Medical Practitioners Disciplinary Tribunal

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DECISION NO: 94/99/39C

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)

Dr F E Bennett, Ms S Cole, Dr A D Stewart, Dr B J Trenwith (Members)

Ms G J Fraser (Secretary)

Ms K G Davenport, Legal Assessor

Mrs G Rogers (Stenographer)

IN ATTENDANCE: Mr T F Fookes, Mrs M Lewis

Hearing held at Auckland on Thursday 23 and Friday 24 September 1999

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

Mr C J Hodson QC for Dr W W N Chan.

1. THE CHARGE:

THE Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that Dr Warren Chan, medical practitioner of Auckland during April and May 1996 at Auckland in the course of his management and treatment of patient A provided medical practice and management below an acceptable standard in regard to Ms A's care indicative of general poor medical practice in regard to other patients. In particular:

Pre-operative Conduct

1. Failing to obtain Ms A's informed consent to the liposuction operation conducted by him on 30 May 1996.
2. Failing to undertake a satisfactory and effective consultation with and assessment of Ms A before the operation.

Operation

3. Failing to:
   (a) undertake an adequate course of study in cardio-respiratory systems and to achieve an appropriate degree of CPR certification before operating on Ms A;
   (b) implement an adequate and effective system for using IV sedation or management of an emergency during the operation;

(c) ensure the presence of properly functional emergency equipment during the operation.

Anaesthesia

4. Failing to:

(a) provide an acceptable level of anaesthesia and pain relief in preparation for the operation;

(b) respond appropriately to Ms A's complaints of pain during and after the operation;

(c) arrange for a properly qualified anaesthetist to administer anaesthesia to Ms A and/or remain present throughout the operation in accordance with paragraphs 2.2.1, 2.2, 2.4 and 2.6 of the policy documents provided by the Australian & New Zealand College of Anaesthetists;

(d) understand adequately or at all the appropriate guidelines relating to sedation for surgical procedures in accordance with paragraph 2.3 of the policy documents.

Operative and Post-operative Care

5. Failing to provide:

(a) continuous patient observation by adequately trained personnel both during the operation and in recovery in accordance with paragraph 2.5 of the policy documents;

(b) adequate post-operative care in an appropriate physical environment and with adequate and continuous monitoring.

Management

6. Failing to implement any or adequate systems of quality control, audit and peer review.

7. Failing to maintain adequate records of operations undertaken including records of case management and pulse oximeter in the context of IV sedation.

Being disgraceful conduct in a professional respect.

2. FACTUAL BACKGROUND:

2.1 **THE** charge against Dr Chan arises in the context of cosmetic surgery undertaken by a female patient of Dr Chan's in May 1996. The subject-matter of the charge is a complaint that Dr Chan's management and treatment of the patient fell below an acceptable standard of care, and that it is indicative of poor medical practice generally on the part of Dr Chan.

2.2 **THE** complainant in this matter first made contact with Dr Chan in 1993. On that occasion, she attended at Dr Chan's clinic to consult with him about a liposuction operation. On that occasion she recalls meeting Dr Chan, and discussing the procedure with him, however she left the consultation undecided about pursuing the matter any further.

2.3 **THAT** visit is recorded in an Information Schedule dated 29 May 1993. Certain details recorded in that document were completed by the complainant, and Dr Chan's handwritten notes record information obtained by him in the consultation. Dr Chan's notes include the comments "*good tone ... lipo - hips, abdomen, buttocks, thighs ... $4,290 ...*" . No consent form of that date was presented to the Tribunal, apparently because the complainant was undecided about proceeding with the operation at that time.

2.4 **THE** complainant's recollection of that consultation is that it lasted approximately ½ to ¾ of an hour, during which time she and Dr Chan discussed the liposuction procedure she was considering; she was weighed; Dr Chan's wife was brought into the consultation *"to show what liposuction can do for people"*; the complainant was examined by Dr Chan.

2.5 **THE** complainant was given a copy of an information brochure entitled *"Liposculpture The Art of Face and Body Contouring A Guide to Permanent Fat Removal"*. At the conclusion of the consultation the complainant decided not to go through with the liposuction operation at that time.

2.6 **THE** complainant returned to Dr Chan on 24 April 1996. In the intervening period the complainant continued to consider liposuction, and, on at least one occasion had made a telephone inquiry to Dr Chan's clinic. At this visit the complainant said that she was told that Dr Chan was very busy and that delaying her decision would see her put back months on the waiting list. She decided to go ahead with the operation, signed a consent form given to her by the nurse and was scheduled for surgery on 30 May 1996. On that occasion also she was given a copy of the information brochure and the nurse read to her some instructions about what to do before liposuction.

2.7 **THE** complainant was told by Ms Braid that the cost of the operation would be $5,000.00, and that she paid a deposit of $500. The complainant said that when she asked Ms Braid to be more specific about how much weight she could lose she was told that she would "easily drop two dress sizes". She was told that it was a simple procedure requiring her to spend half a day at the clinic.

2.8 **HAVING** decided to go ahead, the complainant had photographs taken at the clinic, and was given some pills to take for a number of weeks before the surgery. The complainant says that she did not see Dr Chan on this occasion.

2.9 **THE** events of 24 April 1996 are a matter of dispute between Dr Chan and his employee who gave evidence at the hearing (Ms Braid), and the complainant. The complainant claims a clear recollection of the consultation she says took place between her and Ms Braid. Neither Dr Chan nor Ms Braid have any specific recollection of their meetings with the complainant and rely on their customary practice and Dr Chan's handwritten notes which appear on the Information Schedule of that date. Dr Chan is certain that the notes made on the Information Sheet evidence his attendance at the consultation on 24 April 1996. Neither he or Ms Braid could offer any other explanation for the presence of the notes on the Information Sheet completed on that date.

2.10 **SIMILARLY**, neither Dr Chan nor Ms Braid could recall the operation, or any of the events and circumstances which form the basis of complaint. The complainant alleges:

- that on arrival at the clinic she was asked to pay the balance of the cost of the liposuction;
- she was prepared for surgery and given pre-medication;
- immediately prior to going into the operating theatre, Dr Chan saw her and asked if she still wanted to go ahead with liposuction;
- she was taken into theatre and Dr Chan drew lines on her body and she was positioned for surgery;
- she suffered a great deal of pain during the procedure and, on the second occasion on which she told Dr Chan she was in pain Dr Chan said that he could not give her any more pain relief;
- she was helped from the operating table and escorted from the operating room to the recovery area by two nurses and continued to suffer pain;
- when she woke in the recovery room, Dr Chan was eating a meal beside her bed;

- when she was discharged she was still in pain and had difficulty moving, she was not offered or given any pain relief, but was given two telephone numbers to call over the weekend;
- she subsequently attended the clinic to have sutures removed and was given antibiotics for an infection which had developed at the one of the suture sites. The antibiotic was prescribed by Dr Chan by telephone.

2.11 **THE** complainant returned to the clinic for a three monthly review, at which time she had more photographs taken. The woman who took the photographs commented that she considered any changes in the complainant's body to be insignificant, and advised the complainant to complain as the liposuction appeared not to have made any difference. After she received the photographs, the complainant herself compared the photographs taken before and after liposuction and had trouble distinguishing between them.

2.12 **THE** complainant arranged an interview with Dr Chan and made her complaint. However Dr Chan told the complainant that he considered the liposuction had been successful and that she would not have had a better job done elsewhere. He ruled out carrying out any more liposuction and offered diet pills at what he said was a price discounted because she was an existing client.

2.13 **THE** complainant declined the diet pills and, after later seeing a television item featuring Dr Chan sought advice, which ultimately resulted in this complaint.

3. EVIDENCE FOR THE CAC:

3.1 **THE** complainant and Dr John Walker gave evidence for the CAC. The Secretary of the Tribunal was also called to give evidence relating to the previous complaints made against Dr Chan. For reasons to be given, that evidence has been put aside by the Tribunal and has played no part in its determination of this Charge.

3.2 **THE** evidence given by the complainant has already been outlined, and was carefully considered by the Tribunal in relation to each of the Particulars of the Charge. The Tribunal's deliberations on each of the Particulars is set out later in this Decision.

Dr Walker:

3.3 **DR** Walker's evidence was given in relation to a Report which he had prepared at the request of the CAC. Dr Walker gave evidence that, in his experience, "*few if any of the patients having 3 litres or more [fluid volume] removed by liposuction would be treated as a day case. Most would have general anaesthesia for a lipectomy greater than 4 litres*." (The complainant had a total of 4.2 litres of fat removed).

3.4 **DR** Walker also gave evidence that, while the medications and dosages used by Dr Chan were reasonable, it would be unusual for the complainant to have any memories from the period of sedation. All of the evidence given to the Tribunal in this regard was to the effect that the drugs used by Dr Chan cause amnesia, even hallucinations from time to time, but it would be far more common for the patient to recall painful episodes if there was inadequate local anaesthetic effect at the operative site.

3.5 **THE** particular difficulty with sedation for procedures such as liposuction is that, if they are carried out under local anaesthetic, the dosage must be sufficient to provide adequate sedation to keep the patient comfortable so that the operation can proceed, without 'tipping the patient over' into complete unconsciousness. The most important requirement is that a medical practitioner qualified to administer such sedation should be continuously present, and available to monitor the patient and attend to any problems immediately.

3.6 **DR** Walker expressed his belief that the person responsible for the sedation should not also be the surgeon. However, the viewpoint of the Australian and New Zealand College of Anaesthetists (ANZCA) is that it is satisfactory for the operator to also administer sedation PROVIDED the patient at no point becomes unconscious or unresponsive. Obviously the operator must be skilled to deal with any resuscitation problems, and the right equipment and drugs must be available.

3.7 **THE** longer and more major the procedure, the more difficult it is to provide an appropriate and safe level of sedation. The distinction between sedation and general anaesthesia is a matter of degree, and trying to maintain the patient on the sedation side can be difficult even for an anaesthetist with that sole responsibility.

3.8 **ANOTHER** requirement is for an assistant who is well trained in assisting for resuscitation should it be required. In Dr Chan's case, that would require two assistants, one to assist him and one to monitor and assist with the sedation.

3.9 **DR** Walker noted in relation to the operation record that vital signs were recorded every half hour, and consisted only of blood pressure and pulse. There was no mention of oxygen saturation, which is a requirement of the ANZCA policy document. It is Dr Walker's practice to record all of those measurements every 5 minutes.

3.10 **THE** operation record also did not record the total dose of local anaesthetic used, an important consideration which could have serious consequences if a safe dose was exceeded.

3.11 **DR** Walker conceded that most surgeons he knew did procedures by themselves with one nurse present, "*It is a widespread continuing practice which I believe Australia stopped years ago*." However he also expressed the view that the ANZCA Guidelines constituted a *"minimum standard"* and that he worked to a standard above the Guidelines.

Other evidence:

3.12 **REPORTS** prepared by Dr D J Sage, Specialist Anaesthetist, of Auckland; Associate Professor D F Liggins, Plastic and Reconstructive Surgeon, of Auckland; and Dr Max Lovie, Medical Director, Wellington Regional Plastic & Maxillo Facial Surgical Unit, were also submitted to the Tribunal. All of these reports were referred to in the evidence given by Dr Walker for the CAC, and by Dr Futter, for Dr Chan.

3.13 **IT** is most relevant to record the comment contained in Dr Sage's report that *"the profound and invariable anterograde amnesia produced by the benzodiazipine drugs used, and the associated possibility of hallucination and confabulation, make accurate*

recollection of intraoperative events by the patient impossible and misinterpretation likely."

4. THE RESPONDENT'S EVIDENCE:

4.1 **IN** addition to the respondent himself, Dr M E Futter and Ms Braid gave evidence for Dr Chan.

Dr Chan:

4.2 **DR** Chan gave evidence of his experience conducting over 7,000 liposuction procedures, and more than 10,000 cosmetic surgery procedures overall. He stated that he was vocationally qualified as a general practitioner, and that he held no specialist qualifications recognised by the New Zealand Medical Council.

4.3 **HE** disputed much of the evidence given by the complainant. Most relevantly, he was in no doubt that he did see the complainant when she attended at his clinic on 29 April 1996. He relied upon his handwritten notes on the Information Sheet of that date as verification of his attendance.

4.4 **HE** denied that the complainant was not properly informed about the liposuction procedure, and relied upon the fact that she had two consultations, the opportunity to discuss the procedure with another patient, and was given the brochure. He considered that the complainant had ample time to change her mind before presenting for surgery on 30 May 1996.

4.5 **IN** relation to the procedure itself, Dr Chan did not accept that he would have refused to give the complainant pain relief had she requested it in the course of the procedure. It is his practice to ensure that the patient is kept *"comfortable"* at times, and the operation records showed that the complainant was "*well below the limit*" in terms of the maximum amount of sedation or pain relief which could safely have been administered to her. It would have been possible to give more pain relief had the complainant indicated that she was in pain.

4.6 **DR** Chan also gave evidence of his practice of obtaining the patient's written consent only after he personally has explained the procedure to the patient, and of the post-operative cares given to all of his patients. Because he cannot guarantee results, he makes that clear in the consent form. He indicated no specific knowledge of when or how the consent form is signed, beyond the fact that he leaves this to his nurses, and it is done when the patient 'books in' for surgery.

4.7 **DR** Chan also gave evidence of changes to his practice since 1996, including attendance at CPR courses by him and his staff, and the employment of a doctor to assist him in all procedures.

Dr Futter:

4.8 **DR** Futter generally agreed with the evidence given by Dr Walker. In particular he confirmed that it was likely that the complainant's memory of the events of 30 May 1996 cannot be relied upon. Dr Sage's opinion that all of the medical evidence was to the effect that the blood pressure and pulse recordings made during the liposuction procedure did not indicate any "*sympathetic stimulation associated with excessive pain"* was also relevant.

4.9 **IN** relation to Dr Walker's evidence, Dr Futter expressed the view that a direct comparison between Dr Walker's and Dr Chan's competence might not be appropriate. Dr Walker is a well-trained, experienced, specialist anaesthetist. Dr Chan is a cosmetic surgeon. He suspected "*that many non-anaesthetically trained specialists would do little better than Dr Chan if providing sedation*."

4.10 **IN** relation to the ANZCA Guidelines, Dr Futter confirmed that many proceduralists (surgeons, endoscopists, radiologists) do not observe the Guidelines any more than Dr Chan appears to have done.

Ms Braid:

4.11 **MS** Braid has been employed by Dr Chan for some ten years. She is an enrolled nurse, and assists Dr Chan in his clinic and in operations. Ms Braid confirmed that the complainant had first seen Dr Chan in 1993. She confirmed that when the complainant attended at the clinic in April 1996 she would have seen her, but she did not specifically recall that consultation.

4.12 **MS** Braid gave evidence as to her customary practice on such occasions, and gave evidence as to the events of 30 May 1996. In the absence of any direct recall, Ms Braid gave her evidence on the basis of what was recorded in the Operation Sheet, and usual practice.

5. THE DECISION:

5.1 **HAVING** heard the evidence referred to herein, and for the reasons set out below in relation to each of the Particulars of the Charge, the Tribunal is satisfied that the Charge is proven and

that Dr Chan is guilty of professional misconduct (s. 104(1)(c)). This determination is made notwithstanding that the Charge was laid at the level of disgraceful conduct.

6. REASONS FOR DECISION

Previous charges:

6.1 **IN** bringing this complaint, the CAC referred to disciplinary charges brought against Dr Chan in 1995 and 1996, which resulted in findings of professional misconduct against him. Appeals against both of those findings were subsequently dismissed by the Medical Council, and, in one case, by the High Court.

6.2 **THE** circumstances giving rise to the complaint which was the subject of the 1996 disciplinary proceedings were strikingly similar to those which gave rise to this present complaint. In finding Dr Chan guilty on that occasion, the Medical Practitioners Disciplinary Committee imposed a number of conditions on Dr Chan's right to practise as a medical practitioner.

6.3 **MOST** relevantly in the present context, those conditions from the decision of the Medical Council included:

Conditions on practice pursuant to Section 43(2)(ba)

The Medical Council imposes the following conditions on Dr Chan's right to practise as a medical practitioner:

(a) Dr Chan shall make it clear in all advertising material that he is not a vocationally registered surgeon.

(b) He shall ensure that he consults with all patients prior to their consenting to proceed with treatment or surgical procedures, such consultation to include the patients being seen and to be viewed and examined by him preoperatively.

(c) Dr Chan shall ensure that qualified medical staff are present and properly monitor patients during recovery periods, after any surgical procedures are undertaken.

(d) Dr Chan shall ensure that adequate patient records are completed and maintained.

(e) Dr Chan shall ensure that all patients receive adequate postoperative consultations with and treatment by him or an appropriately experienced practitioner.

(f) Dr Chan shall ensure that any premises on which he undertakes minor surgery are appropriately equipped and maintained for the purpose of minor day surgery.

6.4 **THE** 1995 disciplinary proceedings brought against Dr Chan also resulted in findings that he was guilty of professional misconduct and the imposition of conditions on his right to practise.

6.5 **HOWEVER**, on both occasions the lodging of appeals to the Medical Council and subsequently also to the High Court, resulted in the conditions being stayed pending the outcome of the appeals. Only the 1995 decision of the Medical Council eventually was the subject of a judgment from the High Court. Whilst the judgment dismissed the appeal, the Court determined that, due to the passage of time since the conditions were imposed, it would be unfair to order that the conditions take effect from the date of the appeal judgment. The conditions were permanently stayed.

6.6 **THE** effect of lodging appeals in respect of the decision of the MPDC was therefore to postpone, and ultimately to avoid entirely, the imposition and enforcement of the conditions on practice ordered by the MPDC, and upheld by the Medical Council.

6.7 **IT** was the case for the CAC that the purpose of presenting evidence of previous disciplinary charges, and their outcomes, was not to attack Dr Chan's character, but to establish the nature and extent to which deficiencies in his practice had been identified to him and his knowledge of official condemnation of his failure to obtain the informed consent of patients who presented for liposuction therapy.

6.8 **IT** was asserted by Mr Harrison QC on behalf of the CAC that "*It is irrelevant for [present] purposes that the imposition of the conditions was suspended, whether by process of appeal or otherwise. It is the spirit and intent of those conditions which is important. ... The conditions are ... a warning or guideline to Dr Chan about how he should conduct his practice for the future."*

6.9 **IN** essence, the case for the CAC was that the conditions had been imposed for the protection of the public, and it was the message which was inherent in the conditions which was important. Dr Chan had ignored authoritative warnings that his conduct, if repeated, was placing members of the general public at significant risk.

6.10 **ACCORDINGLY**, it was submitted by the CAC, Dr Chan's conduct was disgraceful for its wilful and flagrant disregard of the message inherent in the findings of both the MPDC and the Medical Council. In placing evidence before the Tribunal as to what had occurred on

previous occasions when Dr Chan had faced disciplinary charges, it was not the case that the CAC was inviting the Tribunal to revisit previous complaints, or that this present charge was laid as a de facto means of enforcement of or punishment for Dr Chan's failure or otherwise to comply with orders made by those disciplinary bodies.

6.11 **HOWEVER**, whilst the Tribunal allowed this evidence to be presented, and it has carefully considered Mr Harrison's submissions as to the basis upon which the CAC sought its production and consideration by the Tribunal, it has determined that any acceptance of it, even for the limited purpose for which is submitted, would be unfair to Dr Chan, and in breach of the requirement that the Tribunal shall observe the rules of natural justice contained in Clause 5, First Schedule to the Act.

6.12 **THE** charge which is now the subject of the Tribunal's deliberations must stand or fall on its own merits; it cannot be bolstered or otherwise elevated to a more serious charge than is warranted on its own facts and circumstances by the incorporation of extraneous considerations, such as previous charges and findings of professional misconduct.

6.13 **ANY** acceptance of the argument that the conduct and circumstances which are the subject of this present charge are made more deserving of condemnation by the fact of previous charges with their concomitant findings of professional misconduct and the imposition of conditions, would inevitably constitute a revisiting of, and retrospective punishment for, conduct that Dr Chan has already answered for.

6.14 **THIS** is especially so given that Dr Chan is entitled by law to lodge an appeal against any decisions of the MPDC and the Medical Council. He cannot now be prejudiced by the fact that he elected to exercise his rights to appeal. If the effect of his exercising his legal rights was to enable him to avoid the imposition of conditions on his practice, that is not a matter that this Tribunal can revisit in the context of its determining the charge now before it.

6.15 **EVIDENCE** of earlier findings of professional misconduct, and the consequences of those, can only be relevant if Dr Chan is found guilty in relation to this present charge, and the Tribunal is required to determine penalty. The extent to which this Tribunal can then take the earlier matters into account, at that stage, will be a matter to be dealt with quite separately and after receiving submissions on the point from Counsel.

6.16 **ACCORDINGLY**, the Tribunal has put all of the evidence relating to the prior charges aside and treated it as irrelevant in the present context. No part of the material presented to the Tribunal in this regard has been taken into account in this Tribunal's deliberations on the present charge.

The level of the Charge:

6.17 **FOR** Dr Chan, Mr Hodson QC submitted that the Charge, having been laid at the level of disgraceful conduct, must be proven at that level, or dismissed. That is he submitted that the charge could only be disgraceful conduct or nothing at all. Mr Hodson quite correctly in the Tribunal's view, acknowledged "at once" as a matter of legal principle, that the Tribunal could amend the charge, and that a charge of disgraceful conduct may at the end of the day be found only to be professional misconduct or conduct unbecoming.

6.18 **HOWEVER**, Mr Hodson submitted, the issue as to whether or not charges could be laid in the alternative was debated at the time this Tribunal came into existence. Ultimately the issue was settled on the basis that charges should not be laid in the alternative, but that the Act required that charges must be laid at the level considered by the CAC or Director of Proceedings to be appropriate given the facts and/or allegations comprising the grounds for the charge.

6.19 **MR** Hodson argued that the problem with laying a charge at the top of the hierarchy of charges is that the Tribunal is going to be faced with charges of disgraceful conduct because "*as all prosecutors do*," CAC's and the Director of Proceedings will lay charges at the top level "*hoping they will have something on the way through*".

6.20 **IF** this was the case, the effect would be that the prosecuting party, by opting to charge at the highest level and inviting the Tribunal to exercise its discretion to find the charge proven at a lower level, would be laying charges in the alternative.

6.21 **MR** Hodson is correct in arguing that s.109 and Clauses 5 and 14 of the First Schedule theoretically permit what would amount to an exploitation of the Tribunal's discretionary right to amend the Charge or to find the charge proven at a lower level of professional misconduct. However, it is the Tribunal's view that such conduct would clearly be in breach of ss. 92, 93, 94 and/or 102 of the Act.

6.22 **AS** such, it seems to the Tribunal that the decision as to the appropriate level of a charge laid under ss. 92, 93, 94 or 102 is a decision on the part of the CAC or the Director of

Proceedings that is susceptible to judicial review proceedings if clearly inappropriate, unreasonable or otherwise laid in bad faith or amounting to an abuse of process. The Tribunal also notes that s.93(b) expressly requires a CAC to "*Frame an appropriate charge …*", thereby providing a standard against which the reasonableness of the level of charge laid by a CAC can be assessed and of course, the level of the charge is but one component of the charge encompassing as it does the allegation/s giving rise to it, and such particulars as are necessary to give the respondent fair and reasonable notice of the case against him or her.

6.23 **THE** Tribunal has also adopted the practice of holding Directions Conferences as soon as possible after a Charge is presented. It is open to Counsel to raise the issue of the level of the Charge at an early stage, and to put the Tribunal on notice that the level of the Charge is contested, and that the Tribunal will be invited to exercise its power to amend the Charge at an early stage of the hearing. There have also been instances recently of charges, and/or particulars, being amended by agreement between the parties prior to hearing.

6.24 **THE** Tribunal is therefore satisfied that the terms of Act prohibit the sort of prosecutorial conduct suggested by Mr Hodson, and that there is a fair opportunity for the parties to discuss the charge at an early stage of the proceedings.

6.25 **IN** this present case, it does not consider that the decision of the CAC to lay the Charge at the highest level was inappropriate, notwithstanding that ultimately it is not satisfied that the Charge is proven at that level. In coming to this view one of the factors which the Tribunal has taken into account is the evidence presented in relation to the previous charges and findings

of the MPDC and the Medical Council and the purpose for which that evidence was given to the Tribunal.

6.26 **ALTHOUGH** the Tribunal ultimately decided that evidence was irrelevant for the purposes of considering this present Charge, the presentation of that evidence, the nature of the allegations made in relation to that evidence, and the way the case for the CAC was presented generally, was consistent with the Charge being laid at the highest level. The Tribunal therefore does not consider that there was any element of bad faith on the part of the CAC in deciding to lay the Charge at the level of disgraceful conduct however, having carefully considered all of the evidence it ultimately determined was relevant, the Tribunal is satisfied that the Charge is upheld at the level of professional misconduct.

OTHER FACTORS:

The Standard of Proof:

6.27 **IT** is well-established that the standard of proof in disciplinary proceedings is the civil standard, on the balance of probabilities. 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. At the level of disgraceful conduct, the highest level of charge, the standard will move accordingly closer to the criminal standard; beyond reasonable doubt.

Disgraceful conduct:

6.28 **DISGRACEFUL** conduct is conduct deserving of the strongest condemnation. It includes conduct which falls well short of the standards accepted by the practitioner's peers. In *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71, the Court held:

" … 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 ***Pillau v Messiter****, 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."*

6.29 **ONCE** the Tribunal determined not to take into account any of the evidence and allegations presented in relation to the previous disciplinary charges, findings and decisions, it was necessary to consider the present charge entirely on its own merits. Having completed that task, the Tribunal was not satisfied that the Charge was established at the level of disgraceful conduct and it was necessary then for the Tribunal to determine whether or not it was satisfied that the Charge was established at a lower level.

Professional misconduct:

6.30 **THE** test for professional misconduct is also well-established, see for example, *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369, 375:

"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. … "

Professional misconduct established:

6.31 **THE** Tribunal is satisfied that two of the Particulars supporting the Charge are established, and that the conduct in relation to those Particulars does meet the test for professional misconduct. In relation to the others, the Tribunal is satisfied that one is proven at the level of conduct unbecoming a practitioner and that reflects adversely on Dr Chan's fitness to practice medicine. The others are not proven.

6.32 **IN** accordance with the decision of the Court of Appeal in *Duncan v MPDC* [1986] 1 NZLR 513, the Tribunal, faced with a comprehensive charge, considered each of the Particulars supporting the charge separately, and, having made findings on each of the Particulars, then determined the overall gravity of the conduct of which it found Dr Chan guilty.

7. FINDINGS IN RELATION TO PARTICULARS:

Particular 1 - Pre-operative conduct:

Failing to obtain [the complainant's] informed consent to the liposuction operation conducted by him on 30 May 1996.

7.1 **A** significant issue with regard to this Particular is the circumstances surrounding the complainant's signing the Consent Form dated 24 April 1996. The complainant is adamant that she did not see Dr Chan on this occasion, and that her consent to the liposuction operation was obtained by Dr Chan's nurse, Ms Braid.

7.2 **NEITHER** Dr Chan nor Ms Braid recall the events of 24 April 1996, both rely on what they say is their customary practice, and are equally adamant that the complainant would have seen Dr Chan before signing the consent form. Dr Chan also relies upon his handwritten notations which appear on the Information Schedule as evidence that he did see the complainant when she attended at his clinic on that date.

7.3 **THE** Tribunal found each of these witnesses to be credible witnesses, and is satisfied that any mistake on the part of the complainant is no more than that. However, while neither of Dr Chan and Ms Braid were able to remember the occasion at all, the Tribunal is satisfied that

Dr Chan should be given the benefit of the doubt on this issue on the basis of the corroborative evidence provided by the handwritten notations.

7.4 **THE** Tribunal acknowledges that the notes on the Information Sheet dated 24/4/96 are almost identical to those appearing on the Information Schedule completed on the occasion of the complainant's consultation with him in 1993, and, on that basis, and, as such, could have been recorded at any time.

7.5 **HOWEVER**, when questioned, Ms Braid corroborated Dr Chan's evidence and stated that, in her experience, Dr Chan had never recorded information on a chart except contemporaneously with the information being obtained. She was sure that he would not have recorded the information on the chart unless he had ascertained the information himself, and on the date recorded.

7.6 **ACCORDINGLY**, on the balance of probabilities, the Tribunal finds that Dr Chan did see the complainant on 24 April 1996, and that it was after seeing Dr Chan that the complainant would have booked her surgery and signed the consent form.

7.7 **HOWEVER**, the Tribunal finds that whether or not Dr Chan saw the patient on that date, does not determine the issue as to whether or not Dr Chan obtained the complainant's informed consent to the liposuction procedure. Having regard to the totality of the evidence available in this regard, the Tribunal has determined that whether or not Dr Chan saw the complainant on 24 April 1996, the consent process he follows is plainly inadequate and falls short of the standards accepted for a practitioner in his position.

7.8 **THE** Tribunal therefore finds that Dr Chan did fail to obtain the complainant's informed consent for the liposuction surgery and that this Particular is established and constitutes professional misconduct.

The information brochure:

7.9 **DR** Chan clearly relies heavily upon the Information Brochure to provide information to his patients. However, it is clear that the Brochure is intended as a marketing tool for "Liposculpture", rather than being truly informative. It is obviously a very influential piece of information, but it has the potential to mislead patients in several respects, principally because of its implicit intention to persuade rather than to inform.

7.10 **FOR** example, in its title it refers to *"Permanent Fat Removal"*. While this may be technically correct, liposuction does permanently remove *fat cells*, but Dr Chan stated in evidence that it may not permanently remove *fat deposits.*

7.11 **THE** consent form requires the patient to confirm that the patient is "*aware that the practice of medicine and surgery is not an exact science and that the results cannot be guaranteed. No such guarantee has been given to me as to the results of this procedure*." But given the tenor of the brochure, including the photographs, most notably the photograph on the front cover, it is unclear what the *"guarantee"* is intended to refer to; and what aspect of the procedure is *"not guaranteed"*?

7.12 **IN** the first line of text, the brochure states "*liposculpture is a simple and effective surgical process that has become the most popular procedure in the western world for*

permanently removing excess fat deposits." It was Dr Chan's evidence that notwithstanding this advice, the patient understands that the operation may not be successful in permanently removing fat because "*it's in the consent form. The patient acknowledges it is not an exact science."*

7.13 **AS** the complainant stated, she knew that she had to be realistic. She did not expect to come out of the procedure as a *"hot babe"*. On that basis, it would seem reasonable for patients not to expect idealistic or overly optimistic results to be *"guaranteed"*. The undertaking as to 'no guarantee' contained in the Consent Form is meaningless.

7.14 **SECONDLY**, the brochure makes no mention of risk. The brochure does make mention of *"some swelling"* but only in the context of some swelling masking the full benefits of surgery. It mentions bruising, but assures the patient that the latest techniques, instrumentation and medication used at Dr Chan's centres minimises bruising considerably.

7.15 **THE** brochure states that all procedures are performed using "*mild sedation and local anaesthesia and are safe and quite painless. There may be some post operative discomfort which can be controlled by a mild analgesic such as panadol."* All of this information is given against the assurance, in the opening line, that the procedure is "*simple*", but plainly it is not.

7.16 **FINALLY**, the brochure states:

"Your procedure is performed by internationally acclaimed Cosmetic Surgeon Dr Warren Chan M.B.B.S (Hons) (Syd)

Board Certified Member of the International Society of Plastic, Aesthetic and Reconstructive Surgery; Member of the American Society of Liposuction; Fellow of the American Academy of Cosmetic Surgery; Honorary Professor of the Spanish Society of Aesthetic Surgery."

7.17 **DR** Chan conceded that the International Society of Plastic, Aesthetic and Reconstructive Surgery is not recognised by the Medical Council of New Zealand and he has no specialist qualification as a plastic surgeon. The complainant said that had she known that Dr Chan was not a specialist plastic surgeon she would not have gone ahead with the liposuction operation under his care.

Other information provided:

7.18 **IN** addition to the brochure, Dr Chan relies upon his nurse employees to inform the patient generally about the procedures he offers, and to answer any questions or inquiries. He also provides information in the course of his consultation with the patient, and he and his nurses provide the names and contact numbers of former patients so that prospective patients can talk to someone who has undergone the procedures.

7.19 **DR** Chan assessed the time he typically spends with patients to be 15 - 25 minutes. During this time he questions them about their general health and any allergies, examines their skin tone and the areas they wish to have treated. He answers any questions they might have. He also sees the patient very briefly immediately prior to surgery, but this is after the patient has been prepared for surgery and pre-medicated.

7.20 **THE** procedure for obtaining the signed consent is normally completed by a nurse after the patient has decided to proceed and is booked in for surgery. The consent form is signed in the presence of the nurse.

Informed consent:

7.21 **DR** Chan is clearly of the view that, in his hands, there is no risk, because of his experience and expertise the procedure is *"simple"*, and, because none of his patients have died or suffered serious complications, any risks are hypothetical; therefore there are no risks, and no obligation to warn. The Tribunal considers this approach to be an arrogant assertion of infallibility on the part of Dr Chan, and, as long as he can continue to practise without any accidents, his patients are not receiving a true summation of the risks of undertaking a liposuction procedure.

7.22 **MORE** significantly, Dr Chan is ignoring any obligation on his part to inform his patients about matters material to their decision to undergo the surgery. It is a seriously flawed approach, and demonstrates either a fundamental misunderstanding on the part of Dr Chan about the concept of "informed consent" and his obligations to his patients, or an indifference to accepted professional standards.

7.23 **IT** is relevant in this regard to note that the liposuction surgery is elective surgery carried out for aesthetic reasons only. The patient truly does have a choice about whether or not to proceed. It is not a situation where the patient must weigh the risks of therapy against the risks of declining treatment. In the circumstances of a purely elective procedure, any risk may be material; the risks should be spelled out for the patient, probably more than once. Dr Chan's

approach gives no credence to the significance of the elective nature of the procedure, and that the Tribunal regards as problematical.

7.24 **BECAUSE** he relies so heavily on the information brochure, the amount of information which Dr Chan's patients obtain depends very much upon the questions they may ask him, and information given to them by his staff, or former patients. The patient has to seek out the information.

7.25 **IT** is now well established that the leading case on informed consent is *Rogers v Whittaker* (1992) 175 CLR 479, a judgment of the High Court of Australia, and followed in New Zealand by in *B v Medical Council of New Zealand* (High Court, Auckland HC 11/96).

7.26 **IN** *Rogers v Whittaker*, a case concerning the provision of information in circumstances where the patient had to make a decision as to whether or not to undergo an elective operation on her eye. The patient was blind in the eye which was to be operated on, and was concerned not to lose her sight in her 'good eye'. The surgeon considered that the risk that she might develop sympathetic opthalmia in her 'good eye' was so small that he did not warn the patient that was a potential complication. The patient had not specifically asked about sympathetic opthalmia, but had made it plain that she was anxious about any risk to her 'good eye' as a result of the surgery.

7.27 **THE** Court had no difficulty accepting that medical practitioners are under a duty to exercise reasonable care and skill in the provision of information sufficient to enable the patient to exercise a choice in accepting or rejecting treatment, and in determining that there is a

"fundamental difference" between diagnosis and treatment on the one hand and the provision of advice or information to a patient on the other hand:

> *"Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often decisive role to play; whether the patient has been given the relevant information to choose between undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. … Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information."* (p 489 - 490)

7.28 **THE** concept of informed consent is based upon the patient's right to self-determination. In *Reibl v Hughes* [1980] 2 SCR 980 a judgment of the Supreme Court of Canada, the Court rejected a test of the '*adequacy*' of the information imparted based on the standards of medical practitioners as inconsistent with the patient's "*right to self-determination on particular therapy*". In considering whether a doctor had disclosed risks which were "material" to the patient, the test was not based upon the assessment of a reasonable doctor, but rather a *reasonable patient*:

> *"[a] risk is thus material when a reasonable person in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in determining whether or not to forego the proposed therapy. …*
>
> *The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities [diagnosis and treatment] by reference to applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment."*

7.29 **THE** result of such an analysis in the context of the circumstances that exist in this case are that Dr Chan was under an obligation to inform the complainant about matters material to her decision whether or not to undergo liposuction, and in particular to inform her about any risks.

Any risks inherent in treatment competently carried out, risks which were not insignificant, should have been disclosed.

7.30 **THE** complainant should have been given an accurate account of what the operation involved and how it would be carried out. The marketing brochure does not, in the Tribunal's view, adequately fulfill that requirement. Dr Chan also gave evidence that his customary practice is to tell patients that "*any surgery carries risk of infection, bleeding applicable to liposculpture, skin unevenness or contour defects which normally doesn't happen in my hands, sometimes area of numbness which normally is totally reversible*." With regard to pain, he would tell patients that they would be "*comfortable*".

7.31 **DR** Chan's obligation also extended to providing a proper explanation of the anaesthetic to be administered, the post-operative procedures and the availability of pain relief, and the nature of any follow-up care.

7.32 **THAT** obligation does not depend upon the patient's ability to ask the 'right' questions, nor can it be delegated by Dr Chan to his staff or former patients.

7.33 **IN** terms of other information which the complainant considered to be 'material' Dr Chan should also have made it clear to his patients that he is a general practitioner who practises as a cosmetic surgeon, he is not a plastic surgeon and he does not hold any specialist qualification. His qualifications as described in the marketing brochure are plainly misleading in this regard.

7.34 **THE** complainant gave evidence to the Tribunal that she *"was shocked to discover"* that Dr Chan was not a registered plastic surgeon, and that she would have declined to have the operation performed by Dr Chan had she been told that he was not a registered plastic surgeon. Whether or not that is so, and it cannot of course be proved or disproved, it is clear that the complainant considered her options over a long period of time. Having found that the brochure is misleading in this regard, it is not unreasonable for the complainant to now assert that accurate information as to Dr Chan's qualifications was information that was 'material' to her decision to undergo liposuction performed by him.

7.35 **THE** complainant's evidence was that Dr Chan did not provide any information to her regarding:

- the nature of the operation
- the risks of the operation
- the type of sedation to be used, for example, what a local anaesthetic involved (she thought that she *"would be out to it"*)
- the use of anaesthetics and drugs to be used and their effects, including side effects and risks
- she was not offered any option as to the use of a local or general anaesthetic
- any alternatives to liposuction
- post-operative care
- follow-up visits or review, for example, she was unaware that the cost of the surgery included a three month review consultation with Dr Chan.

7.36 **THE** complainant was provided with information sheets containing "Pre Operative Instructions" and "Post Operative Instructions", but it is unclear exactly when these were given to her, and by whom. On the available evidence, it is most likely that these were given to her by Ms Braid at the time the complainant booked her surgery, and signed the consent form. There is no evidence that they were given to her by Dr Chan, or that he explained the information contained in them to her in any way.

7.37 **FINALLY**, it is relevant to note the comments made by Her Honour the Chief Justice in a paper on the topic of informed consent given at the Brookfield's Medical Law Symposium held in Auckland in June 1999:

"It is clear that where proposed treatment, ***even if skilfully performed****, carries a "material" risk, a patient has a right to be informed of those risks. ... it seems to me that the reality is that the Courts will not defer to clinical judgment of medical practitioners as to what a patient should be told. Informed consent to treatment is a pre-condition of such treatment. The patient's right imposes a concomitant duty on the medical practitioner to inform. Such a duty necessarily arises out of the relationship between a health professional and a patient. Whether that duty has been performed in the particular case depends upon all the circumstances and is not determined by medical practice."* (emphasis added)

7.38 **THESE** comments are entirely consistent with the rights of a patient to receive information which are confirmed in the Medical Council's *Statement For The Medical Profession On Information and Consent* (1985):

"… the proper sharing of information, and the offering of suitable advice to patient, 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.

7.39 **ACCORDINGLY**, the Tribunal is satisfied, on the balance of probabilities, that Dr Chan did not adequately inform the complainant, and further, that the evidence he gave as to his

approach to the giving of advice and information to patients about the nature and risks of liposuction is indicative of general poor medical practice in regard to other patients.

7.40 **IN** light of the finding that Dr Chan has demonstrated a fundamental misunderstanding of, or indifference to, the meaning of "informed consent", and its centrality to the doctor-patient relationship, the Tribunal is satisfied that Dr Chan's failure to obtain informed consent is conduct which departs significantly from accepted standards, particularly when measured against the Medical Council's Statement referred to in paragraph 7.38 herein.

7.41 **INFORMED** consent is the bedrock of the doctor-patient relationship. It is perhaps most succinctly stated in Kennedy & Grubb's *Principles of Medical Law*, at p.110:

"Consent, or more accurately the need for it, is the legal reflection of the ethical principle of respect for autonomy. In this particular context, the notion might be better expressed as a respect for a person's bodily integrity stemming from a right of self-determination. It is a fundamental principle, now long established, that every person's body is inviolate."

7.42 **A** failure to obtain informed consent, especially if indicative of a general failure to understand the significance of the need to obtain proper informed consent, and of the patient's right to give informed consent, and even if not causative of some transpired risk, cannot be regarded as anything other than a very serious departure from accepted standards of medical practice; *B v The Medical Council* (supra).

7.43 **THE** Tribunal is therefore satisfied that Particular (a) is proven at the level of professional misconduct.

Particular 2 - Pre-operative conduct - Failing to undertake a satisfactory and effective consultation with and assessment of [the complainant] before the operation

7.44 **IN** large part this Particular overlaps Particular 1 and several of the same considerations, legal issues and evidence are relevant. However, the Tribunal has treated Particular 2 as relating to the Pre-operative period between the date of the complainant's consultation on 24 April 1996 and the date of her operation on 30 May 1996.

7.45 **THE** Tribunal is satisfied, having found that Dr Chan did see the complainant on 24 April 1996, that the consultation must have been very brief (possibly because he had seen her three years previously), and limited to no more that Dr Chan's ascertaining the patient information he has recorded on the information sheet.

7.46 **IT** is perhaps relevant to record that in the second of the Information Schedules, the areas for liposuction have been recorded in Ms Braid's handwriting (apparently on the advice of the complainant), and there is no record about "*skin tone*". Dr Chan told the Tribunal, that "*if I haven't seen the patient obviously I would see the patient because the skin tone is very important to decide the outcome so I always assess the skin tone of the patient*." The omission of this information on the second sheet, together with the complainant's inability to recall seeing Dr Chan at all, is strongly suggestive that any communication between Dr Chan and the complainant on 24 April 1996 was very limited.

7.47 **IN** the absence of his providing proper information about the technical nature of the procedure, the sedation to be used, any other options or alternatives, as well as the risks and potential complications (Particular 1 established), the Tribunal also finds the consultation of

24 April 1996 not a satisfactory and effective pre-operative consultation or assessment of the complainant.

7.48 **THE** Tribunal took into account the fact that Dr Chan did consult with the complainant in 1993. Dr Lovie, whose report for the CAC was also presented to the Tribunal, said that he regards any consultation or discussion carried out in 1993 as "*not being satisfactory for a procedure carried out in 1996.*" The Tribunal agrees with that opinion and considers that this earlier consultation was too long before the relevant operation to count either as a satisfactory and effective pre-operative consultation, or for that matter, as a consultation for the purposes of obtaining the complainant's informed consent three years later.

7.49 **THE** only other opportunity for a proper pre-operative consultation and assessment of the complainant was on the day of the operation, 30 May 1996. The complainant's evidence was that she saw Dr Chan "*in his office adjoining the surgery, where the surgery took place*". This was after she had been given pre-operative medication. She said Dr Chan asked her if she still wanted to have surgery. She said she was a little unsure but thought about the deposit she had paid and decided to go through with it.

7.50 **DR** Chan denies this account. He said that he would only have asked the complainant if she had any questions. Both Dr Chan and Ms Braid gave evidence of their intention that the patient remain calm and relaxed immediately prior to surgery. Again, neither of them have any specific recollection of the events of 30 May 1996, and the complainant is at the disadvantage of giving evidence of events which occurred after she had been given drugs which "*inevitably*" make her memory of events unreliable.

7.51 **THE** only consistent theme between the three accounts is that, as a matter of customary practice, any communication between the patient and Dr Chan occurs after the patient is pre-medicated, and is limited. It cannot by any measure be characterised as a satisfactory and effective consultation or pre-operative assessment of the patient. The Tribunal is satisfied that this was the case with the complainant on 30 May 1996.

7.52 **ASSOCIATE** Professor Liggins, in his report, conceded that "*there are no absolute yardsticks of standards, particularly ethical standards*". He provided a description of his own personal opinions and practice which he "*deemed to be both acceptable and wise*" and "*the common practices of my colleagues which may therefore represent a community standard*."

7.53 **ASSOCIATE** Professor Liggins indicated to the Tribunal that it is his practice, and the practice of his plastic and reconstructive surgical colleagues, to be primarily involved in such consultations:

"*Since the surgeon bears the ultimate responsibility for the patient's care then it is difficult to imagine that this can be delegated to someone else. Only the surgeon can explain and answer questions about the technical nature of the surgery and the risks, complications and likely benefits.... It is my experience that the pre-operative consultation is quite time consuming and frequently occupies more time than the surgery itself. I regard this as time well spent as it gives the patient a realistic expectation of the results and it also identifies possibly contra indications to the procedure which may lead to the operation being called off. It seems to me that in the circumstances of this particular case the scheduling and preparation had reached such an advanced stage that it was almost impossible for anyone to change their minds by the time the surgeon met the patient. When the money has been paid and the patient is in the operating theatre and in an operating gown and sedated, it is for practical purposes impossible to change the plan at that stage.*"

7.54 **THE** Tribunal considers that this is a good statement of the minimum standards which a reasonable and competent general practitioner with a specialised area of surgical practice and

holding himself out to the public as possessing and practising specialist skills and experience ought to meet. It is satisfied that Dr Chan fell well short of such standards in his care of the complainant.

7.55 **ACCORDINGLY**, and taking that finding of falling short of accepted standards into account together with it's findings in respect of Particular 1, the Tribunal is satisfied that Particular 2 is established.

7.56 **AS** to the gravity of Dr Chan's failure to undertake a satisfactory and effective pre-operative consultation with and assessment of the complainant, this must be measured again by the extent to which it departs from proper standards, in this case the standards described by Associate Professor Liggins in his report. Further, Dr Chan is holding himself as a specialist practitioner. He cannot take the benefit of that without also taking responsibility for meeting the obligations and profession's standards that go with that status.

7.57 **IN** *Ongley v Medical Council of New Zealand* (supra), the Court said:

"The structure of the disciplinary processes set up by the Act which rely in a large part upon judgment of a practitioner's peers, emphasises that the best guide to what is acceptable professional misconduct is the standards applied by competent, ethical and responsible practitioners."

7.58 **IN** *Pillai v Messiter (No 2)* (1989) 16 NSWLR 197, the test was put in stronger terms:

"But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession, something more is required; it includes a deliberate departure of 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."

7.59 **BOTH** of these cases were referred to with approval in the judgment of Elias J. in *B v Medical Council* (supra). In closing, Mr Harrison submitted that Dr Chan "*had asserted in his defence that because he does a huge number of operations he is effectively a law unto himself, and that he had abused his privileges and, in particular his obligation to obtain informed consent, to run what is a production chain of operations*."

7.60 **IT** is difficult to resist that submission. The overall impression is that Dr Chan is casual to the point of indifference about his professional obligations to inform, prepare and take any meaningful professional interest in his patients' well-being. He appears not to think about his patients as persons, so much as procedures. The Tribunal considers that Dr Chan's conduct in this regard constitutes a significant departure from accepted standards and constitutes professional misconduct.

7.61 **ACCORDINGLY**, and taking into account all of the evidence available in respect of this Particular, the Tribunal is satisfied that Particular 2 is proven at a level of professional misconduct.

Particular 3 - Operation - Failing to:

(a) **undertake an adequate course of study in cardio-respiratory systems and to achieve an appropriate degree of CPR certification before operating on [the complainant]**
(b) **implement an adequate and effective system for using IV sedation or management of an emergency during the operation;**
(c) **ensure the presence of properly functional emergency equipment during the operation.**

7.62 **AS** the party bearing the burden of proof, the CAC was required to establish, as a threshold, exactly what would be an adequate course of study in cardio-respiratory systems, and an

appropriate degree of CPR certification for operating on the complainant. It is the Tribunal's determination that the CAC failed to do so.

7.63 **DR** Chan gave evidence of his attending short courses in CPR; one of which he completed prior to 1996. Apart from these courses, Dr Chan also completed training in CPR in the normal course of his medical training. Dr Futter's evidence was that he doubted "*that more than 10 to 20% of proceduralists providing sedation have recent certification in CPR (personal communication with the organiser of one of NZ's largest courses to provide instruction and certification*)." Accordingly, the Tribunal is satisfied that no departure from the usual and accepted standards on the part of Dr Chan was disclosed by the CAC.

7.64 **SIMILARLY**, there being no emergency arising in the course of the complainant's operation, or on any other occasion according to Dr Chan, it was not established that his system for using IV sedation or for managing an emergency arising during the operation, was deficient or inadequate in any way, or that he did not have available properly functional emergency equipment.

7.65 **DR** Walker's evidence for the CAC, whilst critical of some aspects of the record-keeping, did not specifically address any of the matters the subject of this Particular.

7.66 **ACCORDINGLY**, the Tribunal finds that Particular 3 is not established.

Particular 4 - Anaesthesia - Failing to:

(a) **provide an acceptable level of anaesthesia and pain relief in preparation for the operation**

7.67 **THE** Operation Sheet records that the complainant was given oral pre-medication comprising Prednisone 40 mgs, Valium 5 mgs, Palfium 5 mgs. None of the expert witnesses expressed any criticism of the pre-medication, which accords with standard, acceptable practice.

7.68 **ACCORDINGLY**, the Tribunal is satisfied that this Particular is not established.

Particular 4 - Anaesthesia - Failing to:

(b) respond appropriately to [the complainant's] complaints of pain during and after the operation

7.69 **THE** complainant's evidence was that, approximately ½ hr - 1 hr into the operation she experienced severe pain. She asked for pain relief and on the first request, she was given some more medication. However, when she asked for a second time, she was told that she could not be given any more relief.

7.70 **THE** complainant told the Tribunal that she was in and out of consciousness, and at the conclusion of the surgery, a close fitting garment was put on her by two nurses, she was assisted to another room where she was left on a bed to rest.

7.71 **SHE** continued to suffer a great deal of pain, and, when her brother came to take her home, she told him that she "*was never going to do that again*". This comment was overheard by a nurse who asked if she was alright. The complainant told the nurse that she "*had never been in so much pain in all my life*", and that she was in a lot of pain. The nurse gave the complainant's brother two telephone numbers to ring after hours if necessary. The

complainant was not given any pain relief. The complainant continued to suffer pain for 3 - 4 days.

7.72 **AGAIN**, neither Dr Chan or Ms Braid were able to recall details of the operation, and gave evidence on the basis of the record contained in the Operation Sheet and their customary practice. However, Dr Chan's evidence was unequivocal - he could not carry on his practice if he did not provide an acceptable level of anaesthesia and pain relief in preparation for his procedures. He aims to keep his patients "*comfortable*" throughout the procedure.

7.73 **HE** was adamant that if the complainant had asked for more pain relief he would not have declined to give it to her. In this regard it is relevant that he did not consider that the patient was at any time at the limit of the amount of pain relief which could safely have been administered to her. While the complainant had been given 100mg of pethidine this was "*not the ultimate dose - I could give more if need be and when the patient feels the pain I will inject more local anaesthetic and we are well below the limit in that regard. ...* " Dr Chan told the Tribunal.

7.74 **THE** drugs administered intraoperatively by IV over the 2 ½ hr period of the operation were midazolam (Hypnovel) 4mg, 3mg, 2.5mg (9.5mg total); pethidine 100mg; metoclopramide (maxolon) 10mg; cefotaxime (claforan) 1G. In addition, the liposuction technique used (the tumescent method) involves the continuous infiltration of a large amount of saline with diluted local anaesthetic, comprising xylocaine (Lignocaine), adrenaline and sodium bicarbonate. Dr Lovie referred to this technique as an "*excellent technique used today by the majority of surgeons carrying out liposuction*". Pain is known to be less with the use of this technique.

7.75 **IT** was Dr Sage's opinion provided for the CAC that:

"*Overall the amount of sedative and analgesic drugs used in this case on top of good anaesthetic technique could be expected to produce adequate patient comfort*.

Some mild or moderate discomfit of a similar sort to that experienced during shorter procedures ... would be expected in this case, with considerable variation in the level of stimulation throughout the procedure.

The profound and invariable anterograde amnesia produced by the benzodiazepine drugs used, and the associated possibility of hallucination and confabulation, make accurate recollection of intraoperative events by the patient impossible and misinterpretation likely.

The possibility that the sedation and analgesia was inadequate for this patient exists. The conversation between the patient and the nurse concerning dose is credible. The approximately five BP and HR observations recorded do not reflect sympathetic stimulation associated with excessive pain. ..."

7.76 **DR** Walker for the CAC agreed with Dr Chan's evidence that the level of pain experienced following liposuction is usually able to be alleviated by Paracetamol and an anti-inflammatory agent.

7.77 **THE** Tribunal accepts that the complainant's account of events is unreliable. As noted above, the Tribunal found all of the witnesses to be credible witnesses, albeit perhaps mistaken as to particular details. However, it cannot overlook the consistent nature of the evidence (and the clinical experience of some of its members) regarding the side effects of the cocktail of drugs administered to the complainant. It is well established that the degree of amnesia or other effect is variable, but it is impossible to be categorical as to whether the patient is amnesiac or not.

7.78 **ON** that basis, the evidence of Dr Chan and Ms Braid, together with the records available, must be preferred. The most 'independent' evidence is the Operation Sheet, and Dr Sage's opinion that the recordings do not indicate any sympathetic stimulation associated with pain, a statement that was not disputed by any other witness.

7.79 **BOTH** Dr Chan and Ms Braid gave evidence that patients are always asked if they have paracetamol or panadol available at home, and given some to take with them if they do not. If any more pain relief than that is required, it would be given on receipt of a request or complaint of pain referred to them. This would generally consist of Digesic tablets. All patients are given contact telephone numbers so that they can contact Dr Chan or the clinic if necessary.

7.80 **ACCORDINGLY**, the Tribunal is satisfied that if the complainant was in great pain this was not made known to the Dr Chan or the nursing staff, and they were unaware of the extent of the pain suffered by her. This Particular therefore is not established.

(c) arrange for a properly qualified anaesthetist to administer anaesthesia to [the complainant] and/or to remain present throughout the operation in accordance with paragraphs 2.2.1, 2.2, 2.4 and 2.6 of the policy documents provided by the Australian & New Zealand College of Anaesthetists

(d) understand adequately at all the appropriate Guidelines relating to sedation for surgical procedures in accordance with paragraph 2.3 of the policy documents

7.81 **IT** is convenient to deal with these two Particulars together. They both concern Dr Chan's adherence to the College's Policy Guidelines, a copy of which was provided to the Tribunal in the Agreed Bundle of Documents. The Tribunal has since had an opportunity to read the edition of the Guidelines which was current at the time of the events at issue, and is satisfied

that the copy produced does not differ in any relevant respects from that provided to it in the ABOD.

7.82 **ACCORDING** to Dr Walker, the Guidelines do not require that an anaesthetist administer sedation, and remain with the patient for minor procedures, provided the patient remains conscious and responsive throughout the procedure. The issue is the safety of the patient, particularly if an emergency develops and the surgeon must manage the emergency situation as well as operate on the patient.

7.83 **THE** operator must be skilled to deal with resuscitation problems, and with the equipment which would be used in an emergency. Operating as surgeon and administering sedation may be contra-indicated by pre-existing serious medical conditions in the patient, or the danger of airway compromise, or the patient's age, for example if the patient is very young or very old. Dr Chan's patients are all adult, and undergoing elective surgery.

7.84 **THE** most problematical of the Guidelines for Dr Chan would appear to be paragraphs 2.3, which addresses the practitioner's "*sufficient basic knowledge*" to safely administer sedation, and 2.6: "*Techniques which compensate for anxiety or pain by means of heavy sedation must not be used unless an anaesthetist is present*." To the extent to which the Guidelines were specifically referred to at the hearing, the Tribunal is satisfied that Dr Chan was familiar with them, and no significant departure from the Guidelines on the part of Dr Chan was disclosed.

7.85 **IN** terms of general adherence to the Guidelines among practitioners administering sedation in private surgeries and clinics, it was Dr Futter's evidence that the Guidelines "*are not followed as rigorously as I would wish*". Dr Futter, a Fellow of the Royal College, made this comment in the context of his knowledge of private practice in Auckland. His evidence was that "*while the College may prefer that specialist anaesthetists be present this is not widely practised throughout the country. While it would be appropriate for Dr Chan to have an anaesthetist present during a procedure on a patient undergoing a major procedure or who had given evidence of special concern I do not believe that this need be a standard required of him throughout his practice*."

7.86 **DR** Futter concluded his evidence by stating that "*there are many non- anaesthetists who practise techniques similar to this. They have gathered a lot of experience and I think they are doing the job very well. In the absence of evidence to the contrary I cannot [dis]agree with them.*"

7.87 **THUS**, while it may be desirable if Dr Chan were to adhere to Guidelines in all respects, there is no legal or professional requirement for him to do so. His evidence was that he had a great deal of experience in administering sedation for liposuction procedures. He is certainly a very experienced practitioner in liposuction surgery. He told the Tribunal that he is a very careful operator and he gives all directions in that regard in operations. He has always been assisted by two trained nurses, and more recently, by another practitioner.

7.88 **THE** Tribunal was satisfied that Dr Chan demonstrated a good knowledge of the pharmacology of the drugs he was using; the methods of administration and the safe limits of

medication. Accordingly, the Tribunal finds that Dr Chan's level of competence is not outside of or below the range of standards of practitioners operating in Auckland. It is true that he has not demonstrated his ability to manage an emergency situation, but equally, he has never been called upon in this regard.

7.89 **THE** Tribunal therefore finds that there is no evidence to suggest that Dr Chan is not a technically competent, careful and safe practitioner in this regard.

7.90 **ACCORDINGLY**, these Particulars are not established.

Particular 5 - Operative and Post-operative care:

Failing to provide:

(a) Continuous patient observation by adequately trained personnel both during the operation and in recovery in accordance with paragraph 2.5 of the policy documents;

(b) adequate post-operative care in an appropriate physical environment and with adequate and continuous monitoring.

7.91 **IN** large part the findings of the Tribunal in relation to Particular 4 overlap with Particular 5, and the Tribunal similarly finds that Particular 5 is not established.

7.92 **THE** Tribunal is satisfied that the recordings on the complainant's Operation Sheet evidence that Dr Chan was assisted in theatre by at least two nurses, including Ms Braid who monitored the patient and administered the titrated sedation under Dr Chan's supervision. Ms Braid, an enrolled nurse, has worked with Dr Chan for approximately 10 years, and is clearly also very experienced in assisting with liposuction surgery and in caring for patients' undergoing these procedures.

7.93 **THE** evidence given by the complainant in relation to the immediate post-operative period, during which she would have continued to be affected by the cocktail of powerful sedative drugs, cannot be relied upon, and is not supported by the evidence of Dr Chan or Ms Braid as to standard practices and systems in place at the clinic, and such independent evidence as there is available in the records made at the time.

7.94 **THERE** is no evidence presented that indicates that Dr Chan's operating theatre equipment and environs is inadequate or inappropriate in any way.

7.95 **ACCORDINGLY**, Particular 5 is not established.

Particular 6 - Management:

Failing to implement any or adequate systems of quality control, audit and peer review.

7.96 **THE** CAC provided the Tribunal with very limited evidence as to what is acceptable in terms of general standards of quality control systems, audit and peer review, against which it alleges Dr Chan's conduct ought to be measured.

7.97 **DR** Chan conceded that he did not have a formal quality control programme in place, nor was he aware of any other practice of a similar size embarking on such a process. It was his view that the best quality control is the satisfaction of his patients with the procedure and the results, and it must be noted that he operates in a very competitive commercial environment. He therefore has a strong incentive to maintain quality and high standards of competence and safety.

7.98 **DR** Chan is of the view that peer review is not practicable; there is no one as experienced as himself in New Zealand. This comment is of some concern to the Tribunal. Dr Chan has general registration and does not have any specialist vocational registration in any branch of surgery.

7.99 **CONSEQUENTLY**, Dr Chan is in effect practising in New Zealand in relative isolation and does not have any Collegial obligations for on-going education and is subject to very little, if any, peer review to maintain standards (although this may not be entirely by choice on his part). The Tribunal notes that by mid-2001 Dr Chan will be required to have vocational registration or to be working with oversight from a vocationally registered specialist medical practitioner.

7.100 **CURRENTLY**, the only means by which Dr Chan could be compulsorily subject to peer review would be by way of a Review of his competence pursuant to Section 60 of the Act. Such a review may be undertaken by the Medical Council at any time and whether or not there is reason to believe that the practitioner's competence may be deficient.

7.101 **HOWEVER**, in terms of this Charge and its supporting Particulars, the Tribunal finds that any failure on the part of Dr Chan to institute and maintain any formal systems of quality control, audit or peer review does not constitute conduct that falls below acceptable standards of reasonable and competent practitioners, whether vocationally registered or in general practice. The fact that this might constitute a wider 'systemic' failure of medical practice as it is currently legislated for in New Zealand is not a matter Dr Chan is required to answer for.

7.102 **ACCORDINGLY**, this Particular is not established.

Particular 7 - Management:

Failing to maintain adequate records of operations undertaken including records of case management and pulse oximeter in the context of IV sedation.

7.103 **THE** Tribunal considers that this Particular is too widely drafted for the purposes of this present Charge. The Tribunal can only deal with the evidence presented in relation to the complainant. No evidence of other operations, or of Dr Chan's general practices, was given, nor would it have been appropriate. Accordingly, the Tribunal dealt with this Particular on the basis that it alleged that the operation records completed in respect of the complainant were inadequate.

7.104 **ON** that basis, the Tribunal is satisfied that the record is deficient, and that it falls below acceptable professional standards. The Tribunal also records that Dr Chan acknowledged its deficiencies, and copy of the Operation Sheet now used by him was given to the Tribunal.

7.105 **IN** fact, no record of the operation in the nature of a formal note or record was made by Dr Chan. The only information available is that recorded on the Operation Sheet. The Tribunal considers that, at a minimum, any such operation record should be signed off by the practitioner who carried out the procedure as an accurate record. The record should be confirmed as correct. The operation record made on 30 May 1996 does not record such basic information as who was present, who took professional responsibility or accountability for the procedure, or the timing of the medications given. Such a record should comprise a basic quality control tool and evidence of professional accountability.

7.106 **THE** Tribunal did also carefully consider these deficiencies in the context of Particular 4(d). In relation to that Particular, and its more narrow focus of the ANZCA Guidelines, the Tribunal considered that the failure of Dr Chan to adhere to the Guidelines, in itself, was not a sufficient departure from standard practice to attract the sanction of a finding of a disciplinary offence. This was notwithstanding Dr Sage's opinion that "*the record itself is deficient in terms of the suggested Guidelines.*" However, in the context of this Particular, and its more general allegation, the Tribunal is satisfied that the operation record is a significant departure from the relevant professional standards.

7.107 **PERHAPS** most relevantly, Dr Futter, a very experienced and highly regarded practitioner, gave evidence that he was familiar with operation sheets generally used in public and private practice and, in his experience, the operation record was not satisfactory in terms of 1996 standards. The most striking deficiencies identified by Dr Futter were:

- the frequency of cardiovascular and respiratory recordings (every half hour only)
- no recording of the saturation of oxygen as noted from the pulse oximeter
- no timing of medications recorded
- all medications given should be shown, although he conceded that if an accepted ratio of the lignocaine and adrenaline cocktail was given, a record of the volume of mixture administered would be sufficient.

7.108 **DR** Chan told the Tribunal that, because the records were for his use only, and there was no instance of the patient being 'handed over' to another practitioner, he considered that the record was adequate. However, and taking into account the important function of an operation record, and the seriousness of the nature of the omissions identified by Dr Futter, the Tribunal does not accept that approach and finds that the operation record, with its paucity of information, does not constitute an acceptable discharge of Dr Chan's professional

obligation to maintain an accurate and complete record of the operation he performed on the complainant.

7.109 **AS** it has noted on a previous occasion, it is a fact of modern medical practice, especially in the context of a private commercial practice offering specialised care for specific and discrete procedures, that the medico-legal and risk management aspects of practice will loom as large as the clinical aspects and that a good standard of record-keeping is as important for the doctor as it is for the patient.

7.110 **THE** adequacy of the record must be judged against the standards of a reasonable, experienced practitioner in private practice providing specialist care. Dr Chan is not required to lead the way or to demonstrate the highest standards of medical record-keeping such as would provide a benchmark for his colleagues. However nor may he fall below the standard of his peers, and the Tribunal is satisfied that the operation record does constitute a sufficient departure from accepted standards to warrant the finding of a disciplinary offence. It therefore finds that Particular 7 is established.

Finding in relation to Particular 7:

7.111 **HAVING** found that the sanction of a finding of professional misconduct is warranted in relation to this Particular, the Tribunal went on to consider the appropriate level of such a finding and the seriousness of the sanction it should attract. The Tribunal also considered the seriousness of the departure from acceptable standards in relation to Particular 7, against that found in relation to Particulars 1 and 2. On that basis, the Tribunal considered the level of

culpability in relation to Particular 7 to be at a level of misconduct less than professional misconduct.

7.112 **IT** is by now well-established that the classification of conduct which attracts professional discipline requires an assessment of degrees; *B v The Medical Council* (supra):

"But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available.

A finding of conduct unbecoming is not required in every case where error is shown. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation. The threshold is inevitably one of degree."

7.113 **IN** *CAC v M*, (NP 4533/98, District Court, Auckland, 7/5/99) a case on appeal from this Tribunal in which the Court considered the meaning of "conduct unbecoming" with the so-called "rider", contained in Section 109(1)(c) Judge Doogue held that the essential features of conduct unbecoming given by Elias J "*would seem to cover the same ground as the new definition in the 1995 Act does. … The amendment of the section by the addition of the rider in no way affects the validity of Her Honour's assessment. In my respectful view, that remains a useful analysis of what amounts to conduct unbecoming"*. (at p 15)

7.114 **JUDGE** Doogue went on (at p 16-17) to find that:

"*[the 'rider'] does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. .. The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."*

7.115 **GALLEN** J also addressed the question of the relevant standards against which the practitioner's conduct should be judged in *Faris v Medical Practitioners Committee* [1993] 1 NZLR 60 as follows:

> *"Those standards must be fixed by Members of the Committee themselves but by doing so they must bear in mind they acted in a representative capacity and must endeavour to formulate standards which are themselves seen as representative rather than an expression of their own personal views."*

7.116 **TAKING** all of this into account, together with the findings made in relation to Particulars 1 and 2, the Tribunal is satisfied that Particular 7 is established at a level of conduct unbecoming and that conduct reflects adversely on the practitioner's fitness to practise medicine.

8. CONCLUSION:

8.1 **HAVING** considered each of the Particulars, and recorded its findings in relation to them individually, the Tribunal considered the Charge in its totality and concluded that the Charge as particularised is upheld at a level of professional misconduct. The Tribunal's decision is unanimous.

9. ORDERS:

9.1 **THE** Charge having been upheld, the Tribunal invites submissions from Counsel as to penalty. The timetable for making submissions will be as follows:

9.1.1 Counsel for the CAC should file submissions with the Secretary of the Tribunal and serve a copy on Counsel for the respondent not later than 14 working days from the date of receipt of this Decision.

9.1.2 In turn counsel for the respondent should file submissions in reply with the Secretary of the Tribunal and serve a copy on Counsel for the CAC not later than 14 working days from receipt of the CAC Counsel's submissions.

9.1.3 Costs are reserved.

DATED at Auckland this 29th day of October 1999

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal