31 March 2001.

61. A date was booked for the corrective procedure for Monday 9 July at 11am. Ms A made all the necessary domestic and work-related arrangements in anticipation of the surgery and, on the day prior to it, telephoned the clinic to confirm. She was put onto a paging service and had to persist repeatedly until she was called back. She was astonished and distressed when she was told there was a problem and that there was no booking for her surgery. A further booking was made for 17 August for the corrective procedure. She was told that Dr Goedeke would be operating with Dr Chan assisting.

62. On 17 August she telephoned the clinic at around 9am to confirm she was on her way to the Clinic. Again, she had made careful and detailed domestic arrangements in anticipation of the surgery. During this call she was put on hold and, eventually, she was told by a woman, in a very unsympathetic manner, that the surgery was off, that Ms A could not have the procedure, and that she had no idea when it would be possible. Ms A said she repeatedly asked for the reason why the surgery had been cancelled and when the corrective procedure would be possible but her questions went unanswered. She demanded to speak with someone who could help her.

63. Later that same evening Dr Goedeke telephoned Ms A and spoke to her for about an hour. She told him of her distress and feelings of hopelessness, of having her money taken from her and the corrective procedures cancelled. Dr Goedeke told her that Dr Chan had been suspended from practice and nothing else could therefore be done. Dr Goedeke was sympathetic and Ms A had the impression that he was almost apologetic for his part in being involved with Dr Chan and wanted to distance himself from him. He gave Ms A Dr Chan's telephone number in Australia and asked if there was anything he could do. Ms A requested that the nurse send to her a complete copy of her file which subsequently arrived in the mail.

64. A letter dated Monday, 13 August 2001 was sent to Ms A and signed by a person described as *"Client Liaison"* stating that due to circumstances beyond their control her scheduled surgery for Friday 17 August would no longer take place with an

apology for the inconvenience and stating that she would be contacted as soon as surgery was possible. However, despite the date of this letter, Ms A said it did not arrive until the following week and after she had made the phone call on the day of the surgery.

65. Following the call from Dr Goedeke, Ms A kept dialling Dr Chan's number in Australia until he finally answered. She explained her plight but he refused to discuss how he could help her. She said things to him like *"but you took $7,000 and now I have to live with a deformed hip"*. Dr Chan replied that the *Medical Council* had taken his licence and that it was they who should be blamed for suspending him. She sought financial reparation from him which was not forthcoming.

66. On 6 September 2001 Ms A wrote a three page letter to Dr Chan setting out the history of events and the remedy she was seeking. By any account, it is a plaintive and desperate letter suggesting either a refund of the moneys paid so she could pay to go to another cosmetic surgeon or obtain a quote and undergo the procedure for which Dr Chan could pay. Dr Chan did not respond to that letter.

67. The following week, Ms A spoke to a nurse at the clinic who said that Ms A would have to wait until Dr Chan resumed surgery the following year.

68. In October 2001, Ms A telephoned Dr Chan again. She asked when he was returning to New Zealand. He said he had no plans to return and that she would have to phone the Australasian Cosmetic Surgery Centre to book the procedure. She told him she had been leaving messages there for two months but no-one had called her back and she asked him if someone had taken over his clinic to which he replied they had. She asked if he could help her contact the person who had taken over the clinic and organise the corrective procedure but at that point he said that the telephone reception was bad and he could not hear her. She asked if he could refund some of the money she had paid to him and he replied he would have nothing more to do with the matter.

69. On 26 October 2001 Ms A made a complaint in writing to the Office of the Health and Disability Commissioner.

70. In answer to a question from the Tribunal as to what it was she was seeking when she consulted Dr Chan and what it was she thought he could help her with she replied:

> *"I thought he could make me thin and I thought that having looked through photos of liposculpture bodies that I could have a thin figure like that and that I would pretty much be able to eat what I want but not put on weight because that fat had been removed."*

71. When asked whether her reason for consulting Dr Chan was more for weight loss or body shape she responded:

> *"Weight loss and body shape but primarily weight loss because I had to struggle with eating disorders.*"

72. When asked by the Tribunal why she did not call her general practitioner in view of the lack of response and assistance which she had described from Dr Chan's clinics, Ms A responded that:

> *"… it was such a private thing. I fully thought if I persisted with Dr Chan they were the ones that had performed the procedure, that they would be the best ones to contact for advice. I didn't think my GP would be able to, you know, help, or he'd be mad at me in some way for being so stupid as to go and have this surgery.*
>
> *… I felt I was stupid. I suddenly realised that I was stuck and I didn't have anyone to help me at that stage because Dr Chan and the surgery weren't, you know, weren't really there to offer help, so I didn't know what to do."*

Standard Against Which Dr Chan Assessed

73. Dr Chan was, at the material time, a medical practitioner practising in a specialised area. The Tribunal has assessed him against that standard.

The Charge

74. The charge is that Dr Chan acted in a way that amounted to disgraceful conduct in one or more of several respects.

Particular 1 – Dr Chan continued to consult with and make arrangements for further surgery for Ms A regarding his previously performed liposuction while suspended from practising medicine.

75. In relation to particular 1 the Tribunal was not satisfied that the allegation was proved to the requisite standard of proof.

76. Dr Chan was not suspended until 27 April 2001. There was no evidence before the Tribunal that Ms A saw Dr Chan after that date except for a few seconds at the clinic when she had the photographs taken *"about"* three months after the surgery, which would put the date around the time of the suspension. There is uncertainty about the precise date. The only other evidence relating to direct communications with Dr Chan, following the surgery, were the two telephone communications (in August and October 2001) which Ms A made to Dr Chan while in Australia. On neither of those occasions could it be said that he continued to consult with her and make arrangements for further surgery.

Particular 2 – Dr Chan failed to inform Ms A that he was suspended from practising medicine while continuing to consult with her and to make arrangements for further remedial surgery.

77. The Tribunal is not satisfied that the allegation contained in this particular is proved to the requisite standard.

78. The Tribunal accepts that Dr Chan should have informed or caused his clinic to inform Ms A of his suspension as soon as it occurred, and that this did not occur until 17 August 2001 when Dr Goedeke telephoned Ms A at her home following the second cancellation of the booking for the corrective procedure.

79. However, it is not clear whether the booking for the corrective procedure for 9 July 2001 was made prior to Dr Chan's suspension. Even if it were, it is also not clear from the evidence whether this booking was made with Dr Chan's knowledge and consent, and similarly with the subsequent booking of 17 August 2001. It was wrong for those at Dr Chan's clinic to make the bookings when they must have known that Dr Chan had been suspended and not to have told Ms A but the Tribunal must be satisfied to the requisite standard that the subsequent dealings with Ms A were done at

the direction of or with the knowledge and consent of Dr Chan. It is not so satisfied on the evidence before it.

Particular 3 – Dr Chan failed to inform Ms A that he was not a vocationally registered plastic surgeon in New Zealand.

80. The Tribunal is not satisfied that the allegation contained in this particular is proved to the requisite standard. The Tribunal failed to see what its relevance was. Even if it were proved, such failure would not amount to a disciplinary matter in this case.

Particulars 4 and 5

Particular 4 – Dr Chan failed to carry out an adequate pre-operative patient assessment, including a clinical examination.

Particular 5 – Dr Chan failed to exercise appropriate professional judgment in offering liposculpture to Ms A in view of her history of anorexia nervosa, chronic benzodiazepine use and her recommended weight for her height based on body mass index.

81. The Tribunal is satisfied that the allegation contained in particular 4 is proved to the requisite standard.

82. The Tribunal is also satisfied that the allegation contained in particular 5 is proved to the requisite standard in relation to Ms A's history of anorexia nervosa but is not proved in relation to her history of chronic benzodiazepine use and her recommended weight for her height based on body mass index.

83. The Tribunal accepts as reliable the evidence of Ms A relating to the first consultation of 21 January 2001 and the second consultation of 27 January just prior to the surgery being undertaken.

84. In this regard, the Tribunal has also been assisted by the expert evidence of Mr Beehan, plastic and reconstructive surgeon of Hamilton. He stated that a 15 minute consultation is not adequate time for pre-operative liposuction assessment:

> *"An adequate consultation before lipsocution surgery, especially involving different parts of the body, needs to be assessed very carefully. The complications need to be stated very carefully both in general terms and also in the specifics relating to contour defects and other matters which may go wrong. The patient needs to understand the pros and cons of liposuction – even the risk of contour defects, the fact that it is not a weight loss procedure, and what could be expected as risks of surgery."*

85. Mr Beehan stated that when a patient consults him requesting liposuction he tries to spend as long as is necessary to have a full discussion with that person which can be up to an hour and where appropriate he might even have a second consultation.

86. He stated the length of a consultation often relates to the type of patient one is dealing with, whether the patient's wishes are realistic, what their motivation for the procedure is, and that sometimes it is essential to tell them to go away and think about it and come back for a further consultation.

87. With regard to Ms A's evidence that she thought the procedure was both for weight loss and body shape but primarily for weight loss so that she would be able to eat what she liked after the procedure, Mr Beehan said that he always says to a patient that the purpose of liposuction is to remove abnormal shape and not to reduce the size of the person. He emphasised that it was not a weight reduction procedure and it is not useful as such.

88. Mr Beehan explained that the purpose of liposuction was to correct contour deformities and disproportion and is not effective for the purpose of weight reduction.

89. Mr Beehan stated:

> *"The clinician will want to know whether this person has a body image problem which is unrealistic, and whether there are any other psychological problems which would contra-indicate the surgery. Therefore consultation would need to involve a deeper enquiry in terms of the general examination to assess whether she is going to be a candidate who in fact will be satisfied by what would be performed upon her. In summary I think the history of anorexia nervosa, bulimia and benzodiazepine taking is not in itself a contra indication to the surgery, but a warning of possible abnormal body image problems. The need for informed consent becomes that much stronger."*

90. With regard to advice about anaesthesia, Mr Beehan said it was part and parcel of a consultation to cover all matters including anaesthesia.

91. Dr Short, having heard all the evidence, was asked by the Tribunal whether given the extent of the liposuction did he consider the history that was taken from Ms A as adequate. In his view it was not. He stated that the consultation consisted almost entirely of directive questions without any chance for open questions which might net other problems such as the eating disorders. He stated it was usual to ask about past surgical experience and past medical conditions.

92. The Tribunal finds that the consultation of 21 January with Ms A was inadequate. Essentially, Dr Chan presented himself in a confident manner assuring Ms A that he was exceptionally experienced and could do whatever she wanted. He did not inform Ms A of what was involved in the surgical procedure of liposuction nor what she might expect as to the outcome of the procedure or the risks or complications of it, nor did he discuss what she should do following the conclusion of the procedure, and nor did he inform Ms A in any adequate way of the process of the anaesthesia required for the procedure or the risks and complications associated with it. The Tribunal finds he did little more than briefly examine the areas which Ms A wanted treated and said he could achieve what she wanted. He presented himself as the most experienced cosmetic surgeon in Australasia. He told her of his many happy clients and assured her that if there were any corrective procedures needed that would be done without problem and at no further cost. He did not inform Ms A the true purpose of liposuction (as explained by Mr Beehan)

93. A significant part of this brief consultation, which the Tribunal accepts would have been no longer than 15 minutes duration, concentrated on the cost of the procedure. The document *"Information Schedule"* (referred to above) bears testimony to this which records in some detail Dr Chan's handwritten calculations (*"jottings"*) on it as to the cost of various items showing a total of $7,000.

94. This document's principal focus is designed to elicit information for business and marketing purposes. The request for health information is minimal and secondary.

Particular 6 – Dr Chan failed to obtain Ms A's informed consent to his proposed treatment including the anaesthesia and surgical procedure in that

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

(b) The consent forms for Anaesthesia and for Surgery were given to Ms A to sign after she had been given the preoperative oral sedation.

95. The Tribunal is satisfied that the allegations in this particular are proved to the requisite standard.

96. With regard to sub-particular (a), this has been addressed above.

97. Further, Dr Short, a vocationally registered anaesthetist, gave evidence as an expert about the *"neurolept anaesthetic information sheet"* (which Ms A signed on the day of surgery, and a copy of which may have been given to her by the nurse following the first consultation of 21 January):

> *"The neurolept anaesthetic information sheet contains an adequate amount of information about neurolept anaesthesia and some pre and post-operative instructions. It does not mention complications at all, including the possibility of experiencing significant pain. This is sub-standard. "*

98. The Tribunal agrees with Dr Short's opinion.

99. With regard to sub-particular (b), the Tribunal notes that the *Operation Sheet* dated 27 January 2001 and produced to the Tribunal recorded Ms A as having received hypnovel (a trade name for midazolam) of 7.5mg at 12.05 and 7.5mg at 12.30. The sedatives were given to her via oral administration.

100. The Tribunal accepts Ms A's evidence and finds that following her attendance at the clinic for the surgery on 27 January, she was given the sedatives, and subsequently given the forms *"Consent to Operation for cosmetic surgery"* and *"neurolept anaesthetic information sheet"* which she was asked to read and sign, which she did.

101. Dr Short stated:

> *"As a general principle, a consent form signed after the administration of sedative medication, is not considered a valid consent. It is usual practice to complete necessary explanations, examination of the patient and paperwork before administering sedative medication. A person is not considered able to make informed choices about themselves while under sedation."*

102. Mr Beehan gave evidence to like effect.

103. The Tribunal agrees with the opinions of Dr Short and Mr Beehan.

104. Any documents which Ms A was required to sign prior to the surgery, should have been given to her and explained to her prior to the administration of the sedative medication. Her consent was, therefore, not valid.

Particular 7 - There were serious deficiencies in Dr Chan's anaesthetic practice, namely:

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

105. The Tribunal is satisfied that the allegations contained in sub-particular 7(a) has been proved to the requisite standard. This has already been addressed above.

(b) There was no anaesthetist present during Ms A's surgery and drugs were administered in a dosage and combination contrary to the accepted guidelines laid down by the Australian and New Zealand College of Anaesthetists which state that unless an anaesthetist is present, only conscious sedation may be used. The dosage of drugs and combination of drugs administered to Ms A could reasonably be expected to result in loss of consciousness.

106. The Tribunal is satisfied that some of the allegations contained in sub-particular (b) have been proved to the requisite standard.

107. The Tribunal finds that there was no anaesthetist present during Ms A's surgery and that drugs were administered in a dosage and combination contrary to the accepted

guidelines laid down by the Australian and New Zealand College of Anaesthetists. The Operation Sheet dated 27 January 2001 (referred to above) recorded the following sedative drugs in addition to the midazolam: pethidine 50mg 25mg 25mg 25mg 25mg at 12.45, 12.50, 12.55, 14.25, 14.35 and hypnovel (midazolam) 2mg, 1mg, 2mg, 1.5mg, 3.5mg at 12.45, 12.50, 12.55, 13.45 and 14.25.

108. According to Dr Short's evidence, these doses and titration of drugs over a period of nearly two hours were not excessive. Dr Short stated that the doses and timing of the administration appeared to be consistent with what is known by anaesthetists as *conscious sedation*. Dr Short described *conscious sedation* as a state where a patient is *clearly sleepy, has pain relief, but some verbal contact is maintained with the patient. So, they are not completely unresponsive.* Dr Short stated that it is deemed safe practice for non-anaesthetists to administer *conscious sedation* to patients so long as drugs and doses are not administered in a manner which would constitute a general anaesthetic.

109. In Dr Short's opinion, the dosage and rate of the administration of the drugs other than the local anaesthetic and infiltrate was consistent with conscious sedation. He stated that Ms A's description of events was consistent with that. Hypnovel causes amnesia in the doses which Ms A was given, especially where there is no associated pain, which appeared to the Tribunal to be for most of the procedure. The Tribunal agrees with Dr Short's opinion that the fact that Ms A was unable to recall prolonged periods of the procedure does not necessarily mean that excessive sedation was given during those periods.

110. However, the guidelines of the Australia & New Zealand College of Anaesthetists require that physiological recordings are made and that the device used to make the recordings be specified. In this latter respect, the guidelines were not adhered to in Ms A's case.

111. With regard to the pain which Ms A felt during the procedure, Dr Short stated:

> *"Her description is of surgery continuing despite her protests, is also suggestive of further sedative medication having been administered in response to the pain. It would not be unusual to wake during the procedure*

> *and perhaps have some memories, although these would only really be of significant pain. If significant pain is experienced, it is usual to cease operating while further sedative drugs are administered. It is apparent also that she had no expectation of the procedure possibly being painful and that treatment of this did not involve waiting an adequate period of time for additional sedation to be effective. This is substandard practice."*

112. The Tribunal agrees with Dr Short's opinion regarding this aspect of the procedure. Ms A experienced pain during the actual procedure and the practice exercised in dealing with that by Dr Chan was substandard.

113. Dr Short also commented on the absence of records:

> *"There is no record of local anaesthetic having been given or its dose. Presumably there was local anaesthetic in the infiltration solution, in accordance with normal practice, but it is usual practice to record the drug, its concentration and total dose administered."*

114. The Tribunal notes that the recording was inadequate and not in accordance with normal practice.

115. The Tribunal finds that although Dr Goedeke, a registered general practitioner, is not an anaesthetist, he was present together with Nurse Kathy to assist Dr Chan and that this level of staff was sufficient to assist with the procedure and observe Ms A.

(c) He failed to monitor Ms A's condition adequately during the surgical procedure;

116. The Tribunal is satisfied that the allegations in sub-particular 7(c) have been proved to the requisite standard.

117. The Tribunal refers to the documents produced which record:

> Blood pressure and heart rate at *"Pre, 12.55, 13.00, 13.25 and 13.40 (blood pressures only)"* as is *"fluid in"* and *"lipo out"*.

118. Dr Short stated:

> *"These observations as recorded are not sufficiently frequent to monitor a patient safely. Monitoring every 15 minutes would be the absolute maximum time between such observations and every 5 minutely is standard practice. There is a gap of over 1 hour, during which additional sedation was administered and no recordings written down. No record of supplementary oxygen administration or pulse oximetry is made, which is required practice for procedures under sedation."*

119. The Tribunal could not know whether pulse oximetry was actually carried out at all as there was nothing noted in the records produced of the operation from Dr Chan's file of any evidence of a recording that either one was used or a recording made by one. Dr Short stated that it was standard procedure in this type of operation to use a pulse oximeter. In Dr Short's opinion it was substandard not to use one and if one were used not to record it.

120. The Tribunal finds as accurate the description of facts contained in these statements and agrees with the opinion expressed. Dr Chan failed to monitor Ms A's condition adequately during the surgical procedure.

(d) He failed to monitor Ms A's condition adequately post-operatively.

121. With regard to particular 7(d), the Tribunal accepts Ms A's evidence regarding her condition post-operatively and finds she made many attempts to contact Dr Chan unsuccessfully.

122. Dr Short commented regarding this evidence:

> *"This implies that she may have had significant blood loss. It would be essential to review a patient complaining of these symptoms to ensure that they have not suffered significant blood loss or significant dehydration. It is also usual to have a contact phone number to be used if there are problems post-operatively, but she describes only contacting a message paging service and that her call was not returned. This is definitely sub-standard.*
>
> *According to the "Operation sheet" 3850 mls of fat were removed. There is a record of 500 mls of 5% dextrose and 300 mls of normal saline as intravenous fluid administration. This is a small volume insufficient to re-hydrate after the usual losses expected from a 4 litre liposuction. This volume of fat removed is regarded as a major liposculpture procedure and 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. Same day discharge would only be contemplated after a prolonged period of observation (say 4 hours minimum) and evidence of full recovery from the effects of the sedative drugs, evidence that the patient has adequate pain relief and no evidence of significant ooze from the wound".*

123. The Tribunal finds as accurate the description of facts contained in these statements and agrees with the opinion expressed. It finds Dr Chan failed to monitor Ms A adequately post-operatively.

Particular 8 – Dr Chan discharged Ms A without any of the usual discharge criteria being met thereby potentially compromising her safety.

124. The Tribunal is satisfied that the allegation contained in this particular is proved to the requisite standard.

125. According to the operation note two recordings of blood pressure were made post-operatively at 3.55pm and 4.30pm. While this is a gap of over 35 minutes, it does indicate that Ms A stayed at least 35 minutes after the procedure before discharge. The Tribunal finds that Ms A would have stayed approximately 2 hours at the clinic following the completion of the surgery.

126. Regarding this particular, the Tribunal notes and agrees with the opinion expressed by Dr Short:

> *"It is usual to make observations of heart rate, oxygen saturation and respiratory rate and overall conscious state and physical status for 30-60 minutes after a procedure such as this and to ensure that the patient has adequate pain relief. A written record of this is usually made before considering discharge from medical care. The post-operative records are inadequate to judge that safe discharge was performed."*

127. As stated above, same day discharge would only be contemplated after a prolonged period of observation with a minimum period of 4 hours and with evidence of full recovery from the effects of the sedative drugs, evidence that Ms A had adequate pain relief and that there was no evidence of significant ooze from her wounds.

128. Mr Beehan in his evidence said he agreed with the following observation:

> *"An out-patient should be discharged in the presence of a responsible adult who will accompany him/her home and stay with the patient to observe him/her until the patient can function independently"*.

129. In answer to a question from the Tribunal, Mr Beehan stated that it was part and parcel of the consultation (in this case the 21 January consultation) to cover all the matters, to assess the risk to the patient, to explain to the patient what is best for her and to get her agreement and get on the right footing, to explain the complications of the procedure and to explain what is going to be required of the patient in the post-operative period and what sort of things might affect them.

130. The Tribunal has already found that Dr Chan failed to inform in any adequate way Ms A of these matters.

131. The Tribunal finds that the period during which Ms A was under observation post-operatively was inadequate as were the post-operative records.

132. Ms A should not have been allowed to drive herself in the state she was in. The staff saw her go to her own car to drive it. Dr Chan should have ensured that Ms A was fully and adequately informed prior to the surgery about the effects of the procedure and the anaesthesia. This was not done as stated above.

133. Her discharge in the circumstances was unsafe.

Particular 9 - 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.

134. The Tribunal is satisfied that the allegation contained in this particular is proved to the requisite standard.

135. Mr Beehan stated that he would certainly want to see the patient within the first week of such a major liposuction as Ms A had undergone and particularly so where she had not been an overnight patient but had left the surgery within approximately two hours afterwards.

136. While Mr Beehan had not had the opportunity to examine Ms A personally, he had the benefit of seeing before and after photographs which were produced in evidence. He confirmed that they showed *"quite a marked contour defect in the hip which is significant"*.

137. Not only Mr Beehan but also Dr Goedeke and Nurse Kathy from Dr Chan's clinic (who did see her post-operatively) confirmed that Ms A needed corrective surgery.

138. At the first consultation, Dr Chan had assured her he was the most experienced of cosmetic surgeons and that if there were any unsatisfactory results they would be fixed without further cost. He had taken from her a very significant sum of money but declined to refund any part of it or assist with any referral to another surgeon. Despite Dr Chan's suspension he did not adequately acknowledge or address Ms A's concerns arising from her dissatisfaction with the cosmetic result of the surgery. It was incumbent upon him to provide her, at the very least, with an explanation. He avoided her efforts to contact him and when she finally did make telephone contact he treated her dismissively and contemptuously.

The Law

Disgraceful Conduct in a professional respect

139. In *Allison v General Council of Medical Education & Registration* [1894] 1QB 750, 763, the Court of Appeal held that the test for "disgraceful conduct in a professional respect" was met:

> *"If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency …".*

140. In *Brake v PPC* [1997] 1 NZLR 71 at p77, the High Court set out in its judgment the test laid down in *Allison.* It stated it was an objective test, to be judged by the standards of the profession at the relevant time. The Court specifically rejected a submission that the test for disgraceful conduct required fraud, dishonesty or moral turpitude to be proved. The court stated at p.77:

> *"In considering whether conduct falls within that category, regard should be had to the three levels of misconduct referred to in the Act, namely disgraceful conduct in a professional respect, s58(1)(b); professional misconduct, s43(2); and unbecoming conduct, s42B(2). Obviously, for conduct to be disgraceful, it must be considered significantly more culpable than professional misconduct, that is, conduct that would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct, or as it was put in Pillai v Messiter (No. 2) (1989) 16 NSWLR 197, 200, a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

141. The test expressed by the New South Wales Court of Appeal in *Pillai v Messiter* (1989) 16 NSWLR 197, 200 (referred to above) related to "misconduct in a professional respect" contained in the Medical Practitioners Act 1938 of that state. The President of the Court (Kirby P) stated that while the court must bear in mind that the consequences of an affirmative finding are drastic for the practitioner, the purpose of providing such drastic consequences is not punishment of the practitioner but protection of the public. He observed at p.201:

> *"The public needs to be protected from delinquents and wrong-doers within professions. It also needs to be protected from serious incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements".*

142. Clinical acts or omissions can amount to disgraceful conduct, if they are of a sufficiently serious nature. In this regard, see *Tizard v Medical Council of New Zealand* (unreported, High Court (Barker (presiding), Thorp and Smellie JJ), M.No. 2390/91, 10/12/1992).

143. The High Court recently re-stated the test for disgraceful conduct. In *The Director of Proceedings v Parry and MPDT* (Auckland High Court, AP 61-SW01, 15 October 2001) Paterson J stated (para. 44):

> *"… There is more than one way of describing the test for "disgraceful conduct in a professional respect." The full Court in* ***Brake*** [above] *determined that such conduct could include "serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration 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. …".

Professional Misconduct

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

p.374-5:

"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 a 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 the medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be 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."

145. In *Tizard v Medical Council of New Zealand* (above) the Full Court stated:

" 'Professional misconduct' is behaviour in a professional capacity which would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct. It, too, is an objective test judged by the standards of the profession: Ongley v Medical Council of New Zealand [1984] 4 NZAR, 369, 374." (p16)

146. The Tribunal is also mindful of the observations of the Chief Justice (Elias CJ) in *B v The Medical Council of New Zealand* (unreported, HC 11/96, 8/7/96):

"The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates that usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice but patient interest and

community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

147. The relevant principles therefore are:

147.1 Disgraceful conduct is very serious misconduct, either deliberate, or non-deliberate.

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

147.3 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).

147.4 The departure from acceptable standards and/or the failure to fulfil professional obligations must be *"significant enough"* to attract sanction for the purposes of protecting the public.

148. Following those decisions, which were given in the professional disciplinary context and on appeal from specialist tribunals, the question for this Tribunal is whether Dr Chan's conduct was conduct which is culpable, i.e. conduct deserving of discipline and, if so, whether it amounts to disgraceful conduct or professional misconduct.

149. While the CAC originally laid the charge in terms of disgraceful conduct, counsel for the CAC sought, prior to the hearing, to amend the charge to professional misconduct. The Tribunal did not accede to this request but preferred to hear the evidence before reaching a decision.

150. The Medical Practitioners Act 1995 empowers the Tribunal, at any time during the hearing, to amend the charge in any way (First Schedule cl.14). However, it does not find that course of action necessary in this case.

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 for 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.

153. The Tribunal was unanimous in its decision that Dr Chan's conduct was of a seriously negligent nature portraying indifference and an abuse of the privileges which accompany registration as a medical practitioner.

154. In carefully applying the relevant tests, the Tribunal was also unanimous in its decision that Dr Chan's conduct amounted to disgraceful conduct in a professional respect.

Additional Concern

155. The Tribunal is satisfied from the evidence presented by the Tribunal's Secretary, Ms Fraser, that the secretariat took extensive steps to communicate with and notify Dr Chan of the charges, and of all subsequent notices including notification of the directions conference, the minutes of that conference and the hearing date. These steps included the use of post, email, telephone, facsimile, and process servers. Dr Chan failed to respond to or communicate with the Tribunal in any way at all.

156. The Tribunal records its view that Dr Chan's inaction in respect of this proceeding was itself contrary to the principle of accountability which is at the core of the privilege of registration as a medical practitioner.

157. However, Dr Chan's inaction and failure to take steps has not influenced the Tribunal's findings as to professional misconduct or disgraceful conduct.

Conclusion and Orders

158. The Tribunal finds Dr Chan guilty of disgraceful conduct in a professional respect in relation to particulars 4, 5, 6(a), 6(b), 7(a), 7(c), 7(d), 8, 9 and part of 7(b).

159. The name of the complainant is suppressed.

Penalty

160. The Tribunal invites counsel for the CAC to file submissions as to penalty within 14 days from the date of receipt of this decision.

161. The submissions are to be served personally on Dr Chan, insofar as is practicable or otherwise by substituted service. He shall have a further 14 days from the date of personal service or substituted service to make submissions in reply, should he so wish.

DATED at Wellington this 5th day of March 2003

_____

S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal